A pilot study of the Routine Collection and Reporting of Consumer Perceptions of Care in Private Hospital–based Psychiatric Services

Report for the Private Mental Health Alliance and the Australian Government Department of Health and Ageing regarding the pilot study of the Feasibility and Utility of the Routine Collection and Reporting of Consumer Perceptions of Care in Private Hospital–based Psychiatric Services.

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Foreword

Information regarding consumers' perceptions of care is of great interest to all stakeholders concerned with the assurance of service quality and effectiveness. It is a critical component of an effective quality improvement process.

In the private sector a National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures has been implemented by all private–hospital based psychiatric services. Under the National Model standardised measures of Consumers' clinical status are collected at key occasions in the clinical path. Analyses of changes from one occasion to the next enable consumer outcomes to be evaluated. When linked with information on service utilisation, this data enables stakeholders to gain a comprehensive understanding of the effectiveness and efficiency of those services.

The collection, analysis and reporting of consumer perceptions of care will add a critical element to the overall process of evaluation, enabling consumers to give direct voice to their views regarding the quality and effectiveness of the care they receive.

The findings of this study clearly indicate that the routine collection and reporting of consumer perceptions of care by private hospital–based psychiatric services is both feasible and useful.

Ms Moira Munro
Deputy Chair and Private Hospital Representative
Private Mental Health Alliance

Acknowledgements

The Consumer Perceptions of Care Pilot study was undertaken by the Australian Medical Association with funds jointly provided by the Australian Government Department of Health and Ageing (under the National Mental Health Strategy), the Australian Private Hospitals Association and the Australian Health Insurance Association.

The AMA acknowledges the significant contribution of the many people who facilitated the completion of the study, including:

Ms Janne McMahon (chair of the *Private Mental Health Consumer Carer Network)*, Ms Moira Munro (CEO of the Perth Clinic, Deputy Chair of the Private Mental Health Alliance and PMHA Hospital Representative) and Ms Suzy Saw (at the time of the study, Director, Quality and Effectiveness, Mental Health and Special Programmes Branch, Australian Government Department of Health and Ageing). Their clear and strong support for consumer involvement within the quality improvement process was the key factor in enabling this study to be undertaken.

Members of the Private Mental Health Consumer Carer Network who participated in the initial detailed review of the MHSIP Surveys. Their careful consideration of the measures was instrumental in enabling participants to proceed with the study.

Consumers who completed the survey during the pilot study. Their thoughtful participation was essential to the success of the study.

Hospitals that participated in the study, in particular the Chief Executive Officers and their staff who supported and coordinated the study in each hospital: Mr Peter Selar, CEO, **Delmont Private Hospital**; Mr Andrew Weston, CEO, **The Hobart Clinic**; Ms Karen Gallagher, CEO, and Ms Chris Bartho-Brown, Psychiatric Unit Manager, **Lingard Private Hospital**; Ms Moira Munro, CEO, **Perth Clinic**; Ms Lynn Fishwick, CEO, **South Pacific Private**; Ms Christine Gee, CEO **Toowong Private Hospital**; Ms Tina Sinclair, General Manager, Wesley Health and Counselling Services together with Ms Kerry Marden, Director of Clinical Services, **Wandene Private Hospital** and David McMaster, Director of Clinical Services, **Wesley Private Hospital**;.

Staff of the Strategic Planning Group for Private Psychiatric Services: Ms Erin Pearce (who entered all the submitted surveys and prepared and distributed Hospitals' reports) and Ms Bronwen van der Wal and Mr Phillip Taylor who assisted with and supervised the day–to–day conduct of the study.

Staff in Queensland Health's Mental Health Information Unit: Ms Kerrie Jones (project officer) who assisted in the development of the study questionnaires for both consumers and service providers and Dr Gopal Bose (senior epidemiologist) who provided valuable advice regarding the reporting of the perceptions of care survey results and the analysis of the study questionnaire data.

Finally, we would like to extend our thanks to the staff and associates of the National Association of State Mental Health Program Directors' National Research Institute[1] and the Mental Health Statistics Improvement Program[2]. In particular, without the work of Dr Vijay Ganju and his colleagues in developing the MHSIP Surveys, we would not have been able to undertake this project.

[1] See www.nri-inc.org for more information about the NASMPHD Research Institute.
[2] See www.mhsip.org for more information about the MHSIP.

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Executive brief

Background

Information regarding consumers' perceptions of care (CPoC) is of great interest to all stakeholders concerned with the assurance of service quality and effectiveness and is a critical component of an effective quality improvement process.

In the private sector a National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures (hereafter, National Model) has been implemented by all private–hospital based psychiatric services. Under the National Model standardised measures of Consumers' clinical status are collected at key occasions in the clinical path: admission and discharge from episodes of overnight inpatient care, and both home and hospital–based ambulatory care. Analyses of changes from one occasion to the next enable consumer outcomes throughout the clinical path to be evaluated.

Our hypothesis was that this nationally consistent approach to the collection of data for outcome measurement could provide a framework within which a standardised measure of CPoC might also be collected and reported. In order to test that hypothesis we undertook a pilot study of the collection and reporting process as a whole.

Governance and funding of the study

The principal investigator was Mr Allen Morris-Yates, Director of the Private Mental Health Alliance's Centralised Data Management Service. The conduct of the pilot study was overseen by the PMHA-CDMS's Management Committee.

The Australian Government Department of Health and Ageing provided direct funding of $50,336 for the project. The indirect cost of Mr Morris-Yates' salary whilst he worked on the study and its' final report was borne equally by the PMHA-CDMS's three financial stakeholders: the Australian Private Hospitals Association, the Australian Health Insurance Association, and the Australian Government Department of Health and Ageing.

The survey instrument

Use was made of the Consumer Surveys developed in the United States of America under the auspices of the Mental Health Statistics Improvement Program (MHSIP) and the National Research Institute (NRI) of the National Association of State Mental Health Program Directors (NASMHPD). The MHSIP Consumer Surveys include versions suitable for use in all service settings. The original development process for the Surveys included a high level of consumer and care involvement and consultation. During preparation of the study proposal, seventy private sector consumers and carers reviewed the surveys and found them to be largely acceptable for use in Australia.

Reporting to hospitals during the study

An essential aspect of the pilot study was the provision of timely feedback to participating Hospitals. During the third week following the end of each month of the four month long survey administration phase, a report based on the responses to the CPoC measure was prepared and forwarded to each participating Hospital. The reports were structured in a similar manner to the current Standard Quarterly Reports provided to private Hospitals by the PMHA's CDMS; i.e., identified Hospital's aggregate results

compared with all Hospitals aggregate results. The report generation process was automated, with reports in PDF format being emailed to an identified key staff member in each participating Hospital. At the end of the pilot phase, an aggregate report for the whole period covered by the survey administration phase was also prepared and forwarded to each participating Hospital.

This regular and frequent reporting process served two purposes. First, it enabled all participating Hospitals to have an opportunity to review and possibly act on their survey results during the course of the study. Second, it enabled participants to provide properly informed feedback in their subsequent evaluation of the feasibility and utility of the collection and reporting processes.

During the survey administration phase, respondents to the survey were asked to give their opinions of the survey and the collection process. After provision of final standard reports, participating hospitals management teams were asked their opinions of the surveys, the reports, and the collection and reporting process as a whole.

Findings

Eight private hospitals with psychiatric beds participated in the study.

Over the course of the study a total of 731 Surveys were received by the research team. The *Offered Survey Response Rate* was 40% for Overnight Inpatient Services and 23% for Ambulatory Care Services. Comparison of the rates between participating Hospitals showed significant variability: that for Overnight Inpatient Services ranged from 20% to 82%; for Ambulatory care services it ranged from 2% to 60%.

The principal objective of this study was to test the feasibility and utility of implementing the routine collection and reporting of information on consumer perceptions of care. The results clearly indicate that for private hospitals the implementation of a routine collection based on the administration of the surveys by administrative staff is feasible and very likely to be useful.

There was general agreement that the collection process should be based on a standard set of questions collected across all private hospitals with psychiatric beds. There was also general agreement that the MHSIP Surveys were a good, though certainly not perfect, starting point for the development of that standard set of questions.

Regardless of whether reports are based on a routine or snapshot collection, substantial work needs to be undertaken on the development of the methods of analysis and presentation of the information. During the study it became very clear that the information requirements of quality assurance processes are different to those of quality improvement processes. In particular, information presented to external stakeholders for quality assurance purposes needs to tell a balanced story. In that context, methods of presentation that emphasise problems are likely to be misleading and disheartening.

Summary

Background

At the National Information Priorities Forum in 2004 there was strong agreement among all participants that the development and implementation of a nationally agreed measure of Consumer Perceptions of Care (CPoC) was a priority. Accordingly the AHMAC National Mental Health Working Group's Information Strategy Committee undertook to work on the development of plan to enable this work to be undertaken. The PMHA has agreed that it is important to ensure that the private sector be directly involved in the development of a nationally agreed measurement process. However, agreement on a measure will be of little use if private hospitals are unable to effectively collect, analyse, report and make use of the information.

Collection, analysis and reporting issues

Information regarding consumers' perceptions of care is of great interest to all stakeholders concerned with the assurance of service quality and effectiveness. The collection and utilisation of information regarding consumer perceptions of care is a critical component of an effective quality improvement process. Consequently, the timeliness of any reporting process is critical. The facility for hospitals to engage in benchmarking with their peers is also essential to that process.

The nature of the information collected – direct judgements of the quality of services by the recipients of those services – raises unusual and difficult issues for the collection and analysis of this type of information.

First, in order to reduce any concern that consumers may feel in regards to their making critical comments about a hospital that they may feel dependent on, the survey administration process is usually designed to ensure the anonymity of respondents.

Second, as the data collected may well include responses that are potentially embarrassing for the hospital in question, there is a concern that some might seek to suppress such negative data. This may be of particular concern in cases where the information is to be made available to health insurers and other payers or where it may appear in the public domain.

Conversely, hospitals may be concerned that ill–intentioned or mistaken responses by disgruntled or disturbed consumers may be taken out of context by payers or consumer groups whose principal concern is service quality assurance. Mature resolution of some of these concerns may be assisted by the progressive involvement of local consumer representatives in hospitals' quality improvement activities.

In many cases an external data management service is engaged so that there is no question as to the probity of the collection and analysis process. However, the time between data collection and the provision of reports may then be excessively long, thus effectively prohibiting the use of the information in quality improvement activities.

Third, the two principal uses to which this information may be put – quality assurance and quality improvement – require different methods of both analysis and reporting. That is, the type and format of information that might be of most assistance to hospitals for quality improvement and benchmarking purposes is unlikely to be the same as that presented to external stakeholders for quality assurance purposes. An analysis and reporting framework designed for quality improvement purposes will likely focus on problem identification and monitoring of trends over time using statistical process control techniques. A reporting framework designed to assist external stakeholders' assessment of hospital service quality will

aim to present an overall and balanced view of consumers' perceptions of the hospital's strengths and weaknesses. Careful development of appropriate methods for reporting this information will be essential.

The pilot study

In the private sector the majority of private hospitals with psychiatric beds had implemented the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures (hereafter, National Model). Under the National Model, standardised measures of patients and clients clinical status are collected at key points in the clinical path: admission and discharge from episodes of overnight inpatient care and both home and hospital–based ambulatory care. Both clinician rated and consumer completed measures are collected. Our hypothesis was that this nationally consistent approach to the collection of data for outcome measurement could provide a framework within which consumers' perceptions of care might also be collected and reported.

The principal objective of the pilot study was therefore to assess the feasibility and utility of implementing a data collection and reporting process for consumer perceptions of care that was similar to the existing processes for the collection and reporting of outcome measures. In order to do that, we undertook a pilot study of the collection and reporting process as a whole.

Since the focus was on the methodology for the collection, analysis and reporting of information regarding consumers' perceptions of care, it was important that we did not get involved in and were not seen by participants to be involved in the development of a new CPoC Measure. Rather, use was made of the Consumer Surveys developed in the United States of America under the auspices of the Mental Health Statistics Improvement Program (MHSIP)[3] and the National Research Institute (NRI)[4] of the National Association of State Mental Health Program Directors (NASMHPD). The MHSIP Consumer Surveys include versions suitable for use in the Overnight inpatient setting with adults and older persons, the Ambulatory care setting with adults and older persons, and the Ambulatory care setting with adolescents and their families. The original development process for the Surveys included a high level of consumer and care involvement and consultation.

An essential aspect of the pilot study was the provision of timely feedback to participating Hospitals.

During the third week following the end of each month of the pilot phase, a report based on the responses to the CPoC measure was prepared and forwarded to each participating Hospital. The reports were structured in a similar manner to the current Standard Quarterly Reports provided to private Hospitals by the PMHA's CDMS, i.e., identified Hospital's aggregate results compared with all Hospitals aggregate results. The report generation process was automated, with reports in PDF format being emailed to an identified key staff member in each participating Hospital. During the survey administration phase, the content and format of the reports was modified and enhanced on the basis of feedback from participating Hospitals. At the end of the pilot phase, an aggregate report for the whole period covered by the survey administration phase was also prepared and forwarded to each participating Hospital.

This regular and frequent reporting process served two purposes. First, it enabled all participating Hospitals to have an opportunity to review and possibly act on their survey results during the course of the study. Second, it enabled participants to provide properly informed feedback in the subsequent evaluation of the feasibility and utility of the ascertainment and reporting processes.

[3] The MHSIP's website can be found at www.mhsip.org
[4] The NRI's website can be found at www.nri-inc.org

During the survey administration phase, respondents to the survey were asked to give their opinions of the survey and the collection process. After provision of final standard reports, participating hospitals' management teams were asked their opinions of the surveys, the reports, and the collection and reporting process as a whole. In this way, we hoped to obtain informed comment from key stakeholders on the feasibility and utility of the proposed methodology.

Findings

Response rates

Detailed information regarding response rates and the demographic characteristics of those who responded to the Survey can be found in Section 3 beginning on page 37 of this report.

Over the course of the study a total of 731 Surveys were received by the research team. The *Offered Survey Response Rate* was 40% for Overnight Inpatient Services and 23% for Ambulatory Care Services. Comparison of the rates between participating Hospitals showed significant variability. The *Offered Survey Response Rate* for Overnight Inpatient services ranged from 20% to over 82%; for Ambulatory care services the rate ranged from 2% to 60%.

The content of the Surveys

Survey respondents' views

Detailed information regarding survey respondents' views of the content of the surveys can be found in Section 4.1 beginning on page 43 of this report.

Among those consumers that responded to the survey, 93% indicated that they were comfortable with the questions asked, 11% indicated that the survey they completed contained one or more questions that were very difficult to answer, 86% agreed that the questions addressed issues that were important to them, and 13% identified at least one issue important to them that was not covered by the survey.

Hospital managers' views

Detailed information regarding hospital managers' views of the content of the surveys can be found in Section 4.2 beginning on page 51 of this report.

All hospital managers indicated that the surveys were applicable to the people their hospital provided overnight inpatient services to, whilst 63% indicated they were completely applicable to those whom they provided Ambulatory care. Eighty six percent indicated that the Overnight inpatient surveys were relevant to their hospital's model of service delivery and addressed problems that were relevant to service management. Sixty three percent thought they were applicable to their Ambulatory care service model but 75% thought that survey addressed problems relevant to service management in that setting. However, 50% of managers also indicated that there were important issues that were missed by the Surveys.

The content of the Standard Reports

Hospital managers' views

Overall, as indicated by the aggregate of their responses to the questions, 88% of hospital managers agreed that the reports were useful. All hospital managers agreed that the inclusion of de–identified information regarding the performance of other participating hospitals was useful.

With respect to the utility of the specific components of the reports, 75% agreed that the summary results were useful; 75% agreed that the ranking of individual items by their Consumer Satisfaction Index[5] was useful; all agreed that the detailed reporting of consumers' responses to the individual items was useful; and 75% agreed that the record of consumers' written responses was useful. All agreed that the information helped them understand the outcomes of the care provided by their hospital.

The survey administration and reporting process

Survey respondents' views

Survey respondents were asked a number of questions regarding the process of completing and submitting the surveys. These questions focussed on issues we believed that respondents would be in a good position to comment upon once they had completed the survey. The issues addressed were: (1) the ease of completion of the Survey; (2) respondents' views regarding the effect of anonymity on their willingness to be honest about their perceptions of care; and (3) the extent to which respondents felt their views would be heard, and whether or not that influenced their willingness to complete the survey.

With respect to the ease of completion of the surveys, 5% of respondents indicated that they needed assistance with completing the survey, 93% found the survey easy to complete, and 5% missed completing two or more items in the survey.

With respect to the effects of anonymity, 46% of respondents indicated that they were more comfortable sending the survey to an external agency, 69% indicated that they were confident that they could not be identified, and 42% indicated that they were more honest because they could not be identified.

Overall, 75% of respondents indicated that they were confident that the information they provided would be used, and 77% of respondents indicated that the intended use of the information influenced their willingness to complete the survey.

Hospital managers' views

In addition to the detailed questions about the content and appropriateness of the CPoC Surveys used in the pilot study, hospital managers were also asked two general questions about the survey that relate more generally to their evaluation of the survey administration process.

All hospital managers agreed that it would useful for all hospitals to implement a consumer perceptions of care survey that had a common, nationally agreed, core set of questions. Eighty–eight percent agreed that the surveys used in the pilot study would be a suitable starting point for the development of a nationally agreed set of questions.

Hospital managers were next asked a series of questions regarding the feasibility of routine collection and reporting of information on consumers' perceptions of care. Two models of collection and reporting were addressed by the questions. The collection and reporting of information regarding consumer perceptions of care could be implemented on a routine ongoing basis where surveys are offered to all patients on discharge from Overnight inpatient care and at review and on discharge from Ambulatory care (Day programmes or Outreach care). Under this model, reporting might occur on a monthly, quarterly or six-monthly basis. Alternatively, information on consumer perceptions of care could be collected using a

[5] The meaning and derivation of the Consumer Satisfaction Indices (CSI) used in the reports is described in Section 2.5.1 beginning on page 26 of this report.

snapshot procedure, with a single report provided at the end of the survey period. For example, in an ambulatory care setting it might mean offering the survey to all consumers in care at a given time each year. In the overnight inpatient setting it might mean offering the survey to all patients discharged during a given month.

Hospital managers were first asked: *Putting aside considerations regarding the costs of doing so for the moment, do you think the implementation of the routine ongoing collection, analysis and reporting of information regarding consumer perceptions of care would add to the information that is already routinely collected by the Hospital?* Overall, 88% of managers answered yes whilst 12% thought it would not add to what was already collected.

They were then asked: *Assuming that appropriate resources were available for doing so, do you think it would be feasible (that is, practical and cost-effective) for the Hospital to continue collecting information on consumer perceptions of care on a routine ongoing basis?* Overall, 88% thought it would be feasible. Of those, 29% thought changes would need to be made to the collection protocol.

Then finally they were asked: *Would it be useful for your Hospital to collect information on consumer perceptions of care using a snapshot procedure?* Eighty eight percent thought a snapshot–based collection protocol could also be useful. Of those, 29% thought it would be less useful than a routine collection.

Taken together, hospital managers were more likely to show a preference for a routine collection process.

Conclusions

The principal objective of this study was to test the feasibility and utility of implementing the routine collection and reporting of information on consumer perceptions of care. The results clearly indicate that the answer to that question depends on the consumer population being surveyed.

For private hospitals, the implementation of a routine collection based on the administration of the surveys by administrative staff is feasible and likely to be useful.

There was general agreement that the collection process should be based on a standard set of questions collected across all private hospitals with psychiatric beds. There was also general agreement that the MHSIP Surveys were a good, though certainly not perfect, starting point for the development of that standard set of questions.

Regardless of whether reports are based on a routine or snapshot collection, substantial work needs to be undertaken on the development of the methods of analysis and presentation of the information. During the study it became very clear that the information requirements of quality assurance processes are different to those of quality improvement processes. In particular, information presented to external stakeholders for quality assurance purposes needs to tell a balanced story. In that context, methods of presentation that emphasise problems are likely to be misleading and disheartening.

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1 Background

At the National Mental Health Information Priorities Workshop, held in February 2004, there was strong agreement among all participants that the development and implementation of a nationally agreed measure of Consumer Perceptions of Care (CPoC) was a priority.[6] The National Mental Health Working Group's Information Strategy Committee (ISC) recommended that there be a co-ordinated national approach to the collection of consumer perceptions of care.

Whilst the development of an agreed measure of CPoC for use throughout Australia in both the public and private sectors in all jurisdictions was seen a worthwhile objective, the Strategic Planning Group for Private Psychiatric Services[7] (SPGPPS) had come to the view that agreement upon a measure would be of little benefit if hospitals were unable to effectively collect, analyse, report and make use of the information. In November 2004 the SPGPPS's, Information Strategy Working Group referred the NRI/MHSIP Consumer Survey to the National Network for Private Psychiatric Sector Consumers and Carers (National Network) for it to consider endorsing a trial of this measure in those Australian private hospitals with psychiatric beds willing to participate in such a trial.

Subsequently, the National Network considered the issues of a CPoC Measure specifically in relation to the following.

- The domains and specific issues they thought should be addressed by a consumer perceptions of care survey used in private hospital-based psychiatric services.
- The appropriateness of the NRI/MHSIP Inpatient Consumer Survey for use in Australian private hospital-based psychiatric services, particularly in relation to the following.
    - The correlation between the issues identified by the NRI/MHSIP Inpatient Consumer Survey with the domains identified by the National Network.
    - The appropriateness of the questions contained in the NRI/MHSIP Inpatient Consumer Survey within the Australian cultural context, and for private hospital-based psychiatric services.
    - Any changes that may be necessary to the NRI/MHSIP Inpatient Consumer Survey for its use in Australian private hospital-based psychiatric services.
- The proposed trial of the routine collection of data and regular reporting to Hospitals of information regarding consumer perceptions of care. In particular, the questions to be addressed by the trial, the process for the conduct of the trial, the proposed process for the evaluation of the trial, and the funding of the trial.

During March 2005 the National Network's State and Territory Co-ordinators conducted consumer and carer consultations in each Australian State and the Australian Capital Territory. A total of 73 consumers and carers drawn from a wide cross-section of the private sector, including National Network Members, participated in the consultation process. The use of a standard CPoC Survey in private hospital-based psychiatric services was unanimously supported by all participants consulted. The NRI/MHSIP Inpatient

[6] The National Mental Health Information Priorities Workshop was held in Sydney on 26 and 27 February 2004 and was an initiative of the Information Strategy Committee of the Australian Health Ministers Advisory Council (AHMAC) National Mental Health Working Group. The focus of the Workshop was stakeholder identification and consideration of information priorities and strategies under the National Mental Health Plan 2003-2008. The report of the Proceedings of the Workshop can be obtained from the Australian Government Department of Health and Ageing's website. The report outlines the priorities identified by participants and will assist the Information Strategy Committee in the development of a framework document to guide information development activities under the National Mental Health Plan 2003-2008.

[7] The SPGPPS was dissolved in December 2006. The strategic partnership between the parties to the SPGPPS was reinstated in January 2007 as the Private Mental Health Alliance (PMHA).

Survey was thought to be suitable for this purpose by all those consulted. They all supported the use of an independent third party, for the collection of the Survey, and recommended that the proposed trial of the NRI/MHSIP Inpatient Survey should proceed. The consultation and its findings are discussed in detail in Appendix 3.

In July 2005 a funding proposal was put to the Australian Government Department of Health and Ageing. The proposal outlined a project of approximately twelve months duration to investigate the feasibility and utility of the routine implementation of the ascertainment, reporting and utilisation by service providers of information regarding consumer perceptions of care. The data management and reporting aspects of the project were to be managed by the SPGPPS's Centralised Data Management Service (CDMS) with support from a full-time Research Assistant to be employed for the duration of the study. In December 2005, the Australian Government provided funding of $50,336 under an Agreement with the Australian Medical Association, the organisation responsible for the operation of the CDMS.

The pilot study

The principal objective of the pilot study was to assess the feasibility and utility of implementing a data collection and reporting process for consumer perceptions of care that was similar to the existing processes for the collection and reporting of outcome measures.

In the private sector the majority of private hospitals with psychiatric beds had implemented the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures (hereafter, National Model). Under the National Model, standardised measures of patients and clients clinical status are collected at key points in the clinical path: admission and discharge from episodes of overnight inpatient care, community–based residential care, and both community and hospital–based ambulatory care. Both clinician rated and consumer completed measures are collected. Our hypothesis was that this nationally consistent approach to the collection of data for outcome measurement could provide a framework within which consumers' perceptions of care might also be collected and reported.

In order to test the feasibility and utility of that approach we undertook a pilot study of the collection and reporting process as a whole. A key feature of the study was to focus on the methodology for the collection, analysis and reporting of information regarding consumers' perceptions of care. To that end, it was important that we did not get involved and were not seen by participants to be involved in the development of a new CPoC Measure. Rather, use was made of the Consumer Surveys developed in the United States of America under the auspices of the Mental Health Statistics Improvement Program (MHSIP)[8] and the National Research Institute (NRI)[9] of the National Association of State Mental Health Program Directors (NASMHPD). The MHSIP Consumer Surveys include versions suitable for use in the Overnight inpatient setting with adults and older persons, the Ambulatory care setting with adults and older persons, and the Ambulatory care setting with adolescents and their families. The original development process for the Surveys included a high level of consumer and care involvement and consultation.

An essential aspect of the pilot study was the provision of timely feedback to participating Hospitals.

During the third week following the end of each month of the pilot phase, a report based on the responses to the CPoC measure was prepared and forwarded to each participating Hospital. The reports were structured in a similar manner to the current Standard Quarterly Reports provided to private Hospitals by

[8] The MHSIP's website can be found at www.mhsip.org
[9] The NRI's website can be found at www.nri-inc.org

the PMHA's CDMS, i.e., identified Hospital's aggregate results compared with all Hospitals aggregate results. The report generation process was automated, with reports in PDF format being emailed to an identified key staff member in each participating Hospital. During the survey administration phase, the content and format of the reports was modified and enhanced on the basis of feedback from participating Hospitals. At the end of the pilot phase, an aggregate report for the whole period covered by the survey administration phase was also prepared and forwarded to each participating Hospital.

This regular and frequent reporting process served two purposes. First, it enabled all participating Hospitals to have an opportunity to review and possibly act on their survey results during the course of the study. Second, it enabled participants to provide properly informed feedback in the subsequent evaluation of the feasibility and utility of the ascertainment and reporting processes.

Information regarding the feasibility of the collection process was obtained from both respondents and hospital managers. During the survey administration phase, respondents to the survey were asked to give their opinions of the survey and the collection process. After provision of final standard reports, participating hospitals' management teams were asked their opinions of the surveys, the reports, and the collection and reporting process as a whole. In this way, we hoped to obtain informed comment from key stakeholders on the feasibility and utility of the proposed methodology.

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2 Conduct of the pilot study

2.1 Governance and participant selection and preparation

2.1.1 Governance

The conduct of the pilot study was overseen by the PMHA-CDMS's Management Committee. Details of the membership of the committee, as at March 2007, are provided in Table A of Appendix 1.

2.1.2 Selection of participants

Invitations to participate in the pilot study were sent to all hospitals then participating in the SPGPPS's Centralised Data Management Service. Eight hospitals chose to participate. They ranged in size from a 25 bed co-located psychiatric unit through to two large 80+ bed stand-alone facilities. Participating private hospitals are identified in Appendix 2.

2.1.3 Support for participants

Sites were notified in March 2006 of their inclusion in the pilot study, and in May 2006, the Consumer Perceptions of Care Workbook was distributed to participating hospitals. This Workbook provided participants with the background and rationale for the pilot study, a full explanation of the implementation methodology, and a detailed task checklist covering all phases of the study.

Apart from the CPoC Workbook, each participating hospital was provided with posters and brochures suitable for display in waiting areas which provided information about the Pilot to consumers, staff and other interested people.

Prepared survey packages were delivered to all participants. Each survey package consisted of a brief covering letter which described the study and what was being asked of the mental health consumer, the CPoC survey, and a reply-paid envelope addressed to the CPoC Research Team in Canberra. The survey included in each package included the identification of the Hospital.

2.2 Perceptions of care survey instruments

As the purpose of the pilot study was primarily to test the feasibility of the routine collection and reporting of information regarding consumers' perceptions of care, the study did not require or involve the development of a CPoC Measure. Rather, use was made of the Consumer Surveys developed in the United States of America under the auspices of the Mental Health Statistics Improvement Program (MHSIP)[10] and the National Research Institute (NRI)[11] of the National Association of State Mental Health Program Directors (NASMHPD). The MHSIP Consumer Surveys include versions suitable for use in the Overnight inpatient setting with adults and older persons, the Ambulatory care setting with adults and older persons, and the Ambulatory care setting with adolescents and their families. The original development process for the Surveys included a high level of consumer and care involvement and consultation. Their use in this

[10] The MHSIP's website can be found at www.mhsip.org
[11] The NRI's website can be found at www.nri-inc.org

study incurred no cost as the Surveys are in the public domain. The MHSIP Surveys used in this pilot study are used extensively by both public and private sector specialist mental health services in the USA.

The specific Surveys administered by participating hospitals within each Service Setting were:

NRI/MHSIP Inpatient Consumer Survey	Overnight Inpatient services.
MHSIP Consumer Survey (version 1.1)	Hospital day programmes and Outreach care.

For the purposes of the pilot study a CPoC Pilot Questionnaire (PQ) was assembled. This consisted of: a brief covering letter explaining what was being asked of the patient or client; the substantive questions from the CPoC measure being trialled; some administrative, demographic and clinical questions (see Table 2 on page 24); and a brief Evaluation Questionnaire (EQ) regarding the CPoC measure (see Table 3 on page 24). The package offered to the consumer also included a reply paid envelope addressed to the SPGPPS's Information Officer in Canberra.

Table 1 provides a reference to the substantive questions about perceptions of care asked in the two surveys used in the study: the NRI/MHSIP Inpatient Survey used in the Overnight Inpatient service setting (INP in the table), and the MHSIP Community Survey used in Ambulatory Care service setting (AMB in the table). Every question is identified with an ID code used in this report to refer to the question. The table provides a cross–reference from the ID Code to the Item Number of the question in each Survey.

Table 1: Cross reference for allquestions regarding perceptions of care used in the Pilot Study.

