

**REVIEW OF PATIENT EXPERIENCE
AND SATISFACTION SURVEYS
CONDUCTED WITHIN PUBLIC AND
PRIVATE HOSPITALS IN AUSTRALIA**

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This review has been conducted to inform the development of a national approach to hospital patient experience measurement.

Additional and electronic copies of this paper can be obtained from the Australian Commission on Safety and Quality in Health Care Website.

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1. Executive summary

In 2010, Australian Health Ministers endorsed the Australian Safety and Quality Framework for Health Care developed by the Australian Commission on Safety and Quality in Health Care (the Commission). The framework describes a vision for safe and high-quality care for all Australians and provides direction for improving the healthcare system. The three core principles for safe and high-quality care as documented within the framework are consumer-centred, driven by information and organised for safety.



The consumer-centred principle asserts that patients receive high-quality care when needed, healthcare staff respect and respond to patient choices, needs and values and partnerships are formed between the provider, patients, their family and carers [1]. In order to assess whether our healthcare system is delivering safe and high-quality health care, it is important to measure patient experience.

In March 2011, the National Health Information Strategic Subcommittee (NHISSC) recommended that the development of a national approach to patient experience measurement and reporting be supported by a Patient Experience Information Development Working Group (PEIDWG).

As part of this national process, a review of current patient experience surveys used by public and private hospitals was conducted by the Commission. This paper provides a synthesis of that review.

The key findings from the review are listed below.

- There are differences in the methodologies, administration, scope, rating scales, inclusion and exclusion criteria, sampling, data analysis and reporting methods used across public and private hospitals.

- Most jurisdictions and some private hospitals are using a combination of patient experience and satisfaction questions in their surveys.
- There are documented impacts from the use of the surveys showing how feedback has informed service delivery.
- There was no significant difference in the frequency or number of domains used between private and public hospitals.
- In some jurisdictions and private hospital ownership groups, surveys are conducted state-wide or across one private hospital ownership group, while in certain instances, individual institutions have developed and administered their own surveys.
- Most of the private hospitals included in this review use locally developed tools. These tools are often administered in-house.
- The surveys are not well suited for use with people who speak little or no English, as translated versions are generally not available. Northern Territory (NT) and Victoria have sought to address language barriers. In NT hospital, meaningful pictures and symbols are incorporated within surveys. In Victoria, the surveys are available in English and 16 community languages.

This review also identified ten key domains used in patient experience and satisfaction surveys which vary in their frequency of use. 90% of surveys include domains such as:

- waiting times/ access/ admission process
- information sharing/ communication
- physical environment, and
- overall satisfaction

80% of surveys include:

- Patient involvement/ participation in care decisions
- privacy/ respect/ dignity and consistency/ coordination of care

70% of surveys address discharge/ continuity of care.

The two least frequently used domains are pain control which is used in 50% of surveys and quality/ safety which is used in 20% of surveys.

Some hospitals have reported improvements as a result of patient experience and patient satisfaction measurement. These improvements are reported to include from a reduction in waiting times, medication safety, admission and discharge processes, infrastructure planning, and patient awareness of their rights and complaints management.

2. Introduction

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to ensure that, wherever and whenever care is provided, it is of high quality and is safe. (see Appendix 2)

The Charter states that everyone should work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes. Monitoring patient experience means understanding the consumer perception of their healthcare experiences.

The Patient Experience Information Development Working Group (PEIDWG) has been established under the joint auspices of the National Health Information Standards and Statistics Committee (NHISSC) and the Australian Commission on Safety and Quality in Healthcare to consider the emerging needs for reporting patient experience data and provide advice about how to best progress national patient experience information development. The current and emerging patient experience information needs include:

1. Patient experience reporting under the National Healthcare Agreement and National Performance and Accountability Framework.
2. Patient experience measures to support improvements in quality of care.
3. Work undertaken through the Mental Health Information Strategy Subcommittee (MHISS) to develop a national measure to monitor and report on patients' experiences of mental health care.
4. OECD work to report a core set of common elements in population-based patient experience surveys.
5. Possible inclusion of patient experience information in [Australian Hospital Statistics](#) and the [MyHospitals](#) website.

One of the roles of the PEIDWG is to work alongside jurisdictions and private hospital ownership groups in developing a national approach to hospital patient experience measurement.

To progress this work, the Commission has hosted a series of roundtable meetings. Experts from across the country have attended and provided advice towards the development of core common questions for hospital patient experience measurement.

During the first Patient Experience Roundtable held in Sydney on 8 December 2011, Stephen Murby, chair of the [Consumers Health Forum of Australia](#) (CHF) stated that,

“consumers want timely, good quality health care, an active and informed role in decisions about their health care and are informed when adverse events occur in hospital”.

In order to understand currently practices, the Commission has drafted this paper which is an environmental scan of hospital patient experience surveys used in public and private hospitals in Australia.

Purpose

The purpose of the paper is to:

- (i) identify commonalities and differences between surveys that measure patient experience and patient satisfaction, and
- (ii) to inform the development of core common questions that could be used in hospital patient experience surveys within public and/or private hospitals.

Approach

This paper is structured as follows:

Chapter 2 describes the background, purpose and approach of the project.

Chapter 3 describes patient experience reporting.

Chapter 4 describes the methods adopted for the review.

Chapter 5 describes the approaches taken by each jurisdiction and participating private hospital ownership groups.

Chapter 6 outlines results from the review.

Chapter 7 lists the conclusions.

Appendix A lists the key informants who provided additional information for the review.

Appendix B describes the Australian Charter of Healthcare Rights.

Appendix C describes the principal components of the national health reform process.

3. Background

This review does not exist in isolation. It builds on and contributes to a range of initiatives requiring routine measurement of patient satisfaction or patient experience.

Patient Experience and Satisfaction

Many current surveys have a combination of patient experience (PEX) questions and patient satisfaction (PSat) questions.

Patient experience questions ask patients to give factual responses about what did or did not occur during an episode of care. Two examples of patient experience questions are (1) “Did doctors talk in front of you as if you were not there? (2) Do you think the hospital staff did whatever they could to help control your pain”?¹ Response options to these questions would be either ‘yes’ or ‘no’.

Patient satisfaction questions ask patients to give subjective responses. Two examples of a patient satisfaction questions are (1) “How would you rate the clarity of the information you were given about how to manage your condition and/or recovery at home? (2) How would you rate the communication between staff about your care?”² Response options to these questions would be in the form of a likert rating scale from ‘poor’ to ‘excellent’.

Some PEX and PSat surveys will have a question that asks patients to rate their overall satisfaction with the care and services they received in the hospital. Responses to this questions are often in the form of a likert scale from ‘not satisfied at all’ to ‘very satisfied’.³

Picker methodology

Picker Europe and Picker Institute (USA) are dedicated to advancing the principles of patient-centred care. The eight Picker Principles of Patient-Centred Care are:

- access to reliable health
- effective treatment by trusted professionals
- participation in decisions and respect for preferences
- clear, comprehensive information and support for self-care
- attention to physical and environmental needs
- emotional support, empathy and respect
- involvement of and support for family and carers
- continuity of care and smooth transitions.

¹ Extract from the NSW Overnight Patient Survey

² Extract from the ACT Healthcare Hospital Inpatient Survey

³ Extract from the Gove District Hospital Inpatient Survey

Picker Europe pioneered the use of carefully designed survey instruments to obtain detailed reports of patient experience and identify areas for improvement [4]. Some public and private hospitals in Australia use a modified Picker survey, while others have used these domains to develop questions that are suited to the Australian context.

National Healthcare Agreement

The National Healthcare Agreement (NHA) requires population reporting of indicators of patient experience (PEx) annually, at jurisdictional level. A review of the NHA Performance Framework will be completed for the Council of Australian Governments (COAG's) consideration in the first quarter of 2012. While the Performance Framework is expected to result in a substantial reduction in the number of indicators (from 70 to around 20-30), patient experience is most likely to continue to be part of the framework.

Review of Government Services report (Productivity Commission)

In 2005, Health Policy Analysis Pty Ltd was engaged by the Steering Committee for the Review of Government Service Provision to identify and evaluate patient experience and satisfaction surveys conducted within public hospitals in Australia. The 2005 review noted that

..although there is some potential for harmonising approaches (as most surveys assess similar aspects of patient experience and satisfaction), different survey methodologies posed significant impediments to achieving comparable information.

