

ACCESSIBILITY TO HEALTHCARE IN OUTPATIENT CLINICS IN
SALMANIYA MEDICAL COMPLEX: STAFF AND PATIENT
EXPERIENCE

THESIS DOCUMENT FOR OBTAINING THE
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MASTER OF PUBLIC ADMINISTRATION

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Summary

The purpose of this graduation thesis is to determine the extent of accessibility to healthcare in outpatient clinics in Salmaniya Medical Complex based on staff and patient experience, by adopting the eight dimensions from the Picker Principles that signify patient-centred care. The thesis is composed of six chapters, as follows:

Chapter One introduces the thesis background, the significance of the study, the purpose of the study, the study design, the main research question and sub-questions, a definition of terms and, finally, the study outline.

Chapter Two addresses the literature review by providing Bahrain demographics and a history of healthcare in the country, and the history of Salmaniya Medical Complex. This chapter defines the main subjects of the thesis: the accessibility to healthcare, patient and staff experience studies, patient experience assessment studies and, lastly, the current health situation in Bahrain.

Chapter Three presents the research methodology, starting with research design and data collection and then the conceptual framework. The quantitative and qualitative method sections provide more explanation about each method, starting from the design, sampling, data collection and data analysis, and ending with data validation.

Chapter Four presents the finding of the descriptive analysis, inferential analysis and qualitative analysis.

Chapter Five discusses the research findings and mainly answers the research questions and achieves the objectives of the study. Then the chapter presents current coexisting studies and practical implications of the study, followed by the managerial recommendations. The final section of the chapter indicates the research limitations and further future studies.

Chapter Six provides the conclusion of the study.

Accessibility to Healthcare in Outpatient Clinics in Salmaniya Medical Complex: Staff and Patient Experience

Chapter One: Introduction

1.1 Introduction

This chapter aims to give a brief overview of the research background and present the significance of the study. It does this by laying out the objectives, research question and sub-questions, the study design and, finally, the outline of the study.

1.2 Background

Access to healthcare has remained a debatable topic in recent studies, especially after the COVID-19 pandemic breakout, which significantly changed our lifestyle and social interaction. It is very often used either to praise the universality of the healthcare system or, in contrast, to highlight its shortcomings and, in particular, the inequalities that it allows to persist or develop. Although access to healthcare is no longer a concern for some countries or regions, it is still a universal issue, and it is essential to underline that this subject has become a central axis of the World Health Organization's (WHO's) policy under a different term: universal health coverage, launched in 2013, which has become a constant reference in international efforts to improve health (WHO, 2021). It is clear that "universal health coverage is not possible without universal access to healthcare facilities" (Evans, 2013, p. 546). Accordingly, there is an emergent need to emphasise that healthcare accessibility improves access to comprehensive and quality healthcare services with a high level of justice, equity and quality. It significantly impacts overall physical, social and mental health status and quality of life (ODPHP, 2020).

Recently, the Supreme Council of Health in the Kingdom of Bahrain has targeted all the government health establishments to move forward towards autonomy and health insurance schemes (BSDG, 2021). The focus of the government of Bahrain is on the new government plan, Economic Vision 2030, and achieving sustainable development goals. Salmaniya Medical Complex (SMC), which is the biggest medical complex in the Kingdom of Bahrain, is developing new strategic plans for automation in terms of administration and monetary support, which refers to the hospital's ability to determine its preferences and translate those preferences into authoritative actions (Bach, 2014). Therefore, a broad concept of change

management has been introduced in the hospital's logistics and departments. This change requires a critical observation of patient needs and experiences to handle all the possible obstacles that affect the quality of delivery of the healthcare service and, more importantly, control patient access to healthcare.

1.3 Significance of the Study

This study contributes to the literature in a number of aspects: firstly, this is the earliest study to examine the accessibility level of healthcare in Salmaniya Medical Complex (SMC) and Bahrain by adopting a recognised tool. Secondly, patients have become more aware of their rights when seeking medical services and the COVID-19 pandemic, in particular, has compelled hospitals to evaluate all parts of their healthcare delivery procedures, as evaluation of healthcare provision is critical in the continual assessment and subsequent quality improvement of medical services. Third, SMC lacks an evidence-based assessment of the accessibility to healthcare in outpatient clinics and the services provided within other facilities. Lastly, by comprehending and analysing the two samples of experiences, the outcomes should provide useful feedback. The SMC administration can develop a consumer and employee experience policy or protocol for public service. As a result, it may help SMC's capacity to meet patient expectations and, consequently, validate the feasibility of adapting innovative practices at SMC. Moreover, it may help promote trust in SMC services, image building and reputation, especially when SMC is moving towards automation. Most of the government facilities are targeting the enhancement of consumer interaction and prioritising future healthcare investment plans in SMC.