ID	Question text	INP	AMB
1.02	My sense of wellbeing has improved.	7	-
1.03	My symptoms are not bothering me as much.	2	28
1.04	I am better able to deal with crisis.	1	23
1.05	I deal more effectively with daily problems.	6	21
1.06	I am better able to control my life.	-	22
1.07	I am getting along better with my family.	-	24
1.10	I do better in social situations.	5	25
1.11	I do better in school and/or work.	-	26
1.12	My housing situation has improved.	-	27
2.01	The medications I am taking help me control symptoms that used to bother me.	3	-
2.02	The treatment I received helps me to manage symptoms that used to bother me.	4	-
2.03	My contact with my Doctor was helpful.	31	-
2.04	My contact with nurses and therapists was helpful.	32	-
2.05	The surroundings and atmosphere at the hospital helped me get better.	22	-
2.06	I felt this hospital stay was necessary.	15	-
3.02	Services were appropriate for my age.	27	-
3.03	My other medical conditions were treated.	14	-
3.04	I was able to get all the services I thought I needed.	33	8
4.03	I, not staff, decided my treatment goals.	-	17
4.04	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	20	-
4.05	I had a choice of treatment options.	30	-
4.06	I felt comfortable asking questions about my treatment and medications.	11	11
4.08	I participated in planning my discharge.	19	-
4.09	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	21	-
5.01	I was treated with dignity and respect.	8	-

5.02	I was given information about my rights.	-	13
5.03	Staff were sensitive to my cultural background. Staff were sensitive to my cultural background (race, religion, language, etc.)	26	 18
5.05	I felt safe while I was in the hospital.	24	-
5.06	I felt safe to refuse medication or treatment during my hospital stay.	17	-
5.07	I felt free to complain without fear of retaliation. I felt free to complain.	16	 12
5.08	My complaints and grievances were addressed.	18	-
5.09	I felt I had enough privacy in the hospital.	23	-
5.10	My wishes about who is and is not to be given information about my treatment were respected. Staff respected my wishes about who is and who is not to be given information about my treatment.	9	 16
6.01	Staff here believed that I could grow, change and recover. Staff here believe that I can grow, change and recover.	10	 10
6.02	Staff encouraged me to take responsibility for how I live my life.	-	14
6.03	Staff helped me obtain the information I needed so that I could take charge of managing my illness.	-	19
6.04	I was informed about and encouraged to use self-help/support groups in the community I was encouraged to use consumer-run programs (support groups, drop-in centres, crisis phone line, etc.).	12	 20
6.05	I was given information about how to manage my medication side effects. Staff told me what side effects to watch out for.	13	 15
7.06	With my permission, my nominated carer was involved in my hospital treatment.	29	-
8.01	The location of the hospital services was convenient (parking, public transportation, distance, etc.).	-	4
8.02	Services were available at times that were good for me.	-	7
8.03	I was able to be admitted as soon as I needed to be.	34	-
8.04	I was able to see a psychiatrist when I wanted to.	-	9
8.05	Staff were willing to see me as often as I felt it was necessary.	-	5
8.06	Staff returned my call in 24 hours.	-	6
8.07	My family and/or friends were able to visit me.	28	-
9.02	I like the services that I received here.	-	1
9.03	If I had a choice of hospitals, I would still choose this one. If I had other choices, I would still get services from this hospital.	35	 2
9.04	I would recommend this hospital to a friend or family member.	-	3
9.05	The hospital environment was clean and comfortable.	25	-
C.01	Please feel free to use this space to comment on any of your answers	●	●

During their review of the suitability of the NRI/MHSIP Consumer Survey for use in private hospital–based overnight inpatient services, private sector consumer and carers made a number of suggestions regarding the wording and the possible inclusion of additional items in the Survey. As the focus of this pilot study was on the method of collection and reporting of the information, rather than on the Survey itself, it was agreed that changes in wording of the items would as far as possible be avoided. However a number of additional questions were included in the Surveys offered in the Overnight Inpatient service setting (1.02, 2.02, 3.02, 3.04, 5.10, 7.06, and 8.03). Of the questions added, two were directly based on questions from the other Surveys in the suite (3.04, and 5.10), whilst the remaining five were developed by the National Network (1.02, 2.02, 3.02, 7.06, and 8.03). The consultation and its findings are discussed in detail in Appendix 3, beginning on page 85.

Table 2: Administrative, demographic and clinical questions included in the Surveys used in the Overnight Inpatient (INP) and Ambulatory Care (AMB) service settings.

Question	Coding	INP	AMB
Occasion when offered	2 = Review 3 = Discharge 7 = Other		•
Date survey was offered	Recorded as dd/mm/yyyy	•	•
Are you male or female	1 = Male 2 = Female	•	•
To which age group do you belong	1 = Under 18 years 2 = 18 – 24 years 3 = 25 – 34 years 4 = 35 – 49 years 5 = 50 – 64 years 6 = 65 – 79 years 7 = 80 years or over	•	•
In which country were you born	1 = Australia 2 = U.K. 3 = New Zealand 4 = Greece 5 = Italy 6 = Vietnam 7 = Philippines 8 = Other	•	•
Do you speak a language other than English at home	1 = Yes 2 = No	•	•
How long were you in hospital this time	1 = 2 weeks or less 2 = between 2 and 4 weeks 3 = more than 4 weeks	•	

Table 3: Questions about the content of the survey and the process of administration, included in all Surveys.

	Response format
About the questions	
I was comfortable with the questions that were being asked.	5 point Likert scale
The questions address issues that are important to me.	5 point Likert scale
Were there any questions that you found very difficult to answer.	Yes/No
If yes, please note the item number of each such question.	Open field
What other issues that you think are important were not covered by the questionnaire.	Open field
About the process of completing the questionnaire	
Did you need assistance in completing this questionnaire?	Yes/No
The questionnaire was easy to complete.	5 point Likert scale
I was more comfortable sending the questionnaire to a person outside of the hospital.	5 point Likert scale
I was confident that I could not be identified by the hospital as the person completing the questionnaire.	5 point Likert scale
I was more honest because I knew that I could not be identified by the hospital.	5 point Likert scale
I was confident that the hospital would make use of the information I provided.	5 point Likert scale
The intended use of my feedback made more willing to complete the questionnaire.	5 point Likert scale

2.3 Survey administration and collection protocols

The key objective of the Pilot Study was to test the feasibility of the routine collection of CPoC Measures in private hospitals with psychiatric beds, that is, to test a specified data collection protocol. Such protocols have three key elements: (1) What measures and associated data elements are to be collected; (2) how the data is to be collected, and; (3) at what point or points in the clinical path that data is to be collected.

2.3.1 Administration of the Survey (who offers it)

Within the private hospital sector, the administration of consumer satisfaction surveys is, for most hospitals, a routine part of their discharge process. Participating hospitals indicated that they expected there would be little difficulty in including the administration of the CPoC Surveys within that existing process.

2.3.2 Collection Protocol (when is it offered)

The standard collection protocol for the pilot study utilised the same key concepts and some of the same collection points as are used under the National Model for the routine collection of measures of patients clinical status. The aim was to align the collection of this new information with processes already in place to maximize its integration into routine practice. The standard Collection Protocol appears below.

Table 4: Standard Collection Protocol for the Consumer Perceptions of Care Pilot Study.

Service Setting	*Measure*	*Point of Offer*
Overnight Inpatient	NRI/MHSIP Inpatient Consumer Survey	Prior to discharge (excluding transfer for more intensive care).
Ambulatory Care (both Day programmes and Outreach care)	NRI/MHSIP Consumer Survey	At review (minimum 3 monthly interval); and prior to discharge to no further care.

2.4 Significant events protocol

Given the nature of the information being elicited from consumers there was the possibility that a consumer might report a serious clinical incident, express suicidal intent, or make a serious allegation against a participating hospital. Accordingly, a significant events protocol was developed and implemented by the research team for the duration of the study. The protocol was as follows:

In the event that the research team received a completed survey that contained information about any significant events (suicidal ideation or threats, homicidal ideation or threats, and reports of significant clinical treatment incidents, assault, or professional misconduct) below the Director of the CDMS provided the manager of the identified hospital with a copy of the completed survey. It is important to note that completed surveys only identified the responsible hospital, not the consumer. Only indirect information about the identity of the consumer was included on the form (Sex, Age group, and Month of admission).

The protocol was put into effect on one occasion only, in response to an expression of suicidal ideation. The hospital in question was aware of the matter and had already taken steps to address the issue.

2.5 Provision of reports during the pilot study

The provision of regular "Standard Reports" to participating hospitals was a key component of the pilot study. Our view was that hospital managers could not provide informed answers to questions about either the survey collection process or the utility of analysis and reporting of perceptions of care if they had not had some experience of what feedback was possible.

The approach taken to the development of the analysis and reporting framework was evolutionary, that is, throughout the study we sought to continuously improve the reports and the analyses that underpinned them. In practice this meant that an initial method of analysis and report format was developed by the project team. Based on feedback from participating sites the model of analysis was revised and additional information was included in the reports.

During the study, Standard Reports were provided to hospitals on a monthly basis between 14 and 21 days following the end of the month. This relatively frequent feedback cycle was based on our initial estimates of the number of surveys that would be offered and the expectation that the response rates would be quite high. Unfortunately, those initial estimates of both administration and response rates were overly optimistic. Consequently, for many of the participants the sample size for their monthly reports was often quite low. In retrospect, a less frequent reporting cycle may have been more appropriate.

On completion of the survey administration phase of the study all hospitals were provided with a Final Standard Report based on all surveys received during the study. The final reports had a very similar layout to the final format of the monthly reports, with the exception that more detail on response rates during the administration phase was provided.

The reports presented the results from analysis of the returned surveys in a variety of formats and levels of detail, including:

- Aggregate results across five summary domains, presented as bar charts based on Consumer Satisfaction Indices;
- The top and bottom five ranked items;
- Complete rankings on all items;
- Detailed results for all items;
- Consumers comments, edited so to remove personally identifying information about either the consumer or clinicians

The formatting of the statistical results was generally designed to facilitate comparison of the particular hospital with all its peers as a single group. Statistics were not presented in league table format.

2.5.1 Indices of Consumer Satisfaction

As noted above, the format for the reports was developed through a process of review and consultation. In the first half of 2006, publicly available reports prepared by the state mental health services of California, Connecticut, Delaware, Hawai'i, Nevada, Oregon, Texas and Washington were examined. The findings of that review are summarised in Appendix 7.

A key element of the majority of the published reports was the use of some form of summary statistic. Quite a number of different approaches to calculating and reporting summary statistics were employed. These are described below.

1. Simple average of scores across items constituting each summary score.

2. Percent of respondents with mean score indicating positive or very positive view of the domain identified by the summary score or item. In the case of summary scores, this meant the proportion of respondents with a mean summary score of greater than 3.5, whilst for items this was the proportion of respondents that rated the item positively (scored 4) or very positively (scored 5). This was the most commonly employed approach, with the results usually displayed as simple bar charts.
3. Percentage of respondents at each of the 5 points on the underlying response scale. For individual items this is simply the percentage of each possible score from 1 (indicating strong dissatisfaction) through to 5 (indicating strong satisfaction). For summary scores, the mean score was converted back to a categorical scale (1.0 – 1.49 = Very dissatisfied, 1.50 – 2.49 = Dissatisfied, 2.50 – 3.49 = Neutral, 3.50 – 4.49 = Satisfied, and 4.50 – 5.0 = Very satisfied). This approach was also quite common. The Washington State Department of Social and Health Services in particular appeared to use this approach to good effect by displaying the results as stacked bar charts with the average score plotted as points. This display conveyed detailed information in a vivid format that facilitated comparison across domains.
4. Conversion of aggregate responses to satisfaction indices that weighted negative responses against positive responses. The index developed by the Nevada Department of Health and Human Services (DHHS) is described in more detail below.

Nevada DHHS's approach to reporting

Nevada's report employed a summary statistic, identified as the Consumer Satisfaction Index to identify and rank survey items. Results for each item in the survey were reported in detail, with the percentage of respondents who "Strongly agreed", "Agreed", were "Neutral", "Disagreed" or "Strongly disagreed" all being reported. The three items ranked lowest and three ranked highest on the CSI were then graphed separately. Agency level sub–sections within the report used the CSI as the basis for comparing each Agency's performance from 2003 to 2004. Interestingly, the Nevada report also include all (375) comments made by respondents.

In contrast to the scoring and reporting strategies used by the other states reviewed, Nevada's appeared to offer a model that was particularly suited to a focus on continuous quality improvement. The definition of the CSI from Nevada's report is repeated verbatim below.

> The consumer satisfaction index (CSI) is a numerical measure of consumer satisfaction. It was determined for each of the Likert scale survey items in all four domains: (a) general service; (b) outcome; (c) service coordination; and (d) medication clinic. Each Likert scale item was analyzed and the percentage of respondents who marked "strongly agree", "agree", "no opinion", "disagree", or "strongly disagree" was determined. The satisfaction index was calculated by adding the "strongly agree" to the "agree" percentages and dividing by the sum of the "disagree" and "strongly disagree" percentages. The rationale for the index is simply that the more consumers who agree and the fewer who disagree with an item is an indication of the overall satisfaction of the people responding to that item. Stated mathematically:
>
> CSI = {Strongly agree (%) + Agree (%)} ÷ {Disagree (%) + Strongly Disagree (%)}
>
> The index includes a greater proportion of consumers who completed the survey than a simple percentage of agreements. It incorporates the scores of both those who agreed with an item as well as those who disagreed; only those who selected "no opinion" were excluded. The index maintains a positive perspective in the sense that higher index scores indicate higher overall agreement, and relatively less disagreement, with the survey items. Further, the index may be increased by taking steps to increase the number of "satisfied" consumers and decrease the number of "dissatisfied" consumers, which is precisely the desired change in performance.

Use of CSI's in this study's Standard Reports

Analysis of the responses to items included using a Consumer Satisfaction Index (CSI), as a single statistic that summarizes the responses to each item or group of items. A single index summarises a potentially complex range of responses and has the potential to immediately point services toward areas that need to be addressed.

For the first two months, the Research Team used the Nevada version of the CSI which used the formula:

$$\mathbf{CSI_N} = \{SA\% + A\%\} \div \{D\% + SD\%\}$$

Where SA% is the proportion of respondents that Strongly Agreed, A% is the proportion that Agreed, N% is the proportion that were Neutral, D% is the proportion that Disagreed and SD% is the proportion that Strongly Disagreed with the proposition expressed by the survey item.

This version of the CSI reacted dramatically to any level of disagreement in responses. Feedback from Some participants indicated that such volatile scores could appear misleading and were sometimes difficult to interpret.

After further investigation and comparison with another version of the CSI (Verdict Research Ltd), an alternative CSI was developed. This alternative version of the CSI is based on the weighted sum of the number of responses in each category from Strongly Disagree through to Strongly Agree, divided by the total number of responses. Mathematically, this can be expressed as:

$$\mathbf{CSI_W} = \{(1.00 \times SA\%) + (0.75 \times A\%) + (0.50 \times N\%) + (0.25 \times D\%) + (0.00 \times SD\%)\} \times 100$$

Where SA% is the proportion of respondents that Strongly Agreed, A% is the proportion that Agreed, N% is the proportion that were Neutral, D% is the proportion that Disagreed and SD% is the proportion that Strongly Disagreed with the proposition expressed by the survey item.

This produces a CSI with a range of 0 to 100, where 0 indicated total dissatisfaction, 50 represented the mid-point or neutral, and 100 indicated total satisfaction.

The second version of the CSI was agreed upon because it had the advantage of weighting for different responses, took into account neutral responses, was mathematically sound, and importantly was seen to be less harsh than the Nevada CSI.

This alternative "Weighted CSI" was used in the final overall report provided to each Hospital. However, since private hospital participants had not expressed any significant problems with the use of the Nevada CSI,to retain continuity across the relatively brief pilot reporting phase of the study, the Nevada CSI was retained in their monthly reports.

2.5.2 Description of the final reports provided to participants

The substantive results regarding consumers' perceptions of care in both the monthly reports and the final report were presented in the form of figures, tables and listings. In the reports these we identified as "Exhibits" to avoid the confusion of referring alternately to Figure [N], Table [N] or Listing [N]. In the final report five primary exhibits were employed: two figures, one extended table, and two listings, identified as Exhibits 1 through 5.

Each exhibit is described below, with examples of each provided on the following pages. Several examples of each exhibit are provided so that the effect of employing the Nevada CSI or the Weighted CSI can be seen. Note that the examples are based on data aggregated so that the statistics for "All hospitals or services" do not reflect the actual results for the private sector.

Exhibit 1 used a bar chart format to display a comparison of the subject Hospital's average Consumer Satisfaction Indices for the Survey with those for all Hospitals. Examples comparing two CSIs are shown in Figure 1 on page 30.

Exhibit 2 listed the top and bottom five survey items ranked by their Consumer Satisfaction Indices; providing the Hospital with a means of quickly identifying those issues where consumers thought they were doing best and worst. Examples are shown in Figure 2 on page 31

Exhibits 1 and 2 were presented on one page. This design was chosen to give the hospital an easy way of displaying key results for review by staff and consumers.

Exhibit 3 listed all survey items ranked by their Consumer Satisfaction Indices. Examples are shown in Figure 3 on page 32.

Exhibit 4 gave detailed results for each item. Two sets of statistics were reported: the Hospital's results and, immediately below, the results for all Hospitals. The detailed statistics included: the Number of Respondents who completed the Item; the proportion of Respondents that "Strongly disagreed", "Agreed", were "Neutral", "Agreed" or "Strongly agreed"; the proportion of Respondents that marked the item as "Not applicable", the Mean item score and the item's Consumer Satisfaction Index. Examples are shown in Figure 4 on page 33.

Exhibit 5 reported any comments Respondents may have made. Following the actual survey questions, each type of survey had some space for the consumer to note down any additional comments they may have wanted to make. Any such comments were entered into the Study database, with any personally identifying information about the consumer and any clinicians that may have been mentioned being removed. Those de–identified comments were given verbatim in this section of the report. In the monthly Standard Reports, only comments relevant to that month were included. In the Final Standard Report all the comments were again provided, but in a list format that stratified them by month.

Explanatory Notes were provided in all the monthly reports and the final report. In the monthly reports, the explanatory notes were included at the end of the report. Questions and comments from some participants during the administration phase suggested that many participants did not read the explanatory notes at all and as a consequence were confused by the presented information. In the final report, the explanatory notes were revised and moved to the front of the report.

2.5.3 Examples of exhibits from the Final Standard Report

Extracts from the key exhibits are provided on the following pages. Readers are encouraged to compare the differences in the presented results that arise through the use of the two versions of the Consumer Satisfaction Index.

A complete example of the final report is provided in Appendix 5. As with the examples shown on the following pages, the example report has been fabricated so that the statistics presented do NOT represent the actual aggregate results for the private sector.

2.5.3.1 Exhibit one – Comparison of the participant's average Consumer Satisfaction Indices with those of all their peers

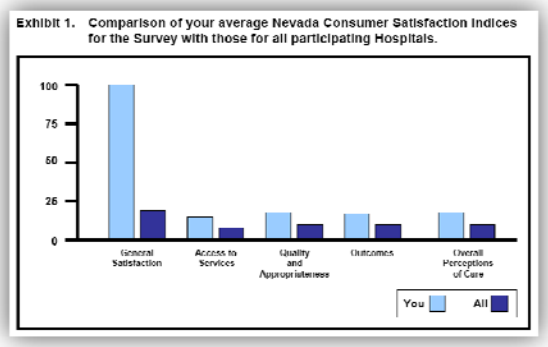

*Exhibit 1 for **Participant A** with Nevada CSI statistics.*

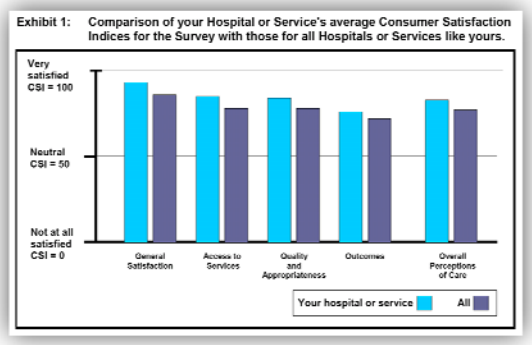

*Exhibit 1 for **Participant A** with Weighted CSI statistics.*

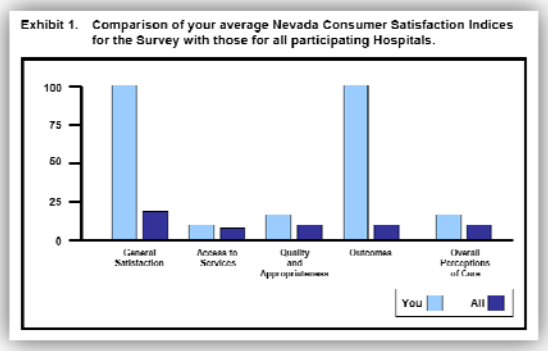

*Exhibit 1 for **Participant B** with Nevada CSI statistics.*

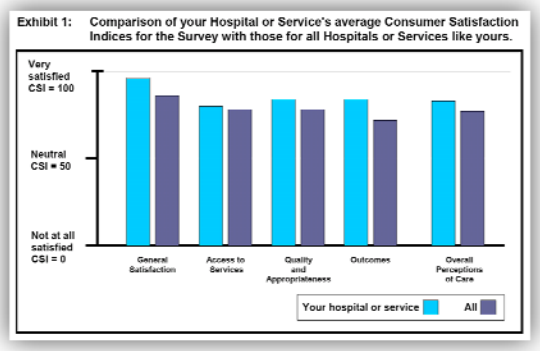

*Exhibit 1 for **Participant B** with Weighted CSI statistics.*

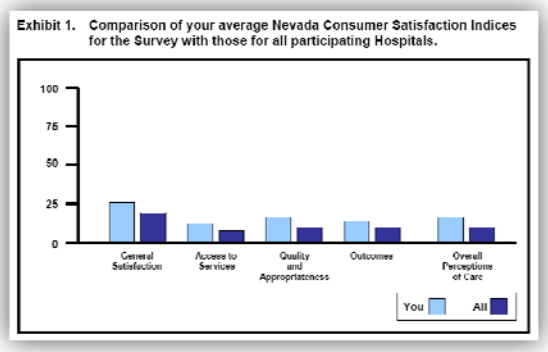

*Exhibit 1 for **Participant C** with Nevada CSI statistics.*

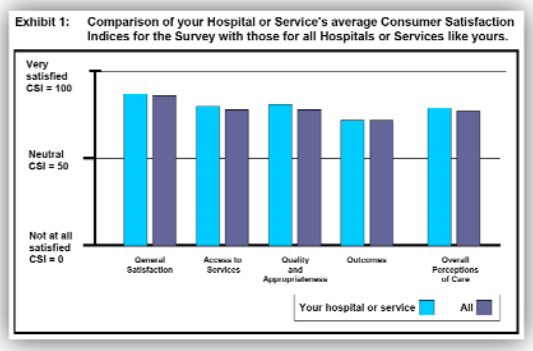

*Exhibit 1 for **Participant C** with Weighted CSI statistics.*

Figure 1: Examples of Exhibit 1 for three participating sites showing the differences between the Exhibits with statistics based on the Nevada CSI compared to those with statistics based on the Weighted CSI.

2.5.3.2 *Exhibit two – Top 5 and bottom 5 items ranked by their Consumer Satisfaction Indices*

*Exhibit 2 for **Participant A** with rankings based on the Nevada CSI.*

Exhibit 2: Top 5 and bottom 5 items ranked by their Consumer Satisfaction Indices

Survey items most strongly agreed with

(25)	The hospital environment was clean and comfortable.	100
(28)	My family and/or friends were able to visit me.	100
(35)	If I had a choice of hospitals, I would still choose this one.	100
(15)	I felt this hospital stay was necessary.	100
(32)	My contact with nurses and therapists was helpful.	75

Survey items most strongly disagreed with

(05)	I do better in social situations.	9
(02)	My symptoms are not bothering me as much.	8
(14)	My other medical conditions were treated.	6
(12)	I was informed about and encouraged to use self-help/support groups in the community.	5
(13)	I was given information about how to manage my medication side effects.	3

*Exhibit 2 for **Participant A** with rankings based on the Weighted CSI.*

Exhibit 2: Top 5 and bottom 5 items ranked by their Consumer Satisfaction Indices

Survey items most strongly agreed with

(25)	The hospital environment was clean and comfortable.	94
(28)	My family and/or friends were able to visit me.	93
(35)	If I had a choice of hospitals, I would still choose this one.	93
(15)	I felt this hospital stay was necessary.	93
(32)	My contact with nurses and therapists was helpful.	90

Survey items most strongly disagreed with

(12)	I was informed about and encouraged to use self-help/support groups in the community	73
(02)	My symptoms are not bothering me as much.	73
(14)	My other medical conditions were treated.	72
(05)	I do better in social situations.	68
(13)	I was given information about how to manage my medication side effects.	66

*Exhibit 2 for **Participant C** with rankings based on the Nevada CSI.*

Exhibit 2: Top 5 and bottom 5 items ranked by their Consumer Satisfaction Indices

Survey items most strongly agreed with

(10)	Staff here believed that I could grow, change and recover.	100
(08)	I was treated with dignity and respect.	100
(26)	Staff were sensitive to my cultural background.	100
(25)	The hospital environment was clean and comfortable.	60
(15)	I felt this hospital stay was necessary.	50

Survey items most strongly disagreed with

(06)	I deal more effectively with daily problems.	10
(02)	My symptoms are not bothering me as much.	9
(17)	I felt safe to refuse medication or treatment during my hospital stay.	7
(30)	I had a choice of treatment options.	6
(13)	I was given information about how to manage my medication side effects.	5

*Exhibit 2 for **Participant C** with rankings based on the Weighted CSI.*

Exhibit 2: Top 5 and bottom 5 items ranked by their Consumer Satisfaction Indices

Survey items most strongly agreed with

(15)	I felt this hospital stay was necessary.	90
(10)	Staff here believed that I could grow, change and recover.	89
(25)	The hospital environment was clean and comfortable.	89
(08)	I was treated with dignity and respect.	88
(26)	Staff were sensitive to my cultural background.	84

Survey items most strongly disagreed with

(30)	I had a choice of treatment options.	71
(13)	I was given information about how to manage my medication side effects.	71
(02)	My symptoms are not bothering me as much.	70
(17)	I felt safe to refuse medication or treatment during my hospital stay.	69
(06)	I deal more effectively with daily problems.	68

Figure 2: Examples of Exhibit 2 for two participating sites.

2.5.3.3 Exhibit three – Ranking of the individual items by their Consumer Satisfaction Indices

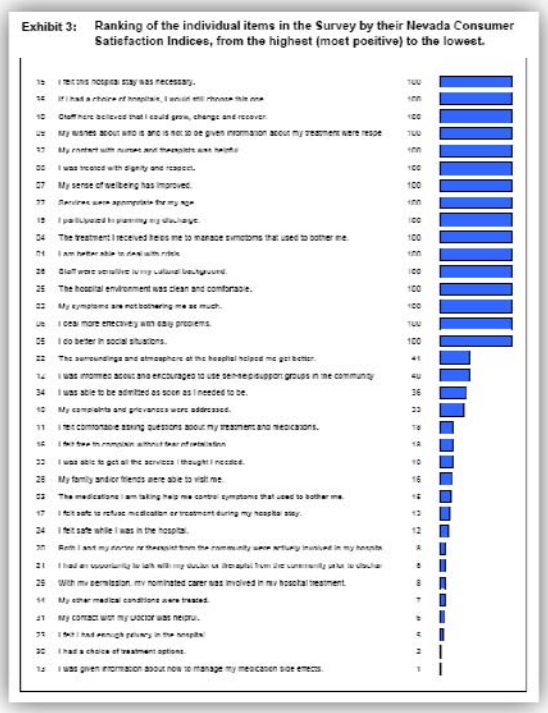

*Exhibit 1 for **Participant B** with Nevada CSI statistics.*

*Exhibit 1 for **Participant B** with Weighted CSI statistics.*

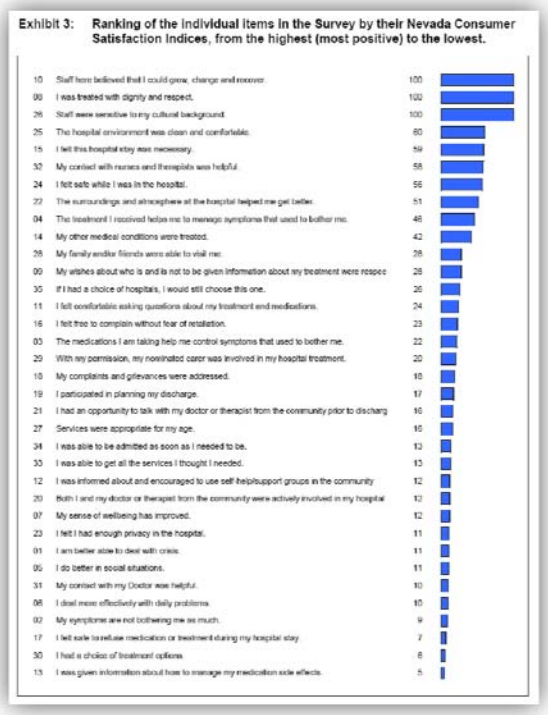

*Exhibit 1 for **Participant C** with Nevada CSI statistics.*

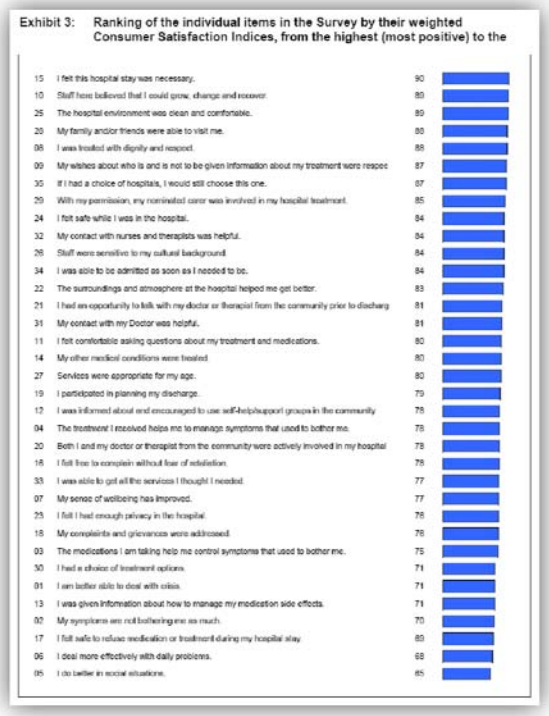

*Exhibit 1 for **Participant C** with Weighted CSI statistics.*

Figure 3: Examples of Exhibit 3 for two participating sites, comparing the effect using the Nevada CSI and the Weighted CSI statistics as the basis for item rankings.

2.5.3.4 *Exhibit four – Detailed results for all items in the Survey*

Outcomes

		responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
01	I am better able to deal with crisis.									
You		97%	1%	1%	10%	55%	30%	4.2	**45**	79
All		93%	2%	5%	16%	48%	21%	3.9	**10**	72
02	My symptoms are not bothering me as much.									
You		98%	1%	8%	16%	47%	26%	3.9	**8**	73
All		92%	3%	6%	14%	47%	22%	3.8	**7**	71
03	The medications I am taking help me control symptoms that used to bother me.									
You		94%	1%	3%	14%	39%	37%	4.2	**20**	79
All		88%	3%	3%	14%	44%	24%	4.0	**12**	74

*Exhibit 4 for **Participant A**.*

Outcomes

		responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
01	I am better able to deal with crisis.									
You		100%	0%	0%	10%	36%	55%	4.5	**100**	86
All		93%	2%	5%	16%	48%	21%	3.9	**10**	72
02	My symptoms are not bothering me as much.									
You		95%	0%	0%	17%	38%	40%	4.3	**100**	81
All		92%	3%	6%	14%	47%	22%	3.8	**7**	71
03	The medications I am taking help me control symptoms that used to bother me.									
You		48%	2%	0%	10%	21%	14%	4.0	**15**	74
All		88%	3%	3%	14%	44%	24%	4.0	**12**	74

*Exhibit 4 for **Participant B**.*

Figure 4: Examples of Exhibit 4 for two participating sites, shown in the format used for the Final Standard Report provided to participating private hospitals.

2.6 Obtaining hospital managers views

In March 2007, following the distribution of the final standard reports in February, a questionnaire was distributed to participating hospitals' chief executive officers.

An example of the Questionnaire for Hospital Management Teams is provided in Appendix 6.

