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PDF Split View Article Content Figures and Tables Video Audio Additional Data Background. Government reviews of restless services in England and Scotland recommended the use of a standard questionnaire to assess patient satisfaction. This is important due to the rapid introduction of new forms of care. Goal. To obtain a short, reliable and reliable measure of patient satisfaction for use by a wide range of providers outside the hours of primary care. Methods. A short questionnaire on the care of the watch was developed and compared with a longer questionnaire, which was tested and used in previous studies. The questionnaires were sent out to 1906 people contacting the out-of-hours GP cooperative. Three versions of the short questionnaire were used in different formats. The analysis compared responses, measurement properties, the simoability and validity of short and long questionnaires, and different versions of the short questionnaire. Results and conclusions. There was no significant difference in the overall response rates obtained from short or long questionnaires (45.7% vs. 41.9%; No 0,17). The effective interest rate of responses to questionnaires, from which all satisfaction scales could be calculated, was higher for the short questionnaire (43.0% vs. 36.4%; No 0,01). There were no significant differences in response rates or the distribution of responses between the different versions of the short questionnaire. There is moderate agreement between the short questionnaire points and the corresponding scales in the long questionnaire. The results, using a short questionnaire, showed an expected relationship with the age and gender of the patients and with characteristics of how the service was delivered. The NHS is valid and reliable for regular use of services. Salisbury C, Burgess A, Lattimer V, Heaney D, Walker J, Turnbull J and Smith H. Develop a standard short questionnaire to assess the satisfaction of patients with extra-stretched primary care. Family practice 2005; 22: 560-569. Introduction Over the past decade, many developed countries have considered or reorganized the way primary care is provided.1 Following a review of out-of-the-way services in 2000, various care models were developed for Public Health England. The review recommends that all providers constantly monitor the satisfaction of their patients.2 However, the conceptualization and evaluation of patient satisfaction is complex, and many organizations are now using locally developed questionnaires that have not been verified. Research questionnaires can be too long and complex for regular use. Following an earlier review of unprepared services in Scotland, the Scottish Government's working group recommended This concept has also been proposed by the National Association of GP Cooperatives (NAGCP) as a standard questionnaire that would help various out-of-prepared services conduct reliable surveys and obtain meaningful results compared to those achieved elsewhere. The Scottish Office funded the initial development of such a document and we have improved and evaluated the questionnaire as part of the assessment of comprehensive services not worked out in England. The need for standardized measurement tools is becoming increasingly important due to radical changes in out-of-work services that may be the result of new contractual agreements for GPs in the UK.7 Our aim was to produce a short, reliable and effective measure of patient satisfaction that could be used by a wide range of providers of off-the-car care. The purpose of this paper is to describe the development and verification of a short questionnaire for the care of unprepared care (SIS). The Methods of Drafting the Questionnaire Panel reviewed the various tools used and developed a draft short questionnaire to address a range of issues in the provision of out-of-hours primary care, which were identified in earlier qualitative and quantitative studies as most important to patients.5,8-12 The most thoroughly verified questionnaire appears to have been developed by McKinley et al.,8 later modified and revised in Salisbury. To create three different versions suitable for patients receiving care at a primary care center, on-home visit, or by phone.11 This long questionnaire has been used in a number of cooperatives previously, but felt it was too complicated for routine use. It was therefore used as a gold standard as a basis for comparison with our new shorter questionnaire. A draft short questionnaire consisting of five sections was developed: demographic details, questions about the type of service received, whether the patient receives the type of services they want, questions about satisfaction and an open question inviting them to general comments. The meeting section consisted of seven questions, with one or two questions being designed to replace each of the scales of several items with different components of satisfaction in the longer questionnaire11 (see table 1). The aim was to obtain a common scale of satisfaction by combining