1.4 Purpose of the Study

The study aims to assess the level of accessibility to healthcare in SMC based on patient and staff experiences. The main objectives are:

- To test a set of major essential dimensions of the Picker Principles that will directly impact the accessibility to healthcare in SMC.
- To identify the level of accessibility to healthcare in SMC as per patient experience.
- To explore patients' complaints about accessibility to healthcare according to the Patient Relation Office in SMC.
- To assess staff members' experience of accessibility to healthcare in outpatient clinics in SMC.

1.5 Study Design

This study utilised a combination of quantitative and qualitative approaches in the data analysis and triangulation method (literature, interviews and survey) to validate its findings. In the first instance, to analyse patient experiences, a questionnaire from the Picker Adult Outpatient Tool with 31 items was utilised to collect data from 316 patients selected based on a probability stratified random sampling technique. Two focus groups and one interview were performed with the medical staff of outpatient clinics at SMC to validate the outcomes. Descriptive and inferential statistics will be utilised to conduct an in-depth analysis of quantitative data and to test the research hypothesis. In contrast, MAXQDA software will be used to manage, organise and analyse qualitative data. The last section will discuss the findings of the study.

1.6 Research Questions

The main question of the research is:

To what extent is accessibility to healthcare dimensions (as per Picker Principles) implemented in outpatient clinics in SMC based on staff and patient experience?

The sub-questions are:

1. What are the main patient complaints about healthcare accessibility in SMC outpatient clinics?
2. How do staff members view accessibility to healthcare in SMC outpatient clinics?
3. What are the key differences between patient and staff experiences of healthcare accessibility at SMC outpatient clinics as per the Picker Principles?

1.7 Definition of Terms

Throughout the study, the following terms are used:

- Accessibility: to reach healthcare services in outpatient clinics at SMC.
- Outpatients: patients receiving healthcare consultations in daily clinics at SMC without staying in the hospital.
- Picker Principles: The eight dimensions of patient-centred care, advocated by the Picker Institute, an independent non-profit organisation dedicated to advancing the principles and value of patient experience.
- Patient Autonomy: the right for a patient to decide on her/his health treatment and self-care management.

1.8 Outline of the Study

The next chapter presents a background on the health system in Bahrain and current issues in healthcare management, highlighting key healthcare challenges at SMC in adapting to the new policies of autonomy and health insurance as per the directions of the government. The third chapter illustrates the methodology and study design of the survey used to collect and analyse data. This is followed by a detailed chapter that illustrates the survey's finding using descriptive and inferential statistics and MAXQDA software. The fifth chapter presents a comprehensive discussion of all the findings, summarises the research, provides recommendations, and highlights the study's limitations and future studies. The last chapter provides the conclusion of the study.

Chapter Two: Literature Review

2.1 Introduction

The literature review is structured as shown in Figure 2.1 below. It starts by introducing Bahrain demographic information and the healthcare system in the Kingdom, the current situation and the main topics that will be addressed, and the definitions of variables. Then, it introduces the model used to study accessibility in healthcare, focusing on some concepts regarding patient and staff experience and patient-centred care principles. This is followed by an examination of relevant studies conducted regionally and internationally, ending with a discussion of the current healthcare situation in Bahrain in general and in SMC specifically.