The questionnaire was put to respondents as an opportunity for them to "provide feedback about the processes and tools trialled in the pilot study". They were asked about their experience of the pilot study – "what worked, what was useful, what is possible". The management team questionnaire included questions about the content and appropriateness of the CPoC Surveys, the content and utility of the standard reports provided to them during the course of the pilot study, and their views about the feasibility of routine implementation of a CPoC Survey process.

Hospital managers views regarding the content and appropriateness of the Surveys offered to consumers are reported in Section 4.2, beginning on page 51. Their views regarding the utility of the Standard Reports provided during and at the end of the survey administration phase of the study are reported in Section 5, beginning on page 61. Finally, their views regarding the Survey collection and reporting process are reported in Section 7, beginning on page 73.

Most questions offered respondents a five point scale ranging from Not at all (coded as 1) through to Most definitely (coded as 5) for their answers, with many also including space for specific comments. For the purposes of this report, responses to the five point scales were grouped into three categories "*Not at all* or *No*", "*Neutral*" and "*Yes or Most definitely*". In most cases, the findings are presented in terms of the proportion of respondents whose answers fell in each of those three categories, with 95% confidence intervals. Where appropriate, respondents' comments are also provided. Comments were excluded if they clearly did not relate to the issue addressed by the question or made specific reference to a problem experienced by an identified hospital.

Completed questionnaires were received from all eight hospital management teams. Generally, due to the small sample size, it is not meaningful to apply statistical significance tests to the obtained results. Ninety five percent confidence intervals around the reported proportions are provided.

2.7 Statistical analysis of consumers responses to questions about the survey and its' collection

Almost all of the survey and process evaluation questions in the Surveys were presented as propositions in a similar format to that used for the primary, substantive questions in the Survey (the evaluation questions are listed in Table 3 on page 24). Respondents degree of agreement or disagreement with the proposition was recorded on a simple five point Likert scale coded from 1 = *Strongly disagree* through to 5 = *Strongly agree*. In most cases the subject of analysis was the proportion of respondents who *Agreed* or *Strongly agreed* with the proposition in question. The reported results include the proportion of interest together with its' 95% confidence interval, calculated using the standard approximation[12].

In each case respondents' answers were subjected to two forms of statistical analysis.

[12] See section 4.7 beginning page 118 in Armitage & Berry (1994) *Statistical Methods in Medical Research* (3rd Edition).

Differences between survey samples

First, the proportions of positive responses for each of the **Survey Samples** were examined. The two **Survey Samples** are: Acute inpatients and Ambulatory care clients.

The presence of statistically significant differences in proportions between Survey Samples were identified by an overall χ^2 (chi–square) test, with the source of significant effects being identified through the examination of standardised residuals. Due to the relatively large sample sizes even quite small effects may be identified as statistically significant. Accordingly, to provide an indication of the magnitude of the effect that is independent of sample size, a standardised measure of association, Cramer's Phi statistic, is also reported. In the written results this statistic is shown immediately preceding the χ^2 statistic and is indicated by the symbol φ_C. Values of φ_C less than or equal to 0.15 are considered to indicate a small association; values around 0.25 are medium, whilst values greater than or equal to 0.35 are large.[13]

The identity of the respondent's Survey Sample captures explicit differences in the type of survey administered and also by definition the type of services respondents were asked to evaluate. However, some of the factors that might be associated with differences in responses to the evaluation questions vary within Survey Sample (e.g., respondents' Sex and Age group) whilst others only apply to one or other service setting (e.g., Length of stay). Therefore a second method of analysis was also undertaken.

Associations with clinical and service–related factors

Second, for each question the proportion of positive responses (coded as a dichotomous indicator) was subjected to a second analysis in which three additional factors were examined. They were:

- Respondents' **Age Group** (coded as 1 = < 25 years, 2 = 25 to 34 years, 3 = 35 to 49 years, 4 = 50 to 64 years, 5 = 65 years and older);
- **Length of Stay** (coded as 1 = Less than 2 weeks, 2 = 2 to 4 weeks, 3 = More than 4 weeks).
- **Hospital** (i.e., the hospital about which the consumer was responding)

Interpreting the results of the analysis

It is important to note that the exploratory nature of this study raises some significant issues for the analysis and reporting of any findings regarding consumers' views of the survey collection process.

Whilst tests of statistical significance have been employed, in most cases, those tests can only be used to indicate whether any apparent differences in the responses of consumers in different services settings or having different characteristics are likely to have arisen by chance. The more important question as to the substantive significance of the results is a somewhat more subjective matter.

Given the nature of the protocols that were followed these results need to be interpreted with some caution. Generally consumers were either offered assistance or asked to complete it in their own time and then mail it to the research team. As a consequence, consumers who had opted to complete it in their own time and then found the survey difficult to complete may have simply given up and not submitted it. To gain a complete picture of consumers' views about the survey collection process we would need the views of consumers who did not return their surveys as well as those who did. Unfortunately, in the present study we were unable to do that. That limitation does not reduce the value of exploring the views of those consumers who did complete and submit the surveys.

[13] See the discussion on pages 85 to 87 and Table 5.1 on page 109 of Grissom and King (2005) *Effect sizes for research.*

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3 Response rates and representativeness of the survey samples

The degree of confidence that may be placed in the findings of a survey–based study depends on several factors. One factor is the absolute number of respondents. Larger samples enable more reliable estimates of population statistics to be calculated. A second factor is the extent to which those who did respond to the survey are representative of the population. The analyses presented in this section of the report speak to those two factors.

3.1 Response rates

3.1.1 Calculation of response rates

There are two ways in which the Response Rate might be calculated. Which of them is found most informative will depend on what model of survey administration was employed and the focus of the analysis framework within which consumers' responses are interpreted. Both response rate statistics can be calculated on the basis of the information provided in Table 5 on page 38.

One method of calculation is to divide the Number of Surveys Received by the reported Number of Surveys Offered. That statistic, reported here as "Received as % of Offered", is most relevant in cases where the survey administration protocol is based on a sampling methodology. It should be noted that a sampling rather than routine collection protocol was effectively what was actually implemented by most private sector Ambulatory Care services. This statistic is referred to as the *Offered Survey Response Rate*. Variations in this statistic provide an indication of the extent to which Consumers' willingness to complete and submit the Survey was affected by the model of survey administration and the context provided by the particular Hospital within which that model was implemented.

Another method of calculation is to divide the Number of Surveys Received by the estimate of the Number of Eligible Respondents. That statistic, reported here as "Received as % Eligible", is essential in any evaluation of the extent to which the sample of responses is representative of the whole population of consumers from which the sample has been obtained. This statistic, referred to as the *Eligible Consumer Response Rate*, is most appropriate in cases where a routine collection protocol has been implemented.

Comparisons between Service Settings and between Hospitals within Service Settings are based on the *Eligible Consumer Response Rate* statistic.

3.1.2 Results

Table 5 provides detailed information regarding the administration and return of surveys during the survey administration phase of the Pilot study, from June 2006 through to November 2006. The statistics provided in the table are partitioned by Service Setting (Overnight Inpatient, Ambulatory Care).

The 1st statistic shown in each partition, "Number of Eligible Respondents", provides an estimate of the number of Patients who could have been offered a Survey. The statistic was derived from data subsequently submitted by the participating Hospitals to the PMHA's CDMS.

The 2nd statistic shown in each partition, "Number Offered a Survey", is intended to identify how many surveys were actually offered to consumers. Unfortunately this information was not recorded during the course of the survey administration phase. Instead, a conservative estimate based on subsequent feedback from the participating Hospitals is provided.

The 3rd statistic shown in each partition, "Number of Surveys Received", is the exact number of Surveys actually received by the research team.

The 4th statistic shown in each partition, "Offered as % of Eligible", gives an indication of the extent to which the Survey administration process employed by the participants enabled Surveys to be offered to all eligible Consumers.

The 6th and 7th statistics shown in each partition, "Received as % of Offered" and "Received as % of Eligible", provide the complementary estimates of the response rate discussed in the introductory paragraphs above.

Over the course of the study a total of 731 Surveys were received by the research team. The *Offered Survey Response Rate* was 40% for Overnight Inpatient Services and 23% for Ambulatory Care Services.

Whilst overall the *Offered Survey Response Rate* did differ between service settings, comparison of the rates between participating Hospitals showed even more variability. The *Offered Survey Response Rate* for the Overnight Inpatient setting, shown in Figure 5, ranged from 20% to over 80%; for Ambulatory care services, shown in Figure 6, the rate ranged from 2% to 60%.

Table 5: Survey administration and response rate statistics.

	Statistic	95% c.i.
Overnight Inpatient Services		
Eligible respondents	1649	
Number Offered a Survey	1456	
Number of Surveys Received	**581**	
Offered as % of Eligible	88.3%	(86.7% – 89.8%)
Received as % of Offered	**39.9%**	(37.4% – 42.4%)
Received as % of Eligible	**35.2%**	(32.9% – 37.5%)
Ambulatory Care Services		
Eligible respondents	814	
Number Offered a Survey	645	
Number of Surveys Received	**150**	
Offered as % of Eligible	79.2%	(76.5% – 82.0%)
Received as % of Offered	**23.3%**	(20.0% – 26.5%)
Received as % of Eligible	**18.4%**	(15.8% – 21.1%)

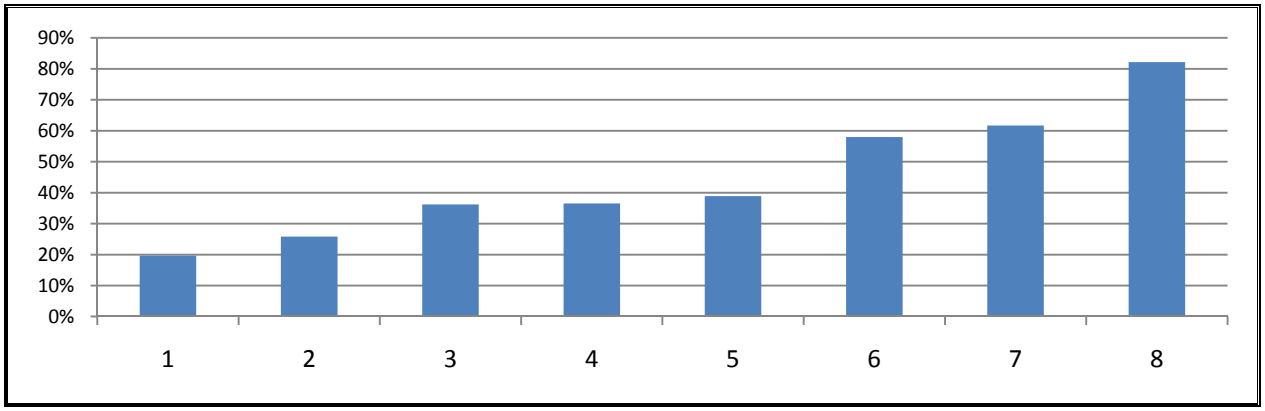

Figure 5: Response rates (Received as % of Offered) for participating hospitals where the Inpatient Services Survey was offered.

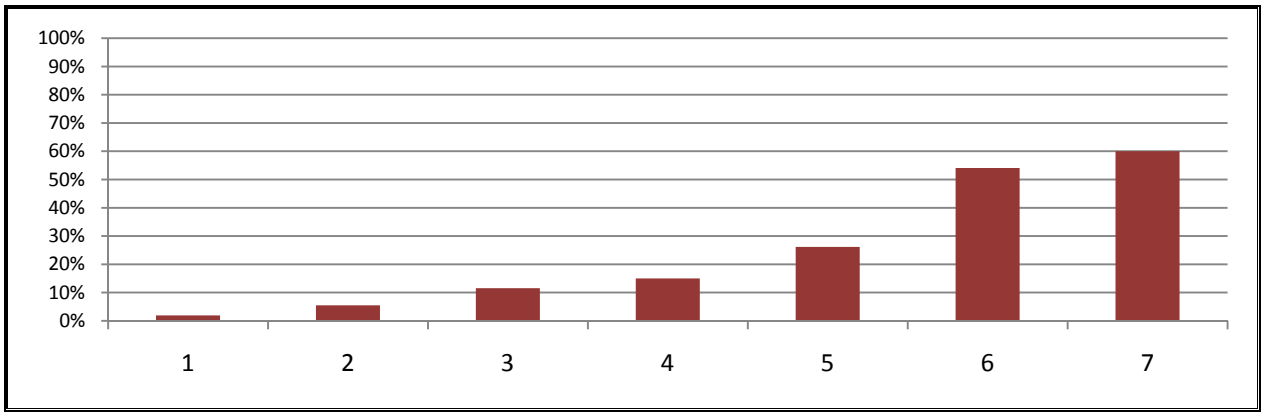

Figure 6: Response rates (Received as % of Offered) for participating hospitals where the Ambulatory Care Services Survey was offered.

3.2 Representativeness of the survey samples

3.2.1 Method

Statistics regarding the demographic profile of patients seen in both the Overnight Inpatient and Ambulatory Care service settings by private hospitals with psychiatric beds during the 2006 calendar year were provided by the PMHA's CDMS. At that time, data submitted by participating private hospitals accounted for over 95% of all separations from such hospitals.

3.2.2 Results

Detailed results of the demographic profile comparisons are provided separately for the Overnight Inpatient and Ambulatory Care service settings. For each respondent group, the proportions of Males and Females and the proportions in each Age Group are tabulated together with 95% confidence intervals around those statistics. Following the table, the profiles are graphed.

Statistical comparisons, based on simple chi–square tests, of the observed profiles with the expected profiles indicated that respondents' Sex profiles were not markedly different to those of the clinical populations from which they were drawn; however their Age Group profile was somewhat different.

Table 6: Comparison of the Demographic profiles of respondents from the Overnight Inpatient service setting and the Ambulatory Care service setting with that estimated for the overall hospital population from which the survey samples were drawn.

	Overnight Inpatients			Ambulatory Care Clients		
	Survey sample		Population in 2006	Survey sample		Population in 2006
Sex						
Male	**32.2%**	(28.3% – 36.0%)	**36.3%**	**37.3%**	(29.6% – 45.1%)	**33.3%**
Female	**67.8%**	(64.0% – 71.7%)	**63.7%**	**62.7%**	(54.9% – 70.4%)	**66.7%**
Age Group						
18 to 24 years	**13.0%**	(10.2% – 15.8%)	**10.1%**	**6.1%**	(2.2% – 10.0%)	**10.2%**
25 to 34 years	**14.6%**	(11.7% – 17.5%)	**15.3%**	**7.5%**	(3.2% – 11.7%)	**16.5%**
35 to 49 years	**29.9%**	(26.1% – 33.7%)	**31.9%**	**28.6%**	(21.3% – 35.9%)	**34.8%**
50 to 64 years	**30.4%**	(26.6% – 34.2%)	**29.2%**	**42.2%**	(34.2% – 50.2%)	**29.9%**
65 to 79 years	**10.5%**	(8.0% – 13.0%)	**9.7%**	**14.3%**	(8.6% – 19.9%)	**6.7%**
80 and older	**1.6%**	(0.6% – 2.6%)	**3.8%**	**1.4%**	(0.0% – 3.2%)	**1.8%**

Note: Percentages of respondents in each Sex and Age Group are shown in bold with 95% confidence intervals in parentheses.

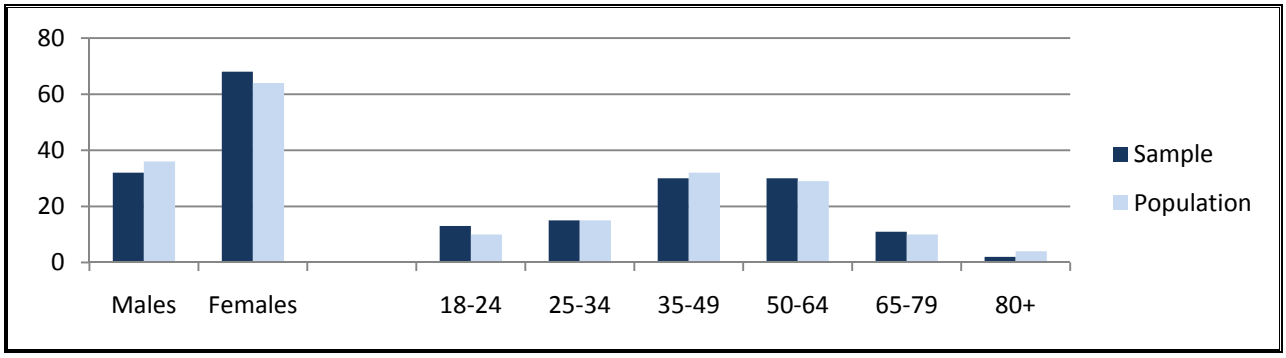

Figure 7: Comparison of the demographic profiles of the sample and estimated population for Overnight Inpatients.

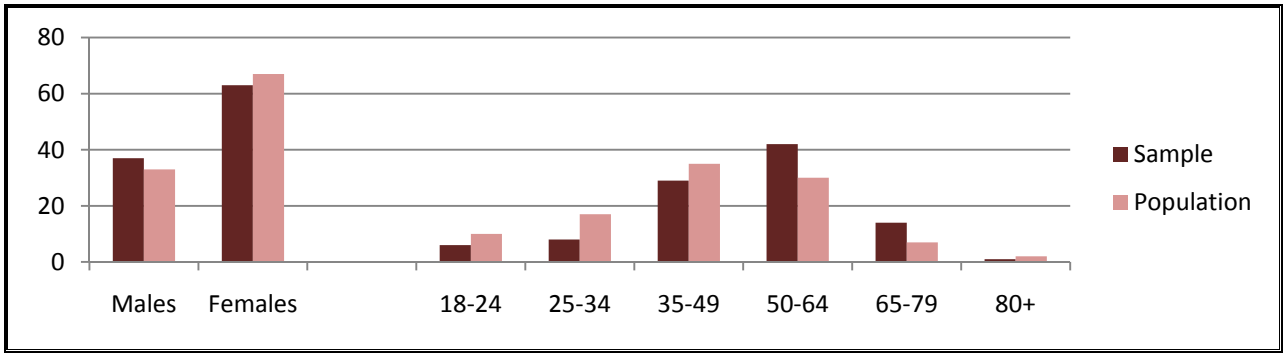

Figure 8: Comparison of the demographic profiles of the sample and estimated population for Ambulatory Care Clients in the Private sector component of the study.

For Overnight Inpatients there was no significant difference in their Sex profile ($\varphi_C = 0.09$, $\chi^2_{(1)} = 1.1$, $p = 0.287$) or their Age Group profile ($\varphi_C = 0.15$, $\chi^2_{(5)} = 3.7$, $p = 0.592$).

For Ambulatory Care Clients there was no significant difference in their Sex profile ($\varphi_C = 0.09$, $\chi^2_{(1)} = 4.3$, $p = 0.038$); but there was a moderate difference in their Age Group profile ($\varphi_C = 0.46$, $\chi^2_{(5)} = 128.2$, $p < 0.000$), with an under–representation of consumers in the 25 to 34 years age group and an over–representation in the 50 to 64 years age group.

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4 The content of the surveys

4.1 Survey respondents views regarding the content of the surveys

Survey respondents were asked a number of questions regarding the content of the Survey. These questions focussed on issues we believed respondents would be in a good position to comment upon given that they had just completed the Survey. They were:

1. The overall ease of completion of the survey.
2. The degree of comfort respondents had with the questions asked.
3. The extent to which the questions addressed issues important to respondents.
4. Whether any of the questions were very difficult to answer.
5. Any issues the respondent thought important that weren't covered.

The method of statistical analysis applied to this data was identical to that applied to consumers' responses to questions regarding the administration of the Surveys. Briefly, two analyses were undertaken. First, the proportions of positive responses for the two Surveys were examined. Second, an analysis of the relationship between various factors that might influence respondents' experience of completing the survey and their positive responses across the aggregate of the two survey samples was undertaken. The statistical procedures employed in these analyses are described in detail in Section 2.7 beginning on page 34.

The results of analyses of responses to the questions regarding the content of the Surveys are reported in detail the following sub–sections.

4.1.1 Did respondents find the survey as a whole easy to complete

All respondents were asked to indicate their agreement or disagreement with the proposition "*The questionnaire was easy to complete*". Basic statistics regarding the proportion of respondents that indicated they either "*Strongly agreed"* or "*Agreed"* with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 7.

Overall, 93% of respondents indicated that they thought the Survey was easy to complete. There was no statistically significant difference in that opinion between the Survey Samples ($\varphi_C = 0.01$, $\chi^2_{(1, N=694)} = 0.1$, $p = .800$). Detailed analysis of their responses indicated no statistically significant difference in that opinion as a function of Age group ($\varphi_C = 0.03$, $\chi^2_{(4, N=680)} = 0.5$, $p = .969$) or Length of Stay ($\varphi_C = 0.01$, $\chi^2_{(2, N=694)} = 0.1$, $p = .991$). There were statistically significant differences in that opinion as a function of the identity of the Hospital ($\varphi_C = 0.16$, $\chi^2_{(7, N=694)} = 17.8$, $p = .013$), with 17% of respondents for one hospital in particular not agreeing that the survey was easy to complete.

Table 7: Proportion of respondents that agreed with the proposition that *"The questionnaire was easy to complete"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**92.9%**	(90.8% – 95.1%)
	Ambulatory	**92.3%**	(87.9% – 96.7%)
Age Group	Less than 25 years	93.7%	(88.8% – 98.6%)
	25 to 34 years	93.5%	(88.4% – 98.5%)
	35 to 49 years	92.3%	(88.6% – 96.1%)
	50 to 64 years	93.7%	(90.5% – 96.9%)
	65 years and older	91.9%	(85.7% – 98.1%)
Length of Stay	Less than 2 weeks	92.6%	(89.1% – 96.1%)
	2 to 4 weeks	92.8%	(89.1% – 96.4%)
	More than 4 weeks	92.9%	(89.9% – 95.9%)
Hospital		97.6%	(94.4% – 100.0%)
		96.0%	(93.1% – 98.9%)
		94.8%	(90.7% – 98.8%)
		92.9%	(85.1% – 100.0%)
		90.6%	(80.5% – 100.0%)
		90.5%	(85.7% – 95.2%)
		87.5%	(77.3% – 97.7%)
		83.1%	(73.5% – 92.6%)

4.1.2 Assistance with completion of the survey

The question "*Did you need assistance in completing this questionnaire?*" was included in both surveys. Statistics regarding the proportion of respondents that indicated they needed assistance is shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 8.

Overall, 5% of respondents indicated that they needed assistance with completion of the Survey. There was a statistically significant difference in the need for assistance between the Survey Samples (φ_C = 0.11, $\chi^2_{(1, N=715)}$ = 8.6, p = .003), with Ambulatory Care respondents being more likely to have required assistance. Detailed analyses indicated statistically significant differences in the need for assistance as a function of Age group (φ_C = 0.27, $\chi^2_{(4, N=702)}$ = 50.4 p < .001), Length of Stay (φ_C = 0.10, $\chi^2_{(2, N=715)}$ = 6.9, p = .032) or identity of the Hospital (φ_C = 0.25, $\chi^2_{(7, N=715)}$ = 43.0, p < .001). Respondents in the 65 and older age range were more likely to need assistance as were respondents who had been in hospital for more than 4 weeks. Feedback from participating hospitals indicated that the marked variation between some hospitals in respondents' reporting the need for assistance was almost entirely due to differences in administrative practice: some hospitals explicitly offered assistance whilst others did not.

Table 8: Proportion of respondents who indicated that they had needed assistance with completing the Survey, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**3.3%**	(1.9% – 4.8%)
	Ambulatory	**9.0%**	(4.3% – 13.6%)
Age Group	Less than 25 years	0.0%	~
	25 to 34 years	0.0%	~
	35 to 49 years	2.9%	(0.6% – 5.2%)
	50 to 64 years	3.1%	(0.8% – 5.3%)
	65 years and older	17.9%	(9.4% – 26.5%)
Length of Stay	Less than 2 weeks	1.8%	(0.1% – 3.5%)
	2 to 4 weeks	4.5%	(1.6% – 7.4%)
	More than 4 weeks	6.6%	(3.7% – 9.4%)
Hospital		13.6%	(5.4% – 21.9%)
		12.6%	(6.6% – 18.6%)
		2.4%	(0.0% – 5.6%)
		2.3%	(0.0% – 6.7%)
		2.0%	(0.0% – 4.2%)
		1.1%	(0.0% – 2.7%)
		0.0%	~
		0.0%	~

4.1.3 Missing data as an index of ease of completion

The proportion of items left uncompleted was examined in some detail, the hypothesis being that respondents who found the survey difficult to understand or of little relevance would be more likely to miss completing some items. Statistics regarding the proportion of respondents that did not complete all items in the survey are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 9.

Among the 731 respondents overall, 84.7% of respondents completed all items in the survey, whilst only 5.3% of respondents missed completing two or more items in the survey. Closer inspection of the surveys revealed that one respondent didn't complete any of the questions regarding perceptions of care, and 2 others only completed the first page of questions.

There was no statistically significant difference in the proportion of surveys having missing responses between the Survey Samples (φ_C = 0.03, $\chi^2_{(1,\ N=731)}$ = 0.6, p = .448). Detailed analyses indicated no statistically significant differences as a function of Length of stay (φ_C = 0.06, $\chi^2_{(2,\ N=731)}$ = 2.2, p = .330) or the identity of the Hospital (φ_C = 0.08, $\chi^2_{(7,\ N=731)}$ = 4.6, p = .712). There was however a statistically significant difference in the proportion of surveys having missing responses as a function of Age group (φ_C = 0.18, $\chi^2_{(4,\ N=713)}$ = 22.4, p < .001): respondents aged 25 to 34 years were less likely to miss items (5%) whilst those aged 65 and older were more likely to miss items (30%).

Table 9: Proportion of respondents that did not complete all the items in the survey, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**15.8%**	(12.9% – 18.8%)
	Ambulatory	**13.3%**	(7.9% – 18.8%)
Age Group	Less than 25 years	11.3%	(5.0% – 17.7%)
	25 to 34 years	5.4%	(0.8% – 10.0%)
	35 to 49 years	17.1%	(12.0% – 22.2%)
	50 to 64 years	14.2%	(9.7% – 18.6%)
	65 years and older	30.0%	(20.0% – 40.0%)
Length of Stay	Less than 2 weeks	17.8%	(12.9% – 22.8%)
	2 to 4 weeks	12.7%	(8.1% – 17.2%)
	More than 4 weeks	15.2%	(11.1% – 19.3%)
Hospital		21.3%	(14.0% – 28.6%)
		15.5%	(10.0% – 20.7%)
		14.7%	(6.3% – 23.1%)
		14.3%	(3.7% – 24.9%)
		13.8%	(6.5% – 21.0%)
		13.5%	(8.2% – 18.9%)
		12.5%	(1.0% – 24.0%)
		12.2%	(2.2% – 22.2%)

4.1.4 Were respondents comfortable with the questions that were asked

All respondents were asked to indicate their agreement or disagreement with the proposition "I was comfortable with the questions that were being asked". Basic statistics regarding the proportion of respondents that indicated that they either "Strongly agreed" or "Agreed" with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 10.

Overall, 93% of respondents indicated that they were comfortable with the questions that were being asked. There was no statistically significant difference between the Survey Samples ($\varphi_C = 0.01$, $\chi^2_{(1, N=700)} = 0.1$, $p = .917$). Detailed analysis of their responses indicated no statistically significant difference in that opinion as a function of Age group ($\varphi_C = 0.06$, $\chi^2_{(4, N=685)} = 2.2$, $p = .700$), Length of Stay ($\varphi_C = 0.04$, $\chi^2_{(2, N=700)} = 1.2$, $p = .541$) or identity of the Hospital ($\varphi_C = 0.12$, $\chi^2_{(7, N=700)} = 10.4$, $p = .166$).

Table 10: Proportion of respondents that agreed with the proposition that *"I was comfortable with the questions that were being asked"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**92.8%**	(90.7% – 95.0%)
	Ambulatory	**93.1%**	(88.9% – 97.2%)
Age Group	Less than 25 years	94.7%	(90.2% – 99.2%)
	25 to 34 years	91.3%	(85.5% – 97.1%)
	35 to 49 years	91.4%	(87.4% – 95.3%)
	50 to 64 years	93.8%	(90.7% – 96.9%)
	65 years and older	94.7%	(89.6% – 99.8%)
Length of Stay	Less than 2 weeks	91.3%	(87.5% – 95.0%)
	2 to 4 weeks	93.9%	(90.5% – 97.2%)
	More than 4 weeks	93.4%	(90.5% – 96.2%)
Hospital		97.6%	(93.0% – 100.0%)
		97.5%	(92.7% – 100.0%)
		95.3%	(90.8% – 99.8%)
		94.8%	(91.5% – 98.1%)
		92.4%	(87.6% – 97.2%)
		90.5%	(85.8% – 95.3%)
		87.5%	(76.0% – 99.0%)
		86.9%	(78.4% – 95.4%)

4.1.5 Were there any particular questions that were very difficult to answer

All respondents were asked to indicate if there were any questions in the survey that they found very difficult to answer. Basic statistics regarding the proportion of respondents that answered "yes" to that question are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 11.

Overall, 11% of respondents indicated that the survey did contain one or more questions that were very difficult to answer. There was a small statistically significant difference between the Survey Samples (φ_C = 0.08, $\chi^2_{(1,\ N=677)}$ = 3.9, p = .049). Detailed analysis of their responses indicated no statistically significant difference in that opinion as a function of Age group (φ_C = 0.04, $\chi^2_{(4,\ N=664)}$ = 0.9, p = .930), Length of Stay (φ_C = 0.03, $\chi^2_{(2,\ N=677)}$ = 0.6, p = .727) or identity of the Hospital (φ_C = 0.11, $\chi^2_{(7,\ N=677)}$ = 8.6, p = .281).

Table 11: Proportion of respondents that indicated that the survey did contain one or more questions that they found very difficult to answer, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**10.0%**	(7.5% – 12.6%)
	Ambulatory	**15.9%**	(9.8% – 22.0%)
Age Group	Less than 25 years	9.7%	(3.7% – 15.7%)
	25 to 34 years	10.0%	(3.8% – 16.2%)
	35 to 49 years	10.9%	(6.5% – 15.4%)
	50 to 64 years	12.2%	(7.9% – 16.5%)
	65 years and older	13.2%	(5.2% – 21.3%)
Length of Stay	Less than 2 weeks	10.0%	(6.0% – 14.1%)
	2 to 4 weeks	10.9%	(6.5% – 15.4%)
	More than 4 weeks	12.3%	(8.4% – 16.2%)
Hospital		15.8%	(6.3% – 25.3%)
		15.0%	(3.9% – 26.1%)
		13.9%	(7.4% – 20.4%)
		12.9%	(7.9% – 18.0%)
		12.5%	(1.0% – 24.0%)
		9.7%	(4.8% – 14.5%)
		4.9%	(0.2% – 9.5%)
		4.7%	(0.0% – 10.9%)

A complete listing of all items with details regarding the percentage of respondents who marked each item as *Not Applicable*, missed completing the question, or identified it as being very difficult to answer is given in Table 18 under Section 4.3 beginning on page 55.

4.1.6 Did the questions address issues that were important to respondents

All respondents were asked to indicate their agreement or disagreement with the proposition "*The questions address issues that are important to me*". Basic statistics regarding the proportion of respondents that indicated that they either "*Strongly agreed*" or "*Agreed*" with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 12.