A starting point for harmonising approaches to hospital patient experience measurement is the creation of a forum through which jurisdictions can exchange ideas and develop joint approaches [2]. The Commission and NHISSC are working with jurisdictions and the private hospital sector to develop a national approach to hospital patient experience measurement.

The 2011 Report on Government Services (RoGS) reported that "if public hospitals respond to patient views and modify services, service quality can be improved to better meet patients' needs. The more public hospitals use patient satisfaction surveys the greater the potential for increasing the quality of public hospital services to better meet patients' needs" [3]. The current review builds upon the review conducted in 2005 with the inclusion of patient experience measurement among select private hospital ownership groups and an update on current approaches taken by jurisdictions.

National Health Reform

A new Performance and Accountability Framework (PAF) under the National Health Reform Agreement may require patient experience reporting by the National Health Performance Authority (NHPA) at Local Hospital Networks (LHNs) and Medicare Local (ML) level. Specific measures for patient experience within hospitals will be finalised in consultation with the NHPA. The draft PAF will be submitted to COAG for endorsement within the first quarter of 2012.

Patient Experiences in Australia

The Australian Bureau of Statistics (ABS) conducts the national Health Services Patient Experience Survey. The survey is broad, covering a range of health services and ten domains. It is administered at the population level. The hospital and emergency department, modules focus on rates of admission to hospital within the last 12 months by age, remoteness and sex. These two modules also contains questions relating to reasons for visiting the ED or hospital, whether staff listened and showed respect and whether satisfactory explanation of treatment was given. The survey does not target people who have had a recent hospital admission or ED presentation. The survey is not designed for hospital-level reporting.

Commonwealth Fund

The Commonwealth Fund runs and reports population-based patient experience surveys in 11 countries, in three year cycles. A population survey of patient experience is run in a number of OECD nations, including Australia, is conducted by the Commonwealth fund every three years. Separately, specified healthcare providers, and patient sub-populations are surveyed in the other years.

The Commission and the NSW Bureau of Health Information worked with the Commonwealth Fund to increase the sample size of the 2010 population survey and report on access to and use of primary care services, use of specialists, out-of-pocket costs, prescriptions, and hospital and emergency department experiences. [REF: Dunbar et al, Improving patient safety and quality by learning from the experience of patients, *Windows 2010*]. The most recent Commonwealth patient experience survey targeted “sicker adults” in 11 countries, of which Australia was one⁴.

⁴ New International Health Survey of Sicker Adults Finds Those With a Medical Home Fare Better.

<http://www.commonwealthfund.org/News/News-Releases/2011/Nov/International-Health-Policy-Survey.aspx>

4. Research methods

The processes used in this review to identify relevant information are described below. The Commission and the Department of Health and Ageing wrote to jurisdictional health departments and private hospital ownership groups, seeking nominations to an expert working group on patient experience, and asking for information on current survey practices and instruments.

Key informants were then contacted, and asked to submit copies of their state-wide or hospital specific patient experience and satisfaction surveys. Surveys were received from all jurisdictions and a select number of private hospital ownership groups including Healthscope, St Vincent's Health Australia, and some day procedure hospitals.

In addition, the key informants were asked to provide responses to the following questions:

1. What is the methodological basis of your survey?
2. What are the objectives of the survey?
3. What are the inclusion and exclusion criteria for patient participation in the survey?
4. What sampling method is used?
5. What data analysis methodology is used?
6. Is risk adjustment conducted?
7. Identify examples of how the use of the surveys has improved service delivery and the patient journey.

A detailed review of each survey received was conducted using qualitative content analysis methodology [5].

5. Survey instruments used in Australia

Public Hospitals

Australian Capital Territory

Background

In 2008, the Australia Capital Territory Government Health Directorate recognised the need to extend the Canberra Hospital Patient Satisfaction Monitor, utilised at the Canberra Hospital since 2005, to all Divisions within the Health Directorate. These include Surgery and Oral Health; Medicine, Critical Care and Diagnostics, Pathology; Women, Youth and Children; Rehabilitation, Aged and Community Care; Mental Health, Justice Health and Alcohol and Drug Services; and the Capital Region Cancer Service.

The Health Directorate contracts *Ultra Feedback*, a Victorian-based research company to administer the survey, analyses the data and report data to participating health services. The survey covers all aspects of the patient experience in acute care, outpatients, dental health, maternal and child health, community and breast screen. Additional focus groups are used to elicit further information for certain client groups.

A key requirement of the survey is to provide reliable, validated consumer satisfaction and experience data to used in reporting against key performance indicators and standards accreditation. Areas that require attention become the focus for quality improvement efforts.

Objectives

The ACT Healthcare suite of surveys covers both acute and community sector. The objective of The ACT Healthcare Survey and report are to:

1. assist the Health Directorate to identify strategies that may improve the care and services provided to consumers, and to
2. enable each Division within the Health Directorate to track performance over time, as well as to compare results with other Divisions and to like-services in Australia (where possible).

Inclusion and exclusion criteria

Adult consumers of health services across all health Divisions participate in the survey. Only consumers who have provided informed consent are eligible to participate. Consumers receive one survey in any 12 month period, regardless of the total number of healthcare services used or hospital visits.

Sampling

The Quality and Safety Unit in the Health Directorate compile a database of eligible consenting patients who have used a health service in the previous month. A random sampling method is used to select patients. The database is sent to Ultra Feedback with a random selection of patients.

Selected consumers may be asked to participate in several ways; some receive a survey and reply paid envelope through the mail, some surveys and replied paid envelopes that may be distributed by treating staff upon discharge. Consumers have the option to 'opt out' of the survey process. Consumers may also be asked to participate in a focus group discussion. These focus group discussions are conducted by the individual hospitals.

Approximately 8,660 surveys were sent out during 2010-2011 period, and 3,189 surveys were returned. This equates to a 37% response rate.

Survey domains

The Health Directorate surveys used in the ACT have 30 core questions covering the following domains:

- access
- information sharing, education and communication
- rights and respect
- feedback
- quality and safety (hand hygiene, patient identification)
- services and equipment (physical environment)
- conduct of staff
- involvement/participation in care decisions
- overall satisfaction

In addition to the core questions there are optional questions for:

- carer experiences
- oncology (for cancer diagnosis or treatment)
- maternity, and
- dental.

There are additional open ended questions relating to how the hospital could improve and what aspects of the hospital stay patients did or did not enjoy. In addition, respondents are asked to provide further comments on their hospital stay. All survey responses are de-identified.

Scoring

Each domain contains mix of patient experience and patient satisfaction questions. For the patient experience questions, respondents are asked to give factual responses to questions about what did or did not occur by selecting 'yes' or 'no'. For the patient satisfaction questions, respondents are asked to rate their response on a likert scale ranging from 'poor' to 'excellent'.

Risk adjustment

Analysis of covariance (ANCOVA) is used to reduce the effect of factors such as age, gender, and consumer type.

Data analysis

For individual questions responses are provided on a 5-point rating scale from 'poor' to 'excellent' and results are presented as a mean score. Where comparisons between mean scores are provided, colour coding is used to represent statistically significant differences in the scores. In all instances, results for hospital consumers are compared against the results for consumers across all other Health Directorate Divisions.

Mean scores are used to provide a more precise indication of the hospital's performance, and are more accurate than frequency of responses in showing differences or changes in consumer satisfaction ratings.

For individual questions that ask for a categorical response (such as 'yes' or 'no'), the proportion of consumers who provided a particular answer are shown (percentage frequency). Results for these questions are shown as the proportion of consumers selecting each response.

All results (where possible) are compared against like Victorian hospitals that are surveyed in the Victorian Patient Satisfaction Monitor (VPSM). This is because the ACT survey is based on the VPSM.

Impact

The survey results are reported to participating health services twice a year with the exception of the exception of the Mental Health Survey which is reported on an annual basis.

Results from the survey have improved service delivery in the following areas:

- medication safety
- clinical handovers, promoting a patient centred care approach
- staff communication, e.g. customer service techniques, education on the Australian Charter of Healthcare rights
- patient identification
- admission and discharge process/continuity of care
- reviewing of IT systems for appointments
- reviewing waiting times
- infrastructure, planning and design for new service areas
- food services
- implementation of a volunteer program within aged care wards to enhance meal and nutrition experience, and
- signage and additional parking.