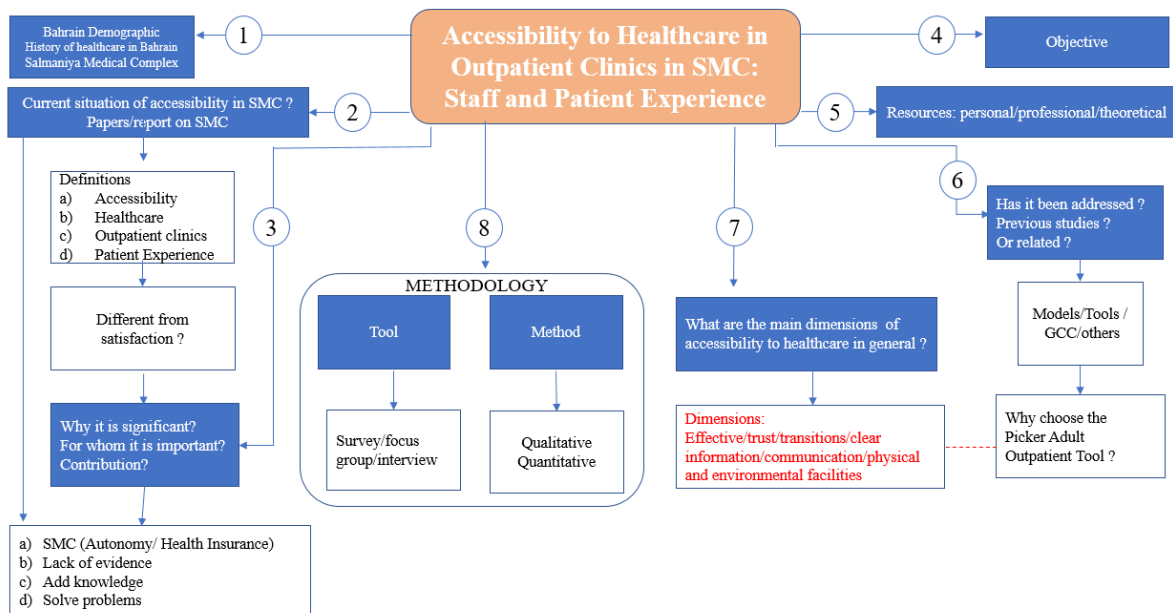


Figure 2.1 Literature Review Mapping

2.2 Bahrain Demographic Information

The Kingdom of Bahrain is located on the Arabian Gulf, east of Saudi Arabia; see Figure 2.3. It is an archipelago made up of 33 islands with a total area of 770.9 km, which comprises four governorates: Al-Muharraq, Capital, Southern and Northern; see Figure 2.2. The population of Bahrain had reached 1,501,635 by March 2021, with 47.4% Bahraini and 52.6% non-Bahraini citizens (712,362 Bahraini and 789,273 non-Bahraini); see Figure 2.4, 2.5 and 2.6. The population density is exceptionally high, with 2,239 inhabitants per km. In 2015, Bahrain was ranked 45th country by the United Nations Development Programme (UNDP) and Human Development Index (UNDP, 2021) and in 2020, ranked 42. Net migration to Bahrain in 2020

was 31.1 migrants per 1,000 inhabitants, the highest in the world; the population growth rate of 4.5% in 2019 was also one of the highest in the world; the total fertility rate was 2.0 children per woman, and the birth rate was 13.99 births per 1,000 inhabitants (World Bank, 2021).

According to the World Health Organization report of 2014, the Kingdom's healthcare costs accounted for 4.98% of gross domestic product (GDP). The enhancement in life expectancy at birth has increased from 73.66% in 2000 to 75.8% in 2019. Likewise, infant mortality fell from 12.5 per 1,000 births in 2000 to 6.9 per 1,000 births in 2019. Bahrain has a high-ranking value in the health system, despite all the challenges shown by the World Health Organization indicators in Figure 2.4 below.

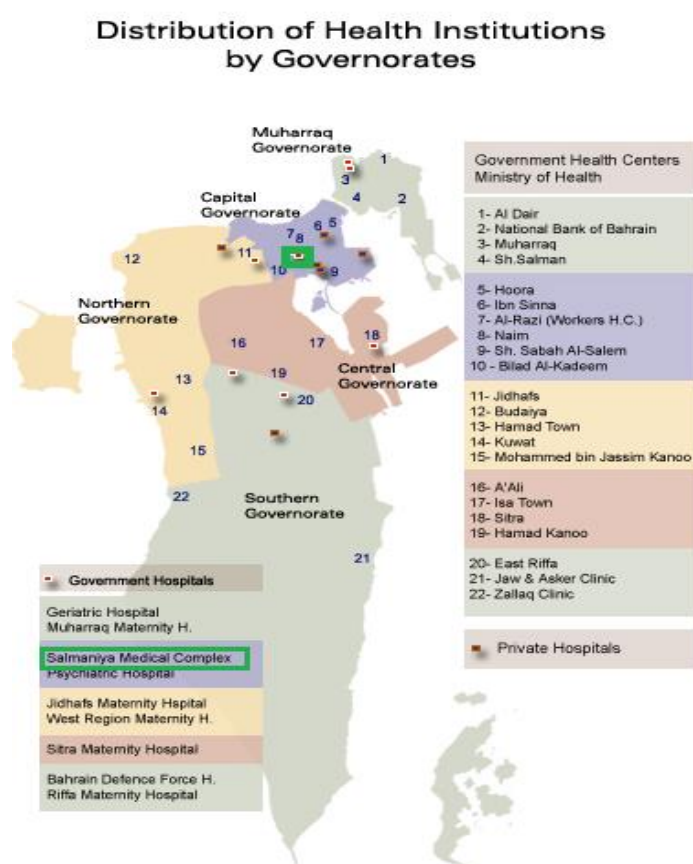


Figure 2.2 Distribution of Health Institutes by Governorates¹

¹ Source: Ministry of Health (2021)