Overall, 86% of respondents agreed that the questions addressed issues that were important to them. There was no statistically significant difference between the Survey Samples ($\varphi_C = 0.05$, $\chi^2_{(1, N=695)} = 1.6$, $p < .208$). Detailed analysis of their responses indicated no statistically significant difference in that opinion as a function of Length of Stay ($\varphi_C = 0.09$, $\chi^2_{(2, N=695)} = 5.8$, $p = .055$) or identity of the Hospital ($\varphi_C = 0.13$, $\chi^2_{(7, N=695)} = 11.6$, $p = .116$). There was a statistically significant difference in that opinion as a function of Age group ($\varphi_C = 0.15$, $\chi^2_{(4, N=680)} = 0.15$ $p = .005$), with older respondents being more likely to agree that the questions addressed issues important to them.

Table 12: Proportion of respondents that agreed with the proposition that *"The questions address issues that are important to me"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**84.8%**	(81.8% – 87.8%)
	Ambulatory	**88.9%**	(83.8% – 94.0%)
Age Group	Less than 25 years	79.8%	(71.7% – 87.9%)
	25 to 34 years	76.9%	(68.3% – 85.6%)
	35 to 49 years	85.6%	(80.6% – 90.5%)
	50 to 64 years	91.2%	(87.4% – 94.9%)
	65 years and older	86.6%	(82.3% – 96.3%)
Length of Stay	Less than 2 weeks	81.1%	(75.9% – 86.3%)
	2 to 4 weeks	89.2%	(84.8% – 93.5%)
	More than 4 weeks	86.6%	(82.7% – 90.6%)
Hospital		92.9%	(85.1% – 100.0%)
		91.3%	(87.1% – 95.5%)
		87.5%	(77.3% – 97.7%)
		85.9%	(78.5% – 93.3%)
		84.4%	(71.8% – 97.0%)
		82.9%	(76.8% – 89.0%)
		81.2%	(74.1% – 88.3%)
		78.7%	(68.4% – 89.0%)

4.1.7 Were there important issues that were not covered by the questions

All respondents were asked "What other issues that you think are important were not covered by the questions that were asked" with space made available on the survey for them to note down any such issues. All issues identified by respondents were recorded in the study database, along with a flag variable indicating whether or not the respondent had identified any issue or issues. Basic statistics regarding the proportion of respondents that identified any such issues are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 13.

Overall, 13% identified at least one issue important to them that was not covered. There were no statistically significant differences between the Survey Samples (φ_C = 0.03, $\chi^2_{(1,\ N=714)}$ = 0.8, p = .367). Detailed analysis of their responses indicated no statistically significant difference in that opinion as a function of Age group (φ_C = 0.08, $\chi^2_{(4,\ N=697)}$ = 4.7, p = .322), Length of Stay (φ_C = 0.06, $\chi^2_{(2,\ N=714)}$ = 2.8, p = .246) or identity of the Hospital (φ_C = 0.12, $\chi^2_{(7,\ N=714)}$ = 10.5, p = .162).

Review of the additional issues identified by respondents revealed a wide range, with most being clearly specific to the clinical care and related services provided to the particular respondent. Unfortunately, more detailed analysis of the additional issues identified by respondents is out of the scope of this current report.

Table 13: Proportion of respondents that identified at least one issue important to them not covered by the questions in the survey, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**13.9%**	(11.0% – 16.7%)
	Ambulatory	**11.0%**	(5.9% – 16.1%)
Age Group	Less than 25 years	14.4%	(7.4% – 21.4%)
	25 to 34 years	18.3%	(10.4% – 26.1%)
	35 to 49 years	14.1%	(9.3% – 18.8%)
	50 to 64 years	12.2%	(7.9% – 16.5%)
	65 years and older	7.6%	(1.8% – 13.4%)
Length of Stay	Less than 2 weeks	10.3%	(6.3% – 14.2%)
	2 to 4 weeks	15.5%	(10.5% – 20.5%)
	More than 4 weeks	14.1%	(10.1% – 18.1%)
Hospital		23.9%	(13.7% – 34.1%)
		18.8%	(5.2% – 32.3%)
		15.6%	(5.0% – 26.1%)
		15.0%	(3.9% – 26.1%)
		13.3%	(7.9% – 18.8%)
		12.0%	(6.1% – 17.8%)
		10.2%	(5.7% – 14.6%)
		9.3%	(3.2% – 15.4%)

4.2 Hospital managers views of the surveys

Hospital managers were asked a series of questions about each type of survey their hospital offered consumers. Eight completed questionnaires were received from hospital management teams. Hospitals were asked separately about the NRI/MHSIP Inpatient Consumer Survey (referred to here as the Ambulatory Survey) and the MHSIP Community Consumer Survey (referred to here as the Inpatient Survey).

4.2.1 Was the survey applicable to the hospital's consumers

Hospital managers were asked to indicate if the specific survey was applicable to the people their hospital provide services to. They recorded their responses on a 5 point scale where "*Not at all applicable*" was coded as 1 and "*Completely applicable*" was coded as 5. They were also asked "*Do you have any specific comments about that?*". Hospital managers' responses in respect of the two surveys are summarised below in Table 14, with their comments being listed below that table.

Table 14: Hospital managers' responses to the question "*Was the ... Survey applicable to the people your hospital provides services for?*"

	Inpatient Survey		Ambulatory Survey	
Not at all applicable or *Not applicable*	**0%**	~	**13%**	(0% – 27%)
Neutral	**0%**	~	**25%**	(5% – 45%)
Applicable or *Completely applicable*	**100%**	~	**63%**	(41% – 84%)

Comments regarding the Inpatient Survey

from those who responded positively

- The opportunity to comment on the treatment patients receive is very important. Asking about areas not covered provides good opportunity for feedback.
- Some of the questions were not appropriate, however the majority were.
- Some of the questions were not applicable.

from those who responded neutrally or negatively

- No comments were made.

Comments regarding the Ambulatory Survey

from those who responded positively

- Needs to be administered whilst [the consumer is] engaged rather than on discharge and therefore some questions may require amendment.

from those who responded neutrally or negatively

- Not as applicable or relevant as the overnight inpatient survey.
- Could be more specific about types of groups and therapy offered and number of home visits.

4.2.2 Did the survey address issues relevant to the hospital's model of service delivery

Hospital managers were asked to indicate if the specific survey addressed issues that were relevant to their hospital's model of service delivery. Managers' were asked to record their responses on a 5 point scale where "*Not at all relevant*" was coded as 1 and "*Completely relevant*" was coded as 5. They were also asked "*Do you have any specific comments about that?*". Hospital managers' responses in respect of the two surveys are summarised below in Table 15, with their comments being listed below that table.

Table 15: Hospital managers' responses to the question "*Did the ... Survey address issues that are relevant to your hospital's model of service delivery?*"

	Inpatient Survey		Ambulatory Survey	
Not at all applicable or *Not applicable*	**0%**	~	**13%**	(0% – 27%)
Neutral	**13%**	(0% – 27%)	**25%**	(5% – 45%)
Applicable or *Completely applicable*	**88%**	(73% – 100%)	**63%**	(41% – 84%)

Comments regarding the Inpatient Survey

from those who responded positively

- A few questions were less relevant but overall it addressed very relevant issues.
- All psych specific. But some were a bit out of scope of our philosophy and approach making it difficult to marry answers with what we are trying to do.
- Good to have some detailed questions about the impact of treatment as well as those about the specific services provided and interactions with staff.

from those who responded neutrally or negatively

- Have some concern regarding promoting and patients expecting immediate responses to their needs - needs are not always appropriate to setting, and this can be contraindicated by the patient's illness.

Comments regarding the Ambulatory Survey

- No additional comments regarding the relevance of the Ambulatory Survey were made.

4.2.3 Did the survey address issues that concern you as a manager

Hospital managers were asked to indicate if each of the surveys addressed issues or problems that concerned them as service managers. Managers' were asked to record their responses on a 5 point scale where "*Not at all*" was coded as 1 and "*Most definitely*" was coded as 5. They were also asked "*Do you have any specific comments about that?*". Hospital managers' responses in respect of the two surveys are summarised below in Table 16. No additional comments regarding the relevance of either the Inpatient or the Ambulatory Survey were made.

Table 16: Hospital managers' responses to the question "*Did the ... Survey address issues or problems that concern you as a service manager?*"

	Inpatient Survey		Ambulatory Survey	
Not at all applicable or *Not applicable*	**0%**	~	**13%**	(0% – 27%)
Neutral	**14%**	(0% – 31%)	**13%**	(0% – 27%)
Applicable or *Completely applicable*	**86%**	(69% – 100%)	**75%**	(55% – 95%)

4.2.4 Were there important issues that were missed

Hospital managers were asked to indicate if there were important issues that could have been addressed by each of the surveys but which were not. Managers' were asked to record their responses on a 5 point scale where "*Not at all*" was coded as 1 and "*Most definitely*" was coded as 5. As well as being asked to provide comments, they were specifically asked to provide examples of important issues they thought were missed. Hospital managers' responses in respect of the two surveys are summarised below in Table 17, with their comments being listed below that table.

Table 17: Hospital managers' responses to the question "*Were their important issues that were missing in the ... Survey?*"

	Inpatient Survey		Ambulatory Survey	
Not at all or *No*	**50%**	(27% – 73%)	**50%**	(27% – 73%)
Neutral	**0%**	~	**13%**	(0% – 27%)
Yes or *Most definitely*	**50%**	(27% – 73%)	**38%**	(16% – 59%)

Issues identified as having been missed in the Inpatient Survey

- No questions regarding or reference to spirituality - important to some patients. (mentioned by two Hospitals)
- Whether they felt an adequate after-care plan had been developed to support them in maintaining their recovery.
- Food and catering.
- Satisfaction with food. Nothing enquiring regarding financial consent and understanding and acceptance of costs. No reference to rights and responsibilities of patients being understood and accepted.
- Possibly more information about hotel services such as quality and variety of food.
- It is likely that individual hospitals have specific concerns that are not an issue for other hospitals. Perhaps provision for this could be made at the end section of the survey so it could be detached and used by the hospital.
- (1) Pre-admission issues around access, whether patient felt they were dealt with appropriately leading up to admission, and the admission process/reception itself. (2) Confidence in expertise of the staff. (3) Maintenance of confidentiality. (4) Questions about informed financial consent process and out of pocket expenses, particularly as this may impact on care after discharge. (5) May be useful to have an area for comment after each main area of questioning. The questions around being listened to are really important. The survey did ask these, but maybe could ask a few different questions around how we could do things differently or better to improve service provision.

- Questions around being informed of financial obligations; respect and privacy; crises dealt with effectively; family/carer involvement; follow-up support and discharge planning; Group program appropriateness and involvement level; involvement and care by team and hospital.
- Yes there were however, there is a limit as to how many questions and how specific they can be in a survey of this nature.

Issues identified as having been missed in the Ambulatory Survey

- How the assessment process went.
- The variety of psychotherapy programs matching patient needs was not captured in the survey. Confidentiality was not addressed. Perception of feeling understood by staff.
- For day program question to address outcomes of the specific services – otherwise questions become too general.

4.3 Statistical analysis of the content

The statistical analysis of the responses by consumers to the substantive questions regarding consumer perceptions of care is presented in Table 18 beginning on page 57. Statistics addressing three distinct issues are provided for each question.

4.3.1 Applicability and difficulty of questions

The first set of statistics consists of three indicators of the applicability and difficulty of the questions: the proportion of respondents that marked the question as *Not Applicable*; the proportion that did not record any response at all to the question (the *Missing* rate); and the proportion of respondents that identified the question as one that was *Very Difficult* for them to answer.

Items frequently rated as Not Applicable

Twelve items were rated as *Not Applicable* by 10% or more of respondents. They were:

1.12 My housing situation has improved. (Not Applicable for 48.0%)
1.11 I do better in social situations. (Not Applicable for 44%)
7.06 With my permission, my nominated carer was involved in my hospital treatment. (Not Applicable for 41%)
5.03 Staff were sensitive to my cultural background. (Not Applicable for 38%)
8.06 Staff returned my call in 24 hours. (Not Applicable for 30%)
5.08 My complaints and grievances were addressed. (Not Applicable for 24%)
3.03 My other medical conditions were treated. (Not Applicable for 23%)
8.04 I was able to see a psychiatrist when I wanted to. (Not Applicable for 22%)
4.05 I had a choice of treatment options. (Not Applicable for 16%)
5.06 I felt safe to refuse medication or treatment during my hospital stay. (Not Applicable for 15%)
6.05 I was given information about how to manage my medication side effects. (Not Applicable for 14%)
5.02 I was given information about my rights. (Not Applicable for 11%)

As can be seen from the above listing, in almost cases the relatively high proportion of ratings of *Not Applicable* made good sense. For example, it appears reasonable that a consumer would only want to rate the extent of improvement in their housing situation if they felt that there had been previously a problem with it.

Identification of particularly difficult items

Eleven questions were identified as being very difficult to answer by 1% or more of respondents. Interestingly, each of those five questions was either about the outcomes of care or the efficacy of interventions. They were:

1.12 My housing situation has improved. (Difficult for 3.3%)
1.11 I do better in school and/or work. (Difficult for 2.7%)
1.07 I am getting along better with my family. (Difficult for 1.3%)
6.03 Staff helped me obtain the information I needed so that I could take charge of managing my illness. (Difficult for 1.3%)
8.04 I was able to see a psychiatrist when I wanted to. (Difficult for 1.3%)
2.01 The medications I am taking help me control symptoms that used to bother me. (Difficult for 1.2%)

1.10 I do better in social situations. (Difficult for 1.1%)

3.03 My other medical conditions were treated. (Difficult for 1.0%)

1.04 I am better able to deal with crisis. (Difficult for 1.0%)

1.05 I deal more effectively with daily problems. (Difficult for 1.0%)

6.05 I was given information about how to manage my medication side effects. (Difficult for 1.0%)

Identification of a question as very difficult was associated with the frequency with which the question was identified as *Not Applicable* (r = 0.61) and, to a much lesser extent, with the frequency of missing responses (r = 0.13). Even so, among the ten items most frequently marked as *Not Applicable*, on average only 1.2% of respondents marked those items as very difficult to answer. Similarly, among the five items most frequently missed, on average only 0.5% of respondents identified those items as very difficult.

4.3.2 Central tendency and variability of responses

The second set of statistics report the overall central tendency and variability of responses to each question: the Mean response, its' 95% confidence interval, and the Standard Deviation.

These substantive statistics regarding Consumer Perceptions of Care are reported to enable readers to examine the relationship of those attributes to each question's difficulty and its capacity to discriminate between participating Hospitals. From a purely statistical perspective, questions with low mean scores overall may represent issues that could usefully be subjected to quality improvement initiatives.

Each item is rated on a 5 point Likert scale ranging from 1 (indicating strong dissatisfaction) through to 5 (indicating strong satisfaction). When an average of ratings is taken for a particular item the obtained mean score may be converted back to an ordinal rating as follows: 1.0 – 1.49 = Very dissatisfied; 1.50 – 2.49 = Dissatisfied; 2.50 – 3.49 = Neutral; 3.50 – 4.49 = Satisfied; and 4.50 – 5.0 = Very satisfied.

The mean rating of individual items ranged from a low 3.7 (*Satisfied*) for item 6.05 "*I was given information about how to manage my medication side effects*" to a high of 4.7 (*Very satisfied*) for item 9.04 "*I would recommend this hospital to a friend or family member*". The mean rating of all the individual questions was 4.2, indicating that consumers overall perception of private hospital–based psychiatric services was generally positive.

4.3.3 Capacity to discriminate between Hospitals

The third pair of statistics addresses each question's capacity to discriminate between participating Hospitals. Two statistics were obtained from simple analyses of variance in which each question's response score was the dependent variable and the single independent variable was the Hospital. The statistics provided are a measure of the proportion of the overall variance in responses to each question explained by the Hospital (Eta^2) and the associated probability of its statistical significance. Higher values of Eta^2 indicate a greater degree of variation between Hospitals on that particular question.

From a purely statistical perspective, questions with high Eta^2 values are likely to represent issues where some Hospitals perform markedly better than others, and may perhaps provide a useful focus for benchmarking.

On the other hand, questions with both a low Eta^2 and a low average rating may indicate issues where collaborative work by all hospitals is required. For example, the low Eta^2 of 0.9% for item 6.05 mentioned above suggests that this lowest rated item may represent an issue that would be an appropriate candidate for collaborative work by all hospitals.

Table 18: For items from the Inpatient and Ambulatory Surveys, statistical indicators of the applicability and difficulty of each item, the overall central tendency of responses to each item, and the capacity of each item to discriminate between participating Hospitals.

Item		Not Applicable	Missing	Very Difficult	Mean	95%ci	S.D.	Eta^2	P
1.02	My sense of wellbeing has improved.	0.7%	0.5%	0.5%	4.07	(3.99 – 4.14)	0.89	4.0%	0.001
1.03	My symptoms are not bothering me as much.	0.8%	2.3%	0.7%	3.87	(3.80 – 3.94)	0.95	2.9%	0.004
1.04	I am better able to deal with crisis.	1.6%	1.2%	1.0%	4.00	(3.94 – 4.06)	0.83	5.5%	0.000
1.05	I deal more effectively with daily problems.	2.2%	1.1%	1.0%	3.91	(3.85 – 3.98)	0.86	2.2%	0.029
1.06	I am better able to control my life.	0.0%	0.7%	0.7%	4.13	(4.00 – 4.26)	0.81	8.1%	0.095
1.07	I am getting along better with my family.	7.3%	0.7%	1.3%	4.04	(3.89 – 4.18)	0.88	2.2%	0.886
1.10	I do better in social situations.	5.9%	1.4%	1.1%	3.71	(3.64 – 3.78)	0.91	3.7%	0.001
1.11	I do better in school and/or work.	44.0%	1.3%	2.7%	3.78	(3.58 – 3.98)	0.93	6.6%	0.629
1.12	My housing situation has improved.	48.0%	1.3%	3.3%	3.75	(3.53 – 3.97)	0.97	6.7%	0.552
2.01	The medications I am taking help me control symptoms that used to bother me.	8.1%	1.0%	1.2%	4.03	(3.96 – 4.11)	0.87	2.1%	0.143
2.02	The treatment I received helps me to manage symptoms that used to bother me.	2.2%	1.2%	0.9%	4.07	(4.00 – 4.13)	0.83	4.0%	0.002
2.03	My contact with my Doctor was helpful.	4.1%	1.2%	0.3%	4.33	(4.25 – 4.40)	0.93	5.4%	0.000
2.04	My contact with nurses and therapists was helpful.	0.2%	0.5%	0.3%	4.45	(4.39 – 4.51)	0.71	4.4%	0.001
2.05	The surroundings and atmosphere at the hospital helped me get better.	0.3%	0.3%	0.0%	4.22	(4.15 – 4.30)	0.91	3.6%	0.004
2.06	I felt this hospital stay was necessary.	0.2%	1.0%	0.0%	4.62	(4.57 – 4.68)	0.68	2.6%	0.040
3.02	Services were appropriate for my age.	2.4%	1.0%	0.2%	4.31	(4.24 – 4.37)	0.78	5.3%	0.000
3.03	My other medical conditions were treated.	23.1%	1.0%	1.0%	3.88	(3.78 – 3.98)	1.03	2.4%	0.156
3.04	I was able to get all the services I thought I needed.	1.1%	0.7%	0.7%	4.19	(4.13 – 4.26)	0.91	0.8%	0.563
4.03	I, not staff, decided my treatment goals.	8.0%	2.7%	0.7%	4.02	(3.86 – 4.18)	0.95	12.1%	0.020
4.04	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	5.5%	0.3%	0.7%	4.16	(4.07 – 4.24)	1.02	5.8%	0.000
4.05	I had a choice of treatment options.	16.2%	1.5%	0.5%	3.76	(3.66 – 3.86)	1.08	5.7%	0.000
4.06	I felt comfortable asking questions about my treatment and medications.	1.5%	1.0%	0.4%	4.36	(4.30 – 4.42)	0.83	4.8%	0.000
4.08	I participated in planning my discharge.	3.3%	2.4%	0.2%	4.24	(4.17 – 4.32)	0.87	2.0%	0.146
4.09	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	7.7%	0.7%	0.3%	4.17	(4.08 – 4.26)	1.02	7.0%	0.000
5.01	I was treated with dignity and respect.	0.2%	0.7%	0.3%	4.52	(4.46 – 4.58)	0.73	5.6%	0.000
5.02	I was given information about my rights.	10.7%	2.7%	0.7%	4.31	(4.16 – 4.45)	0.83	3.1%	0.782
5.03	Staff were sensitive to my cultural background.	37.5%	1.4%	0.3%	4.26	(4.19 – 4.34)	0.80	4.2%	0.008
5.05	I felt safe while I was in the hospital.	0.2%	0.5%	0.3%	4.39	(4.33 – 4.46)	0.77	3.9%	0.002

Item		Not Applicable	Missing	Very Difficult	Mean	95%ci	S.D.	Eta^2	P
5.06	I felt safe to refuse medication or treatment during my hospital stay.	15.0%	1.4%	0.5%	3.89	(3.80 – 3.98)	1.03	3.9%	0.009
5.07	I felt free to complain without fear of retaliation.	6.3%	1.6%	0.7%	4.05	(3.98 – 4.13)	0.98	2.3%	0.027
5.08	My complaints and grievances were addressed.	24.1%	1.0%	0.7%	3.99	(3.90 – 4.08)	0.96	3.0%	0.074
5.09	I felt I had enough privacy in the hospital.	0.0%	1.0%	0.2%	4.09	(4.02 – 4.17)	0.96	8.5%	0.000
5.10	My wishes about who is and is not to be given information about my treatment were respected.	7.4%	1.0%	0.7%	4.45	(4.40 – 4.51)	0.77	4.7%	0.000
6.01	Staff here believed that I could grow, change and recover.	1.5%	0.7%	0.7%	4.48	(4.42 – 4.53)	0.71	3.7%	0.000
6.02	Staff encouraged me to take responsibility for how I live my life.	5.3%	0.7%	0.7%	4.45	(4.33 – 4.57)	0.72	3.4%	0.692
6.03	Staff helped me obtain the information I needed so that I could take charge of managing my illness.	5.3%	0.0%	1.3%	4.23	(4.08 – 4.38)	0.91	3.6%	0.660
6.04	I was informed about and encouraged to use self-help/support groups in the community	5.9%	0.7%	0.7%	4.02	(3.95 – 4.10)	0.98	3.5%	0.001
6.05	I was given information about how to manage my medication side effects.	13.7%	1.5%	1.0%	3.65	(3.56 – 3.75)	1.15	0.9%	0.558
7.06	With my permission, my nominated carer was involved in my hospital treatment.	40.8%	1.4%	0.5%	4.08	(3.98 – 4.19)	0.99	1.6%	0.631
8.01	The location of the hospital services was convenient (parking, public transportation, distance, etc.).	2.0%	0.0%	0.0%	4.18	(4.03 – 4.32)	0.91	3.9%	0.592
8.02	Services were available at times that were good for me.	5.3%	0.7%	0.0%	4.29	(4.17 – 4.41)	0.71	10.6%	0.034
8.03	I was able to be admitted as soon as I needed to be.	0.5%	0.5%	0.5%	4.23	(4.14 – 4.31)	1.07	3.9%	0.002
8.04	I was able to see a psychiatrist when I wanted to.	22.0%	1.3%	1.3%	4.10	(3.93 – 4.26)	0.89	14.1%	0.020
8.05	Staff were willing to see me as often as I felt it was necessary.	8.0%	0.7%	0.0%	4.43	(4.31 – 4.55)	0.74	8.8%	0.097
8.06	Staff returned my call in 24 hours.	30.0%	0.0%	0.7%	4.38	(4.23 – 4.53)	0.78	5.4%	0.595
8.07	My family and/or friends were able to visit me.	2.6%	1.4%	0.0%	4.58	(4.53 – 4.63)	0.64	3.1%	0.016
9.02	I like the services that I received here.	0.0%	1.3%	0.0%	4.64	(4.54 – 4.73)	0.62	7.7%	0.120
9.03	If I had a choice of hospitals, I would still choose this one.	0.7%	0.7%	0.0%	4.56	(4.50 – 4.61)	0.76	3.8%	0.000
9.04	I would recommend this hospital to a friend or family member.	0.0%	0.7%	0.0%	4.66	(4.57 – 4.74)	0.53	5.1%	0.372
9.05	The hospital environment was clean and comfortable.	0.2%	1.0%	0.2%	4.54	(4.49 – 4.59)	0.65	8.2%	0.000

4.4 Summary of findings and conclusions

Among those consumers who responded to the survey, 93% thought that the survey was easy to complete, whilst only 5% indicated that they needed assistance with completion of the survey. Ninety three percent of respondents indicated that they were comfortable with the questions asked, 11% indicated that the survey they completed contained one or more questions that were very difficult to answer, 86% agreed that the questions addressed issues that were important to them, and 13% identified at least one issue important to them that was not covered by the survey. There were no statistically significant differences between the Overnight Inpatient and Ambulatory Care surveys.

All hospital managers agreed that the Overnight Inpatient survey was applicable to the consumers their hospital admitted, 88% agreed that it was applicable to their model of service delivery and 86% agreed that it addressed issues relevant to service management. Managers were less sure about the Ambulatory Care survey. Only 63% agreed that it was applicable to consumers their hospital saw in that setting, 63% agreed that it was relevant to their model of service delivery and 75% thought it relevant to service management. Hospital managers also thought that both the Overnight Inpatient and Ambulatory Care surveys missed some important issues.

The statistical analysis of the survey items indicated that few items were rated as being particularly difficult by respondents. Five percent of respondents missed completing two or more items in the survey but no items were missed by more than 3% of respondents. Some items were frequently rated as *Not Applicable*, however the use of that rating seemed generally appropriate, suggesting that the *Not Applicable* response option was understood by respondents. Whilst ratings on all items indicated that consumers were generally satisfied or very satisfied with the quality of care, issues that could be subject to improvement were identifiable. Similarly, significant variation between hospitals on certain issues was apparent.

The two surveys used in the pilot study were generally acceptable to both consumers and hospital managers. From a statistical perspective, the surveys performed well.

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5 The utility of the standard reports

5.1 Method

The contents of the Standard Reports provided to participating Hospitals during the survey administration phase of the study and the Final Standard Report provided at the end are detailed in Section 2.5, beginning on page 26 of this report.

Hospital managers were asked seven specific questions about the major components of the reports. The questions addressed their utility and the extent to which they were of assistance in understanding the outcomes of the care provided by their hospital. The preamble to the questions asked managers to consider if the information in the Final Standard Report could be used to inform changes in hospital – whether they believed the information provided was fit for that purpose.

The seven questions were as follows:

1. Were the aggregate statistics based on the Consumer Satisfaction Index (CSI), shown in Exhibit 1 of the final report, useful?
2. Did the aggregate statistics, shown in Exhibit 1 of the final report, help your management team understand the outcomes of the care being provided by your hospital?
3. Was the ranking of items by their CSIs, shown in Exhibits 2 and 3 of the final report, useful?
4. Were the detailed results regarding consumers' responses to the individual items, shown in Exhibit 4 of the final report, useful?
5. Did the detailed results regarding consumers' responses to the individual items, shown in Exhibit 4 of the final report, help your management team understand the outcomes of the care being provided by your hospital?
6. Was the record of consumers' written comments, provided in Exhibit 5 of the final report, useful?
7. Was the inclusion of de-identified information regarding the performance of other participating hospitals useful?

Responses to the questions were recorded on a 5 point Likert scale ranging from 1 – "Not at all" through to 5 "Most definitely". A summary indicator was derived by taking the average of their responses and then coding the average such that scores greater than 3.5 were taken to indicate responses of "Yes" or "Most definitely", scores between 2.5 and 3.5 were taken to indicate a "Neutral" view, whilst responses of less than 2.5 were taken to indicate response of "No" or "Definitely not".

5.2 Results

Responses to the questions are summarised below in Table 19. Statistical tests of the significance of any differences in the response profiles of public and private sector respondents are shown in the note below each table.

Overall, as indicated by the aggregate of their responses to the questions, 88% of hospital managers agreed that the reports were useful. With respect to the utility of the specific components of the reports, 75% agreed that Exhibit 1 was useful; 75% agreed that the ranking of items by their CSIs in Exhibits 2 and 3 was useful; all agreed that the detailed reporting of consumers' responses to the individual items provided in Exhibit 4 was useful; and 75% agreed that the record of consumers written responses was useful. Eighty–

eight percent agreed that the summary provided in Exhibit 1 helped them understand the outcomes of the care provided by their hospital. All agreed that the details provided in Exhibit 4 helped them do so.

Table 19: Hospital managers responses to questions regarding the utility of the reports.

Overall utility of the reports as indicated by the aggregate of responses to the questions			
	Not at all or *No*	**0%**	~
	Neutral	**13%**	(0% – 35%)
	Yes or *Most definitely*	**88%**	(65% – 100%)
1. Were the aggregate statistics based on the Consumer Satisfaction Index (CSI), shown in Exhibit 1 of the final report, useful?			
	Not at all or *No*	**25%**	(0% – 55%)
	Neutral	**0%**	~
	Yes or *Most definitely*	**75%**	(45% – 100%)
2. Did the aggregate statistics shown in Exhibit 1 of the final report help your management team understand the outcomes of the care being provided?			
	Not at all or *No*	**13%**	(0% – 35%)
	Neutral	**0%**	~
	Yes or *Most definitely*	**88%**	(65% – 100%)
3. Was the ranking of items by their CSIs, shown in Exhibits 2 and 3 of the final report, useful?			
	Not at all or *No*	**25%**	(0% – 55%)
	Neutral	**0%**	~
	Yes or *Most definitely*	**75%**	(45% – 100%)
4. Were the detailed results regarding consumers' responses to the individual items, shown in Exhibit 4 of the final report, useful?			
	Not at all or *No*	**0%**	~
	Neutral	**0%**	~
	Yes or *Most definitely*	**100%**	~
5. Did the detailed results regarding consumers' responses to the individual items, shown in Exhibit 4 of the final report, help your management team understand the outcomes of the care being provided?			
	Not at all or *No*	**0%**	~
	Neutral	**0%**	~
	Yes or *Most definitely*	**100%**	~
6. Was the record of consumers' written comments, provided in Exhibit 5 of the final report, useful?			
	Not at all or *No*	**0%**	~
	Neutral	**25%**	(0% – 55%)
	Yes or *Most definitely*	**75%**	(45% – 100%)
7. Was the inclusion of de-identified information regarding the performance of other participating hospitals useful?			
	Not at all or *No*	**0%**	~
	Neutral	**0%**	~
	Yes or *Most definitely*	**100%**	~

Comments from those who generally responded positively

- Happy with scales and rating codes.
- I found the tool very useful. Limited by the response rate we achieved. Need to encourage greater utilisation to improve efficacy.
- Exhibit 1: The CSI required a fair amount of explanation for the layman to understand. Exhibits 2 and 3: These were great. They gave us a great snapshot on how our organisation is perceived - our strengths and weaknesses. Exhibit 4: Necessary for more in depth analysis. Exhibit 5: Specific comments are always interesting, if not as useful; they do help evaluate the tone.
- With slight differences between contributes the reporting scales are reflecting these as major [CSI emphasises negative responses]. A bit disconcerting. Doesn't look like we do anything well.
- We had difficulty in interpreting the consumers' comments without knowing the context the comments were made in.
- I would like to see more specific focus in this area (outcomes), so as to reliably to diagnoses improvement (e.g., less/more depressed; less/more anxious; troubled less/more by auditory/visual hallucinations; know where/how to access ongoing support).