all the points of the short questionnaire, provided that the satisfactory internal consistency of the scale was confirmed. Table 1Rep rates on items on a short questionnaire and scales on a long item questionnaire on a short questionnaire. The speed of the response. Scale on a long questionnaire. The speed of the response. χ^2 (P) value. n No 748 n No 558. n (%) . n (%) . No 8. Receiving by calling 330 (44.1) Contact the service' 220 (39.4) 2.89 2.89 The way the initial call was handled 328 (43.9) 'Receptionist' 220 (39.4) 2.57 (0.11) No. 10. Time to wait 331 (44.3) 'Wait for visits/telephone consultation/visit center 220 (39.4) 3.05 (0.08) No11. The manner of a doctor or nurse 331 (44.3) Medical manner 221 (39.6) 2.83 (0.09) No12. Explanation 329 (44.0) 'Explanation and Advice' 212 (38.0) 4.73 (0.03) No13. Treatment or Advice 332 (44.4) 'Explanation and Advice' 212 (38.0) 5.37 (0.02) No14. Total Satisfaction 337 (45.1) All scales 203 (36.4) 5.91 (0.01) Initial pilot project questionnaire studies were conducted in three locations in Scotland, 5.91 (0.01) Initial pilot project questionnaire studies were conducted in three locations in Scotland, minor changes were then made to improve the clarity of the wording of the questions. Experimental studies have shown that the distribution of responses for each item is sharply skewed towards satisfaction. Therefore, three additional versions with different response formats have been developed in an attempt to increase the range of responses (Box 1). Box 1Response variants on various versions of the short Basic Study Installation questionnaire were conducted in the cooperative's general practice of providing out-of-hours care for 139,000 patients from 77 GP members. The Cooperative covers a range of urban, sub-urban and rural areas with pockets of affluence and deprivation. It is one of thirty-four exemplary sites in England where registered patients contacted by a doctor outside the surgery watch were initially assessed by NHS Direct. Those assessed by NHS Direct Nurse as needing the doctor's attention are referred to the co-operative, with a recommendation on whether they need telephone counselling, a visit to a primary care centre or at home. Participating patients who were transferred to a CO-op GP for a six-week period in July and August 2003 were potentially eligible for the study (n No. 3291). Calls were excluded in cases where the co-operative doctor felt that sending the questionnaire would lead to disaster (n No. 559) if the questionnaire had already been sent to the same household (n No. 775), or if the address data was incomplete (n No. 51). The final sample consisted of 1906 patients who sent the questionnaire in the mail. The evaluation of the study's short questionnaire focused on four main issues. First, compare response rates when patients have been sent a short or long questionnaire. Second, compare the internal consistency and distribution of responses from different versions of the short questionnaire with different response options. Third, examine the agreement between the answers to individual questions on the short questionnaire and the corresponding scale of the long questionnaire (simultaneous veracity). Fourth, to examine whether satisfaction ratings have been shown with the new questionnaire relationship with patient characteristics or treatment to demonstrate the validity of the design. Chi-square statistics were used to compare the response. The internal consistency of the questionnaire was assessed using Cronbach's alpha statistics. The level of agreement between the answers to each question item in the short questionnaire and the corresponding multi-point scale in the long questionnaire was assessed using the intra-class correlation factor (ICC), which describes the variance between individuals to the variance between the two dimensions.13 In calculating the scale where one point of the question contributing to the scale was applied from the average level for that person. If more than one element was missing, the entire scale was hammered as missing. The score of the SSC scale, based on a short questionnaire, was calculated as a percentage of the maximum score attainable on all counts, so that potential scores ranged from 0 (very unsatisfied) to 100 (very satisfied). Administration questionnaire Using a computer sequence of randomization, successive patients (n No. 1306) who contacted the cooperative were randomly singled out to send one of four versions (with different response categories) a short questionnaire or long questionnaire (one of three versions depending on whether they had counseling at the center, home or by phone). In the second phase, successive patients (n No. 600) who contacted the cooperative were asked to complete both the initial version (version A) of the short questionnaire and the corresponding version of the long questionnaire. Patients were sent questionnaires to the co-op within 7 days of their initial contact. One reminder was sent 14 days later. The results of the Answer Rate Response was 45.7% (342/748) from patients