Figure 2.3 Bahrain's Location on a World Map²

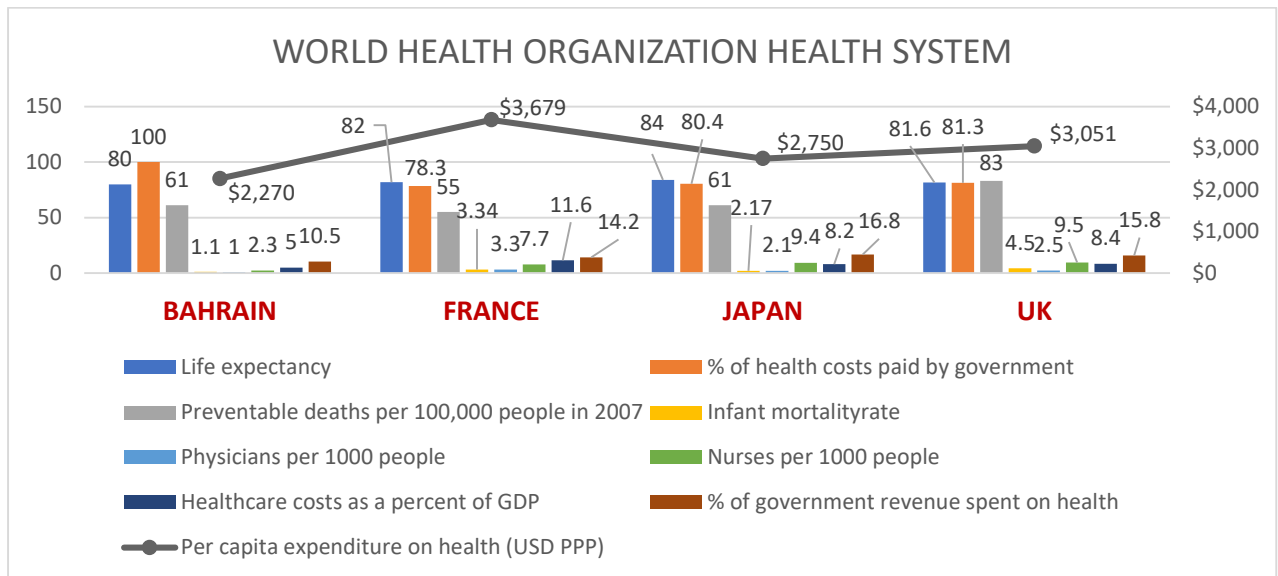


Figure 2.4 World Health Organization Health System³

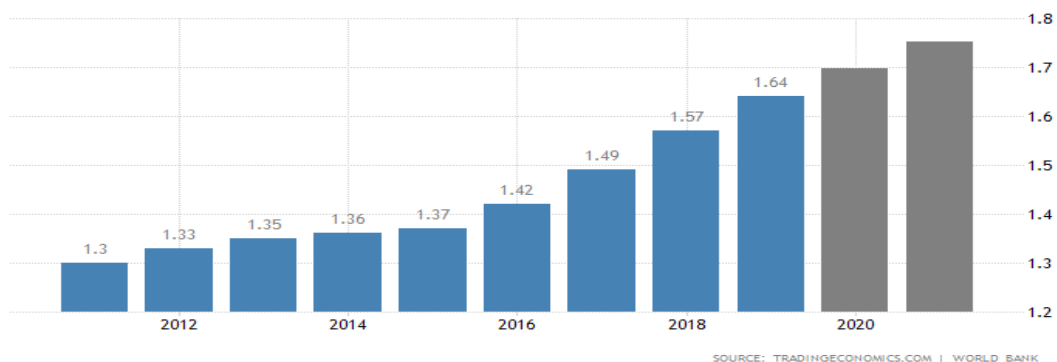
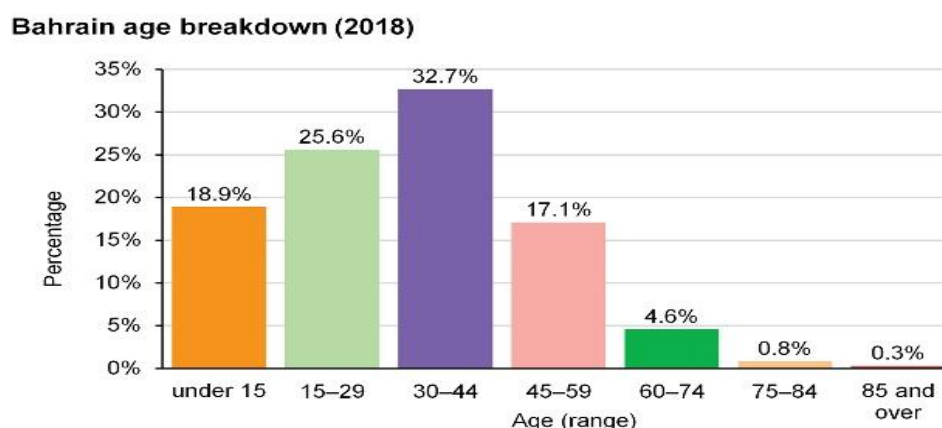