Comments from those who responded negatively

- The ranking of items would be OK if the CSI was not used in its' current format. The outcome graphs seem to bias against any positives the hospital may be providing. The CSI calculations could be influenced by a small number of disgruntled people. The Weighted CSI seems to offer some solution to the problem.

5.3 Summary of findings and conclusions

Hospital managers appear to have found the standard reports provided to them during the course of the study to be useful. However, the analysis and reporting framework needs further refinement. Managers' comments clearly indicate that the reporting process needs to support two quite distinct uses – quality assurance and quality improvement. The one type of analysis cannot suite both purposes. Quality assurance is about just that. The analysis and reporting methodology used for that purpose needs to give a balanced view in a format that can be readily understood by external, non–technical, stakeholders. On the other hand, reports used in the continuous quality improvement cycle will need to drill down and across so that problems can be identified and progress with their amelioration tracked over time.

The relatively small sample of hospital managers available to this study does somewhat limit the generality of the findings. However, their comments present a consistent view and indicate that the reports provided during the course of the study may provide a useful foundation for further development.

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6 Feedback from respondents regarding the survey administration and collection process

6.1 Questions asked of respondents

Survey respondents were asked a number of questions regarding the process of completing and submitting the surveys. These questions focussed on issues we believed that respondents would be in a good position to comment upon once they had completed the survey. These were:

1. Respondents' views regarding the effect of anonymity on their willingness to be honest about their perceptions of care.
2. The extent to which respondents felt their views would be heard, and whether or not that influenced their willingness to complete the survey.

As noted earlier in this report, the final section of the survey also included a number of questions about the content of the Survey. Responses to those questions are reported and analysed in Section 4.1 beginning on page 43.

Like the questions in the Perceptions of Care Surveys proper, the process evaluation questions were phrased as propositions to which the respondent was asked whether they Strongly agreed, Agreed, were Neutral, Disagreed or Strongly disagreed.

The method of statistical analysis applied to this data was identical to that applied to consumers' responses to questions regarding the content of the Surveys. Briefly, two analyses were undertaken. First, the proportions of positive responses for each of the Survey Samples were examined. Second, an analysis of the relationship between various factors that might influence respondents' experience of completing the survey and their positive responses across the aggregate of the two survey samples was undertaken. These two procedures are described in detail in Section 2.7 beginning on page 34.

The results of the analyses are reported in sub–section 6.2 beginning on page 66.

6.2 Results of the analysis of respondents views regarding the survey process

6.2.1 Were respondents more comfortable sending the surveys to an external agency?

All respondents were asked to indicate their agreement or disagreement with the proposition "*I was more comfortable sending the questionnaire to a person outside of the hospital*". Basic statistics regarding the proportion of respondents that indicated they either "*Strongly agreed*" or "*Agreed*" with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 20.

Overall, 46% of respondents indicated that they were more comfortable sending the survey to an external agency. There was no statistically significant difference in that opinion between the Survey Samples (φ_C = 0.01, $\chi^2_{(1,\ N=682)}$ = 0.1, p = .820). Detailed analysis of their responses also indicated no statistically significant differences in that opinion as a function of Age group (φ_C = 0.09, $\chi^2_{(4,\ N=669)}$ = 6.0, p = .202), Length of stay (φ_C = 0.03, $\chi^2_{(2,\ N=682)}$ = 0.7, p = .714), or the identity of the Hospital (φ_C = 0.08, $\chi^2_{(7,\ N=682)}$ = 4.5, p = .718).

Table 20: Proportion of respondents that agreed with the proposition that *"I was more comfortable sending the questionnaire to a person outside of the hospital"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**46.1%**	(41.9% – 50.3%)
	Ambulatory	**47.2%**	(39.0% – 55.4%)
Age Group	Less than 25 years	52.2%	(42.0% – 62.4%)
	25 to 34 years	49.5%	(39.2% – 59.7%)
	35 to 49 years	45.4%	(38.4% – 52.4%)
	50 to 64 years	40.7%	(34.2% – 47.2%)
	65 years and older	53.5%	(41.9% – 65.1%)
Length of Stay	Less than 2 weeks	48.6%	(41.9% – 55.3%)
	2 to 4 weeks	45.8%	(38.7% – 52.9%)
	More than 4 weeks	45.0%	(39.1% – 50.8%)
Hospital		55.4%	(42.3% – 68.4%)
		52.4%	(37.3% – 67.5%)
		49.1%	(39.9% – 58.3%)
		46.2%	(38.6% – 53.7%)
		43.6%	(28.0% – 59.2%)
		43.5%	(35.5% – 51.6%)
		42.9%	(32.3% – 53.4%)
		38.7%	(21.6% – 55.9%)

6.2.2 Were respondents confident that they could not be identified?

All respondents were asked to indicate their agreement or disagreement with the proposition "*I was confident that I could not be identified by the hospital*". Basic statistics regarding the proportion of respondents that indicated they either "*Strongly agreed*" or "*Agreed*" with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 21.

Overall, 69% of respondents indicated that they were confident that they could not be identified. There were no statistically significant differences between the Survey Samples (φ_C = 0.04, $\chi^2_{(1,\ N=691)}$ = 1.0, p = .338). Detailed analysis of their responses also indicated no statistically significant differences in that opinion as a function of Age group (φ_C = 0.02 $\chi^2_{(4,\ N=677)}$ = 0.2, p = .996), Length of stay (φ_C = 0.07, $\chi^2_{(2,\ N=691)}$ = 3.5, p = .171), or the identity of the Hospital (φ_C = 0.12, $\chi^2_{(7,\ N=691)}$ = 0.1, p = .246).

Table 21: Proportion of respondents that agreed with the proposition that *"I was confident that I could not be identified by the hospital"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**69.9%**	(66.0% – 73.7%)
	Ambulatory	**65.7%**	(58.0% – 73.5%)
Age Group	Less than 25 years	68.1%	(58.7% – 77.5%)
	25 to 34 years	69.2%	(59.7% – 78.7%)
	35 to 49 years	69.9%	(63.5% – 76.3%)
	50 to 64 years	69.7%	(63.6% – 75.7%)
	65 years and older	68.0%	(57.4% – 78.6%)
Length of Stay	Less than 2 weeks	73.1%	(67.2% – 79.1%)
	2 to 4 weeks	69.7%	(63.3% – 76.2%)
	More than 4 weeks	65.4%	(59.8% – 70.9%)
Hospital		77.1%	(68.1% – 86.1%)
		75.0%	(61.6% – 88.4%)
		72.3%	(65.6% – 78.9%)
		71.4%	(57.8% – 85.1%)
		68.4%	(60.0% – 76.8%)
		64.4%	(56.6% – 72.2%)
		60.3%	(47.8% – 72.9%)
		59.4%	(42.4% – 76.4%)

6.2.3 Were respondents more honest because they knew that they could not be identified?

All respondents were asked to indicate their agreement or disagreement with the proposition "*I was more honest because I knew that I could not be identified by the hospital*". Basic statistics regarding the proportion of respondents that indicated they either "*Strongly agreed*" or "*Agreed*" with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 22.

Overall, 42% of respondents indicated that they were more honest because they could not be identified. There was no statistically significant difference between the Survey Samples ($\varphi_C = 0.04$, $\chi^2_{(1, N=689)} = 1.3$, $p = .255$). Detailed analysis of their responses also indicated no statistically significant differences in that opinion as a function of Age group ($\varphi_C = 0.06$, $\chi^2_{(4, N=675)} = 2.3$, $p = .680$) and Length of stay ($\varphi_C = 0.02$, $\chi^2_{(2, N=689)} = 0.2$, $p = .922$). There was however a statistically significant difference in that opinion as a function of the identity of the Hospital ($\varphi_C = 0.16$, $\chi^2_{(7, N=689)} = 17.8$, $p = .013$), with only one hospital having a significantly different result, in their case due to respondents being less likely to agree (32%). Interestingly, respondents for that hospital were also a little more likely to indicate confidence that they could not be identified (72%).

Table 22: Proportion of respondents that agreed with the proposition that *"I was more honest because I knew that I could not be identified by the hospital"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**43.3%**	(39.2% – 47.5%)
	Ambulatory	**38.0%**	(30.0% – 46.0%)
Age Group	Less than 25 years	38.3%	(28.5% – 48.1%)
	25 to 34 years	37.4%	(27.4% – 47.3%)
	35 to 49 years	41.8%	(34.9% – 48.7%)
	50 to 64 years	43.2%	(36.6% – 49.7%)
	65 years and older	47.3%	(35.9% – 58.7%)
Length of Stay	Less than 2 weeks	43.3%	(36.7% – 49.9%)
	2 to 4 weeks	41.5%	(34.5% – 48.4%)
	More than 4 weeks	41.9%	(36.1% – 47.7%)
Hospital		59.4%	(42.4% – 76.4%)
		55.0%	(42.4% – 67.6%)
		45.9%	(37.8% – 54.0%)
		45.1%	(34.4% – 55.9%)
		43.1%	(34.1% – 52.1%)
		41.0%	(25.6% – 56.5%)
		33.3%	(19.1% – 47.6%)
		32.0%	(25.0% – 38.9%)

6.2.4 Associations between anonymity and perceptions of care

As was noted in the background discussion, regardless of whether surveys are conducted in–house or are handled by an external agency, the process of administration is usually designed to ensure that as far as reasonably possible consumers responses to the survey remain anonymous; the rationale being that consumers may be more willing to be honest under conditions of anonymity. The three propositions: "I was more comfortable sending the questionnaire to a person outside of the hospital", "I was confident that I could not be identified by the hospital" and "I was more honest because I knew that I could not be identified" address different aspects of the issue of anonymity.

As can be seen from the preceding analysis, a significant minority of consumers (46%) did prefer to send their completed surveys to an external agency. A significant minority (42%) also agreed that they were more honest because they knew that they could not be identified. Those two groups were strongly associated, with 70% of the latter preferring to send their survey to an external agency ($\varphi_C = 0.39$, $\chi^2_{(1, N=676)} = 104.8$, $p < .001$). Does that in turn affect their overall ratings of the quality of care? To answer that the relationship between answers to the preceding three questions and a dichotomised version of the Overall perceptions of care score[14] was undertaken. The results of that analysis are given below in Table 23.

There were no statistically significant differences in perceptions of care as a function of either preference for sending the survey to an external agency ($\varphi_C = 0.03$, $\chi^2_{(1, N=682)} = 0.6$, $p = .423$) or confidence regarding anonymity ($\varphi_C = 0.06$, $\chi^2_{(1, N=690)} = 2.2$, $p = .140$). There was however a statistically significant difference in perceptions of care between those who did and did not agree that they were more honest due to their anonymity ($\varphi_C = 0.10$, $\chi^2_{(1, N=689)} = 5.8$, $p = .016$). Respondents who indicated that anonymity had affected their honesty were more likely to report perceptions of care in the low half of the range.

Table 23: Proportion of respondents whose overall perceptions of the quality of care was in the lowest half of ratings, as a function of their views regarding anonymity.

	Proportion having low perceptions of care		95% C.I.
I was more comfortable sending the questionnaire to a person outside of the hospital			
	Agreed	**52.5%**	(47.0% – 58.0%)
	Neutral/Disagreed	**49.5%**	(44.3% – 54.6%)
I was confident that I could not be identified by the hospital			
	Agreed	**48.8%**	(44.4% – 53.3%)
	Neutral/Disagreed	**54.9%**	(48.2% – 61.6%)
I was more honest because I knew that I could not be identified by the hospital			
	Agreed	**56.0%**	(50.3% – 61.7%)
	Neutral/Disagreed	**46.7%**	(41.8% – 51.6%)

[14] The Overall Perceptions of Care summary score was calculated as the average rating across all completed items in the survey. That average score could in theory range from a minimum of 1.0 indicating completely negative perceptions for all items through to a maximum of 5.0 indicating completely positive perceptions. To aid interpretation, the simple average score was then converted to a standardised score ranging from 0 to 100 by a simple algebraic transformation.

6.2.5 Were respondents confident that the hospital would make use of the information they provided?

All respondents were asked to indicate their agreement or disagreement with the proposition "*I was confident the hospital would make use of the information I provided*". Basic statistics regarding the proportion of respondents that indicated they either "*Strongly agreed*" or "*Agreed*" with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 24.

Overall, 75% of respondents indicated that they were confident that the information they provided would be used. There was no statistically significant difference in that opinion between the Survey Samples (φ_C = 0.01, $\chi^2_{(1,\ N=694)}$ = 0.1, p = .724). Detailed analysis of their responses also indicated no statistically significant differences in that opinion as a function of Length of stay (φ_C = 0.05, $\chi^2_{(2,\ N=694)}$ = 1.4, p = .496) or the identity of the Hospital (φ_C = 0.11, $\chi^2_{(7,\ N=694)}$ = 7.6, p = .367). There was however a statistically significant difference in that opinion as a function of Age group (φ_C = 0.17, $\chi^2_{(4,\ N=679)}$ = 20.1, p < .001). Respondents aged between 15 and 49 were more likely to express confidence whilst those 50 and older were less likely to express confidence.

Table 24: Proportion of respondents that agreed with the proposition that *"I was confident the hospital would make use of the information I provided"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**77.1%**	(73.6% – 80.6%)
	Ambulatory	**78.5%**	(71.8% – 85.2%)
Age Group	Less than 25 years	70.7%	(61.3% – 80.0%)
	25 to 34 years	69.6%	(60.2% – 79.0%)
	35 to 49 years	71.4%	(65.1% – 77.8%)
	50 to 64 years	85.3%	(80.6% – 89.9%)
	65 years and older	85.3%	(77.3% – 93.3%)
Length of Stay	Less than 2 weeks	76.4%	(70.7% – 82.1%)
	2 to 4 weeks	75.3%	(69.2% – 81.3%)
	More than 4 weeks	79.6%	(74.9% – 84.3%)
Hospital		84.6%	(73.3% – 95.9%)
		82.1%	(74.0% – 90.3%)
		79.2%	(73.1% – 85.2%)
		78.6%	(66.2% – 91.0%)
		76.9%	(70.1% – 83.7%)
		76.7%	(69.0% – 84.4%)
		68.8%	(52.7% – 84.8%)
		67.2%	(55.4% – 79.0%)

6.2.6 Did the intended use of their feedback influence respondents' willingness to complete the survey

All respondents were asked to indicate their agreement or disagreement with the proposition "*The intended use of my feedback made me more willing to complete the questionnaire*". Basic statistics regarding the proportion of respondents that indicated they either "*Strongly agreed"* or "*Agreed"* with that proposition are shown stratified by Survey Sample, Age group, Length of stay and Hospital in Table 25.

Overall, 77% of respondents indicated that the intended use of the information influenced their willingness to complete the survey. There was no statistically significant difference in that opinion between the Survey Samples ($\varphi_C = 0.00$, $\chi^2_{(1, N=694)} = 0.0$, $p = .924$). Detailed analysis of their responses also indicated no statistically significant differences in that opinion as a function of either Length of stay ($\varphi_C = 0.03$, $\chi^2_{(2, N=694)} = 0.6$, $p = .759$) or the identity of the Hospital ($\varphi_C = 0.10$, $\chi^2_{(7, N=694)} = 6.4$, $p = .496$). There was however a statistically significant difference in that opinion as a function of Age group ($\varphi_C = 0.14$, $\chi^2_{(4, N=679)} = 13.1$, $p = .011$). Respondents aged 25 to 34 were more likely to agree.

Table 25: Proportion of respondents that agreed with the proposition that *"The intended use of my feedback made me more willing to complete the questionnaire"*, stratified by various factors.

Factor	Domain	Statistic	95% C.I.
Setting and Survey Format	Overnight Inpatient	**77.5%**	(74.0% – 80.9%)
	Ambulatory	**77.1%**	(70.2% – 83.9%)
Age Group	Less than 25 years	74.5%	(65.7% – 83.3%)
	25 to 34 years	65.2%	(55.5% – 74.9%)
	35 to 49 years	77.6%	(71.7% – 83.4%)
	50 to 64 years	81.6%	(76.5% – 86.7%)
	65 years and older	85.1%	(77.0% – 93.2%)
Length of Stay	Less than 2 weeks	75.7%	(70.0% – 81.4%)
	2 to 4 weeks	77.7%	(71.8% – 83.6%)
	More than 4 weeks	78.4%	(73.7% – 83.2%)
Hospital		87.2%	(76.7% – 97.7%)
		82.4%	(74.2% – 90.5%)
		81.3%	(67.7% – 94.8%)
		79.3%	(71.9% – 86.7%)
		78.6%	(66.2% – 91.0%)
		75.1%	(68.7% – 81.6%)
		74.1%	(67.1% – 81.2%)
		71.7%	(60.3% – 83.1%)

6.3 Summary of findings and conclusions

The questions analysed in this section of the focussed on those factors that might influence respondents' willingness to provide honest and complete answers to surveys regarding their perceptions of care.

The first three questions addressed the issue of anonymity. This is often held to be a key reason for preferring the use of an external agency rather than an in-house collection. However, external agencies are too expensive to be used on a routine basis, so almost all hospitals also implement an in–house collection for their continuous quality improvement processes. From that perspective, it would be most useful to know that the results of an in–house collection where anonymity was assured could be used with equal confidence to an external agency–based approach.

A significant minority of respondents (46%) indicated that they were more comfortable sending their survey to an external agency. A significant minority (42%) also agreed that they were more honest because they knew that they could not be identified. Those views were strongly associated, such that overall, 30.5% of respondents were more comfortable sending their completed survey to an external agency and indicated that they were more honest because they knew they could not be identified. Of greatest interest is the fact that those for whom anonymity was important were more likely to have lower perceptions of the quality of care.

The next two questions addressed the issue of motivation. A substantial majority of respondents (75%) believed that hospitals would make use of the information and 77% indicated that the intended use of the information influenced their willingness to complete the survey.

In conclusion, it appears that obtaining honest information from as many consumers as possible will likely require that hospitals are able to assure consumers that the process used to collect their perceptions of care protects their anonymity and that real use will be made of the information they do provide.

7 Hospital managers views regarding the survey collection and reporting process

7.1 The utility of a standardised measure of CPoC

Hospital managers were asked detailed questions about the content and appropriateness of the CPoC Surveys used in the pilot study. (Responses to those questions are reported under Section 4.2, beginning on page 51 of this report.) They were also asked two general questions about the survey that relate more generally to their evaluation of the survey administration process. The two questions were:

1. Do you think it would be useful for all private hospitals to implement a consumer perceptions of care survey tool that had a common, nationally agreed core set of questions?
2. In your view, would the CPoC surveys used in the pilot study be a suitable starting point for the development of a nationally agreed set of questions?

Responses to the two questions are summarised below in Table 26.

All hospital managers thought that it would useful for all hospitals to implement a consumer perceptions of care survey that had a common, nationally agreed, core set of questions. Eighty eight percent thought that the surveys used in the pilot study would be a suitable starting point for the development of a nationally agreed set of questions.

Table 26: Hospital managers responses to questions regarding the utility of a standardised measure of consumer perceptions of care.

1. Do you think it would be useful for all hospitals to implement a CPoC survey tool that had a common, nationally agreed core set of questions?			
	Not at all or *No*	**0%**	~
	Neutral	**0%**	~
	Yes or *Most definitely*	**100%**	~
2. Would the surveys used in the pilot study be a suitable starting point for the development of a nationally agreed set of questions?			
	Not at all or *No*	**0%**	~
	Neutral	**13%**	(0% – 35%)
	Yes or *Most definitely*	**88%**	(65% – 100%)

Comments from those who responded positively

- Definitely needs to be a standardised National tool for benchmarking purposes. Currently no such tool exists. The general hospital tool commonly used is not appropriate for mental health consumers.
- Provides capacity for benchmarking and setting some universal standards across different sites.
- Provided the information was standardised and reporting was balanced.
- It's great that we are on the way to providing a standardised tool across mental health sites. There is no appropriate current tool to assist service providers to improve outcomes. It needs to be easy to use. It might be able to be done on site. Ideally, an independent evaluation of data needs to happen. Resources need to be given otherwise it won't happen effectively.
- Even if it is not collected nationally it is a good tool that individual organisations can use and will assist smaller benchmarking projects for interested parties.

Comments from those who responded neutrally

- There were no further comments.

7.2 The utility and feasibility of routine versus snapshot collection and reporting of CPoC

Hospital managers were next asked a series of questions regarding the feasibility of routine collection and reporting of information on consumers' perceptions of care. Two models of collection and reporting were addressed by the questions. The collection and reporting of information regarding consumer perceptions of care could be implemented on a routine ongoing basis where surveys are offered to all patients on discharge from Overnight inpatient care and at review and on discharge from Ambulatory care (Day programmes or Outreach care). Under this model, reporting might occur on a monthly, quarterly or six-monthly basis. Alternatively, information on consumer perceptions of care could be collected using a snapshot procedure, with a single report provided at the end of the survey period. For example, in an Ambulatory care setting it might mean offering the survey to all consumers in care at a given time each year. In the Overnight inpatient setting it might mean offering the survey to all patients discharged during a given month.

The three questions asked were:

1. Putting aside considerations regarding the costs of doing so for the moment, do you think the implementation of the routine ongoing collection, analysis and reporting of information regarding consumer perceptions of care would add to the information that is already routinely collected by the Hospital?
2. Assuming that appropriate resources were available for doing so, do you think it would be feasible (that is, practical and cost-effective) for the Hospital to continue collecting information on consumer perceptions of care on a routine ongoing basis?
3. Would it be useful for your Hospital to collect information on consumer perceptions of care using a snapshot procedure?

Responses to the above questions are summarised below in Table 27.

Table 27: Hospital managers responses to questions regarding the model for collection and analysis.

1.	Would routine ongoing collection, analysis and reporting of information regarding consumer perceptions of care would add to the information that is already routinely collected?		
	Not at all or *No*	**13%**	(0% – 35%)
	Neutral	**0%**	~
	Yes or *Most definitely*	**88%**	(65% – 100%)
2.	Would it be feasible (that is practical and cost–effective) for the hospital to continue collecting information on consumer perceptions of care on a routine ongoing basis?		
	Not at all	**13%**	(0% – 35%)
	Yes, but only with changes to the collection protocol	**25%**	(0% – 55%)
	Yes, routine collection would be feasible	**63%**	(29% – 96%)
3.	Would it be useful for your hospital to collect information on consumer perceptions of care using a snapshot procedure?		
	Not at all	**13%**	(0% – 35%)
	Yes, but not as useful as a routine collection	**25%**	(0% – 55%)
	Yes, it would be useful	**63%**	(29% – 96%)

Comments from those who responded positively to the routine collection model

- Definitely. Certainly long overdue. Standardised tool essential to all private services. (to Q1)
- Yes routine collection would be feasible, but could be done just as efficiently by doing the snapshot survey. (to Q2)
- Yes but, timing, which questions, feedback and turnaround time, benchmarking would all need to be addressed. (to Q2)

Comments from those who did not respond positively to the routine collection model

- We consider periodic collection (e.g., twice a year) appropriate. Ongoing collection is too onerous for patients. For day patients adjust questionnaire and administer while still engaged. (to Q1)

Comments from those who responded positively to snapshot collection model

- A snapshot audit over a 2 month period might be useful and viable as opposed to all discharges. Some evaluation of average length of stay needs to be considered so a turn-over of population completing survey can be done in one time frame. The longer collection period the more accurate reflection of service issues and therefore more useful. (to Q3)
- This could be more cost effective and give as valuable a result. It would also be easier to ensure greater effort was put into ensuring we maintained our response rate. (to Q3)

7.3 Other implementation issues

Since mid 2001, the majority of private hospitals with psychiatric beds have been routinely collecting two clinical outcome measures, the HoNOS and MHQ–14, in accordance with a standard protocol. They submit that data on a quarterly basis to the PMHA's CDMS and based on that data, those participating Hospitals and also Health Insurance Funds are provided with Standard Quarterly Reports on service provision and

outcomes. Private hospitals are thus well used to a routine collection and reporting process. In that context, three additional questions were asked of the private hospitals that participated in the pilot study. The questions were:

1. If this type of information were to be collected by Hospitals on a routine ongoing basis, would it also be useful if a routine data submission, analysis and reporting process, similar to that now employed for the clinical outcome measures (HoNOS and MHQ-14), were to be implemented?
2. Would it be best to provide reports on a monthly, quarterly or half–yearly basis from a routine ongoing collection or on an annual or bi–annual basis from a snapshot–based collection?
3. Do you think information regarding Consumers Perceptions of Care should also be reported to Health Insurance Funds and other Payers?

Responses to these questions are summarised below.

7.3.1 Should the CDMS analyse and report CPoC data collected by private Hospitals

The majority of hospital managers answered *Yes* or *Most definitely* (88%; c.i. = 65% – 100%) whilst the remaining respondent was Neutral (12%; c.i. = 0% – 35%).

Comments on this issue

- The benchmarking would be valuable.
- Yes, a significant part of the value of the survey is the ability to benchmark the outcomes.
- Would be useful but need to consider the differences that exist between the various organisations submitting data. It may not always be a direct or fair comparison.
- Agree – excellent idea. Would have to be universal questions; query whether appropriate for all settings in psych.
- Concept is great – reporting scales and some questions need review.
- Look at amalgamation of information and processing.
- It's great that we are on the way to providing a standardised tool across mental health sites. There is no appropriate current tool to assist service providers to improve outcomes. It needs to be easy to use. It might be able to be done on site. Ideally, an independent evaluation of data needs to happen. Resources need to be given otherwise it won't happen effectively.
- I think that it is worthwhile having an independent body conduct these services.

7.3.2 How frequently should reports be provided

The majority of hospital managers (63%; c.i. = 29% – 96%) indicated a preference for quarterly reports based on a routine collection. Twelve percent (c.i. = 0% – 35%) indicated a preference for monthly reporting. Twenty five percent (c.i. = 0% – 55%) indicated a preference for annual or bi–annual collection and reporting.

Comments on this issue

from those with a preference for routine collection

- At least quarterly to better see trends or correlations. It is much easier to see patterns and relationships of extraneous factors in a shorter period of time. I definitely would prefer a short monthly report than a bi-annual or annual report.

- Ideally a monthly report would be good, but it depends on the return rates, information obtained, and what other processes each organisation has in place for collection and evaluation of consumer feedback.

from those with a preference for a snapshot–based collection

- We would like to see the survey conducted for one month twice yearly. A number of the questions asked provide patient evaluation of many aspects of care as required by ACHS.

7.3.3 Should CPoC statistics be reported to Health Funds and Other payers

There was significant variation in responses to this question. Three respondents answered *Yes* (38%; c.i. = 4% – 71%), two were Neutral (25%; c.i. = 0% – 55%) and three answered *No* or *Definitely not* (38%; c.i. = 4% – 71%). Respondents' comments reflected significant concern about Payers capacity to understand the information and what use they would make of the information.

Comments on this issue

- Yes, but not directly. It needs to go to hospital CEO in form of a report before it goes to funds. Whilst I think the process of evaluation should be transparent, obviously health funds have a different agenda to direct service providers and therefore I think this will need to be well thought out. The purpose of the pilot was to establish a tool and survey process for service providers' benefit to improve their customer service. More discussion around this question is needed.
- There could be benefits but also disadvantages. It would need further discussion.
- My concern is that some programs may show more positive outcomes than others but may not be as effective. For example, our eating disorders program is more compartmentalised than some other programs. Although this may provide better clinical outcomes, it may not look as good in a perception of care survey. The more difficult or challenging the program is the lower it may rate with consumers.
- Yes, but only the general information, not the detailed item information or comments.
- What would health funds and other payers do with this information?
- At this stage the Nevada CSI results would be open to complete misinterpretation. We would wish to retain control of our information. Having seen the way health funds already misuse and misinterpret the HoNOS and MHQ-14 and use it to selectively contract with hospitals, reduce reimbursements etc, I would be ardently opposed to any further information going to any health fund.

7.4 Summary of findings and conclusions

All hospital managers thought that it would useful for all hospitals to implement a consumer perceptions of care survey that had a common, nationally agreed, core set of questions. Most agreed that a routine collection based on the same data submission and reporting model as that currently used for the HoNOS and MHQ–14 outcome measures would be preferable.

Hospital managers were quite ambivalent regarding the provision of this type of information on a routine basis to Health Funds and other Payers. The comment made by one manager – "*What would [they] do with this information?*" – probably best expresses their concerns.

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8 Conclusions and recommendations

Principal conclusions

The objective of this study was to test the feasibility and utility of implementing the routine collection and reporting of information on consumer perceptions of care. The results clearly indicate that for private hospital–based psychiatric services the answer is yes.

There was general agreement that the collection process should be based on a standard set of questions collected across all private hospitals with psychiatric beds. There was also general agreement that the MHSIP Surveys were a good, though certainly not perfect, starting point for the development of that standard set of questions.

Regardless of whether reports are based on a routine or snapshot collection, substantial work needs to be undertaken on the development of the methods of analysis and presentation of the information. During the study it became very clear that the information requirements of quality assurance processes are different to those of quality improvement processes. In particular, information presented to external stakeholders for quality assurance purposes needs to tell a balanced story. In that context, methods of presentation that emphasise problems are likely to be misleading and disheartening.

Recommendations

Full implementation of the routine collection analysis and reporting of consumer perceptions of care by private hospitals with psychiatric beds needs to be approached with care.

First, an agreed survey suite needs to be developed. Whilst the two MHSIP surveys used in this study worked very well, both consumers and hospital managers identified issues that were missed and wording that could be made more appropriate to the Australian context.

Second, given an agreed suite of surveys, hospitals should then be asked to agree on a standard collection protocol. In addition to issues about when the surveys are to be offered, this protocol will need to also recommend mechanisms for ensuring anonymity of respondents. In particular, as it became clear to the research team that hospital staff are able to identify many consumers by their handwriting and style of written response, written complaint and other comment processes will need to be clearly separated from the CPoC Survey administration and collection process.

Third, hospitals may also wish to determine if they wish the PMHA's CDMS to support their implementation of the collection and analysis of CPoC in the same way as it now supports their use of outcome measures. If they do, the CDMS will need to implement the suite of CPoC measures within the existing outcomes measures collection, analysis and reporting framework. That will entail the specification and implementation of changes to: (1) the data submission formats; (2) the data entry, data submission and analysis reporting functions with the HSMdb software now provided by the CDMS to participating hospitals; and, (3) the CDMS data warehouse data processing, analysis and reporting functions.

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Appendices

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Appendix 1 — Funding and governance of the study

The study was jointly funded from three sources. Direct funding of $50,336 was provided the Australian Government Department of Health and Ageing. The indirect cost of Mr Morris-Yates' salary whilst he worked on the study and its' final report was borne equally by the PMHA-CDMS's three financial stakeholders: the Australian Private Hospitals Association, the Australian Health Insurance Association, and the Australian Government Department of Health and Ageing.

The conduct of the pilot study was overseen by the PMHA-CDMS's Management Committee. Membership of that committee as at the end the main survey administration and reporting phase of the study in March 2007 is shown below in Table A.

Table A: Membership of the Management Committee of the Private Mental Health Alliance's Centralised Data Management Service, as at March 2007.