sent a short questionnaire alone, 41.9% (234/558) for patients sent a long questionnaire alone and 39.7% (238/600) for patients sent as questionnaires (although 1 of these patients did not complete the short option and 4 is not a long option). A total of 579 short and 468 long questionnaires were prepared for analysis (Figure 1). When comparing patients sent only by a short questionnaire (n No. 748) or a long questionnaire (n No. 558), the difference in percentage of responses was not statistically significant (Chi squared 1.86; No 0,17). In addition, there was no difference in the interest rate of responses to the various versions of the short questionnaire (Chi squared 4.16; No 0,25). However, scales for satisfaction components can only be calculated once all items have been completed, which will reduce the number of questionnaires with fully useful data. The effective overall response rate, where all the scales could be calculated, was higher for the short questionnaire of 43.0% (322/748) than for the long questionnaire 36.4% (203/558) (Chi squared 5.91; P 0.01), even after the points are inuted, where one item is missing (table 1). Respondents who took long and short questionnaires had very similar age and sexual characteristics. The age and sexual characteristics of non-relief workers are unknown. Internal consistency and distribution of answers Four versions of the short questionnaire with different response formats generated a similar overall average score scale (table 2). All four versions showed a similar distribution of responses, skewed towards satisfaction (Figure 2). For each version, the overall satisfaction scale, calculated from all seven satisfaction questions, demonstrated a high level of internal consistency assessed using Cronbach alpha statistics (table 2). For comparison, the internal consistency of the overall satisfaction scale with a long questionnaire was 0.79. Table 2Scores and internal consistency of four versions of the short questionnaire with different answer options version of the short questionnaire. A description of the scale. N. Average scale score. Standard deviation. alpha chronobach (a). 5-pointed alpha scale (very satisfied, satisfied, neutral, unsatisfied, very unsatisfied) 78 77.5 24.5 0.81 81 10-ton numerical scale (1 - very unsatisfied to 10 - very satisfied) 82 77.3 22.0 0.88 82 5-to-10 alpha scale (very unsatisfied, satisfied, neutral, neutral, neutral, neutral very dissatisfied) with emojis above the scale 90 75.9 23.6 0.94 83 5-toe alpha scale (very poor, poor, uncertain, good, excellent) with smiling faces above scale 72 80.0 21.0 0 All short questionnaires 322 77.5 22.8 0.92 Each of the individual satisfaction points in the short questionnaire correlate with the general satisfaction point (see table 3), suggesting to build a reality, but without excessive correlation, which means redundancy of items. Table 3Scores for each meeting item on the short questionnaire How satisfied are you with the following? Answer to the point. N. Means. Sd. % is fairly satisfied. % are very satisfied. Correlation with general satisfaction. Getting through by phone 311 3.85 1.22 36.3 36.3 0.64 As your initial phone call was processed 309 4.09 1.10 40.1 42.7 0.73 The time you had to wait before you, finally saw or talked to a doctor or nurse 312 3.93 1.18 34.6 39.4 0.73 Attitude doctor or nurse 313 4.28 1.11 28.4 57.5 0.79 Explained doctor or nurse gave you about your problem 311 4.04 1.18 33. 1 45.0 0.81 Treatment or advice You were given 313 4.07 1.12 36.1 43.8 0.84 In general, how satisfied were you with the service received? 315 4.09 1.12 38.1 44.1 Action: Agreement between short and long questionnaires. Table 4 shows consent between points on the and the scales on a long questionnaire. This is based on 233 patient responses, completing both a short questionnaire and a long questionnaire. Table 4 Meet the correlation ratios for the respective scales on short and long questionnaires A short version of the question. The scale of the long version. Icc. How satisfied were you? Getting through by phone Contact service 0.54 As your initial call was handled by 'Receptionist' 0.38 Time, when you had to wait before you finally saw or spoke to a doctor or nurse wait for a visit/telephone consultation/center of attendance'a 0.39 Manner doctor or nurse doctor manner 0.45 Explanation the doctor or nurse gave you about problem explanation and advice 0.45 Treatment or advice you were given' explanation and advice' 0.40 Overall, how satisfied are you with the service you have received? Total Satisfaction' 0.50 Build Reality: Patient Relationships and Organizational Factors. The high level of internal reliability of the satisfaction points indicates that satisfaction with the short questionnaire can be expressed in a single scale. In order to establish preliminary regulatory estimates for each item in the short questionnaire, as well as to examine the validity of the design, an assessment was made of how the scores vary according to the age and gender of the respondent and whether they receive a