Figure 2.5 Evolution of Bahrain's Population from 2012 to the Present⁴

² Source: Geology.com (2021)

³ Source: World Health Organization (2021)

⁴ Source: World Bank (2021)



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Figure 2.6 Bahrain Population Age Breakdown 2018⁵

2.3 History of Healthcare in Bahrain

Bahrain became independent in 1971. In the 19th and 20th centuries, the country was a British protectorate. In 1902, the government built the oldest hospital in the region, the American Mission Hospital (AMH), founded by the Reform Church of America. The hospital provided care for both residents and foreigners. In 1925, a small clinic in a store was established by the government. Only one Indian doctor worked there, mainly to treat injured pearl divers. In the same year, the Directorate of Public Health was created.

In 1936, a small police hospital was established and converted to an isolation ward the following year, which remained open until 1941 (Abuzeyad et, 2018). In 1932, the first oil field was discovered in Bahrain; thus, a comprehensive healthcare system was developed and funded by oil revenues. And, with a capacity of 37 beds, Awali Hospital was established and run by the Bahrain Petroleum Company to serve company workers between 1940 and 1942; the first official government hospital, Al Noaim Hospital in Manama, was inaugurated.

The Salmaniya Medical Complex was established in 1957 in the same area due to demographic changes and population increase. Subsequently, the population continued to increase in line with strategies to prevent the spread of infectious diseases and improve the population's general health (Abuzeyad et, 2018).

In 1967, Bahrain joined the World Health Organization (WHO, 2021) Therefore, Bahrain has a universal healthcare system, which means that all the population has access to health services without any restrictions, e.g., due to financial hardship. These services include a full

⁵ Encyclopaedia Britannica (2021)

range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care (WHO, 2021). The Bahraini government provides free healthcare to Bahraini citizens and subsidises non-Bahrainis. The health sector's workforce comprises a majority of Bahraini doctors, nurses and medical services.

Primary healthcare services are the cornerstone of healthcare delivery. They are provided by 28 health centres operating under the Ministry of Health's governance (MOH, 2021) which offer a wide range of curative services, prevention and support by family doctors and general practitioners. Secondary and tertiary healthcare services are provided by three leading government hospitals: SMC, King Hamad University Hospital and the Bahrain Defence Force Hospital. The Ministry of Health also delivers specialised services through other hospitals, including a maternity ward, a psychiatric hospital and a geriatric hospital.

In 2009, the Ministry of Health transferred the task of regulating the healthcare sector to the National Health Regulatory Authority (NHRA). The authority is in charge of regulating the healthcare sector through the licensing and accrediting of healthcare facilities and also licensing healthcare professionals, registration and pricing of pharmaceuticals, empowering drug manufacturers, granting approvals for clinical trials, investigating complaints, and conducting disciplinary hearings for healthcare professionals (NHRA, 2019).

In 2015, the Supreme Council of Health (SCH) became the board of directors of the NHRA to emphasise the importance of an independent health regulator. The SCH established in 2012, is in charge of formulating national policies regarding the total number of hospital beds required in Bahraini in addition to embarking on and mandating a policy for financing healthcare services through the enforcement of a health insurance system. The SCH emphasises endorsing standardised policies for health professional training in hospitals, and estimating the distribution of healthcare facilities throughout the Kingdom (SCH, 2019).