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Queensland

Background

Queensland Health has previously conducted patient experience surveys for medical, surgical and maternity patients. In 2011, the concept of an annual state-wide Emergency Department (ED) Patient Experience Survey was progressed in response to a greater Queensland Health strategic focus on the quality of services delivered in EDs and to align with the Queensland Health Patient Flow Strategy's goal of improving the patient's journey.

The ED Patient Experience Survey has been adapted from a suite of patient experience surveys for a range of patient groups, developed by the Picker Institute Europe and the UK National Health Service. Queensland Health modified questions that were designed for a paper questionnaire to suit a telephone interview methodology. Hospitals delivering the survey have the option to include additional questions relating to their local priorities.

A pre-approach letter was sent to all selected patients informing them of their selection in the survey and advising them that they could expect to receive a phone call in the following weeks. The letter also provided:

- details on the Emergency Department admission that they had been selected for;
- an assurance of confidentiality, as the information would be collected under the Statistical Returns Act; and
- contact phone numbers where they could receive further information about the survey or change their contact details.

Objectives

The objective of the hospital inpatient survey is to:

- identify areas for improvement at local, district and state-wide levels and
- inform the development of appropriate initiatives.

Inclusion and exclusion criteria

Patients who visited emergency departments in Queensland's public hospitals between 1 May and 31 July 2011 were randomly selected on a monthly basis from the hospitals' emergency department information systems to participate in the survey. In order for the patient to be considered in-scope, they needed to satisfy the following criteria:

- the patient attended an emergency department at one of the 31 largest hospitals between 1 May 2011 and 30 June 2011;
- the patient was discharged to their home or usual place of residence, or admitted to a hospital as an inpatient;
- the patient was a resident of Australia;
- the patient had not already been selected to participate in the survey in an earlier month of the survey period.

Patients were excluded if it was determined they:

- did not wait for treatment;
- left after treatment had commenced;
- were admitted to a Mental Health Unit or ward;
- were discharged to a nursing home or institution;
- were transferred to another health care facility, other than a hospital;
- were deceased in the ED or subsequently;
- presented for a Mental Health issue (except drug or alcohol related);
- presented with self harm;
- were in a known or suspected domestic violence situation;
- had a miscarriage, stillbirth, live birth where the neonate subsequently died before discharge, intrauterine death, hydatidiform mole, or complications following miscarriage or termination;
- had requested an interpreter in the hospital;
- usually resided outside Australia;
- were included in the previous month's sample; or
- had refused consent to be contacted to provide feedback

Sampling

The total sample size for each hospital was calculated by Queensland Health to satisfy the following criteria:

- achieving a 75% response rate; and
- providing a 95% confidence interval achieving a margin of error up to 6 percentage points either side of a point prevalence estimate of 60%.

Two months of patient data is used with the sample drawn each month. Approximately half of the total sample required is drawn each month. For health facilities where the expected number of in-scope patients was less than the number of patients required to achieve the required level of precision or where the number of patients was only marginally higher, a census is attempted of all in-scope patients.

In the case of patients aged less than 16 years the accompanying adult is interviewed.

Survey domains

The hospital inpatient survey used in Queensland has 82 questions covering the following domains:

- consistency and coordination of care
- treatment with respect and dignity
- involvement in care, treatment and decisions
- conduct of staff
- access

- information sharing, education and communication
- physical environment (i.e cleanliness of service)
- continuity of care
- pain control
- privacy
- patient satisfaction

There are additional open ended questions relating to how the hospital could improve and what aspects of hospital stay the patients enjoyed and did not enjoy. In addition, respondents are also asked to provide any further comments on their hospital stay. All survey responses are de-identified.

Scoring

Respondents are asked to give factual responses to questions about what did or did not occur by selecting various response categories e.g. 'yes completely', 'yes to some extent' or 'no'.

Risk adjustment

Weighting and benchmarking is applied to adjust for non-response in the sample and to standardise the results between the hospital and peer group.

Data analysis

Significance testing was undertaken on responses by testing whether the 95% confidence intervals on each estimate intersect or not. While there is still a possibility the difference is due to chance, the probability of this is only 1% for each pairwise comparison made. Significance testing was also performed on non-overlapping groups. Testing between the hospital and the peer group or state was performed excluding the hospital from the peer group or state results. Non-overlapping groups fulfill the statistical assumption of independence. Testing results of non-overlapping groups may also improve the likelihood for the detection of differences between the results. Significance testing was not performed when one of the two estimates to be compared had a relative standard error larger than 50% or when both estimates had a relative standard error larger than 25%.

Where no variation in the responses occurred, tests for significant differences were not carried out. A hospital estimate of 0% or 100% will therefore not be shown as significantly different from an estimate of any other value, unless the estimate was rounded down to 0% or rounded up to 100%. Where estimates were rounded to 0% or 100% there was some variation in responses allowing a standard error and confidence interval to be estimated.

Impact

The first Emergency Department Patient Experience Survey was conducted in Queensland in 2011. Hospitals were presented with their overall results in December and encouraged to identify areas of concern and actions to address these concerns. This survey will be repeated mid 2012 to assist in evaluating the implemented initiatives.

Victoria

Background

The Victorian Patient Satisfaction Monitor (VPSM) was implemented in 2000 as an ongoing study to monitor the experiences and satisfaction of in-patients in Victorian public acute hospitals. Sub-acute hospitals were included from 2005. This survey is conducted for the Victorian Department of Health, and operates on a monthly cycle. The VPSM is a self-completed mailed out questionnaire with an online completion implemented in 2009. Participation in the survey is voluntary. In addition to the hospital inpatient survey, a maternity module is sent to eligible patients. An emergency department module will commence in the first half of 2012. A cancer and mental health patient experience survey are under development. The survey is administered by Ultra Feedback.

Objectives

The objectives of the VPSM survey are to:

1. determine indices (domains) of patient satisfaction with respect to key aspects of service delivery,
2. identify and report on the perceived strengths and weaknesses of the healthcare service provided to patients,
3. provide hospitals with information that will assist them to improve service delivery and
4. set benchmarks and develop comparative data to allow hospitals to measure their performance against other similar hospitals.

Inclusion and exclusion criteria

There are a number of patient groups who are excluded from the sample:

- patients who decline participation
- patients under 18 years of age
- episodes involving perinatal death
- patients who die in hospital
- patients transferred to another hospital
- episodes involving termination of pregnancy
- four hour admissions to the emergency department
- patients in care tyPSat for Drug and Alcohol services
- mental health patients
- palliative care patients
- patients whose preferred language is other than the sixteen community languages.

Sampling

Patients participating in the survey are sampled by selecting a random sample from the Victorian admitted patients database. Approximately 28,000 surveys are completed each year.

Survey domains

The hospital inpatient survey used in Victoria has 28 questions, some with a number of items, covering the following domains:

- access and admission
- general patient information
- treatment and related information
- complaints management
- physical Environment
- discharge and follow up
- overall hospital experience

The maternity module has eight questions, all of which have a number of items.

Scoring

Each domain contains a mix of patient experience and patient satisfaction questions. For the patient experience questions, respondents are asked to give factual responses to questions about what did or did not occur by selecting 'yes' or 'no'. For the patient satisfaction questions, respondents are asked to rate their response on a likert scale ranging from 'poor' to 'excellent'. The responses to the questions within each domain are combined and weighted to create an Overall Care Index (OCI), which is used as a global measure of satisfaction.

Data analysis

When constructing the composite indices of satisfaction, only actual satisfaction ratings can be considered. People who responded 'Don't know' or 'Not applicable' to an item are providing perfectly reasonable responses, but their data for that item is of no use to the calculation of the index. For index construction purposes, 'Don't know' and 'Not applicable' must be considered missing data. Using limited or partial sub-samples (e.g. 21% of the sample for OCI calculation) can create validity issues.

The solution to this issue is to allow the calculation of an index score for a respondent provided he/she has answered at least two-thirds (66%) of the items in a valid way. Calculation of a final index score is based on the mean of those items validly answered. This has been termed the '66% rule'

Examination of existing historical VPSM data has revealed that data weighting via adjustment of sample mix is not the optimal method of data treatment. A different analytical strategy, based on analysis of covariance, has been adopted for use. Analysis of covariance is used to control for patient traits (such as age, and stay type) which have the potential to impact on the satisfaction result. This alternative strategy allows for the controlling of contributions via covariates without artificially inflating sample size and standard error of the mean via case duplication.

Impact

Health services receive reports every six months. The report includes benchmarking between peer hospitals and with state averages. An annual report documents the state-wide results.