home visit, telephone consultation or attended the primary health care centre (table 5). Table 5Satisfaction in different age groups (limited to 320 patients who returned questionnaire A). The average SCORE of the SOC scale (SD). n (%) patients are very satisfied on the overall point of satisfaction. Assessment of logistical regression for being very satisfied. Sex n = 304a n = 315a n = 311a Male (n = 113) 75.7 (23.9) 41 (36.3) 1 (reference) Female (n = 202) 77.4 (23.2) 98 (48.5) 1.6 (1.0 to 2.6) Missing sex = 5 Age group n = 302a n = 309a Under 20 (n = 97) 73.9 (21.9) 36 (37.1) 1 (reference) 20-39 (n = 76) 77.3 (22.9) 34 (44.7) 1.5 (0.8 to 2.8) 40-59 (n = 44) 75.3 (25.6) 17 (38.6) 1.2 (0.5 to 2.5) 60+ (n = 96) 78.4 (26.3) 50 (52.1) 2.2 (1.1 to 4.2) Missing age = 7 Setting n = 308a n = 315a Telephone advice (n = 82) 71.7 (26.3) 27 (33.8) 1 (reference) Visit to Primary Care Centre (n = 178) 77.4 (21.9) 82 (46.3) 2.0 (1.1 to 3.7) Home Visit (n = 60) 78.8 (27.1) 30 (51.7) 1.8 (0.9 to 3.8) All patients in above categories 76.2 (24.2) 139 (43.4) One item on the questionnaire asked people if they received telephone advice received a visit to the house or asked to visit the primary health care center. The next question asked was whether they felt that their call should have been handled differently (e.g. with a visit, telephone consultation or a visit to the center). For evaluation from the short questionnaire, table 6 shows the proportion of respondents who were very satisfied with each item classified by whether the patient was satisfied or not satisfied with the type of service received, as well as their assessment of the SOC scale. Table 6Ds between satisfaction and whether patients received care in the conditions they wished for. Are the conditions in which assistance been provided satisfied? Significant difference (P value) . YES (n No 274) n (%) who were very pleased. NO (n No 22) n (%) who were very pleased. Getting through by phone 111/272 (40.8) 0/22 (0.0) qit:0.001 How your initial call was handled 129/271 (47.6) 2/22 (22.9.1) qit:0.001 The time when you had to wait before you finally saw or spoke to a doctor or nurse 118/272 (43.4) 2/22 (9.1) qit:0.001 Manner doctor or nurse 172/271 (63.5) 2/22 (9.1) zit:0.001 Explanation doctor or nurse gave you about the problem 132/270 (48.9) 2/22 (9.1) qit:0.001 Treatment or advice you were given 128/272 (47.1) 2/21 (9.5) 134/273 (49.1) 0/20 (0.0) qit:0.001 n No 270 n 22 SOC Scale Satisfaction Score-Average (SD) 80.0 (22.0) 4 4 0 7.0 (19.1) zit:0.001 95% CI 77.4 to 82.7 38.5 to 55.4 Talk There is a need for standardized data collection tools if we are to measure care standards over time and between organizations. This need is particularly relevant given the radical changes in out-of-hours care experienced in the UK as responsibility for care shifts from GPs to primary care organisations.7 Out-of-hours care is also being reorganised in many other European countries.1 Patient perspective is not the only indicator of the quality of care that primary care providers should assess, but this is one of the most important indicators. We have developed a short satisfaction questionnaire to overcome some of the perceived shortcomings of longer questionnaires for regular use outside the clock. Two recent systematic reviews have addressed issues in the development of health-care questionnaires. One concluded that shorter questionnaires were associated with higher response rates14, although another described the association as ambiguous.15 In our study, although the number of valid responses was higher compared to the long questionnaire, the difference was surprisingly small. In addition, the different response formats did not result in significant differences in average estimates or the distribution of responses. We recommend using the B2 version, with a smiling face, as well as a writing scale, as it seems to offer the best combination of response speed, score allocation and internal (Figure 3). Open in the new tabDownload slideThe longer questionnaire includes 32 questions in 4 pages, using combination combinations answers on several points to ensure a score scale of seven satisfaction measurements. Respondents are asked to agree or disagree with a number of similar statements that have been expressed in different ways, some of which are positive and some negatively worded. The stated advantages of questionnaires of this type are that multi-point scales provide more reliable conclusions and a wider distribution of responses for varying degrees of satisfaction. However, people sometimes give explicitly incompatible answers, or omit question items, perhaps because they are confused or annoyed by being repeatedly asked similar questions in different ways. These inconsistencies will lead to a wider distribution of responses, which does not necessarily indicate greater reliability. In addition, a lower response rate for a longer questionnaire means that any increase in sensitivity and reliability may be due to loss of representativeness. The short questionnaire has some advantages. In addition