In 2019, the total number of registered healthcare facilities reached 746 - an increase of 4% from 2018. The growth was mainly due to a 10% increase in the number of registered medical centres. Recent reports indicated that the total number of hospitals decreased to 19 from 21 in 2018 as there was a change in the classification of two hospitals into medical centres (NHRA, 2019). The healthcare facilities provide comprehensive healthcare services to the whole population, including expatriates (non-nationals), in compliance with the WHO global objectives.

2.4 Salmaniya Medical Complex (SMC)

SMC is the largest healthcare facility in the Kingdom (MOH, 2021), established in 1957 with a 50-bed capacity. It was substantially expanded in 1978 to reach a bed capacity of 926. SMC delivers emergency, secondary and tertiary healthcare services and hosts several specialised outpatient clinics. In 2014, the Hereditary Blood Disorders Centre opened with 90 beds at the SMC, providing healthcare for patients suffering from a range of haematological conditions, mainly sickle cell disease. The complex is affiliated with the Arabian Gulf University and functions as a teaching and research centre. In addition, the Department of Accident and Emergency, which is the largest department, has a bed capacity of 85, with an annual census of approximately 300,000 patients per year.

The outpatient clinics are located at the SMC main building, Al-Fateh Building, and Oncology Centre at SMC's new extension. The clinics provide healthcare to referred patients from Saturday to Wednesday (excluding public holidays) from 7.30 a.m. to 1.30 p.m.

To ensure that the medical and healthcare teams provide the best outpatient healthcare, the outpatient clinics are supported by radiology and laboratory services for diagnostic purposes, while physiotherapy, radiotherapy, pharmacy, etc., provide therapeutic services to patients. SMC speciality departments are medical, surgical, orthopaedics, plastic surgery and paediatric clinics, oncology & hematology clinics, radiotherapy and chemotherapy obstetrics & gynaecology, ear, nose and throat, ophthalmology and dental clinics. In addition to outpatient consultation services, support services such as ECG, EEG, EMG, audiometry, speech therapy, refraction test, etc., are also available for diagnostic purposes, as well as more than 50 specialist clinics. Also, they provide emergency care to patients referred from health centres and other health facilities on working days.

SMC is considered to be the largest public hospital in Bahrain. In 2018 alone, it received 233,158 cases in the outpatient clinics, a daily average of 6,889 patients. In the same year, it received more than 43,286 as inpatients and 15,631 surgeries were performed, of various types, as the minister of health indicated in her interview with Al Watan Newspaper (Allam, 2019). Around 2,000 employees in SMC deliver the services.

2.5 Accessibility to Healthcare

It is important to define access to healthcare and identify the dimension of accessibility.

Classically, three concepts are described by Chambaud (2018): 1. Physical Accessibility. An offer of care services must be available at a reasonable distance for people who need it. 2.

Affordability. This consists of analysing people's capacity to pay for the services without suffering financial hardship. 3. Acceptability. This term mainly covers the reality of people in need using the services or requesting a healthcare service. In practice, it is about better understanding the many factors other than the obstacles, geographic or financial aspects involved in using care. They can indeed be of different natures – some determinants are linked to social structure. Thus age, sex, profession, status, family and residence can influence health services. According to Chambaud (2018), the degree of knowledge and acculturation to the complexity of our care offer is also a factor that can be differentiating. The country of origin's culture can also strongly tint both intimate recognition of the pathology and contact with health services.

The US Office of Disease Prevention and Health Promotion has indicated that access to comprehensive, quality healthcare services is essential for promoting and maintaining health, preventing and managing the disease, reducing unnecessary disability and premature death, and achieving good health (ODPHP, 2020). According to Gulliford (2002, p.186), who emphasised that accessibility is obtained by the availability of an adequate supply of services and health service existence, the population may “have access to services”. On the other hand, the World Health Organization (WHO) restricts the definition of healthcare accessibility to three main aspects: Physical, Economic and Information accessibility. Moreover, Haggerty (2011) defined accessibility as the ease with which a person can obtain needed care (including advice and support) from the practitioner of choice within a time frame appropriate to the problem's urgency.

Measuring the accessibility to healthcare in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Also, the availability of services and barriers to access must be considered in the context of the differing perspectives, health needs, and material and cultural settings of diverse groups in society.

This paper emphasises that healthcare accessibility improves access to comprehensive and quality healthcare services with a high level of justice, equity and quality. The Office of Disease Prevention and Health Promotion emphasised that accessibility significantly impacts overall physical, social and mental health status and quality of life and patients are more aware of their rights when seeking medical services (ODPHP, 2020). Especially, the COVID-19 pandemic compelled hospitals to evaluate all parts of their healthcare delivery procedures, as evaluation of healthcare provision is critical in the continual assessment and subsequent quality improvement of medical services.