Each health service is required to report to their community on their overall care index and the consumer participation indicator in their annual quality of care report. This report is available to the public from the Victoria Health website.

Results from an independent evaluation conducted in 2003 showed that the VPSM had made valuable contributions to quality improvement activities within Victorian public hospitals. Since 2004, Victoria has implemented the recommendations from the review which included:

- continuing the use of VPSM.
- Undertaking a detailed review of the questions used in the survey.
- improving the timeliness of reporting survey results back to hospitals
- and,
- developing survey modules for patients not included in previous surveys.

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Western Australia

Background

The measurement of patient satisfaction and experience began in Western Australia (WA) in 1996. The current Patient Evaluation of Health Services Questionnaire was designed in-house using feedback from consumer focus groups. A letter is mailed to selected eligible patients informing them that they will receive a phone call to complete the survey. The survey is conducted continually with new samples sent on a monthly basis. In addition to the hospital inpatient survey, a maternity, outpatient and emergency survey are also in use.

Objectives

The objectives of the hospital inpatient survey are:

1. To determine the most important concerns for WA hospital patients.
2. To assess the degree to which patients' needs are met during their hospital stay.
3. To assess the importance of physical aspects of hospital care, with special regard to food, cleanliness and environmental surroundings.
4. To determine whether or not patients have been given information which allows them to make informed decisions about their care.
5. To determine the degree of involvement patients have in decisions about their treatment.
6. To determine the perceived level of communication between professionals connected to the patient's treatment and continuing care.
7. To assess the coordination of discharge planning.
8. To ascertain the promptness of hospital service provision, with particular emphasis on waiting times.
9. To assess access to hospital services both in terms of ability to get into hospital within a reasonable time and ability to actually get to the hospital once an appointment for admission has been made.
10. To determine the amount of information the patient has about his/her rights while in a public hospital.

Inclusion and exclusion criteria

The scope of the adult surveys includes in-patients aged 16 to 74 years, with hospital length of stay of one or more nights, had a Western Australian address and landline or mobile phone number and who were discharged to their place of residence from hospital in the previous month. The scope of the child survey is as above but parents and guardians respond on behalf of children aged 0-15 years.

The survey excludes patients coded as having a mental health care day, funding codes other than the Australian Healthcare Agreement, non-acute care episodes, and those patients requiring an interpreter.

Sampling

The annual number of surveys conducted is dependent upon the funding obtained from the WA Department of Health and the unit cost of interviews. The sample size is calculated so that the overall indicator of satisfaction score can be generated with the lowest possible error margin (95% confidence interval).

Sampling is performed monthly using all inpatient data obtained from the respective data custodians for metropolitan and country health services. Software specifically developed for sampling patient satisfaction data is then used to generate the final monthly sample. The monthly samples are sent via secure encrypted email to the Edith Cowan University Survey Research Centre for administration using the CATI system. The optimum period of administration is from the discharge charge to 6 weeks. In 2010/2011 nearly 6000 surveys were completed with an eligible response rate of 87% for inpatient adults and 90% for inpatient children.

Survey domains

The hospital inpatient survey used in WA has 108 questions covering the following domains:

- time and attention paid to patients' care
- access
- information and communication between patients and staff
- meeting personal as well as clinical needs
- involvement/participation in care decisions
- coordination and consistency of care
- physical environment (e.g. food, room/ward)
- overall patient rated outcome

In addition, patients are asked to rank the first seven domains from most important to least important to allow comparison of importance and satisfaction with each domain.

Scoring

Each domain contains questions on the patients' experience while in hospital. Questions are grouped into the above domains based on a principal component analysis. All questions have been tested for internal consistency and test-retest reliability. Responses are categorical and vary on the type of question, where the patient either reports on something (eg yes/no); rates some aspect of service (eg poor, adequate, good, excellent; rates the degree or amount of service (eg got none, wanted more, as much as needed, too much); or rates the frequency of service (eg never, sometimes, usually, always).

Risk adjustment

No risk adjustment is performed on the measures.

Data analysis

Firstly, frequency tables are generated for each question within the survey. Secondly, scale scores are created from the questions in each domain. For each of these questions a score is calculated. This is done by weighting the possible responses. Any inadequate rating is treated as totally unacceptable and given a weighting of 0. If the question had two answers, they were either 'Yes' (it happened) or 'No' (it did not happen). The percentage who answered 'Yes' were weighted by 100 and the percentage who answered 'No' were weighted by 0. If a question had three possible answers, the percentage selecting the choice which implies no improvement required was weighted by 100; the percentage selecting the choice which implied some improvement necessary was weighted by 50; and the percentage selecting the choice which implied service totally inadequate was weighted by 0.

The scales are presented as scores out of 100. They are indications of patient levels of satisfaction with various domains of their hospital stay. They are not percentages of people saying that they are satisfied. These scales were then weighted by degree of importance to the patient and the results added together to make up the composite or overall score. 'Refused' or 'not applicable' responses are not included in the data analysis.

Impact

Annual reports are provided to each individual hospital as well as metropolitan and country Health Regions and Health Areas. State-wide reports for adults and children are also available.

It has been reported that service quality has improved in the WA as a result of feedback from the survey. The improvements include reduction of waiting times, increase in patient involvement, proper food management, improvements in the quality of patient education materials and discharge planning processes.

South Australia

Background

The measurement of patient satisfaction was initiated in South Australia in 2001. The aim was to identify key dimensions of care and measure consumer satisfaction with hospital in-patient care. Since then, Population Research and Outcome Studies (PROS) has undertaken a program of surveys resulting in a range of consumer satisfaction indicators being monitored and reported at hospital level through the South Australia Patient Experience Surveys (PEHS). The survey is administered annually, biannually (or occasionally, 3-yearly). Aboriginal, maternity and palliative care modules are under development.

Following the implementation of the PEHS, South Australia shifted from a focus on patient satisfaction to a focus on patient experience. This new shift is reflected in the state-wide initiative, the South Australia Consumer Experience Surveillance System (SACESS) will allow benchmarking between peer hospitals and hospitals within the same region.

A letter is mailed to all eligible patients informing them that they will receive a phone call to complete the survey over the phone.

Objectives

The objectives of the hospital in-patient survey is to:

1. measure and monitor high quality, representative data on consumers' experiences of health services, including satisfaction with care;
2. identify sub-groups of consumers who are less or more satisfied with health care and services;
3. disseminate findings, in the form of annual reports, to relevant professionals and administrators within SA Health, the broader public hospital system and the wider community with engagement from consumers;
4. address State and Commonwealth indicators and targets; and
5. identify gaps and deficiencies as perceived by consumers' about the quality of care and service provision.

Inclusion and exclusion criteria

The scope of the surveys includes in-patients aged 16 years or more, with hospital length of stay of one or more nights, patients with an address or phone number and discharged from hospital in the previous month.

The survey excludes patients coded as Aboriginal or Torres Strait Islander, patients from the Women's and Children's Hospital, palliative care, cancer care, overnight stay more than 35 nights, mental health conditions, patients under going renal dialysis, radiotherapy and chemotherapy, maternity patients, patients who have died, patients discharged to a nursing home or another hospital and patients with an unknown administrative separation.

Sampling

A random sample of eligible in-patients are drawn from the Open Architecture Clinical Information System (OACIS) and the Country Data Mart (CDM) datasets. Data is collected on a monthly bases to avoid any bias associated with seasonal peaks. Approximately 2,400 interviews are conducted per annum [6].

Survey domains

The hospital in-patient survey used in SA has 66 questions covering the following domains:

- consistency and coordination of care
- treatment with respect and dignity
- involvement in care, treatment and decisions
- doctors and nurses
- cleanliness of service
- pain control
- privacy
- consumer feedback
-

Scoring

Each domain contains and mix of patient experience and patient satisfaction questions. For the patient experience questions, respondents are asked to give factual responses to questions about what did or did not occur by selecting 'yes' or 'no'. For the patient satisfaction questions, respondents are asked to rate their response on a likert scale ranging from poor to excellent.

Risk adjustment

The measures were risk adjusted to take account of differences relating to responses by patients.

Impact

The survey results are reported on a quarterly KPI and full annual report basis. Key areas for action are highlighted in the report, including a system for reporting on action taken to address the areas mentioned in the report. Service quality is improved in South Australia by identifying sub-groups of patients who are either less or more satisfied with hospital care which in term highlights gaps in services and assist hospital administrators to set priorities for allocation of resources [6].