Name	Position
Dr Bill Pring	Chair of the Management Committee Australian Medical Association
Ms Janne McMahon	Consumer representative Chair of the National Network of Private Sector Consumers and Carers
Ms Ruth Carson	Carer representative Member of the National Network of Private Sector Consumers and Carers
Ms Moira Munro	Hospital representative and Deputy chair of the PMHA CEO of the Perth Clinic
Ms Deborah Stephenson	Health funds representative Provider Relations Manager, BUPA
Mr Peter Callanan	Australian Government Department of Health and Ageing, Private Health Services Branch
Mr Allen Morris-Yates	Director, PMHA-CDMS
Mr Phillip Taylor	Director, PMHA

Appendix 2 — Participating hospitals

Delmont Private Hospital
298 Warrigal Road, Glen Iris (Melbourne), Victoria.
Stand-alone psychiatric hospital.
For more information go to: www.delmonthospital.com.au

The Hobart Clinic
31 Chipmans Road, Rokeby (Hobart), Tasmania.
Stand-alone psychiatric hospital.
For more information go to: www.thehobartclinic.com.au

Lingard Private Hospital
23 Merewether Street, Merewether (Newcastle), New South Wales.
Psychiatric unit located within a general private hospital.
For more information go to: www.lingardprivate.com.au

Perth Clinic
29 Havelock Street, West Perth, Western Australia.
Stand-alone psychiatric hospital.
For more information go to: www.perthclinic.com.au

South Pacific Private
18 Beach Street, Curl Curl (Sydney), New South Wales.
Stand-alone psychiatric hospital.
For more information go to: www.southpacificprivate.com.au

Toowong Private Hospital
496 Milton Road, Toowong (Brisbane), Queensland.
Stand-alone psychiatric hospital.
For more information go to: www.toowongprivatehospital.com.au

Wandene Private Hospital
7 Blake Street, Kogarah (Sydney), New South Wales.
Stand-alone psychiatric hospital.
For more information go to: www.wesleymission.org.au/Centres/whs/Wandene_Hospital/

Wesley Private Hospital
91 Milton Street, Ashfield (Sydney), New South Wales.
Stand-alone psychiatric hospital.
For more information go to: www.wesleymission.org.au/Centres/whs/Wesley_Private_Hospital/

Appendix 3 — The Network's State and Territory Consultations regarding the Measurement of Consumer Perceptions of Care (CPoC)

About the Network

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance and/or who receive their treatment and care, and those that care for them, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

The Network was established in August 2002 and then known as the National Network for Private Psychiatric Sector Consumers and Carers to improve the participation of consumer and their carers in the design, delivery and evaluation of private sector mental health services. Funding support has been provided from the Australian Medical Association (AMA), beyondblue, the Australian Private Hospitals Association, the Australian Health Insurance Association (AHIA) and the Australian Government, Department of Health and Ageing, with a donation from the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The Network is comprised of ***consumers*** who are using, or who have used, a private sector mental health service and their ***carers*** who are people, other than a service provider, whose life is affected by virtue of their close relationship with a private sector mental health consumer, or who has a chosen caring role with such a consumer. There is a representative for each Australian State, the Australian Capital Territory (ACT), and Bluevoices on the Network.

Background to the consultation

In the public sector, there has been strong agreement for some time that the development and implementation of a nationally agreed measure of Consumer Perceptions of Care (CPoC) is a priority. Work has taken place concerning a national approach for the Mental Health Consumer Perceptions and Experiences of Services (MHCoPES), an 18-month project carried out by NSW CAG and the Centre for Mental Health in NSW. That project looked at the availability of services, access to services, getting information, treatment and assistance, staff, consumer participation and the hospital setting. The MH-CoPES Project aimed to develop or identify an instrument or process to collect, collate, measure and report consumer perceptions and experiences of mental health services. While the Strategic Planning Group for Private Psychiatric Services (SPGPPS) now the Private Mental Health Alliance (PMHA) has agreed that it is important to ensure that the private sector be directly involved in the development of a nationally agreed measure, that is suitable for use in all service settings and sectors, is likely to be a difficult and time consuming undertaking.

In the private sector, there is wide variation in the nature, extent and quality of the processes used in the evaluation of consumer perceptions of care by private hospitals with psychiatric beds (Hospitals). In November 2004, the SPGPPS, Information Strategy Working Group (ISWG) carefully considered this matter and suggested that a possible option would be to implement the twenty eight item *NRI/MHSIP Inpatient Consumer Survey* (NRI/MHSIP), developed in the USA. NRI/MHSIP differs from the currently widely used Press Ganey, a 63 item survey of consumer perceptions of satisfaction, based on hospital structure, organisation and hospital processes. MHSIP is specifically outcome focused and asks the hard questions

about how consumers feel regarding their clinical outcomes. Accordingly, the ISWG established a small CPoC Project Team to prepare the project brief titled:

> *National implementation of a Consumer Perceptions of Care measure in private Hospital–based psychiatric services: Analysis of the issues and a plan for the evaluation and possible trial of a suitable measure* (hereafter CPoC Project Brief).

The ISWG referred the CPoC Project Brief and the NRI/MHSIP to the Private Mental Health Consumer Carer Network (Australia) (hereafter Network) for it consider and advise the ISWG specifically in relation to:

1. The issues of perceptions of care thought by the Network to be important in the receipt of services from private hospital-based psychiatric services.
2. The appropriateness of the NRI/MHSIP for use in Australian private hospital-based psychiatric services, particularly in relation to the following.
   - 2.1. The correlation between the issues identified by the NRI/MHSIP with the domains identified by the Network.
   - 2.2. The appropriateness of the questions contained in the NRI/MHSIP within the Australian cultural context, and for private hospital-based psychiatric services.
   - 2.3. Any changes that may be necessary to the NRI/MHSIP for its use in Australian private hospital-based psychiatric services.
3. The relationship between the MH-CoPES Project and the proposed CPoC Project.
4. The proposed trial of the routine collection of data and regular reporting to Hospitals of information regarding consumer perceptions of care. In particular, the questions to be addressed by the trial, the process for the conduct of the trial, the proposed process for the evaluation of the trial, and the funding of the trial.

Consultation process and participants

Initial consumer consultation process

The first stage of initial consultations took place at the face-to-face meeting of the Network held on 21st and 22nd February 2005. The first day of this meeting was devoted to a workshop to the review of the issues detailed above and the proposed trial. The PMHA Information Officer and ISWG Chair attended the workshop.

Second Stage of initial consultations

The second stage of initial consultations took place between 28th February to 14th March 2005 and involved the Network State Co-ordinators convening meetings in the Australian Capital Territory (ACT), Queensland (QLD), New South Wales, (NSW), Tasmania (TAS), South Australia (SA), Western Australia (WA), and Victoria (VIC). The table on the following page sets out where the consultations were held, how many people participated and what their status was at the time of their participation.

State coordinators were responsible for facilitating and conducting the consultations and compiling their results. Only consumers and their carers were counted as participants in the consultations and State Coordinators used the same consultation kit. All participants had experience with the services provided in private psychiatric hospitals, and all State Coordinators had experience in conducting consumer consultation processes in these facilities. Reports of these consultations were submitted to the PMHA Secretariat by close of business Monday 14th March, 2005.

Details regarding the Consumer and Carer Consultations

Location		Date	Convenor	Number of Participants	Status of Participants
State	Venue				Admitted/Non-admitted
ACT	Griffin Community Centre	9 March 2005	Ms Nadia Docrat	3	Non-admitted
QLD	New Farm Clinic	2 March 2005	Ms Julie Hutson	7	Non-admitted
NSW	Wesley Private Hospital	3 March 2005	Ms Alvina Hill	7	Non-admitted
TAS	Hobart Clinic	1 March 2005	Mr Trevor Bester	4	2 Non-admitted 1 Admitted 1 Day of Discharged
	St Helens Private Hospital	3 March	Mr Trevor Bester	4	3 Admitted 1 Day of Discharge
SA	Adelaide Clinic	7 March 2005	Ms Marjorie Smith	4	Non-admitted
WA	Perth Clinic	2 March 2005	Ms Anita Fratel	2	Non-admitted
VIC	Delmont Private Hospital	28 February 2005	Ms Ingrid Ozols	7	Admitted
	Pinelodge Clinic	28 February 2005	Ms Ingrid Ozols	5	Admitted
	Victoria Road Clinic	28 February 2005	Mr Wayne Chamley	5	Admitted
	The Melbourne Clinic	28 February 2005	Mr Wayne Chamley	7	Admitted
	Geelong Clinic	2 March 2005	Mr Wayne Chamley	9	Admitted
			TOTAL	64	

Participants were advised that their task was to continue the discussion and review process initiated at the February 2005 meeting of the National Network to obtain the advice of local consumers' regarding the appropriateness of the proposed measure and its proposed trial.

Hospitals were advised of the consultation process and provided with a project rationale and outline by email. Hospitals were informed that participation of their consumer and carer representatives in this second stage of consultation and their possible endorsement of the trial of the NRI/MHSIP Inpatient Consumer Survey would not be taken as an indication that the Hospital intends to, or may be expected to, participate in the trial.

Network State and Territory Co-ordinators were provided with a consultation kit comprised of the following materials.

1. The Draft Agenda for the meeting.
2. Copy of the consumer and carer views as identified by the February 2005 National Network Meeting.
3. Copy of the *NRI/MHSIP Inpatient Consumer Survey* questions as amended and correlated by the February 2005 Network meeting.
4. A reporting back template, including recommendations to proceed to trial or otherwise.

Responses to general questions regarding the measurement of CPoC and use of the NRI/MHSIP Inpatient Consumer Survey

A total of 74 consumers and their carers, including Network Members, participated in the consultation process. The use of a CPoC Measure in private hospital-based psychiatric services was unanimously supported by all 74 participants. The NRI/MHSIP was thought to be suitable for this purpose by 73 of those consulted, with 1 person abstaining. Of the 74 people consulted, 73 supported the use of an independent third party, for the collection of the NRI/MHSIP, with 1 person unsure. Of those consulted, 73 recommended that the proposed trial of the NRI/MHSIP should proceed, with 1 person abstaining.

1. Does the group support the use of a Consumer Perceptions of Care measure in private hospital-based psychiatric services in your state?

Responded Yes: 64
No: 0

Suggestions and comments offered during consultations:

- Very timely, great work.
- No doubts concerning the need for such a measure.
- All participants felt strongly that an across the board questionnaire was very important.
- Absolutely…very positive response
- Though in favour of the measure, there is concern that there may not be the will to trial the measure. A number of facilities use the Press Ganey measure as well as numerous others to gauge consumer satisfaction. Consumers feel that this measure may be added to, rather than replace other measures and therefore, will not be used effectively. There is in principle support for the measure, hospital co-operation will be imperative.
- Fully supported and patients appreciated that they were given the opportunity to have input.

2. Is the NRI/MHSIP Inpatient Consumer Survey, as amended by the National Network for Private Psychiatric Services Consumers and Carers, suitable for this purpose?

Responded Yes: 63
No: 0
Abstained: 1

Suggestions and comments offered during consultations:

- We send our recommendations.
- The amendments make sense and are very clear. Keeping the number of questions below 40 is a good idea, as the Press Ganey measure is very long. Perhaps make it clear on the survey that the information is completely confidential and that there is no way of tracking respondents.
- Ideal for comparisons/benchmarking.
- The trial should sort out any question deficiencies.
- Group wished to retain questions 21 & 27. Saw some value for data collection purposes in retaining appropriate elements of race/ethnicity box and the age aggregation boxes.
- Also recommended that it be noted that on the survey that it was not compulsory to complete it and that a disclaimer be attached to it.
- The name NRI/MHSIP was felt to be unwieldy and needs to be changed.
- Results of the surveys should be made available to hospital consumer and carer committees.
- Appears relevant and broad enough.
- Suggestion to amend date of discharge to be date of discharge, month and year only, not day.
- Reword some questions so that the language is more Australian.
- Some minor changes to questions would improve likelihood of getting most meaningful response.

- Should be introduced immediately. Patients should see a summary of the Hospital's performance every 3 months.

3. Are there any major areas NOT covered by the amended NRI/MHSIP Inpatient Consumer Survey?

Areas identified as NOT covered during consultations:

- One wanted a question on appropriateness of visiting hours
- Question 9 is too verbose and should be replaced with 'My confidentiality was respected'.
- Some felt that some patients would not understand the word 'retaliation' in Q15.
- Discharge planning – provision for after-care not adequately addressed. It is imperative to quantify Hospital Funds discharge plans
- The survey needs to ask more questions in the environmental areas to convince users of standard patient satisfaction surveys that an outcomes–oriented survey like the MHSIP is more relevant to their needs.
- Looks good as it is.
- Does not appear to be so. Some questions appear to double up but could also be analysed for different purposes, so they are.
- Address/include question on amenities/activities hospital and during stay, e.g. TV, reading materials, AA meeting, self-help books.
- Information about rights and responsibilities.
- An additional question: If you witnessed/experienced a serious incident, did you feel that the staff's response was satisfactory?
- Query by one group – Is the 'date' on top of page 1 the date of discharge or date of form completion?

4. Is the use of an independent third party (eg the SPGPPS's Centralised Data Management Service (CDMS) supported for the collection of the NRI/MHSIP Inpatient Consumer Survey?

Responded Yes:	63
No:	0
Don't know:	1

Suggestions and comments offered during consultations:

- Consider the cost of an independent party and ability to collect questionnaires; easier at hospital. Hospitals in this State are large enough to ensure confidentiality.
- This was seen to be essential; consumers felt more secure and would be confident of their anonymity if the data was collected by a third party.
- Better for patients and hospitals, but some worried that some patients may forget to post it if not completed at discharge.
- Strongly supported
- Very important.
- This is essential.
- Privacy not an issue.
- Great idea. This way consumers and carers will feel more comfortable about being honest and give accurate responses.

5. Do participants recommend that the proposed trial of the amended NRI/MHSIP Inpatient Consumer Survey proceed?

Responded Yes:	63
No:	0
Abstained:	1

Suggestions and comments offered during consultations:

- Feel it would be very useful and look forward to consumer comparison
- If the facility is willing to participate.

6. Do you have any general comments regarding the NRI/MHSIP Inpatient Consumer Survey?

Suggestions and comments offered during consultations:

- In the preamble at the top of page one, 'Please indicate your level of agreement or disagreement' the negative should be last. Also 'Your answers WILL BE confidential and will not affect the services you receive, hopefully improve them.
- Suggest that the numbers 5 – 1 rather than 1 – 5 go across the top of the form, putting the 'agrees' first in the left-hand column, with boxes below staying blank for consumers to tick.
- More headings to separate out groups of questions. The easier it is to fill out the better will be the response.

Suggested amendments to specific questions within the NRI/MHSIP Inpatient Consumer Survey.

Q. 1 (As a direct result of the services I received) I am better able to deal with crisis.

Suggestions and comments offered during consultations:

- Replace the word "crisis" with the phrase "large problems".

Information officer's comments:

The suggested change to the wording of the question changes its meaning quite significantly. The concept of "large problems" probably includes significant issues or difficulties that arise either suddenly or unexpectedly and also significant ongoing issues that cause difficulties for a person. Rather than modify the original question it may be more appropriate to include an additional question about dealing with "large problems". That additional question should then be trialled in parallel with the original.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 2 (As a direct result of the services I received) My symptoms are not bothering me as much.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 3 The medication I am taking helps me control symptoms that used to bother me.

Suggestions and comments offered during consultations:

- NN members suggested that the wording be changed to "The treatment I received helps me to control symptoms that used to bother me."
- Further change wording to "The treatment I received helps me to manage my symptoms better."

Information officer's comments:

The proposed changes refer to a different aspect of the services likely to have been provided whilst in hospital than those addressed by the original wording. It is likely that the perceived efficacy of both medications and any therapy that may have been provided is of interest. The differences between the two forms of suggested wording for the alternative question raise complex issues. My sense of the matter is that medication helps "control" symptoms whilst therapy enables a more active engagement with both symptoms and underlying vulnerabilities and thought patterns so that the person is able to better "manage" their symptoms.

Recommendation with respect to the pilot study:

Retain the question with its original wording. **Include an additional question** worded as follows "The treatment I received helps me to manage symptoms that used to bother me". Insert this additional question immediately after the original Question 3.

Q. 4 (As a direct result of the services I received) I do better in social situations.

Suggestions and comments offered during consultations:

- Not worded well, suggest change to "I am more confident in social situations" or "I cope better in social situations".
- Change to "I can now 'better approach' social situations".

Information officer's comments:

The two alternative wordings that have been suggested both change the meaning of the question. "Confidence" in social situations is a narrower issue than the overall experience captured by the original wording. Similarly, the idea of being able to "better approach" a situation, social or otherwise, is likely to relate most strongly to confidence, but will also tap into certain specific social skills related to the initiation of contact. Before either version could be accepted, it would be necessary to trial both in parallel with the original version.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 5 (As a direct result of the services I received) I deal more effectively with daily problems.

Suggestions and comments offered during consultations:

- Change to "I deal with daily problems more effectively".
- NN members suggested that an additional question be inserted after Question 5 that asks "My sense of wellbeing has improved". Suggestions and comments regarding this additional question (A) are documented in the next part of this report.

Information officer's comments:

The suggested change to the wording does not appear to change the meaning of the question in any way, however it is less grammatically correct. Acceptance of the change should hinge on whether the alternative is significantly more easily understood than the original wording.

Recommendation with respect to the pilot study:

Retain question 5 with its original wording.

Q. 6 (During my hospital stay) I was treated with dignity and respect.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 7 (During my hospital stay) Staff here believed that I could grow, change and recover.

Suggestions and comments offered during consultations:

- Change to "Staff here believed that I could improve and recover".
- Recovery is not always possible, suggest either "Staff here believed I could improve and manage my illness" or "staff here believed I could improve/recover with regard to my illness".
- Change to "I felt that staff believed I could improve and recover".
- Two groups commented that as it is worded the question could elicit a response influenced by paranoia.

Information officer's comments:

The comments regarding problematic interpretations of the question reflect the difficulty encountered in getting at the issue. If one answers yes, staff did believe I could grow and change then that may amount to an admission that growth and change was needed. It may or may not be appropriate for a person to see their mental health problems in that light. Nevertheless, the question addresses an important issue regarding staff attitudes to the patients in their care. The suggested changes do go some way to addressing the problem. Unfortunately, before any of the suggested changes to the wording could be accepted, it would be necessary to trial the changes in parallel with the original version.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 8 (During my hospital stay) I felt comfortable asking questions about my treatment and medications.

Suggestions and comments offered during consultations:

- No changes were suggested.
- NN members suggested that an additional question be inserted before Question 8 as follows "My wishes about who is and is not to be given information about my treatment were respected". Suggestions and comments regarding this additional question (B) are documented in the next part of this paper.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 9 (During my hospital stay) I was encouraged to use self help/support groups.

Suggestions and comments offered during consultations:

- NN members suggested that the wording be changed to "I was informed about, and encouraged to use, self-help/support groups."
- As the question could be misinterpreted to refer to the use of such groups within the hospital during the person's stay, change wording to "I was informed about and encouraged to use community self-help/support groups".
- Alternatively, change wording to "I was informed about and encouraged to use self-help/support groups both inside and outside the clinic".

Information officer's comments:

In some private hospital settings this question could be quite ambiguous. The final alternative wording extends the meaning to include self help and support groups that may have been offered during the hospital stay. This was probably not the intent of the original question. The use of the term "clinic" rather than "hospital" may be confusing as only some hospitals now prefer to refer to themselves as a "clinic".

Recommendation with respect to the pilot study:

Retain the question but **change the wording** as follows: "I was informed about and encouraged to use self-help/support groups in the community".

Q. 10 (During my hospital stay) I was given information about how to manage my medication side-effects.

Suggestions and comments offered during consultations:

- Change wording to "I was given information about how to manage my medication and any side-effects".
- Change wording to "I was given information about how to manage my medication and potential side-effects".

Information officer's comments:

The original wording may imply that all medication will definitely have significant side-effects. The suggested alternative wordings both cover the broader range of medication–related issues that should be addressed during the hospital stay without implying that all patients will suffer serious side–effects. However, in doing so it extends the requirement for the provision of information quite widely to "any side–effects" and "potential side–effects". The original question was focussed just on the one key issue and kept focussed to issues that are known to affect the respondent. That may or may not be a good thing. Before any of the suggested changes to the wording could be accepted, it would be necessary to trial the changes in parallel with the original version.

From a psychometric and statistical perspective the issue is whether broadening the focus of the question gives a more or less accurate account of hospital practice. It may be that the more focussed question captures the most critical aspect of practice. For example, if the side-effects issues are dealt with appropriately then it may be likely that more general medication management issues are also dealt with. The more complex wording of the broader question may then only have the effect of increasing the difficulty of the questionnaire.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 11 (During my hospital stay) My other medical conditions were treated.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 12 I felt this hospital stay was necessary.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 13 (During my hospital stay) I felt free to complain without fear of retaliation.

Suggestions and comments offered during consultations:

- Change wording to "I felt free to complain without fear of retribution.
- Comment was made that the language used in the question was overly emotive.

Information officer's comments:

The sense of the question is that hospital staff are perceived as being likely to act in a manner that discourages complaint. "Retribution" describes a different level of response and is also a less commonly used word than "retaliation".

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 14 I felt safe to refuse medication or treatment during my hospital stay.

Suggestions and comments offered during consultations:

- Change wording to "I felt free to refuse medication".
- Change wording to "I felt confident to refuse medication or treatment during my hospital stay" or "I felt comfortable about refusing medication about refusing medication or treatment during my hospital stay".

Information officer's comments:

The suggested changes from "safe" to "free", "confident" or "comfortable" will change the meaning of the question. Safety is a key issue. Feelings of confidence and comfort are also likely to be very strongly related to a person's mental state. A person may not feel confident or comfortable in their desire to refuse a particular medication or treatment, but nevertheless they may strongly wish not to accept it. In that situation, their right to refuse will be enhanced if they feel that if they refuse the medication or treatment they will not be treated harshly by staff and that staff will still do their best to maintain the person's physical and emotional safety.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 15 (During my hospital stay) My complaints and grievances were addressed.

Suggestions and comments offered during consultations:

- Add something to suggest that "my complaint was handled in a timely manner".
- Change wording to "Any complaints or grievances I may have had were adequately addressed".

Information officer's comments:

The basic question gets straight at the issue. The addition of the factor of timeliness may confuse the issue.

The difficulty being addressed by the second suggested change in wording also arises with a number of other questions. As with those other questions, it must be assumed that respondents will use the "Not Applicable" option if they feel the question is not relevant. That is in this case, that they did not have any complaints or grievances that they wanted to raise during their stay.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 16 (During my hospital stay) I participated in planning my discharge.

Suggestions and comments offered during consultations:

- Change wording to "I participated in planning my return home". A quick survey of current inpatients revealed that very few knew what the phrase "discharge planning" meant.
- Change wording to "I was invited in planning my discharge".
- Amend phrase so as to change wording to "I participated in planning my discharge which gave me adequate information about allied health services and support groups".

Information officer's comments:

The suggested changes indicate that there may be some difficulty for patients in understanding the question. It might be argued that if the respondent had been properly involved in their "discharge planning" then they would know it and answer accordingly. If they were not and did not understand the meaning of the question, then it is likely to be answered "Not Applicable" or left blank. The more problematic scenario is one where the respondent was actively involved in their "discharge planning" but was not aware that that was what they were participating in.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 17 Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.

Suggestions and comments offered during consultations:

- NN members suggested that this question be re-worded as "I participated in planning my treatment".
- Change wording to "I was invited in planning my treatment".

Information officer's comments:

This question is particularly problematic. It was developed in a public-sector context where the clinician responsible for the patient in the community is usually different to the psychiatrist responsible for their care in hospital. This question will remain relevant in the Australian public sector, although the phrase "case manager" will need to be added in that context. However in the private sector, the patient's treating psychiatrist during their hospital stay is almost always the doctor they have in the community. In order to enable comparison between public and private sectors it will be important to retain this question.

"Active involvement" in treatment planning is a stronger form of engagement than either "participation" or simple "invitation". Positive responses to the question in its originally

proposed form would reflect a real effort on the part of the patient's treating psychiatrist and hospital staff to engage with the patient in treatment planning.
The original wording of the question is also problematic in the sense that the focus on the involvement of the patient may easily be lost. One solution, consistent with the NN's recommendation might be to add the additional question that focuses specifically on the patient's involvement and also retain the original question. For example, include an additional question worded as follows: "(During my hospital stay) I was actively involved in planning my treatment". This question could be inserted before the original question 17.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 18 I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

Suggestions and comments offered during consultations:

- NN members suggested that this question should be deleted.

Information officer's comments:

The issues with this question are similar to those discussed above in relation to Question 17.

Recommendation with respect to the pilot study:

Retain the question but change the wording as follows: "I had an opportunity to talk with my doctor, therapist or case manager from the community prior to discharge".

Q. 19 (During my hospital stay) The surroundings and atmosphere at the hospital helped me get better.

Suggestions and comments offered during consultations:

- Change wording to "The surroundings and atmosphere at the hospital aided my recovery".

Information officer's comments:

The changed wording results in a conceptually more complex question having a somewhat different meaning to the original. It is arguable that the focus of acute inpatient care is not "recovery" in the technical sense now current. The simple phrase "get better" may be closer to what can reasonably be expected from an acute admission.

Recommendation with respect to the pilot study:

Retain the question.

Q. 20 I felt I had enough privacy in the hospital.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 21 I felt safe while I was in the hospital.

Suggestions and comments offered during consultations:

- Change wording to "I felt safe and secure while I was in hospital and my personal belongings were secure".

Information officer's comments:

The additional clause refers to a separate, though related, issue. It should be asked as a separate question. The principle issue is safety. If ones belongings are not secure then one's sense of safety will be correspondingly reduced. As a general principal, increasing the complexity of a question with the addition of a related issue will not improve its validity or reliability. The more direct and simple the wording the better.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 22 The hospital environment was clean and comfortable.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 23 (During my hospital stay) Staff were sensitive to my cultural background.

Suggestions and comments offered during consultations:

- Change wording to "Staff recognised and catered for my cultural/religious background".

Information officer's comments:

If during the pilot study respondents indicate that they have difficulty understanding the question as it is currently worded, then the suggested changes should be trialled.

Recommendation with respect to the pilot study:

Retain the question.

Q. 24 (During my hospital stay) My family and/or friends were able to visit me.

Suggestions and comments offered during consultations:

- Change wording to "My family and/or friends were able to visit me at times that were convenient and appropriate".
- NN members suggested that this question be deleted.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Q. 25 (During my hospital stay) I had a choice of treatment options.

Suggestions and comments offered during consultations:

- No changes to this question were suggested.

- NN members suggested that two additional questions be inserted before Question 25. First, "Services were appropriate for my age". Second, "With my permission, my nominated carer was involved in my hospital treatment". Suggestions and comments regarding these additional questions (D and E) are documented in the next part of this report.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question. **Recommendations regarding the additional questions** are provided in the next part of this paper.

Q. 26 (During my hospital stay) My contact with my Doctor was helpful.

Suggestions and comments offered during consultations:

- NN members suggested that the wording be changed to "My contact with my treating psychiatrist was helpful".
- Retain original wording, that is, "doctor" rather than "treating psychiatrist".
- Change wording to "My contact with my treating psychiatrist assisted my recovery".

Information officer's comments:

Discussion of this question among different groups indicates that there is no general agreement as to the best term. If the use of the term "doctor" is confusing to patients then, in the pilot study, it would be likely that this question is frequently left unanswered or answered as "not applicable".

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 27 (During my hospital stay) My contact with nurses and therapists was helpful.

Suggestions and comments offered during consultations:

- Split question in two to better identify differences between the two professional groups, that is "My contact with nurses was helpful" and "My contact with therapists was helpful".
- Modify wording so that there is more emphasis on time spent with these professionals.

Information officer's comments:

The proposed split into two questions does better reflect the way in which services are delivered in both the public and private hospital sectors. The separation would only be warranted if it became clear that patients understood the distinction and that the distinction being drawn was at the appropriate level. The latter point is probably the more important. The distinction of most interest is between general psychiatric nursing care and specific therapeutic programmes. The latter may be run by nurses or by allied health professionals. Whilst nurses are likely to be principally responsible for the former, it is likely that allied health professionals will also provide "general psychiatric care" when necessary. The issue of the utility of specific treatment programmes has already been addressed above under Question 3. It is therefore recommended that the question be left in its present form.

The issue of how much time nursing and other staff were able to spend with patients is also important. A respondent may well feel that what contact they did have was very "helpful" but also feel that there just wasn't enough of it. This is a distinct issue that is not addressed by the current question. It would be useful to develop and trial an additional question to address the "time spent" issue.

Recommendation with respect to the pilot study:

Retain the question with its original wording.

Q. 28 If I had a choice of hospitals, I would still choose this one.

Suggestions and comments offered during consultations:

- No changes were suggested.
- NN members suggested that two questions be inserted after Question 28. First, "I was able to get all the services I thought I needed". Second, "I was able to be admitted as soon as I needed to be". Suggestions and comments regarding these additional questions (F and G) are documented in the next part of this report.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question. Recommendations regarding the additional questions are provided in the next part of this paper.

Background Question Age group

Suggestions and comments offered during consultations:

- Suggest age groupings be broader, for example, under 25; 26 – 40; 41 – 60 and over 60.

Information officer's comments:

The current age groupings used in the Hospitals' Standard Quarterly Reports are "Less than 15 years", "15 to 24 years", "25 to 44 years", "45 to 64 years" and "65 years and older". These groupings were agreed after technical consultations with hospital and payer representatives. It is suggested that if the response options are to be reduced, then they be reduced to this standard set.

Recommendation with respect to the pilot study:

Retain the question but reduce the set of response options so that they correspond to the Age groupings used in Hospitals' Standard Quarterly Reports.

Background Question Gender

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Background Question Ethnicity

Suggestions and comments offered during consultations:

- NN members suggested that this question be deleted.
- Suggested that this question be retained. No suggestions regarding the appropriate response set were offered.

Information officer's comments:

This may be an important question for public sector services. The response set needs to be modified so that it encompasses the most relevant set of options for the Austrlain context.

Recommendation with respect to the pilot study:

If public sector consumers and service providers recommend its retention, then retain the question with a modified response set, otherwise, delete it.

Background Question Marital status

Suggestions and comments offered during consultations:

- NN members suggested that this question be deleted.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Delete the question.

Background Question Date of discharge

Suggestions and comments offered during consultations:

- Change to Month and Year of Discharge rather than exact date.

Information officer's comments:

Agreed. The exact date of discharge together with Age group, Sex and grouped Length of stay could enable the identification of the respondent. That should be avoided.

Recommendation with respect to the pilot study:

Retain the question but with the suggested modification to the response format.

Background Question Length of stay

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Background Question Legal status

Suggestions and comments offered during consultations:

- No comments.

Information officer's comments:

As a basic principle, all Patients, regardless of their Legal status, either during their stay in hospital or on discharge, should be offered the CPoC measure. It is possible that patients who have been involuntary may be treated differently whilst in hospital and it would be very useful to be able to identify such differences.

For private hospitals with few involuntary patients, information about Legal status could enable the identification of the respondent. That should be avoided.

For public sector psychiatric units this is likely to be less of an issue. A decision to include the question in the public sector should hinge on whether that would influence patients' willingness to complete the measure.

If the question is to be included, then the response set should be modified to better reflect the Australian context. Its wording may also need to be modified so that respondents are clear that if they were admitted as an involuntary patient or where otherwise treated as an involuntary patient during their stay then they should answer yes.

Recommendation with respect to the pilot study:

Exclude the question in the private sector only.