2.6 Patient and Staff Experience

As recent studies have indicated in several articles that measure patient experience or employee engagement, hospitals' ratings and profits have improved. Further, the data reveal that there can be a compounding effect when organisations improve in both experience and engagement measures simultaneously (Buhlman & Thomas , 2019).

Larson et al. (2019) and his team indicated that patient experience is a critical aspect of quality for two reasons. First, it is essentially vital because, when individuals are using healthcare services, they have the right to be treated with dignity and respect. Second, it is instrumentally essential as person-centred care is associated with improved healthcare utilisation and health outcomes.

To clarify the importance of relating patient-centred experience and accessibility, Dr. Quinn (2017) and her team explored 31 existing Instruments to Assess Patient Experiences with Access and Coordination across Health Care Settings. One major striking issue indicated that existing survey instruments focused on whether patients could access care and whether care was coordinated, not on the patient effort needed to achieve access and care coordination. The study recommended that surveys ensure that as many key domains related to access and coordination are represented in survey items (Quinn, 2017).

As Wolf et al. (2014) concluded in their paper after 14 years of synthesising existing literature and other sources from 2000 to 2014, the definition of patient experience is beyond patient satisfaction and perception. It is integrally tied to the principles and practice of patient- and family-centred care (Wolf, 2014). The table below presents the differences between patient experience and satisfaction.

Table 2.1 Summary of Differences between Patient Experience and Satisfaction

Element/ Patient	Domain of Question	Answers	Definition	Author	Impact
Experience	What happened? How often did you get help when you wanted it? * Question- related: -Number of patients seen	Always to never.	Reflect the interpersonal aspects of quality of care received: three domains: effective communication, respect and	Larson et (2019	-Identify gaps, changes in quality resulting from interventions or policy -Measures quality of care

Element/ Patient	Domain of Question	Answers	Definition	Author	Impact
	-Ratio of healthcare providers to patients		dignity, and emotional support.		
	-Availability of services and resources		Reflect occurrences and events that happen independently and collectively across the continuum of care	Wolf (2014)	Significant transition in healthcare, evolving and engaged patient and family population, corresponding emergence of a consumer mindset
	-Patients' characteristics (e.g., sociodemographic characteristics, clinical history)		The sum of all interactions, shaped by an organisation's culture, influences patient perceptions across the care continuum.	LaVela, (2014)	Opportunity to improve care, enhance strategic decision.-making, meet patients' expectations, effectively manage and monitor healthcare performance, and document benchmarks for healthcare organisations
Satisfaction	How did we do? Did your doctor spend enough time with you? * Question-related to:	very poor to very good	The measure of a patient's experiences of care, along with health outcomes and confidence in the health system	Larson et, 2019	Identify service provision are essential to individuals. -measures patients' responses to care

Element/ Patient	Domain of Question	Answers	Definition	Author	Impact
	-patient's needs and expectations		health system responsiveness, to the manner and environment	Wolf, 2014	Focus on expectations, individualised care, and tailored services
			Predominantly affective judgement formed by the patient alone, influenced by both internal and external factors	LaVela, 2014	It is important to healthcare organisations: loyalty (re- patronage), positive word of mouth, referrals, and other behaviours that directly positively impact the bottom line.

In contrast, according to Dawson (2014), staff's experience refers to factors such as staff engagement, motivation, satisfaction, morale, work pressure, stress and intention to leave – attitudinal or psychological factors that determine how an individual employee feels about their job, their colleagues and their organisation.

Goodrich (2018) stated that it is essential to involve patients and staff in improving and implementing the ideas in a co-design approach, as the experiences of patients have nearly always been prioritised over those of the staff. This is because staff experience is important in discussions about designing healthcare; additionally, staff will become more engaged and motivated through being involved in making the changes.

A very wide spectrum survey was conducted in 2007 to analyse the link between the staff working in acute inpatient services in the UK's National Health Service (NHS). The report indicated that, of over 12,000 correlations examined, more than 56% were statistically significant. The largest associations were found as follows: to provide good-quality job design, staff intention to leave jobs, health and safety training, work pressure felt by staff, discrimination experienced by staff, bullying, harassment and abuse of staff, and confidentiality of patient information (Dawson, 2018).