Northern Territory

Background

Northern Territory does not have a state-wide hospital patient experience survey. However, Gove District Hospital, Alice Springs Hospital, Katherine Hospital and Royal Darwin Hospital have developed their own surveys. The four surveys have been in use since 2002.

The four surveys are not based on standard methodologies but have been developed in consultation with Aboriginal liaison officers, social workers and feedback from patients. The surveys are administered face-to-face since the majority of patients speak English as a second language and have low literacy levels.

This method of survey administration is also preferred since many patients live in rural and remote regions and it is difficult for the hospital to contact patients once discharged. Surveys are mailed to patients living in the local urban region. The response rate from the mailed surveys is very low.

Objectives

The objectives of the surveys are to solicit feedback on patient care and patient experience.

Inclusion and exclusion criteria

The inclusion and exclusion criteria differ between hospitals. In some hospitals, the survey is administered to all in-patients, while other hospitals have inclusion criteria of age 18 and above. Parents or carers complete the survey on behalf of their children.

Sampling

Since the sample size is small, the survey is administered to all patients prior to discharge. At the Royal Darwin Hospital, a random selection of patients are administered the survey.

Survey domains

The Gove District Hospital Patient Experience Survey was revised in August 2009 and contains 14 questions. The questions cover the following domains:

- information sharing
- participation
- overall satisfaction

A separate survey was designed for a specific ward at Gove District Hospital. The survey includes pictures and questions written in English and the local Yolgnu language. The ward 1 survey is broader than the general in-patient survey and includes the following domains:

- information sharing and communication
- respect
- involvement
- conduct of staff

- physical environment
- overall satisfaction

The Alice Springs Hospital Patient Experience Survey was revised in June 2011 and contains 24 questions. The questions cover the following domains:

- access
- involvement/participation in care decisions
- information sharing and communication
- physical environment
- continuity of care
- overall satisfaction

The Royal Darwin Hospital Patient Experience Survey was revised in June 2011 and contains 20 questions. The questions cover the following domains:

- information sharing
- physical environment
- information sharing and communication
- respect

The Katherine Hospital Patient Experience Survey was revised in June 2011 and contains 20 questions. The questions cover the following domains:

- information sharing
- physical environment
- information sharing and communication
- respect

Scoring

For each question, respondents are asked to give factual responses to questions about what did or did not occur by selecting 'yes' or 'no'. For the Alice Springs and Royal Darwin Hospital surveys, open ended questions are asked relating to how the hospital could improve and what aspects of their hospital stay patients enjoyed. Respondents are also asked to provide further comments on their hospital stay. All survey responses are de-identified.

Risk adjustment

The responses are not risk adjusted.

Impact

It has been reported that service quality has improved in the Northern Territory as a result of feedback from the survey. Aboriginal liaison officers now have a private area to meet with patients. DVD players have been purchased to play DVDs created to demonstrate to patients what to expect in hospital. In addition, ward pamphlets with information on how to make complaints have been developed and distributed [6].

Tasmania

Background

At hospital-level a number of patient surveys are conducted on a regular basis to capture and evaluate patient feedback about care and services provided. A range of methods are used to capture feedback from patients and their family/carers about their hospital experience including consumer forums, mail out surveys, surveys at the bedside and on discharge.

The most recent state-wide patient satisfaction survey undertaken in Tasmania was in 2007. Press Ganey Associates Pty Ltd conducted the survey on behalf of the Department of Health and Human Services (DHHS) using the Press Ganey survey tool. This was a survey of in-patients and emergency department patients accessing care at Tasmania's large public hospitals over an eight week period in 2007. The previous state-wide survey was of in-patients only, and conducted in 2004 using an 'in-house' tool which had been in use since 1997.

Objectives

The objective of conducting hospital patient satisfaction surveys is to capture data and information from patients and their family /carers in order to evaluate service delivery and make improvements. Recommendations also form part of broader hospital quality improvement programs.

Inclusion and exclusion criteria

The scope of the Press Ganey survey included all discharged in-patients and emergency department patients over an eight week period.

Sampling

A mail out survey was conducted of a random sample of hospital emergency and in-patients over an 8 week period.

Survey domains

The Press Ganey survey used in Tasmania has 25 questions covering the following domains:

- access
- information sharing, education and communication
- effective treatment by trusted professionals
- conduct of staff
- involvement/participation in care decisions
- rights and respect
- services and equipment (physical environment)
- discharge and continuity of care
- overall satisfaction

There are additional open ended questions relating to areas which a service is doing particularly well and areas that require further focus. Respondents are also asked to provide further comments on their hospital stay. All survey responses are de-identified. In addition to the above domains, respondents are invited to participate in a focus group discussion administered by the hospital.

Scoring

The majority of questions in the survey are patient satisfaction questions with a rating scale of 'very poor' to 'very good'. There are additional patient experience questions with 'yes' or 'no' response options.

Data analysis and reporting

Data analysis is conducted by Press Ganey. The data is presented in a report that includes:

- demographic profile of aggregated respondents graphically displayed
- overall mean score for each DHHS Tasmania facility compared to industry benchmarks
- mean score for each section (eg. nursing care, doctor care) and individual questions compared to industry benchmarks
- analysis of the number and percentage of responses who gave the highest - lowest ratings for each individual question;
- the relative importance (correlation) of each question to overall satisfaction displayed and given a ranking by the coefficient;
- an internal index developed, "priority index internal" to assist in determining where resources would best be directed for the improvement of quality and overall satisfaction
- scores associated with a given percentile rank within either the national or first peer group benchmark (public or private, not both)
- comparative analysis by specialty presented as compared to national specialty benchmarks;
- mean score and t-test analysis for each ward (without benchmark analysis);

Impact

Results of patient experience and satisfaction surveys are fed back to all levels of the organisation to inform quality improvement initiatives at ward, unit and hospital levels. It has been reported that quality improvement initiatives in Tasmania have been undertaken in a range of areas as a direct result of input from patients through satisfaction surveys. For example, improving discharge practices, conducting communications training and improving quality of information provided to patients about their care and treatment. Follow up focus groups with patients and their family or carers have also been undertaken where they have indicated an interest to work with hospitals to improve the patient experience.

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Private Hospitals

Healthscope

Healthscope collects, collates and benchmarks patient satisfaction responses for its 44 hospitals. The recent introduction of patient experience measurement has been due to the development of the Patient Centred Care Project which involves an annual survey. The annual survey is based on the Hospital Consumer Assessment Healthcare Providers and Systems (HCAHPS) from the United States. Healthscope has revised the HCAHPS survey to suit the Australian context.

The modified HCAHPS survey used by Healthscope has 35 questions covering the following domains:

- access
- admission
- services and equipment / physical environment
- information sharing/communication
- involvement/participation in care decisions in care decisions
- pain management
- respect and dignity
- discharge process/continuity of care
- overall satisfaction

Healthscope has identified advantages for the use of the HCAHPS. These include:

1. reliability of a validated tool
2. availability of benchmarking data
3. focus on actual patient experience
4. focus on what actually happened (objective) rather than how happy patients were (subjective)
5. it separates the care of doctors and nurses which is important to private hospitals
6. focus on factors that are sensitive to change
7. limited number of questions which leads to a high response rate.

Healthscope also uses a locally developed patient experience survey. This survey is administered on a quarterly basis by mail. It will be revised in 2012 following consultation with a process that will include consumer input.

St Vincent's Health Australia

St Vincent's Health Australia has recently conducted a review of its PEx and PSat surveys in order to inform the development of a standard methodology. During this review, two potential key performance indicators (KPIs) that could be used to measure patient experience were identified.

The candidate KPIs are:

1. Likelihood of recommending the hospital to family and friends.
2. Overall rating of care.

Table 1 details the different surveys used by St Vincent's Hospitals.