Background Question Occasion when survey was completed

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Retain the question.

Suggested amendments to additional questions proposed by members of the Network

Additional question A My sense of wellbeing has improved

This was identified as Question 6 in the amended version of the Survey used in consultations.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

The suggested additional question allows the respondent to provide a final summary of the outcomes of the services they have received. It is likely to capture the gestalt of symptoms and disability together with more subtle concepts of social and emotional health. Despite the technical complexity of the concept, the idea of "wellbeing" is likely to be intuitively understood even if respondents, when asked, are unable to say exactly what they think it means.

Recommendation with respect to the pilot study:

Include the question in its suggested form.

Additional question B My wishes about who is and is not to be given information about my treatment were respected.

This was identified as Question 9 in the amended version of the Survey used in consultations.

Suggestions and comments offered during consultations:

No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Include the question in its suggested form.

Additional question C Services were appropriate for my age.

This was identified as Question 28 in the amended version of the Survey used in consultations.

Suggestions and comments offered during consultations:

- Change wording to "Services and facilities were appropriate for my age".

Information officer's comments:

The suggested change complicates the question with two distinct issues.

Recommendation with respect to the pilot study:

Include the question in its originally suggested form.

Additional question D With my permission, my nominated carer was involved in my hospital treatment.

This was identified as Question 29 in the amended version of the Survey used in consultations.

Suggestions and comments offered during consultations:

- Change wording to "With my permission my nominated carer/family was involved in my hospital treatment".

Information officer's comments:

The original wording specifies "nominated carer". This is a more restrictive term than the suggested change and also implies a more intense level of involvement. Consequently, the suggested change asks a different question.

Recommendation with respect to the pilot study:

Include the question in its originally suggested form.

Additional question E I was able to get all the services I thought I needed.

This was identified as Question 34 in the amended version of the Survey used in consultations.

Suggestions and comments offered during consultations:

- No changes were suggested.

Information officer's comments:

No comments.

Recommendation with respect to the pilot study:

Include the question in its suggested form.

Additional question F I was able to be admitted as soon as I needed to be.

This was identified as Question 35 in the amended version of the Survey used in consultations.

Suggestions and comments offered during consultations:

- Change wording to "I feel confident and secure knowing that, if the need arises, I can re-apply for admission at any future time."

Information officer's comments:

The suggested change in wording refers to a different, though related, issue. Also, the phrasing of the suggested change is not consistent with the general procedure followed when a patient is admitted – that is, the patient does not apply to the hospital for re-admission, their treating psychiatrist admits them.

Recommendation with respect to the pilot study:

Include the question in its originally suggested form.

Appendix 4 — Examples of the Survey Formats and the attached Covering Letters

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«Hospital_ Name»

Perceptions of Care Survey for Overnight Inpatients

Date offered: |__|__| |__|__|
month year

Dear Participant,

«Hospital_Name» is participating in a national study to investigate how hospitals can standardise their approach when evaluating patient services and facilities. The study includes a number of private and public hospitals across Australia. This survey questionnaire has been assembled by the research team in Canberra to gather feedback about the care you received at the hospital. The information obtained from the questionnaire may be used to improve future care for patients.

Your participation is voluntary and strictly confidential. You will not be asked for your name or any other identifying information. The hospital will not see your individual answers. The questionnaire will go directly to the independent research team responsible for the study. They will collate the information and provide a summary of results to each hospital.

The survey questions are different from questions normally asked in hospitals' patient satisfaction surveys. We apologise for the extra time involved in your completing this additional survey.

It is really important that you help us get it right. Please feel free to give both positive and negative comments about your care at «Hospital_Name».

Please complete the following three pages of this survey and send it in the attached reply-paid envelope to the research team at Reply-Paid 3383, Manuka ACT 2603.

If you have any questions about the research, please contact «Hospital_Name»'s «Contact_Role», «Contact_Name», on «Contact_Telephone_Number».

Thank you for your time.

«Manager_Name»
«Manager_Title»
«Manager_Organisation»

First page of the Overnight Inpatient Survey offered to consumers by private hospitals.

In order to provide the best possible mental health services, we need to know what you think about the services you received during this hospital stay, the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers.

Please indicate your level of disagreement or agreement with each of the following statements by **circling the number** that best represents your opinion. If the question is about something you have not experienced, circle **NA** to indicate that this item is "not applicable" to you.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Not Applicable
As a direct result of the services I received						
1. I am better able to deal with crisis.	1	2	3	4	5	NA
2. My symptoms are not bothering me as much.	1	2	3	4	5	NA
3. The medications I am taking help me control symptoms that used to bother me.	1	2	3	4	5	NA
4. The treatment I received helps me to manage symptoms that used to bother me.	1	2	3	4	5	NA
5. I do better in social situations.	1	2	3	4	5	NA
6. I deal more effectively with daily problems.	1	2	3	4	5	NA
7. My sense of wellbeing has improved.	1	2	3	4	5	NA
During my hospital stay						
8. I was treated with dignity and respect.	1	2	3	4	5	NA
9. My wishes about who is and is not to be given information about my treatment were respected.	1	2	3	4	5	NA
10. Staff here believed that I could grow, change and recover.	1	2	3	4	5	NA
11. I felt comfortable asking questions about my treatment and medications.	1	2	3	4	5	NA
12. I was informed about and encouraged to use self-help/support groups in the community	1	2	3	4	5	NA
13. I was given information about how to manage my medication side effects.	1	2	3	4	5	NA
14. My other medical conditions were treated.	1	2	3	4	5	NA
15. I felt this hospital stay was necessary.	1	2	3	4	5	NA
16. I felt free to complain without fear of retaliation.	1	2	3	4	5	NA
17. I felt safe to refuse medication or treatment during my hospital stay.	1	2	3	4	5	NA
18. My complaints and grievances were addressed.	1	2	3	4	5	NA
19. I participated in planning my discharge.	1	2	3	4	5	NA
20. Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	1	2	3	4	5	NA
21. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	1	2	3	4	5	NA
22. The surroundings and atmosphere at the hospital helped me get better.	1	2	3	4	5	NA

Second page of the Overnight Inpatient Survey offered to consumers by private hospitals.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Not Applicable
23. I felt I had enough privacy in the hospital.	1	2	3	4	5	NA
24. I felt safe while I was in the hospital.	1	2	3	4	5	NA
25. The hospital environment was clean and comfortable.	1	2	3	4	5	NA
26. Staff were sensitive to my cultural background.	1	2	3	4	5	NA
27. Services were appropriate for my age.	1	2	6	4	5	NA
28. My family and/or friends were able to visit me.	1	2	3	4	5	NA
29. With my permission, my nominated carer was involved in my hospital treatment.	1	2	3	4	5	NA
30. I had a choice of treatment options.	1	2	3	4	5	NA
31. My contact with my Doctor was helpful.	1	2	3	4	5	NA
32. My contact with nurses and therapists was helpful.	1	2	3	4	5	NA
33. I was able to get all the services I thought I needed.	1	2	3	4	5	NA
34. I was able to be admitted as soon as I needed to be.	1	2	3	4	5	NA
35. If I had a choice of hospitals, I would still choose this one.	1	2	3	4	5	NA

Please feel free to use this space to comment on any of your answers. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

_____

_____

_____

_____

_____

Please answer the following questions to let us know a little about you.

1. Are you male or female?

   ☐ Male ☐ Female

2. To which age group do you belong?

   ☐ Under 18 years ☐ 18 – 24 years
   ☐ 25 – 34 years ☐ 35 – 49 years
   ☐ 50 – 64 years ☐ 65 – 79 years
   ☐ 80 years or over

3. In which country were you born?

   ☐ Australia ☐ U.K.
   ☐ New Zealand ☐ Greece
   ☐ Italy
   ☐ Other *(please specify)*: _____

4. Do you speak a language *other* than *English* at home?

   ☐ No ☐ Yes (please specify): _____

5. How long were you in Hospital this time?

   ☐ 2 weeks or less
   ☐ between 2 and 4 weeks
   ☐ more than 4 weeks

6. Did you need assistance in completing this questionnaire?

   ☐ Yes ☐ No

7. Date Completed: _____/_____/_____

Please also complete the questions on the next page ➔

Third page of the Overnight Inpatient Survey offered to consumers by private hospitals.

Thank you for completing the questionnaire regarding this Hospital. It would be appreciated if you could spare a few minutes and provide some feedback about the questionnaire you have just completed.

About the questions

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree
1. I was comfortable with the questions that were being asked	1	2	3	4	5
2. The questions address issues that are important to me.	1	2	3	4	5

3. Were there any questions that you found very difficult to answer? ☐ No ☐ Yes

3a. If yes, please note down the item number of each such question here: _____

4. What other issues that you think are important were not covered by the questionnaire?

_____

_____

_____

_____

About the process of completing the questionnaire

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree
1. The questionnaire was easy to complete.	1	2	3	4	5
2. I was more comfortable sending the questionnaire to a person outside of the hospital.	1	2	3	4	5
3. I was confident that I could not be identified by the hospital as the person completing the questionnaire.	1	2	3	4	5
4. I was more honest because I knew that I could not be identified by the hospital.	1	2	3	4	5
5. I was confident that the hospital would make use of the information I provided.	1	2	3	4	5
6. The intended use of my feedback made me more willing to complete the questionnaire.	1	2	3	4	5

Thank you for taking the time to answer these questions!

Please place this completed form in the reply–paid envelope, seal the envelope and either post it at your nearest Post Office or place it in the designated area at the Hospital.

Final page of the Overnight Inpatient Survey offered to consumers by private hospitals.

«Hospital_ Name»

Perceptions of Care Survey for Day and Outreach Patients

Occasion: |___| Date offered: |__|__| |__|__|
month year

Dear Participant,

«Hospital Name» is participating in a national study to investigate how hospitals can standardise their approach when evaluating patient services and facilities. The study includes a number of private and public hospitals across Australia. This survey questionnaire has been assembled by the research team in Canberra to gather feedback about the care you received at the hospital. The information obtained from the questionnaire may be used to improve future care for patients.

Your participation is voluntary and strictly confidential. You will not be asked for your name or any other identifying information. The hospital will not see your individual answers. The questionnaire will go directly to the independent research team responsible for the study. They will collate the information and provide a summary of results to each hospital.

The survey questions are different from questions normally asked in hospitals' patient satisfaction surveys. We apologise for the extra time involved in your completing this additional survey.

It is really important that you help us get it right. Please feel free to give both positive and negative comments about your care at «Hospital_Name».

Please complete the following three pages of this survey and send it in the attached reply-paid envelope to the research team at Reply-Paid 3383, Manuka ACT 2603.

If you have any questions about the research, please contact «Hospital_Name»'s «Contact_Role», «Contact_Name», on «Contact_Telephone_Number».

Thank you for your time.

«Manager_Name»
«Manager_Title»
«Manager_Organisation»

First page of the Ambulatory Care Survey offered to consumers by private hospitals.

In order to provide the best possible mental health services, we need to know what you think about the services you have recently received as a day or outreach patient, the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers.

Please indicate your level of disagreement or agreement with each of the following statements by **circling the number** that best represents your opinion. If the question is about something you have not experienced, circle **NA** to indicate that this item is "not applicable" to you.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Not Applicable
1. I like the services that I received here.	1	2	3	4	5	NA
2. If I had other choices, I would still get services from this hospital.	1	2	3	4	5	NA
3. I would recommend this hospital to a friend or family member.	1	2	3	4	5	NA
4. The location of the hospital services was convenient (parking, public transportation, distance, etc.).	1	2	3	4	5	NA
5. Staff were willing to see me as often as I felt it was necessary.	1	2	3	4	5	NA
6. Staff returned my call in 24 hours.	1	2	3	4	5	NA
7. Services were available at times that were good for me.	1	2	3	4	5	NA
8. I was able to get all the services I thought I needed.	1	2	3	4	5	NA
9. I was able to see a psychiatrist when I wanted to.	1	2	3	4	5	NA
10. Staff here believe that I can grow, change and recover.	1	2	3	4	5	NA
11. I felt comfortable asking questions about my treatment and medication.	1	2	3	4	5	NA
12. I felt free to complain.	1	2	3	4	5	NA
13. I was given information about my rights.	1	2	3	4	5	NA
14. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	NA
15. Staff told me what side effects to watch out for.	1	2	3	4	5	NA
16. Staff respected my wishes about who is and who is not to be given information about my treatment.	1	2	3	4	5	NA
17. I, not staff, decided my treatment goals.	1	2	3	4	5	NA
18. Staff were sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	NA
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	1	2	3	4	5	NA
20. I was encouraged to use consumer-run programs (support groups, drop-in centres, crisis phone line, etc.).	1	2	3	4	5	NA

Second page of the Ambulatory Care Survey offered to consumers by private hospitals.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Not Applicable
As a direct result of the services I received						
21. I deal more effectively with daily problems.	1	2	3	4	5	NA
22. I am better able to control my life.	1	2	3	4	5	NA
23. I am better able to deal with crisis.	1	2	3	4	5	NA
24. I am getting along better with my family.	1	2	3	4	5	NA
25. I do better in social situations.	1	2	3	4	5	NA
26. I do better in school and/or work.	1	2	3	4	5	NA
27. My housing situation has improved.	1	2	3	4	5	NA
28. My symptoms are not bothering me as much.	1	2	3	4	5	NA

Please feel free to use this space to comment on any of your answers. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

_____

_____

_____

_____

_____

_____

_____

_____

Please answer the following questions to let us know a little about you.

1. Are you male or female?

   ☐ Male ☐ Female

2. To which age group do you belong?

   ☐ Under 18 years ☐ 18 – 24 years
   ☐ 25 – 34 years ☐ 35 – 49 years
   ☐ 50 – 64 years ☐ 65 – 79 years
   ☐ 80 years or over

3. In which country were you born?

   ☐ Australia ☐ U.K.
   ☐ New Zealand ☐ Greece
   ☐ Italy
   ☐ Other *(please specify)*: _____

4. Do you speak a language *other* than *English* at home?

   ☐ No ☐ Yes (please specify): _____

5. Did you need assistance in completing this questionnaire?

   ☐ Yes ☐ No

6. Date Completed: _____/_____/_____

Please also complete the questions on the next page ➔

Third page of the Ambulatory Care Survey offered to consumers by private hospitals.

Thank you for completing the questionnaire regarding this Hospital. It would be appreciated if you could spare a few minutes and provide some feedback about the questionnaire you have just completed.

About the questions

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree
1. I was comfortable with the questions that were being asked	1	2	3	4	5
2. The questions address issues that are important to me.	1	2	3	4	5

3. Were there any questions that you found very difficult to answer? ☐ No ☐ Yes

3a. If yes, please note down the item number of each such question here: _____

4. What other issues that you think are important were not covered by the questionnaire?

_____

_____

_____

_____

About the process of completing the questionnaire

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree
1. The questionnaire was easy to complete.	1	2	3	4	5
2. I was more comfortable sending the questionnaire to a person outside of the hospital.	1	2	3	4	5
3. I was confident that I could not be identified by the hospital as the person completing the questionnaire.	1	2	3	4	5
4. I was more honest because I knew that I could not be identified by the hospital.	1	2	3	4	5
5. I was confident that the hospital would make use of the information I provided.	1	2	3	4	5
6. The intended use of my feedback made me more willing to complete the questionnaire.	1	2	3	4	5

Thank you for taking the time to answer these questions!

Please place this completed form in the Reply–Paid envelope, seal the envelope and either post it at your nearest Post Office or place it in the designated area at the Hospital.

Final page of the Ambulatory Care Survey offered to consumers by private hospitals.

Appendix 5 — Example of the Final Standard Report for participating private hospitals

This example is provided so that the reader may gain a complete understanding of how the information and accompanying notes was presented to participants.

Please note that the example provided on the following pages is based on fabricated data. The statistics for all hospitals shown in this example do NOT represent the average statistics for the private sector.

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CPoC Pilot Study

Final report regarding the period June to November 2006

This is the final report from the survey administration and routine reporting phase of the Consumer Perceptions of Care Pilot Study

Appendix 5 – Example of the Final Standard Report for participating private hospitals.

Preface

The development, preparation and distribution of this report has been undertaken by the CPoC Research Team to assist Private Hospitals and Public Mental Health Services participating in the Consumer Perceptions of Care Pilot Study. The CPoC Research Team have made every reasonable effort to ensure that the information contained in this report is free from errors and omissions. However, the Research Team do not warrant the accuracy of the report. The report is provided by way of information only to participating hospitals and services.

A detailed explanation of the Figures and Tables included in this report can be found on the following pages. An explanation of the CPoC Study and the protocol under which the Surveys were offered to consumers can be found in your CPoC Study Manual.

If you have any questions, concerns or comments in regards to this report, please direct them to Allen Morris-Yates, the Director of the Private Mental Health Alliance's Centralised Data Management Service.

Administration and receipt of the Surveys

This first brief section of the report provides basic information about the administration and receipt of surveys.

The principal statistic reported below is the Number of Surveys Received. In both Exhibits A and B, this is given for each survey Reference Month and for the whole of the survey administration phase of the Pilot Study, from June to November 2006. Where the person who offered the survey to the consumer did not identify the Reference Month and Year, the date the survey was completed or, if that was not completed, the date three days before the survey was received by the CPoC Research Team, is used to derive the Reference Month and Year. All surveys received and entered until 31 December 2006 are included in this analysis.

With respect to the comparative statistics shown in both Exhibits A and B, the comparison group for your Hospital includes all participating Hospitals in the private sector, not just those Hospitals like yours. This particularly affects the statistics shown in Exhibit B. For example, the Number of Surveys Received is the sum of all Types of Surveys received, not just the particular type of Survey your Hospital may have offered during the pilot study.

Exhibit A: Number of Surveys received from Consumers

Private Hospital Overnight Inpatient Survey	Jun	Jul	Aug	Sep	Oct	Nov	Total
This Hospital							
Participating Hospitals in the Private Sector							

Private Hospital Day or Outreach Patient Survey	Jun	Jul	Aug	Sep	Oct	Nov	Total
This Hospital							
Participating Hospitals in the Private Sector							

Exhibit B: Indications of the overall response rate.

This Hospital	Jun	Jul	Aug	Sep	Oct	Nov	Total
Eligible Collection Occasions							
Surveys Received							
Surveys Received as % of Eligible Occasions							

Participating Hospitals in the Private Sector	Jun	Jul	Aug	Sep	Oct	Nov	Total
Eligible Collection Occasions							
Surveys Received							
Surveys Received as % of Eligible Occasions							

Estimating the Response Rate

Response rates can be calculated on the basis of the information provided in Exhibits A and B. You may calculate the Response Rate for your hospital by dividing the Number of Surveys Received by the number that could have been offered. The count of eligible collection occasions for your Hospital and all other participating Hospitals has been derived from the data submitted to the PMHA's CDMS in respect of the period from April to September 2006. As the survey administration phase of the study in the private sector started on the 19th of June and finished on the 8th of October, the count of eligible collection occasions for June and October are less than that for July, August and September. The count of eligible collection occasions for the period 1 Oct to 8 Oct is based on the weekly average over the preceding six months.

In general, you should remember that the validity of the overall results for your Hospital will depend on the response rate and on the overall number of surveys received. A very low response rate may be indicative of several things. It may be that the survey wass not being offered to consumers in as effective and open a manner as it could have been. Perhaps consumers felt that there was no point in completing and sending in the surveys. Alternatively, the consumers seen by your Hospital may have had very severe problems that made it very difficult for them to complete and submit the survey.

Regardless of the response rate, if your Hospital was not able to offer many surveys, the results will be somewhat more difficult to interpret. If fewer than 30 surveys have been completed, the Consumer Satisfaction Indices and other statistics may be unreliable. However, you should always pay close attention if a majority of respondents have consistently rated certain items poorly.

The Consumer Satisfaction Index (CSI)

The principal Consumer Satisfaction Index reported in the Standard Monthly Reports and in this Final Report is based on the Nevada State Mental Health Service's method of calculating a single statistic summarising consumers responses. The Nevada CSI is particularly useful in highlighting those issues where consumers have expressed any concern about the quality or efficacy of the care they received. It maintains a positive perspective, in that higher index scores indicate higher overall agreement and relatively less disagreement. The index may be increased by taking steps to increase the number satisfied and decrease the number dissatisfied.

The Nevada CSI is calculated as the ratio of Agreement to Disagreement. That is:

$$\text{Nevada CSI} = \frac{\%\ \text{Strongly agree} + \%\ \text{Agree}}{\%\ \text{Disagree} + \%\ \text{Strongly disagree}}$$

In cases where no consumers indicated Disagreement, the Nevada CSI score is coded as 100. Similarly, where the observed ratio is greater than 100, as it may be in cases where there is a very small but non-zero proportion of consumers who disagree, the statistic is recoded as 100.

The major limitation of the Nevada CSI is that it does not discriminate at the top end of the scale. That is, in cases where the only variation between consumers perceptions of care is that some respond with 'Agree' whilst others respond with 'Strongly agree', the Nevada CSI will always be 100. Dr Gopal Bose of Queensland Health's Mental Health Services has suggested an alternative method of calculating the CSI. In this report, that alternative is referred to as the 'Weighted CSI'.

The Weighted CSI used in this final report is calculated as the weighted sum of the number of responses in each category, from 'Strongly Disagree' through to 'Strongly Agree', divided by the Total number of responses. That is:

$$\text{Weighted CSI} = \frac{\begin{array}{l}(0.00 \times \text{Number of 'Strongly Disagree' responses}) + \\ (0.25 \times \text{Number of 'Disagree' responses}) + \\ (0.50 \times \text{Number of 'Neutral' responses}) + \\ (0.75 \times \text{Number of 'Agree' responses}) + \\ (1.00 \times \text{Number of 'Strongly Agree' responses})\end{array}}{\text{Total Number of Responses (not counting Missing responses)}} \times 100$$

The resulting index ranges from 100, indicating that consumers were, on average, very satisfied,

through to 0 indicating that consumers were not at all satisfied. Weighted CSIs around fifty being neutral. The particular weighting scheme has been chosen because: first, discriminates well at both ends of the response scale; second, it provide a reasonably linear index (unlike the Nevada CSI); and third, it maintains a positive perspective. It is included in this final report because of those psychometric characteristics, particularly its' capacity to discriminate at the top, more positive, end of the range of ratings.

Detailed results for each type of Survey offered

The remainder of this report is partitioned into sections, one for each Type of CPoC Survey that was completed and submitted about your Hospital or Service. The layout and content of each of these partitions is the same for each type of survey. Each of the figures and tables within each partition are referred to as numbered 'Exhibits'. The content of each is explained below.

Note that Exhibits 1 and 2 are shown together on a single page so that it may be displayed as a poster for review by staff and, if deemed appropriate, also by patients.

Exhibit 1: Comparison of your average Consumer Satisfaction Indices for the Survey with those for all Hospitals or Services like yours

The items in each Survey have been grouped together under four common domains. They are 'General Satisfaction', 'Access to Services', 'Quality and Appropriateness', and 'Outcomes'. The average responses across the items within each domain is calculated. This also enables an average item score and an average CSI for each domain to be calculated. It is the latter statistic, the average CSI for each domain and for the survey as a whole (referred to as 'Overall Perceptions of Care') that is shown in this figure. The results for your Hospital are compared with the results for All private hospitals participating in the study.

Exhibit 2: Your top 5 and bottom 5 Survey Items ranked by their CSIs

The first five items listed in this table are the Survey Items most strongly agreed with by Consumers - the things your Hospital was rated best on. The remaining five items are the Survey Items most strongly disagreed with - the things your Hospital was rated worst on.

Exhibit 3: Ranking of the Consumer Satisfaction Indices for the individual items in the survey from the highest (most positive) to the lowest

As its' title indicates, this figure simply ranks each item in the survey by their CSI. Items with high CSIs appear at the top of the figure. These are the issues on which consumers have rated your hospital or service unit most highly. Those items ranked at the bottom are those given the lowest rating by your consumers. Depending on their clinical importance, these are the issues that you may wish to address as soon as possible.

As was noted under the section describing the calculation of the CSI, the Nevada CSI does not discriminate between items when all responses are positive, whereas the Weighted CSI does do so. Accordingly, the items in this table are ranked by the Nevada CSI and then, within that, by the Weighted CSI. This means that the item at the top of the table has the highest Nevada CSI and the highest Weighted CSI of all items. Thus, the visual rank order of the items in the table is informative, even for those items that share the same Nevada CSI of 100. Note this applies to the rankings of items in Exhibit 2 also.

Exhibit 4: Detailed Results for All items in the Survey

As its' title indicates, this table provides detailed statistics on responses to all the items in the survey. Use the results shown in Exhibits 2 and 3 to quickly identify items that you may wish to know more about, then turn to the item's detailed statistics in this table. Here you will find exactly what proportion of consumers strongly disagreed, disagreed, were neutral, agreed or strongly agreed with the item.

You may note that for some items the sum of the percentage of responses to 'Strongly Disagree' through to 'Strongly Agree' does not add up to 100%. This occurs in cases where an item was not given a valid response by all consumers who completed the survey. The percentages shown under each valid response option take that possibility into account. For example, if 100 consumers

completed at least some part of the survey, but only 80 completed item 1 and of those 80, 20 rated it as 'Strongly Agree', then the percentage who responded 'Strongly Agree' would be reported as 20%, not 25% (that is 20 over 100, not 20 over 80). If the percentage shown in the column labelled 'responses to item' is less than 100% then that indicates that not all consumers who completed the survey also completed the item in question.

Exhibit 5: Consumers' Comments

Following the actual survey questions, each type of survey had some space for the consumer to note down any additional comments they may have wanted to make. Those comments are given verbatim in this section of the report. Note that when such comments were entered into the Study database, personally identifying information about the consumer and any clinicians that may have been mentioned was removed.

Private Hospital Overnight Inpatient Survey

Summary based on the Nevada Consumer Satisfaction Index

Exhibit 1. Comparison of your average Nevada Consumer Satisfaction Indices for the Survey with those for all participating Hospitals.

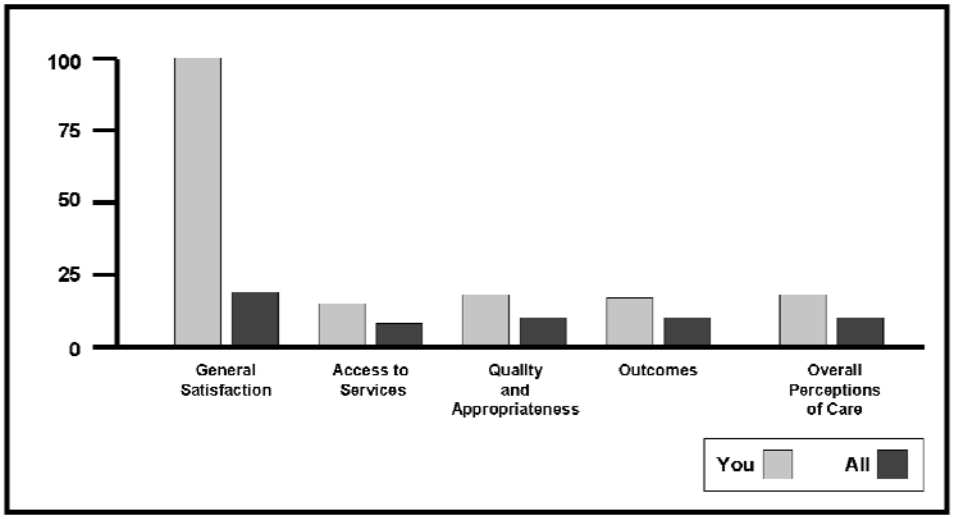

Exhibit 2: Top 5 and bottom 5 items ranked by their Consumer Satisfaction Indices

Survey items most strongly agreed with		
(25)	The hospital environment was clean and comfortable.	100
(28)	My family and/or friends were able to visit me.	100
(35)	If I had a choice of hospitals, I would still choose this one.	100
(15)	I felt this hospital stay was necessary.	100
(32)	My contact with nurses and therapists was helpful.	75
Survey items most strongly disagreed with		
(05)	I do better in social situations.	9
(02)	My symptoms are not bothering me as much.	8
(14)	My other medical conditions were treated.	6
(12)	I was informed about and encouraged to use self-help/support groups in the community	5
(13)	I was given information about how to manage my medication side effects.	3

Note: Item numbers are shown in parentheses. Consumer satisfaction indices are shown in the right hand column of the table.

Exhibit 3: Ranking of the individual items in the Survey by their Nevada Consumer Satisfaction Indices, from the highest (most positive) to the lowest.