to the slightly higher level of responses, it makes it easy to administer and enter data, and is useful when it is necessary to include questions about satisfaction in a longer questionnaire that addresses other issues. As expected, the short questionnaire in our study lacked noted ceiling effects (high satisfaction scores on most issues) and they were not significantly reduced as a result of our attempts to develop different scales of response. In addition, the correlation between the scales in the long questionnaire and the paragraphs of the short questionnaire was only moderate. However, the short questionnaire did demonstrate the expected link between satisfaction and age, as well as lower patient satisfaction with telephone advice compared to home visits, according to previous studies. In addition, it was responsive enough to identify differences between patients who received or did not receive care under the desired conditions. The study was conducted in only one GP cooperative, and satisfaction scores can vary from environment to population, as well as to different provider organizations. Responses to both long and short questionnaires (42% and 46% respectively) were lower than in previous studies, which ranged from 50% to 71%,8,11,16-18, perhaps because only one reminder was sent. However, non-response bias is unlikely to be a problem for this review study, comparing responses in the questionnaire or between different versions of the questionnaire than would be the case in the surveys to evaluate services. It is not clear how large the difference in satisfaction scores represents a significant difference, but this criticism also applies to almost all satisfied with satisfaction questionnaires. Although the verification of internal coherence suggests that it is appropriate to merge the merger in one scale, the structure of responses to age and type of services shown in Table 6 indicates that the representation of information on the proportion of people very satisfied with each item may be more useful than reporting on the combined end scale, as it provides greater variability and additional information on aspects of the service that cause dissatisfaction. Bamford suggested that, given the high level of satisfaction typically obtained from patient satisfaction surveys in the health sector, the response is fairly satisfied indicating the need for better care.19a patient satisfaction assessment was criticized because of the ambiguity of the concept, and doubts about its usefulness as a measure of quality of care.3,20,21 Problems include positively distorted findings from the surveys, although people are critical of specific aspects of health22 and the impact of previous expectations and socio-demographic factors on patient responses.21 Some questionnaires have been developed in an attempt to overcome these problems, for example by distinguishing between individual experiences and satisfaction with different aspects of services,23 or between the perceived importance and performance of different aspects20 however, such questionnaires are inherently more complex and lengthy. The purpose of the study was to develop a short questionnaire instead of a well-recognized and proven questionnaire that assesses satisfaction rather than experience. This new short questionnaire for extracurricular care (SOC) is now widely used by many general practitioners outside of cooperative hours following its adoption in the UK by the National Association of General Cooperatives. A package of instructions was developed to describe issues such as sample size and survey management, as well as a computer programme to assist in the input and analysis of data to provide a convenient package of services for service providers. The sizes assessed in this questionnaire are not specific to the United Kingdom and are likely to be important for service users without having to use hours in a wide range of parameters, so the questionnaire can be useful to primary health care providers providing out-of-hours care in many different countries. The electronic version of the questionnaire is available . Funding for the declaration: The development of the questionnaire was partly funded by the Scottish Office. The study was funded by the Ministry of Health. The views expressed here are the views of only the authors. Ethical statement: Trent Multicenter Ethics Research Committee.Conflicts of Interest: No. We'd like to thank Bristol GP cooperative to support this study, cooperatives that helped with the pilot work, all patients who completed the questionnaires, Colin Colin to develop a data entry program, Judith Lathlean for comment on the document, and the National Association of GP Cooperatives for their support. Links 1Salisbury C, Dale J, Hallam L. 24-hour primary care. Abingdon: Radcliffe Medical Press.; 2 Health Division. Raising standards for patients New partnerships in non-hour care. An independent review of out-of-the-way GP services in England. London: Department of Health. ;3Locker D, Dunt D. 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