Table 1: Survey tools used among St Vincent's hospitals

		State level	Tool used	Tool description	Frequency of reporting	Valid tool	No. of Questions	KPI 1	KPI 2
NSW	SVH & SHC, STJ	State wide since 2007, by IPSOS	Picker	PEx	Annual now monthly, Q4	Yes	70-90**	yes	yes
	SVPH	N/A	Press Ganey	PEx and PSat	Monthly, Q4	Yes	57 + 10 special	yes	yes
	Mater	N/A	Press Ganey	PEx and PSat	Monthly, Q4	Yes	55 + some special	yes	yes
QLD	HSNS	Nil but required as part of health fund contract	Local	PSat	Annual	No	72	yes	no
	SVHB		Local	PSat	Annual	No	36	yes	yes
	SVHT		Local*	PSat	Continuous	No	65	yes	yes
VIC	SV & MP	Nil Under development	Local	PSat	Monthly	No	21	yes	yes
	SVH M		Local	PSat	6 Monthly		65	no	no

Codes

*Specific Day surgery and emergency tools used ** Current , proposed to reduce to 50-60

PEx - patient experience, PSat - patient satisfaction

SVH - St Vincent's Hospital, SHC - Sacred Heart, STJ - St Joseph's Hospital, SVOPH - St Vincent's Private Hospital (public), HSNS - Holy Spirit Northside Hospital, SVHB - St Vincent's Hospital Brisbane, SVHT - St Vincent's Hospital Toowoomba, SV & MP - St Vincent and Mercy Private, SVHM - St Vincent's Hospital Melbourne

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Day Hospitals

A select number of members from the Australian Day Hospitals Association participated in this review. Surveys were received from nine day hospitals. These hospitals include Robina Procedure Centre in Queensland, Centre for Digestive Diseases and Liverpool Day Surgery in NSW, Buderim Gastroenterology Centre in Queensland, the Women's Clinic Day Hospital in Western Australia, Eye Tech Day Surgery in Queensland, Colin Street Day Surgery and the Eye Hospital in Tasmania.

These hospitals use a range of survey tools. Most were developed locally. Some of the day hospitals use QPS Patient Satisfaction Survey. The survey is developed by QPS Benchmarking which is an Australian and New Zealand based health care quality improvement organisation. The QPS Benchmarking Program has the ability to measure internal performance as well as compare results between day surgeries and other healthcare facilities. The data collection process is underpinned by standardised definitions, criteria, data collection tools and scorecards. The data cleansing process identifies errors and outliers to ensure valid and reliable reports. QPS regularly reviews and updates the program, including the Key Performance Indicators and data collection tools, to ensure it remains relevant to the health care industry. In addition, data collection tools are reviewed and revised by experts on a continuous basis [8].

A range of sampling methods are used by day hospitals. Some survey all patients while others conduct random sampling.

The QPS Benchmarking Patient Satisfaction Survey (Version 3) has 20 questions covering the following domains:

- appointment/waiting times
- information sharing/communication
- respect and dignity
- conduct of staff
- physical environment
- overall satisfaction
- pain management
- services and equipment
- billing process
- discharge/continuity of care

The survey is conducted 1-2 weeks post-discharge. The QPS scorecards automatically provide a numerator and denominator as well as question by question graphical and numerical results.

The surveys used in these facilities focus on patient experience except the survey used in the Eye Hospital in Tasmania which focuses on patient satisfaction. They are all conducted within stand alone hospitals without the capacity to benchmark across peer hospitals. The surveys have all been developed in-house and are not based on any commercially available surveys. The inclusion and exclusion criteria differ across the different hospitals. The surveys are short with less than 15 questions in most instances. Scoring of responses is conducted manually and does not include any risk adjustment.

6. Comparison of methods

This section focuses on comparison of the hospital in-patient surveys used within jurisdictions and participating private hospital ownership groups in Australia.

Survey methodologies

Table 2 provides a summary of patient experience and satisfaction surveys used in Australia among public and private hospitals.

Table 2: Patient experience and satisfaction surveys used in Australia

Provider	Tool	Administration	Scope	Tool description
Jurisdiction				
Northern Territory	Local	In-house	Hospital	PEx
Australia Capital Territory Health	Victoria Patient Satisfaction Monitor	Mail	State-wide	PEx and PSat
Tasmania	Local	Mail	State-wide till 2007. Hospital thereafter	PEx and PSat
South Australia	SACCESS	CATI	State-wide	PEx and PSat
Western Australia	Local	CATI	State-wide	PEx and PSat
Queensland	Picker-based	CATI	State-wide	PEx and PSat
Victoria	Victoria Patient Satisfaction Monitor	Mail and online	State-wide	PEx and PSat
Private Hospitals				
Eye Tech Day Surgery, QLD	QPS	CATI	Hospital	PSat
Colin Street Day Surgery, WA	QPS	CATI	Hospital	PSat
Mater Hospital North Sydney	Press Ganey	CATI	Hospital	PEx and PSat
Healthscope (44 hospitals)	HCAPS	Mail	National	Pex and PSat
St Vincent's Hospitals (2 public, 8 private)	Picker and Press Ganey in NSW, local in QLD and VIC	Mail	National	PEx and PSat in select NSW PSat in QLD and VIC
Robina Procedure Centre, QLD	Local	In-house	Hospital	PEx
Centre for Digestive Diseases, NSW	Local	In-house	Hospital	PEx
Buderim Gastroenterology Centre, QLD	Local	In-house	Hospital	PEx
Liverpool Day Surgery, NSW	Local	In-house	Hospital	PEx
The Women's Clinic Day Hospital, WA	Local	In-house	Hospital	PEx
The Eye Hospital, Tasmania	Local	In-house	Hospital	PSat

Codes:

CATI - computer aided telephone interviewing, PEx - Patient Experience, PSat - Patient Satisfaction

As shown in table 2 above, there are differences in the methodological basis, methods of administration and the scope of patient experience and satisfaction surveys used in Australian public and select private hospitals. Public hospitals in the NT and private hospitals tend to use locally developed tools. These tools have been developed in consultation with consumer representatives. Whereas, jurisdictions use commercially available tools that have been slightly modified to suit the Australian context.

The delivery process for the survey varies – most use mailed surveys, others use computer aided telephone interviewing while others deliver the survey within the hospital prior to discharge.

Benchmarking activity

Benchmarking activities occurs within large private hospital ownership groups such as Healthscope, and within the ACT, South Australia, Western Australia, Queensland, NSW and Victoria.

Selection criteria

The inclusion criteria for patient participation within surveys are relatively similar i.e patients with a minimum hospital length of stay one night and are local residents. There are significant differences in the exclusion criteria. For example, some surveys exclude patients below age 16 while others exclude patients below age 18.

Domains

Table 3 shows the domains and frequency of use within patient experience and satisfaction surveys.

Table 3: Frequency of domains used in hospital patient experience and satisfaction surveys in Australia

Domain	WA	QLD	SA	ACT	NT	TAS	VIC	NSW	HCAHPS	QPS	Frequency
Access/waiting time,/admission process	✖	✖		✖	✖	✖	✖	✖	✖	✖	90%
Information sharing,/communication	✖	✖		✖	✖	✖	✖	✖	✖	✖	90%
Physical environment	✖	✖	✖	✖	✖	✖	✖		✖	✖	90%
Overall satisfaction	✖		✖	✖	✖	✖	✖	✖	✖	✖	90%
Involvement/participation	✖	✖	✖	✖	✖	✖		✖	✖		80%
Privacy/respect/dignity		✖	✖	✖	✖	✖		✖	✖	✖	80%
Consistency/coordination of care	✖	✖	✖	✖	✖	✖	✖			✖	80%
Discharge/continuity of care		✖			✖	✖	✖	✖	✖	✖	70%
Pain control		✖	✖					✖	✖	✖	50%
Safety/quality (i.e hand hygiene, patient identification)				✖	✖			✖			20%

Codes: HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems

Ten key domains used in patient experience and satisfaction surveys which vary in their frequency of use. These domains include:

- waiting times/access/admission process, information sharing/communication, physical environment and overall satisfaction are used in 90% of surveys.
- Patient involvement/participation in care decisions, privacy/respect/dignity and consistency/coordination of care are used in 80% of surveys.
- Discharge/continuity of care is reported in 70% of surveys.
- Pain control which is used in 50% of surveys and safety/quality which is used in 20% of surveys. The quality and safety domain covers items such as hand washing and detailed patient identification.

The number of domains within each survey ranges from 6 to 8. There were no differences in the frequency of domains or number of domains used between private and private hospitals.

This review did not include a detailed comparison of questions within each domain by survey type.

Impact

Some hospitals have reported improvements as a result of patient experience and patient satisfaction measurement. These improvements are listed below.