25	The hospital environment was clean and comfortable.	100
28	My family and/or friends were able to visit me.	100
35	If I had a choice of hospitals, I would still choose this one.	100
15	I felt this hospital stay was necessary.	100
32	My contact with nurses and therapists was helpful.	75
09	My wishes about who is and is not to be given information about my treatment were respe	72
10	Staff here believed that I could grow, change and recover.	71
08	I was treated with dignity and respect.	52
27	Services were appropriate for my age.	50
24	I felt safe while I was in the hospital.	49
22	The surroundings and atmosphere at the hospital helped me get better.	47
01	I am better able to deal with crisis.	45
26	Staff were sensitive to my cultural background.	43
11	I felt comfortable asking questions about my treatment and medications.	30
31	My contact with my Doctor was helpful.	29
07	My sense of wellbeing has improved.	27
23	I felt I had enough privacy in the hospital.	24
19	I participated in planning my discharge.	22
04	The treatment I received helps me to manage symptoms that used to bother me.	22
03	The medications I am taking help me control symptoms that used to bother me.	20
20	Both I and my doctor or therapist from the community were actively involved in my hospita	15
06	I deal more effectively with daily problems.	15
29	With my permission, my nominated carer was involved in my hospital treatment.	14
21	I had an opportunity to talk with my doctor or therapist from the community prior to dischar	13
18	My complaints and grievances were addressed.	13
16	I felt free to complain without fear of retaliation.	12
30	I had a choice of treatment options.	12
17	I felt safe to refuse medication or treatment during my hospital stay.	11
34	I was able to be admitted as soon as I needed to be.	9
33	I was able to get all the services I thought I needed.	9
05	I do better in social situations.	9
02	My symptoms are not bothering me as much.	8
14	My other medical conditions were treated.	6
12	I was informed about and encouraged to use self-help/support groups in the community	5
13	I was given information about how to manage my medication side effects.	3

Exhibit 4: Detailed results for all Items in the Survey

General Satisfaction

		responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
35	If I had a choice of hospitals, I would still choose this one.									
You		99%	1%	0%	3%	19%	76%	4.7	**100**	93
All		94%	2%	2%	6%	26%	57%	4.4	**19**	86
S	Average results for this summary score.									
You		99%	1%	0%	3%	19%	76%	4.7	**100**	93
All		94%	2%	2%	6%	26%	57%	4.4	**19**	86

Access to Services

		responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
28	My family and/or friends were able to visit me.									
You		97%	1%	0%	0%	24%	72%	4.7	**100**	93
All		91%	1%	1%	2%	35%	52%	4.5	**49**	88
30	I had a choice of treatment options.									
You		82%	1%	4%	17%	25%	36%	4.1	**12**	77
All		80%	4%	9%	15%	31%	20%	3.7	**4**	67
33	I was able to get all the services I thought I needed.									
You		99%	3%	6%	8%	32%	50%	4.2	**9**	81
All		95%	3%	5%	9%	38%	40%	4.1	**10**	78
34	I was able to be admitted as soon as I needed to be.									
You		99%	3%	7%	1%	24%	65%	4.4	**9**	86
All		94%	5%	7%	6%	33%	43%	4.1	**6**	77
S	Average results for this summary score.									
You		94%	1%	4%	6%	26%	56%	4.4	**15**	85
All		89%	3%	5%	8%	34%	39%	4.1	**8**	78

Quality and Appropriateness

		responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
08	I was treated with dignity and respect.									
You		100%	1%	1%	1%	24%	73%	4.7	**52**	92
All		95%	2%	2%	5%	33%	52%	4.4	**21**	85
09	My wishes about who is and is not to be given information about my treatment were respected.									
You		93%	1%	1%	3%	24%	68%	4.6	**72**	91
All		90%	3%	3%	6%	33%	44%	4.3	**13**	81

10	Staff here believed that I could grow, change and recover.								
You	99%	1%	1%	9%	25%	64%	4.5	71	88
All	93%	1%	2%	9%	34%	47%	4.4	32	84
11	I felt comfortable asking questions about my treatment and medications.								
You	98%	1%	2%	1%	24%	69%	4.6	30	90
All	94%	2%	4%	7%	38%	43%	4.2	14	81
12	I was informed about and encouraged to use self-help/support groups in the community								
You	94%	2%	12%	14%	29%	38%	3.9	5	73
All	92%	2%	9%	13%	37%	31%	3.9	6	73
13	I was given information about how to manage my medication side effects.								
You	86%	4%	12%	21%	24%	26%	3.7	3	66
All	85%	6%	13%	16%	32%	17%	3.5	3	62
14	My other medical conditions were treated.								
You	71%	2%	6%	16%	24%	23%	3.9	6	72
All	75%	4%	6%	13%	30%	22%	3.8	5	70
15	I felt this hospital stay was necessary.								
You	98%	0%	1%	1%	24%	72%	4.7	100	93
All	95%	2%	2%	4%	26%	61%	4.5	22	87
16	I felt free to complain without fear of retaliation.								
You	93%	2%	4%	14%	33%	39%	4.1	12	78
All	88%	5%	5%	13%	36%	29%	3.9	7	73
17	I felt safe to refuse medication or treatment during my hospital stay.								
You	86%	2%	4%	9%	36%	34%	4.1	11	78
All	81%	6%	7%	15%	32%	21%	3.7	4	67
18	My complaints and grievances were addressed.								
You	70%	1%	3%	17%	24%	25%	4.0	13	75
All	73%	3%	5%	12%	33%	20%	3.9	7	72
19	I participated in planning my discharge.								
You	94%	2%	2%	8%	40%	43%	4.3	22	82
All	89%	3%	4%	6%	41%	35%	4.1	12	79
20	Both I and my doctor or therapist from the community were actively involved in my hospital treatment								
You	96%	2%	4%	6%	31%	52%	4.3	15	84
All	90%	4%	4%	8%	36%	37%	4.1	8	77
21	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.								
You	93%	2%	4%	7%	26%	54%	4.4	13	84
All	87%	3%	5%	7%	35%	37%	4.1	9	78
22	The surroundings and atmosphere at the hospital helped me get better.								
You	100%	0%	2%	9%	38%	51%	4.4	47	84
All	95%	2%	6%	11%	38%	37%	4.1	9	77

23	I felt I had enough privacy in the hospital.								
You	99%	1%	3%	3%	34%	58%	4.5	**24**	87
All	94%	3%	9%	8%	43%	31%	4.0	**6**	74
24	I felt safe while I was in the hospital.								
You	99%	1%	1%	6%	29%	63%	4.5	**49**	88
All	94%	2%	3%	7%	39%	43%	4.3	**16**	81
25	The hospital environment was clean and comfortable.								
You	99%	0%	0%	1%	21%	77%	4.8	**100**	94
All	94%	1%	2%	5%	35%	50%	4.4	**24**	85
26	Staff were sensitive to my cultural background.								
You	62%	1%	1%	7%	19%	35%	4.4	**43**	85
All	60%	1%	1%	12%	24%	23%	4.1	**23**	78
27	Services were appropriate for my age.								
You	98%	1%	1%	3%	37%	57%	4.5	**50**	88
All	90%	3%	4%	9%	38%	37%	4.1	**12**	79
29	With my permission, my nominated carer was involved in my hospital treatment.								
You	59%	1%	2%	13%	16%	28%	4.1	**14**	78
All	62%	2%	2%	9%	26%	21%	4.0	**10**	75
31	My contact with my Doctor was helpful.								
You	98%	1%	2%	4%	26%	66%	4.6	**29**	89
All	91%	3%	3%	7%	35%	44%	4.3	**15**	81
32	My contact with nurses and therapists was helpful.								
You	99%	1%	1%	4%	29%	65%	4.6	**75**	90
All	94%	1%	2%	5%	40%	47%	4.4	**28**	84
S	Average results for this summary score.								
You	91%	1%	3%	8%	28%	51%	4.4	**18**	84
All	87%	3%	4%	9%	35%	36%	4.1	**10**	78

Outcomes

	responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
01	I am better able to deal with crisis.								
You	97%	1%	1%	10%	55%	30%	4.2	**45**	79
All	93%	2%	5%	16%	48%	21%	3.9	**10**	72
02	My symptoms are not bothering me as much.								
You	98%	1%	8%	16%	47%	26%	3.9	**8**	73
All	92%	3%	6%	14%	47%	22%	3.8	**7**	71
03	The medications I am taking help me control symptoms that used to bother me.								
You	94%	1%	3%	14%	39%	37%	4.2	**20**	79
All	88%	3%	3%	14%	44%	24%	4.0	**12**	74

04	The treatment I received helps me to manage symptoms that used to bother me.								
You	99%	2%	2%	11%	51%	33%	4.1	**22**	78
All	92%	2%	3%	13%	47%	26%	4.0	**14**	75
05	I do better in social situations.								
You	94%	1%	5%	31%	39%	18%	3.7	**9**	68
All	89%	2%	7%	24%	40%	15%	3.7	**6**	67
06	I deal more effectively with daily problems.								
You	97%	1%	4%	17%	52%	23%	3.9	**15**	74
All	92%	2%	5%	20%	48%	17%	3.8	**9**	70
07	My sense of wellbeing has improved.								
You	99%	1%	2%	11%	51%	34%	4.2	**27**	79
All	94%	3%	4%	13%	45%	30%	4.0	**12**	75
S	Average results for this summary score.								
You	96%	1%	3%	16%	47%	29%	4.0	**17**	76
All	91%	3%	4%	17%	46%	22%	3.9	**10**	72

Overall Perception of Care

	responses to item	strongly disagree	disagree	neutral	agree	strongly agree	average rating	consumer satisfaction indeces Nevada	Weighted
S	Average results for this summary score.								
You	93%	1%	3%	9%	31%	48%	4.3	**18**	83
All	89%	3%	5%	10%	37%	34%	4.1	**10**	77

Exhibit 5: Consumers' Comments

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Appendix 6 — Example of the Questionnaire for Hospital Managers

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CPoC Pilot Study

Evaluation Questionnaire for Hospital Management

This questionnaire is a critical component of the evaluation phase of the Consumer Perceptions of Care pilot study. Four main topics are addressed:

- the content of the surveys;
- the content and utility of the reports;
- the process of survey administration;
- the feasibility of future implementation; and
- the conduct of the pilot study.

The responses to this final evaluation survey by staff in all the participating hospitals, services and service organisations will be aggregated and included in the final report for participating private hospitals. Please be assured that the privacy and confidentiality of both yourself and your Hospital will be protected in the report from this evaluation phase. Aggregate statistical results from analyses of the questions in this evaluation survey will not be stratified by hospital.

In reviewing and answering these questions please involve any other members of your management team who have responsibility for clinical governance or quality improvement and, if appropriate, the staff member responsible for the administration of the pilot within your Hospital. Note that we only require the one survey to be completed and submitted by your Hospital.

Before you complete this survey, please ensure that you have had an opportunity to review the final standard report for your Hospital. The standard reports you received included the detailed results for each item in the CPoC Surveys that your service offered to consumers. For your reference, Appendix A includes copies of the two types of CPoC Survey used in the pilot study.

As some of the questions in this questionnaire are related to each other, please read through the whole questionnaire first before completing any of the questions. Many of the questions ask for your comments. If you find there is insufficient space to say all you wish, please note them on separate pages marked with the question number and attached to this completed questionnaire.

If you have any questions about completing this questionnaire, please don't hesitate to call the CPoC Pilot Study's principal investigator, Allen Morris-Yates, on either 0417 268 386 or 08 8278 5811.

On completing this survey, please mail it to Allen at the following address:

Allen Morris–Yates
CPoC Pilot Study
PO Box 750
Blackwood, SA 5051

Considering the questions asked of consumers in the **CPoC Survey for Overnight Inpatients**

1.1 Was the CPoC Survey for Overnight Inpatients applicable to the people your Hospital provides services for?

Not at all applicable 1 ----- 2 ----- 3 ----- 4 ----- 5 Completely applicable

Do you have any specific comments about that?

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1.2 Did the CPoC Survey for Overnight Inpatients address issues that are relevant to your Hospital's model of service delivery?

Not at all relevant 1 ----- 2 ----- 3 ----- 4 ----- 5 Completely relevant

Do you have any specific comments about that?

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1.3 Did the CPoC Survey for Overnight Inpatients survey address issues or problems that concern you as a hospital manager?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that?

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1.4 Were there important issues that could have been addressed by the CPoC Survey for Overnight Inpatients but were not?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that, particularly examples of important issues you think were missed?

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1.5 Were there questions that were not at all relevant and which could have been excluded from the CPoC Survey for Overnight Inpatients? If so, please identify them by number.

Questions that could have been excluded: ____ ____ ____ ____ ____ ____ ____ ____

Do you have any specific comments about that?

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1.6 In your view, was the wording of the questions in the CPoC Survey for Overnight Inpatients appropriate?

Yes	1
Generally yes, but there were a few problems	2
Quite a few questions could have been better worded	3
Mostly not, many questions need to be re-worded	4
Not at all, the survey needs to be completely re-worded	5

If you indicated that there were problems with the wording, could you please comment on the nature of those problems and identify any questions you thought particularly needed revision:

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Considering the questions asked of consumers in the **CPoC Survey for Day and Outreach Patients**

2.1 Was the CPoC Survey for Day and Outreach Patients applicable to the people your Hospital provides services for?

Not at all applicable 1 ----- 2 ----- 3 ----- 4 ----- 5 Completely applicable

Do you have any specific comments about that?

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2.2 Did the CPoC Survey for Day and Outreach Patients address issues that are relevant to your Hospital's model of service delivery?

Not at all relevant 1 ----- 2 ----- 3 ----- 4 ----- 5 Completely relevant

Do you have any specific comments about that?

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2.3 Did the CPoC Survey for Day and Outreach Patients address issues or problems that concern you as a hospital manager?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that?

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Evaluation Phase Questionnaire for Hospital Management **page 4**

2.4 Were there important issues that could have been addressed by the CPoC Survey for Day and Outreach Patients but were not?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that, particularly examples of important issues you think were missed?

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2.5 Were there questions that were not at all relevant and which could have been excluded from the CPoC Survey for Day and Outreach Patients? If so, please identify them by number.

Questions that could have been excluded:

___ ___ ___ ___ ___ ___ ___ ___

Do you have any specific comments about that?

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2.6 In your view, was the wording of the questions in the CPoC Survey for Day and Outreach Patients appropriate?

Yes	1
Generally yes, but there were a few problems	2
Quite a few questions could have been better worded	3
Mostly not, many questions need to be re-worded	4
Not at all, the survey needs to be completely re-worded	5

If you indicated that there were problems with the wording, could you please comment on the nature of those problems and identify any questions you thought particularly needed revision:

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Evaluation Phase Questionnaire for Hospital Management **page 5**

In this next set of questions we ask you to consider if the survey results reported in the standard monthly reports and the recently distributed final report are capable of being used to inform changes in hospital or service practice. Note that we are not asking you if you actually implemented any changes in response to your consideration of the reported results, but rather we are interested in whether or not you believe that the information was fit for that purpose.

3.1 Were the aggregate statistics based on the Consumer Satisfaction Index (CSI), shown in Exhibit 1 of the final report, useful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

3.2 Was the ranking of items by their CSIs, shown in Exhibits 2 and 3 of the final report, useful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

3.3 Were the detailed results regarding consumers' responses to the individual items, shown in Exhibit 4 of the final report, useful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

3.4 Was the record of consumers' written comments, provided in Exhibit 5 of the final report, useful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

3.5 Was the inclusion of de-identified information regarding the performance of other participating hospitals useful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

3.6 Are there any comments you would like to make about the utility of the reports?

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Evaluation Phase Questionnaire for Hospital Management **page 6**

An important feature of the surveys used in the pilot study was their inclusion of questions regarding consumers' perceptions of the outcomes of care.

4.1 Did the aggregate statistics shown in Exhibit 1 of the final report help your management team understand the outcomes of the care being provided?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

4.2 Did the ranking of individual items by their CSIs, shown in Exhibit 3 of the final report, help your management team understand the outcomes of the care being provided?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

4.3 Did the detailed results regarding consumers' responses to the individual items, shown in Exhibit 4 of the final report, help your management team understand the outcomes of the care being provided?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

4.4 Are there any comments you would like to make about this aspect of the survey process?

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One of the factors that may limit the usefulness of the collection, analysis and reporting of consumer of perceptions of care may be the extent to which an Hospital's resources allow it to focus on optimising service delivery.

4.5 Do you think that in a hospital or service which was struggling to meet minimum service requirements, the collection, analysis and reporting of this information would be useful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

4.6 Are there any comments you would like to make about this issue?

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The pilot study required consumers to submit their responses to the SPGPPS's CDMS in a reply paid envelope. Submitted surveys were entered and participating Hospitals were provided with reports on a monthly basis followed by a final report which covered the whole survey administration phase of three to four months.

These next questions ask for your views on the feasibility and utility of some possible ways of implementing consumer perceptions of care surveying in the future.

5.1 Do you think it would be useful for all private hospitals with psychiatric beds to implement a consumer perceptions of care survey tool that had a common, nationally agreed core set of questions?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that? .....

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5.2 If so, in your view would the CPoC surveys used in the Pilot be a suitable starting point for the development of a nationally agreed set of questions?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that? .....

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The collection and reporting of information regarding consumer perceptions of care could be implemented on a routine ongoing basis where surveys are offered to all patients on discharge from Overnight inpatient care and at review and on discharge from Day or Outreach care.

5.3 Putting aside considerations regarding the costs of doing so for the moment, do you think the implementation of the routine ongoing collection, analysis and reporting of information regarding consumer perceptions of care would add to the information that is already routinely collected by the hospital?

It would not add anything 1 ----- 2 ----- 3 ----- 4 ----- 5 It would be very useful

Do you have any specific comments about that? .....

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5.4 Assuming that appropriate resources were available for doing so, do you think it would be feasible (that is, practical and cost-effective) for the Hospital to continue collecting information on consumer perceptions of care on a routine ongoing basis?

Yes, it would be feasible	1
Yes, it would be feasible, but only if some changes were made to the processes trialled in the Pilot	2
No, it would not be feasible for it to be done routinely	3

Do you have any specific comments about that? .....

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5.5 If this type of information were to be collected by Hospitals on a routine ongoing basis, would it also be useful if a routine data submission, analysis and reporting process, similar to that now employed for the clinical outcome measures (HoNOS and MIIQ-14), were to be implemented?

It would not add anything 1 ----- 2 ----- 3 ----- 4 ----- 5 It would be very useful

Do you have any specific comments about that? .....

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Alternatively, information on consumer perceptions of care could be collected using a snapshot procedure, with a single report provided at the end of the survey period. For example, in an ambulatory care setting it might mean offering the survey to all consumers in care at a given time each year. In the overnight inpatient setting it might mean offering the survey to all patients discharged during a given month.

5.6 Would it be useful for your Hospital to collect information on consumer perceptions of care using a snapshot procedure.

Yes, it would be useful	1
Yes it would be useful, but not as useful as a routine ongoing collection	2
No, it would not be useful to use a snapshot procedure	3

Do you have any specific comments about that? .....

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The provision of reports on a routine and relatively frequent basis was an important feature of the pilot study. If this data was to be collected by an independent agency for the Hospital or was collected by the Hospital and submitted to a central agency for benchmark reporting purposes, either on an ongoing routine basis or a snapshot basis –

5.7 Would it be best to provide reports on a:

monthly basis from a routine ongoing collection	1
quarterly basis from a routine ongoing collection	2
half–yearly basis from a routine ongoing collection	3
annual basis from a snapshot–based collection	4
bi–annual basis from a snapshot–based collection	5

Do you have any specific comments about that? .....

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Evaluation Phase Questionnaire for Hospital Management **page 10**

5.8 Do you think information regarding Consumers Perceptions of Care should also be reported to Health Insurance Funds and other Payers?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that? .....

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5.9 Are there any further comments you would like to make in regards to the appropriateness and long–term feasibility of the collection, analysis and reporting of information regarding consumer perceptions of care?

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These final few questions address certain administrative aspects of the Pilot study.

6.1 Was the Consumer Perceptions of Care Study Manual provided at the beginning of the Pilot study helpful?

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that? .....

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6.2 Was the content and wording of the explanatory material accompanying the survey appropriate? (A copy of the letter is included in Appendix B)

Not at all 1 ----- 2 ----- 3 ----- 4 ----- 5 Most definitely

Do you have any specific comments about that? .....

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6.3 Are there any other comments you would like to make about the administration or conduct of the pilot study?

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Thankyou very much for your help.

Evaluation Phase Questionnaire for Hospital Management **page 12**

Appendix 7 — Key references and review of models for reporting CPoC

Key references

There are three key documents describing the development work which led to the publication of the standard versions of the MHSIP Adult Consumer Survey and the NRI/MHSIP Inpatient Consumer Survey. They are:

1) Ganju, et al (1996) Final Report of the Mental Health Statistics Improvement Program Task Force on a Consumer-Oriented Mental Health Report Card. Mental Health Statistics Improvement Program.
http://www.mhsip.org/reportcard/overview.pdf

2) Ganju (1999) The MHSIP Consumer Survey: History, Development, Revisions, Applications and Commonly asked questions. Mental Health Statistics Improvement Program.
http://www.mhsip.org/documents/MHSIPConsumerSurvey.pdf

3) Schacht (2001) NRI/MHSIP Inpatient Consumer Survey: Results of Pilot Implementation, Final Report. Alexandria, VA: NASMHPD Research Institute, Inc.

The first and second documents relate to the development of the MHSIP Adult Consumer Survey, the measure used as the basis for the *Perceptions of Care Survey for Day and Outreach Patients* in the present study. The third document relates to the development of the NRI/MHSIP Inpatient Consumer Survey, the measure used as the basis for the *Perceptions of Care Survey for Overnight Inpatients* in the present study.

Please note that the survey administration procedure followed in the Pilot study is that described in the body of this report, NOT any procedure or variant thereof that may be described in any of the above documents.

Review of models for reporting CPoC

California Department of Mental Health

Adult Survey, Youth Services Survey and Youth Services for Families Survey, Statewide Summary Report for the May 2005 Collection Period; December 2005.

In the above named report, the items that comprise each of the MHSIP subscales (i.e., access to services, quality and appropriateness of services received, consumer participation in treatment planning, service outcomes and general satisfaction) were averaged and then grouped into the following categories: 1.0 – 1.5 = 'Dissatisfied', 1.5001 – 2.5 = 'Somewhat Dissatisfied', 2.5001 – 3.5 = 'Neutral', 3.5001 – 4.5 = 'Satisfied', and 4.5001 – 5 = 'Very Satisfied'. As a general guideline for interpretation, the report stated that the national benchmark for satisfaction is an overall scale score above 3.5. Mean and standard deviation of the average scores for each subscale were also reported separately.

Current information regarding California State's reporting can be found at:

http://www.dmh.cahwnet.gov/POQI/

State of Connecticut, Department of Mental Health & Addiction Services

Consumer Survey 2005, Annual Report; October 2005.

The above named report used the standard scoring procedure employed in the 2002 national survey results reported by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute.

The percentage of respondents agreeing with the proposition expressed by an item was reported in analyses of item level results.

Current information regarding Connecticut State's reporting can be found at:

http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334726

Delaware Health & Social Services Division of Substance Abuse & Mental Health

The Delaware DSAMH Consumer/Client Satisfaction Survey, Fiscal Year 2004; January 2005.

This report used the standard scoring procedure employed in the 2002 national survey results reported by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute.

In contrast to other states, Delaware's report took an almost completely narrative approach. Statistics regarding the proportion of respondents who agreed or disagreed were reported only within the text. No tabulated results at all were provided. Excerpts of comments by individual respondents were included.

Current information regarding Delaware State's reporting can be found at:

http://www.dhss.delaware.gov/dhss/dsamh/

Hawai'i State Health Department, Behavioral Health Administration, Adult Mental Health Division

Consumer Survey Fiscal year 2004; August 2004.

Mean and standard deviation of the average scores for each subscale were reported together with the percentage of positive responses. Item responses were coded as 1 – Strongly agree, 2 – Agree, 3 – Neutral, 4 – Disagree, and 5 – Strongly disagree. Consequently, lower mean scores indicate more favourable experiences with the specific agency or service.

Current information regarding Hawai'i State's reporting can be found at:

http://amh.health.state.hi.us/Public/ConsumerSatisfaction.htm

Nevada Department of Health & Human Services, Division of Mental Health & Developmental Services

2003 Consumer Survey Report; February 2004.

Nevada's report employed a summary statistic, identified as the Consumer Satisfaction Index to identify and rank survey items. Results for each item in the survey were reported in detail, with the percentage of respondents who Strongly agreed, Agreed, were Neutral, Disagreed or Strongly disagreed all being reported. The three items ranked lowest and three ranked highest on the CSI were then graphed separately. Agency level sub–sections within the report used the CSI as the basis for comparing each Agency's performance from 2003 to 2004. Most interestingly, the Nevada report also include all (375) comments made by respondents.

The definition of the CSI from Nevada's report is repeated verbatim below.

> The consumer satisfaction index (CSI) is a numerical measure of consumer satisfaction. It was determined for each of the Likert scale survey items in all four domains: (a) general service; (b) outcome; (c) service coordination; and (d) medication clinic. Each Likert scale item was analyzed and the percentage of respondents who marked "strongly agree", "agree", "no opinion", "disagree", or "strongly disagree" was determined. The satisfaction index was calculated by adding the "strongly agree" to the "agree" percentages and dividing by the sum of the "disagree" and "strongly disagree" percentages. The rationale for the index is simply that the more consumers who agree and the fewer who disagree with an item is an indication of the overall satisfaction of the people responding to that item. Stated mathematically:
>
> CSI = {Strongly agree (%) + Agree (%)} ÷ { Disagree (%) + Strongly Disagree (%)}
>
> The index includes a greater proportion of consumers who completed the survey than a simple percentage of agreements. It incorporates the scores of both those who agreed with an item as well as those who disagreed; only those who selected "no opinion" were excluded. The index maintains a positive perspective in the sense that higher index scores indicate higher overall agreement, and relatively less disagreement, with the survey items. Further, the index may be increased by taking steps to increase the number of "satisfied" consumers and decrease the number of "dissatisfied" consumers, which is precisely the desired change in performance.

Current information regarding Nevada State's reporting can be found at:

http://mhds.state.nv.us/

Oregon Department of Human Services, Office of Mental Health & Addiction Services

Oregon Youth Services Survey for Families of Youth Receiving Outpatient Oregon Health Plan Services, 2003; January 2004.

Oregon's report summarizes the findings from their survey in the form of performance indicators.

> A factor analysis method was used to detect commonality among survey items and classify them into factors associated with performance indicators. The items of the survey were statistically group into five performance domains: access, family participation in treatment, cultural sensitivity, appropriateness, and outcomes. Based on those classifications, performance levels were assessed for each performance indicator using a method suggested by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services [the original developers of the YSS and YSS-F].
>
> The performance score for each of the domains is the percentage of responses for the domain items that had an average positive value for the scores (agreeing or strongly agreeing). For example, convenience of office hours and location are the two survey items used to assess the access domain. Access performance was calculated by taking the percent of those with an average value for those two items that is greater than or equal to 3.5.

Current information regarding Oregon State's reporting can be found at:

http://www.oregon.gov/DHS/mentalhealth/publications/main.shtml

Texas Department of State Health Services

Results of the Child and Family Mental Health Consumer Surveys, FY 2004; August 2004.

The above named report included a detailed description of the revised standard method for the calculation of aggregate statistical indicators from consumers responses. The full text relevant to that explanation is given below.

> The survey instruments feature 21 items. … Consumers rated each item on a scale of 1–5, i.e. Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree. In the analysis, ratings of Agree and Strongly Agree were combined and ratings of Disagree and Strongly Disagree were combined. For simplicity, in the report column headings of Agree, Neutral, and Disagree refer to these collapsed categories.
>
> The survey results focus on the "agreement rates" for each domain. Agreement rates refer to the percentage of respondents who gave a "positive" rating to the items in a domain. A positive rating means that, on average, a consumer agreed with the items in the domain. To calculate the agreement rate, the number of consumers who responded positively was divided by the total number of respondents. In other words, the 80.6% Access agreement rate [shown in Figure 1 in their report] means that 80.6% of the respondents agreed with the items in the Access domain.

Beginning with last year's FY 2003 Adult Mental Health Consumer Survey, we are using two new calculation methods recommended by CMHS. The first method is to calculate the agreement rates by respondents (consumers) rather than by responses. In other words, in the past we counted the number of positive responses for individual items in each domain; now we count the number of consumers whose average rating across items was positive for each domain. For example, using the old method, if a consumer rated the three items in the Participation in Treatment domain 1, 2, and 3, that would count as two positive responses (1 and 2). The new method counts the average of those questions (2) as one single positive response. To calculate the agreement rate, the number of consumers who answered positively is divided by the total number of respondents. The new method allows us to report the numbers of consumers in each MHA that responded positively to each domain. In other words, an 80.6% Access agreement rate means that 80.6% of the respondents agreed with the items in the Access domain.

Second, CMHS recommended that respondents needed to complete at least two thirds of the items in a given domain in order to be counted in that domain agreement rate. For example, there are three items in the Participation in Treatment domain. In order to be counted in that domain a consumer needed to complete at least two of the three questions. If a consumer only rated one of the three items, he or she would not be counted for Participation in Treatment. However, if this same consumer completed two-thirds of the items in the Cultural Sensitivity domain he or she would be counted for that domain.

In comparison, to calculate the agreement rates of each individual item *[included as Appendix A in their report]*, all responses were included. Therefore, the MHA domain agreement rates included in this report cannot be replicated by simply averaging the item agreement rates in each domain because doing this does not account for the item responses that were eliminated in the domain agreement rates due to missing data.

Results were reported at the domain level only, with results for the 2002, 2003 and 2004 fiscal years being compared in bar graphs.

Current information regarding Texas State's reporting can be found at:

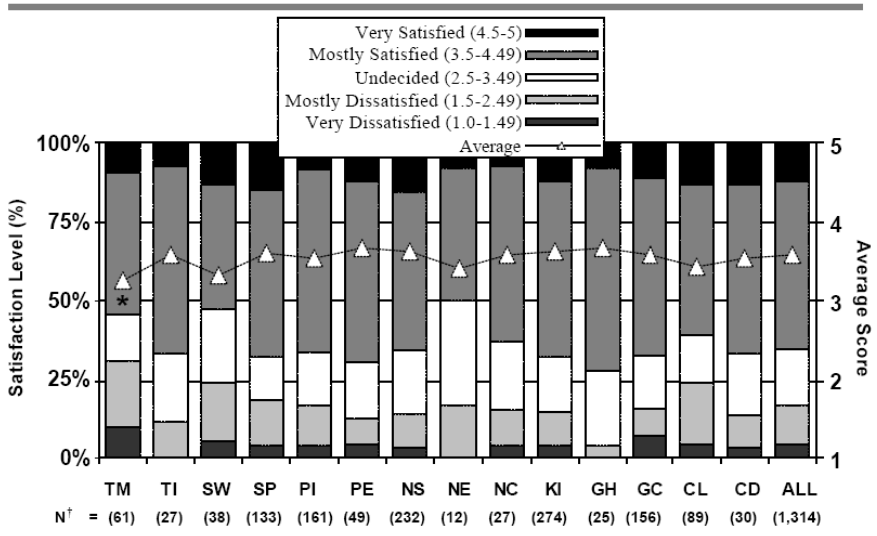
http://www.dshs.state.tx.us/mhreports/Surveys.shtm

Washington State Department of Social & Health Services

Child Consumers of Mental Health Services, Children's Survey, 2002; report prepared by The Washington Institute for Mental Illness Research and Training, September 2003.

Item responses were coded as 1 – Strongly disagree, 2 – Disagree, 3 – Neutral, 4 – Agree, and 5 – Strongly agree. Average scores for each domain were calculated by taking the mean of each individual respondents ratings on the constituent items. The average score was then converted back into a categorical rating scale using the following criteria: 4.5 – 5.0 = Very Satisfied, 3.5 – 4.49 = Mostly Satisfied, 2.5 – 3.49 = Undecided [neutral], 1.5 – 2.49 = Mostly Dissatisfied, 1.0 – 1.49 = Very Dissatisfied. The results were reported as stacked bar graphs. An example is shown in the Figure below.

Figure 15. General Satisfaction by RSN



† Some RSNs provide publicly funded mental health services to a relatively small number of persons. When groups are represented by a small number of respondents (e.g., Northeast RSN was represented by only 12 respondents), questions necessarily arise over the validity of such findings.

* Statistically significant difference.

Current information regarding the Washington State's reporting can be found at:

http://www1.dshs.wa.gov/mentalhealth/

Verdict Research Ltd

The full text of the explanation of their Consumer Satisfaction Index, given in the paper titled "*UK Consumer Satisfaction Index 2007*" published in March 2007 and available on Verdict Research's website at the URL given below, is provided here:

> **Step 1.** Groups of customers who shop at certain stores across each of the retail sectors are identified. These people have to be regular users of the store and classify it as their main destination for a particular product; we don't look at people who might just visit the store very occasionally.
>
> **Step 2.** Customers are split into those who are loyal to the retailer and those who are not. Loyal customers are those who, given a free choice, would not shop anywhere else; disloyal customers would prefer to shop somewhere else. Loyal customers are, overall, generally satisfied with the store; disloyal customers are, overall, dissatisfied.
>
> **Step 3.** Loyal customers are asked what they like about the store; they are able to pick from a range of factors that fall into eight categories. Disloyal customers are asked what they dislike about the store; again they can pick from a range of factors which fall into the eight categories.
>
> **Step 4.** For each of the eight categories, the number of negative mentions (i.e. disloyal customers saying they are dissatisfied with the corresponding factor) are deducted from the number of positive mentions (i.e. loyal customers saying they are satisfied with the factor). This figure is then divided by the total number of people in the survey who shop at the retailer under examination.
>
> **Result.** From this calculation we get individual CSI scores for each of the factors of satisfaction. In their totality these range from -100 to +100. The overall CSI score is simply the sum of the eight factors.

Assuming that consumers' responses may be grouped into those that are Positive, Neutral or Negative, the above may be stated mathematically as:

$$CSI_V = \%Positive - \%Negative$$

Current information regarding Verdict Research Ltd's Consumer Satisfaction Index can be found at:

http://www.verdict.co.uk/Marketing/Consumer_Satisfacion_Index.pdf