1. In the Australia Capital Territory, improvement have been made in medication safety, clinical handovers, promoting a patient centred care approach, staff communication, admission and discharge process/continuity of care, reviewing of IT systems for appointments, reviewing of waiting times, infrastructure, planning and design of new service areas and a volunteer program within aged care wards to enhance meal and nutrition experience.
2. In Victoria, improvements have been made in the management of complaints and patient discharge and follow-up process.
3. In Western Australia, improvements have been made in reducing waiting times, access, appropriate storage for care plans, recording and cross referencing food for allergens, improved communication and information sharing between staff and patients.
4. In South Australia, improvements have been made in the introduction of administrative processes to allow appropriate allocation of resources.
5. In Northern Territory, Aboriginal liaison officers now have a dedicated room to meet with clients, there has been increased patient knowledge on health care rights and improvements in the variety of available meals.
6. In Tasmania, improvement shave been made in discharge practices, staff communication and the quality of information provided to patients.

7. Conclusion

The key findings from this review are listed below.

- There are differences in the methodologies, administration, scope, rating scales, inclusion and exclusion criteria, sampling, data analysis and reporting methods used across public and private hospitals.
- Most jurisdictions and some private hospitals are using a combination of patient experience and satisfaction questions in their surveys.
- There are documented impacts from the use of the surveys showing how feedback has informed service delivery.
- There was no significant difference in the frequency or number of domains used between private and public hospitals.
- In some jurisdictions and private hospital ownership groups, surveys are conducted state-wide or across one private hospital ownership group, while in certain instances, individual institutions have developed and administered their own surveys.
- Most of the private hospitals included in this review use locally developed tools. These tools are often administered in-house.
- The surveys are not well suited for use with people who speak little or no English, as translated versions are generally not available. Northern Territory (NT) and Victoria have sought to address language barriers. In NT hospital, meaningful pictures and symbols are incorporated within surveys. In Victoria, the surveys are available in English and 16 community languages.

Appendix A: Key informants

The Australian Commission on Safety and Quality in Health Care would like to thank the following key informants for their contribution in the development of this paper.

Public Sector	Contact Name, Title, Organisation
Northern Territory	Ms Penny Parker, Acting Senior Quality Officer, Department of Health and Families Ms Arti Nazareth AIMM, Quality Manager, Katherine Hospital, Department of Health and Families
Australian Capital Territory	Ms Sonia Hogan, Director, Operational Services Section, Quality and Safety Unit, ACT Health
Tasmania	Ms Adrienne Prendergast, Coordinator Safety and Quality, Care Reform, Department of Health and Human Services
South Australia	Ms Michele McKinnon, Director, Safety and Quality, Public Health and Clinical Coordination, South Australia Health
Western Australia	Mr Peter Somerford, Principal Epidemiologist, Epidemiology Branch, Public Health Division, Department of Health
Victoria	Ms Cath Harmer, Manager, Policy and Strategy, Quality, Safety and Patient Experience Branch, Department of Health Ms Cathy Fraser, Senior Project Officer, Victorian Patient Satisfaction Monitor, Department of Health
Queensland	Ms Kirstine Sketcher-Baker, Director, Measurement and Monitoring, Patient Safety and Quality Improvement Service, Queensland Health
New South Wales	Mr Jason Boyd, Senior Researcher, Bureau of Health Information Mr Lee Holmes, Acting Senior Manager, Health Service Performance Improvement Branch, NSW Ministry of Health
Private Sector	
St Vincent's Australia	Dr Annette Pantle, Group General Manager, Clinical Governance, St Vincent's Health Australia Ltd
Healthscope	Ms Cathy Jones, National Manager, Quality & Compliance, Healthscope
Australian Day Surgery Council (representative)	Ms Anne Crouch, Executive Member, Australian Day Surgery Council
Australia Day Hospital Association (representative)	Ms Deanne Day, Chief Executive Officer, Buderim Gastroenterology Centre

Appendix B: Australian Charter of Healthcare Rights

On 22 July 2008, Australian Health Ministers endorsed the Australian Charter of Healthcare Rights, and recommended its use nationwide.

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit
www.safetyandquality.gov.au

**AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE**

What can I expect from the Australian health system?

MY RIGHTS

WHAT THIS MEANS

Access

I have a right to health care.

I can access services to address my healthcare needs.

Safety

I have a right to receive safe and high quality care.

I receive safe and high quality health services, provided with professional care, skill and competence.

Respect

I have a right to be shown respect, dignity and consideration.

The care provided shows respect to me and my culture, beliefs, values and personal characteristics.

Communication

I have a right to be informed about services, treatment, options and costs in a clear and open way.

I receive open, timely and appropriate communication about my health care in a way I can understand.

Participation

I have a right to be included in decisions and choices about my care.

I may join in making decisions and choices about my care and about health service planning.

Privacy

I have a right to privacy and confidentiality of my personal information.

My personal privacy is maintained and proper handling of my personal health and other information is assured.

Comment

I have a right to comment on my care and to have my concerns addressed.

I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Appendix C: Principal components of the national health reform process

A program of national health reform has been undertaken to address the challenges facing Australia's health system and ensure its sustainability and continued delivery of world class health care. Since early 2010, work has been underway across the Australian health system in eight key streams of health reform. These streams are:

1. hospitals
2. general practitioner and primary health care
3. aged care
4. mental health
5. national standards and performance
6. workforce
7. prevention
8. e-health [10].

Safety and quality is central to the delivery of health care, and considerations about safety and quality are embedded in all aspects of the health reforms. There is a strong link between the Australian Safety and Quality Goals for Health Care and the health reform process. This Appendix provides a summary of the principal components of the current health reforms.

National Health Reform Agreement

The National Health Reform Agreement sets out the architecture of national health reform, which has been designed to deliver major structural reforms to establish the foundations of Australia's future health system. In particular, the Agreement focuses on providing more sustainable funding arrangements for Australia's health system.

The Agreement was made between the Commonwealth of Australia and all states and territories on 2 August 2011 and sets out the shared intention of the Australian, state and territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system [11].

As part of the reforms to local health governance, the National Health Reform Agreement outlines the role of Local Hospital Networks and Medicare Locals to improve local accountability and responsiveness to the needs of communities.

The Agreement also sets out the establishment of several national bodies, including the Independent Hospital Pricing Authority, the National Health Performance Authority, and the Australian Commission on Safety and Quality of Health Care [11].

Performance and Accountability Framework

The Commonwealth, states and territories will develop a new Performance and Accountability Framework, which will incorporate national performance indicators agreed by the Council of Australian Governments (COAG), and national clinical quality and safety standards to be developed by the Australian Commission for Safety and Quality in Health Care. This framework will provide the basis for national reporting for Medicare Locals and Local Hospital Networks [11].

National bodies

Australian Commission on Safety and Quality in Health Care

The *National Health Reform Act 2011* establishes the Australian Commission on Safety and Quality of Health Care (the Commission) as a permanent, independent, statutory authority under the *Commonwealth Authorities and Companies Act 1997*.

The role of the Commission is to lead and coordinate improvements in safety and quality in health care across Australia. The functions of the permanent Commission, as outlined in the legislation, are:

- (a) to promote, support and encourage the implementation of arrangements, programs and initiatives relating to health care safety and quality matters;
- (b) to collect, analyse, interpret and disseminate information relating to health care safety and quality matters;
- (c) to advise the Minister about health care safety and quality matters;
- (d) to publish (whether on the internet or otherwise) reports and papers relating to health care safety and quality matters;
- (e) to formulate, in writing, standards relating to health care safety and quality matters;
- (f) to formulate, in writing, guidelines relating to health care safety and quality matters;
- (g) to formulate, in writing, indicators relating to health care safety and quality matters;
- (h) to promote, support and encourage the implementation of:
 - (i) standards formulated under paragraph (e); and

- (ii) guidelines formulated under paragraph (f);
- (i) to promote, support and encourage the use of indicators formulated under paragraph (g);
- (j) to monitor the implementation and impact of:
 - (i) standards formulated under paragraph (e); and
 - (ii) guidelines formulated under paragraph (f);
- (k) to advise:
 - (i) the Minister; and
 - (ii) each participating State/Territory Health Minister;
 about which standards formulated under paragraph (e) are suitable for implementation as national clinical standards;
- (l) to formulate model national schemes that:
 - (i) provide for the accreditation of organisations that provide health care services; and
 - (ii) relate to health care safety and quality matters;
- (m) to consult and co-operate with other persons, organisations and governments on health care safety and quality matters;
- (n) such functions (if any) as are specified in a written instrument given by the Minister to the Commission Board Chair;
- (o) to promote, support, encourage, conduct and evaluate training programs for purposes in connection with the performance of any of the Commission's functions;
- (p) to promote, support, encourage, conduct and evaluate research for purposes in connection with the performance of any of the Commission's functions;
- (q) to do anything incidental to or conducive to the performance of any of the above functions.

As part of its role to in accreditation reform, the Commission developed the National Safety and Quality Health Service Standards to drive the implementation and use of safety and quality systems and improve the quality of health service provision in Australia.³

The Standards focus on areas that are essential to improving patient safety and quality of care and include:

1. Governance for Safety and Quality in Health Service Organisations
2. Partnering with Consumers
3. Preventing and Controlling Healthcare Associated Infections
4. Medication Safety
5. Patient Identification and Procedure Matching
6. Clinical Handover

7. Blood and Blood Products
8. Preventing and Managing Pressure Injuries
9. Recognising and Responding to Clinical Deterioration in Acute Health Care
10. Preventing Falls and Harm from Falls.

National Health Performance Authority

The National Health Reform Amendment (National Health Performance Authority) Bill 2011 was passed on 14 October 2011. The Bill established a new statutory authority, the National Health Performance Authority (NHPA).

The Government's decision to establish the NHPA is part of a broader commitment to "increasing the transparency of government and the services it delivers" and establishing "more effective reporting and monitoring of health service providers" [12]. It is expected that this will improve the quality of healthcare services and drive value for money in the health system.

The functions of the NHPA under the *National Health Reform Act 2011* will be:

- (a) to monitor, and prepare reports on, matters relating to the performance of the following:
 - (i) local hospital networks;
 - (ii) public hospitals;
 - (iii) private hospitals;
 - (iv) primary health care organisations;
 - (v) other bodies or organisations that provide health care services;
- (b) to publish (whether on the internet or otherwise) reports prepared by the Performance Authority in the performance of the function conferred by paragraph (a);
- (c) to formulate, in writing, performance indicators to be used by the Performance Authority in connection with the performance of the function conferred by paragraph (a);
- (d) to collect, analyse and interpret information for purposes in connection with the performance of the function conferred by paragraph (a);
- (e) to promote, support, encourage, conduct and evaluate research for purposes in connection with the performance of any of the functions of the Performance Authority;
- (f) such functions (if any) as are specified in a written instrument given by the Minister to the Chair of the Performance Authority with the agreement of COAG;
- (g) to advise the Minister, at the Minister's request, about matters relating to any of the functions of the Performance Authority;

- (h) to do anything incidental to or conducive to the performance of any of the above functions.

The basis for the reports to be prepared by the NHPA will be the Performance and Accountability Framework [12].

Independent Hospital Pricing Authority

The National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011 was introduced into the House of Representatives on 24 August 2011. If passed, this Bill will amend the *National Health Reform Act 2011* to establish the Independent Hospital Pricing Authority (IHPA) as a permanent statutory body.

An interim IHPA has been established as an executive agency from 1 September 2011, pending the passage and enactment of the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011.

The Commonwealth intends that the main function of the IHPA will be to determine the nationally efficient price for public hospital services that are funded by activity based funding (ABF), and to provide advice to state and territory governments about those prices [13]. This is intended to improve the transparency of public hospital funding.

The functions of the IHPA, as outlined in the Bill, are:

- (a) to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;
- (b) to determine the efficient cost for health care services provided by public hospitals where the services are block funded;
- (c) to develop and specify classification systems for health care and other services provided by public hospitals;
- (d) to determine adjustments to the national efficient price to reflect legitimate and unavoidable variations in the costs of delivering health care services;
- (e) to determine data requirements and data standards to apply in relation to data to be provided by States and Territories, including:
 - (i) data and coding standards to support uniform provision of data; and
 - (ii) requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions;
- (f) except where otherwise agreed between the Commonwealth and a State or Territory – to determine the public hospital functions that are to be funded in the State or Territory by the Commonwealth;
- (g) to publish a report setting out the national efficient price for the coming year and any other information that would support the efficient funding of public hospitals;
- (h) to advise the Commonwealth, the States and the Territories in relation to funding models for hospitals;

- (i) to provide confidential advice to the Commonwealth, the States and the Territories in relation to the costs of providing health care services in the future;
- (j) such functions as are conferred on the Pricing Authority by Part 4.3 of this Act (cost-shifting disputes and cross-border disputes);
- (k) to publish (whether on the internet or otherwise) reports and papers relating to its functions;
- (l) to call for and accept, on an annual basis, public submissions in relation to the functions set out in paragraphs (a) to (f);
- (m) such functions (if any) as are specified in a written instrument given by the Minister to the Chair of the Pricing Authority with the agreement of COAG;
- (n) to do anything incidental to or conducive to the performance of any of the above functions.

Local governance

Local Hospital Networks

Local Hospital Networks (LHNs) are organisations established in accordance with the National Health Reform Agreement which provide public hospital services. LHNs are designed to “devolve operational management of public hospitals to the local level”[14].

LHNs will comprise single or small groups of public hospitals with a geographic or functional connection. They are intended to be large enough to operate efficiently and to provide a reasonable range of hospital services and small enough to enable the LHNs to be effectively managed to deliver high quality services [11].

With the introduction of LHNs, states and territories will continue to own, operate and manage public hospitals, including service planning and performance, the purchasing of public hospital services, and capital planning.¹⁹¹ It is intended that service agreements between jurisdictions and LHNs will regulate the provision of services and the flow of funding [15].

The NHPA will assess and report on LHN performance against the measures in the Performance and Accountability Framework and provide advice to states and territories on poor performing LHNs [11].

Jurisdictions remain in control of public hospitals. A key source of advice to jurisdictions will be the newly established Lead Clinicians Groups at national and local levels. The Lead Clinicians Groups will promote evidence-based clinical practices and assist with prioritising and implementing clinical standards and guidelines

Medicare Locals

Medicare Locals are organisations funded by the Commonwealth to be the general practice and primary healthcare partners of Local Hospital Networks in accordance with the National Health Reform Agreement.

It is intended that Medicare Locals will be responsible for supporting and enabling better integrated and responsive local general practice and primary healthcare services to meet the needs and priorities of patients and communities. Medicare Locals will, among other functions, have responsibility for:

- assessing the health needs of the population in their region
- identifying gaps in general practice and primary healthcare services
- putting in place strategies to address these gaps [11].

The strategic objectives for Medicare Locals are:

- improving the 'patient journey' through developing integrated and coordinated services
- providing support to clinicians and service providers to improve patient care
- identifying the health needs of their local areas and development of locally focused and responsive services
- facilitating the implementation of primary healthcare initiatives and programs
- being efficient and accountable with strong governance and effective management [11] .

It is intended that Medicare Locals will be independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services. Medicare Locals will reflect their local communities and healthcare services in their governance arrangements.¹

Medicare Locals and Local Hospital Networks will be expected to share some common membership of governance bodies where possible. Medicare Locals will be expected to work closely, and establish a formal engagement protocol, with LHNs. The Commonwealth, states and territories will work together to create linkages and coordination mechanisms, where appropriate, between Medicare Locals and other services that interact with the health system, for example services for children at risk, people with serious mental illness and homeless Australians [11].

The NHPA will develop and produce reports on the performance of Medicare Locals and will provide confidential advice to the Commonwealth on poor performing Medicare Locals where ongoing poor performance has been identified [11].

The first group of 19 Medicare Locals were established in June 2011, with the process expected to be complete by 1 July 2012.

Lead Clinicians Groups

Lead Clinician Groups will seek to engage clinicians in the reform of the Australian health system and involve them in the planning and coordination of healthcare services. Participation of clinicians at this level, particularly at a local level, is expected to make health services more responsive to local needs and ensure they are informed by best clinical practice, leading to improved safety, quality, efficiency and effectiveness of care. Membership of the groups will be multidisciplinary and multi-sectoral [16].

National

The National Lead Clinicians Group was established on 29 September 2011 and has been created to advise the Minister for Health and Ageing on nationally relevant priorities and strategies to improve patient care across healthcare sectors [16].

Local

Local Lead Clinicians Groups (LCGs) will be established in each Local Hospital Network in order to improve clinical leadership and engagement. They will provide advice to LHNs and Medicare Locals on local implementation of standards and guidelines, and promote and facilitate better integration of services and the optimal 'patient journey'. It is envisaged that local LCGs will evolve from existing clinician advisory groups wherever possible, and include consumer representatives [16].

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