2.7 Patient and Staff Experience Assessment Studies

The literature review regarding topics related to patient experience in Bahrain was very limited, especially in terms of patient experience, and evaluating accessibilities or any form of healthcare was not initiated. Some studies are based on assessing the quality of services and performance by measuring satisfaction. For example, a study was conducted using the convenience sampling technique and used the SERVQUAL survey to investigate patients' expectations, perceptions and satisfaction levels at public and private Bahrain hospitals (Ramez, 2013). Other questionnaires related to healthcare performance and satisfaction using a Modified Version of the General Practice Assessment Questionnaire (Almuhana, 2020). This implies a need to introduce patient experience domains specifically as a strategy for measuring or assessing a service or healthcare in Bahrain. This lack of studies may be due to a lack of awareness of the concept of evaluating patient experience itself.

Regionally, in Saudi Arabia, there are studies relating to patient experience and instruments and questionnaires based on patient experience tools. For example, research was conducted using the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey to assess the relationship between patients' demographics, the quality of physician-patient communication, care coordination and the overall satisfaction rating of primary healthcare centres (Mohammed , 2020).

Globally, patient and staff experience in the healthcare delivery system is receiving growing attention. For example, in Norway, patient satisfaction studies have attracted increasing attention in recent years and consider many healthcare qualities. But there is a lack of validated instruments for their measurement in the substance dependence literature (Haugum, Iversen, & Bjer, 2017). The same applies to several other countries, such as England, Switzerland and Germany (Jackinson, 2002).

Another instrument was mentioned in some articles. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems Survey) is the first standardised, publicly reported survey of patients' hospital care perspectives in the US. The survey consists of 29 items that measure patients' perceptions of their hospital experience and are considered instruments and data collection methodologies in health facilities. While hospitals collected information on patient satisfaction for their internal use before HCAHPS, there were no common metrics and no national standards for collecting and publicly reporting patient care experience. It is still an ongoing review by the Centres for Medicare & Medicaid Services that

initiated a multi-faceted study of HCAHPS content to be applied and used nationally in the US (HCAHPS, 2021)

Most studies have emphasised the effects of patient sociodemographic characteristics on overall satisfaction, for example, age, education, occupation, income, insurance and health status, as mentioned previously. The studies also direct the researcher of the topic to search for a conceptual tool to assess a healthcare services need first, determine the priorities, and secondly the barriers and factors that reflect the concerns of patients and staff while delivering the services.

Different instruments and tools are used to measure the patient experiences and staff needs; through the literature review valid and reliable questionnaires are used in a selected healthcare context to determine the quality of services in the healthcare sector. They measure the level of people's satisfaction with the health service, which generates rapid evidence regarding public perceptions (not experiences) of the quality of healthcare. In Norway, the Norwegian questionnaire's (PEQ-ITSD) purpose was to systematically measure user experiences of healthcare as a basis for quality improvement, healthcare management, patient choice and public accountability (Haugum, Iversen, & Bjer, 2017).

Another reliable patient experience tool that the literature indicated was the Picker survey of patient experiences adopted in the UK's National Health System. During a meeting with Mr. Stylianides, who is the marketing sector supervisor of Picker Europe Institute in Oxford, he explained about the tools and studies used to assess patient experience, saying that, "There is an extensive range of studies done using the Picker Outpatient tool. The following regulators use Picker tools: The Care Quality Commission in the English NHS and Health Information and Quality Authority in the Republic of Ireland – they both produce national-level studies used to assess the quality of care from the patient experience and, wise, using the result as a part of their regulatory evidence for hospital performance. We conducted the first-ever national perceptions/experience study in KSA in 2016 in collaboration with The Saudi Central Board for Accreditation of Healthcare Institutes. For now, there are no Arabic versions that Picker has approved."

The Picker Institute's Eight Principles of Patient-Centred Care originated from the seven dimensions of patient-centred care developed in 1993 through a leading-edge book, 'Through the Patient's Eyes' (Piker Institue Europe, 2021). The seven primary dimensions of the patient-centred care were adopted after and firmly established by applying a wide range of focus groups with recently discharged patients, family members, physicians and non-physician hospital staff – combined with a review of pertinent literature, by researchers from the Harvard Medical

School. On behalf of the Commonwealth Fund and Picker Institute, the seven primary dimensions of patient-centred care were defined. The eighth dimension was added in 1987 in the USA, and the measurements were renamed the Picker Principles of Patient-Centred Care, which symbolises the Picker Institute's conviction that all patients deserve high-quality healthcare and that patients' views and experiences are integral to improvement efforts.

In 2000, Picker (then called Picker Institute Europe) was formally created and based in the UK (Piker Institue Europe, 2021). The Eight Picker Principles of Patient-Centred Care were defined accordingly by the institute, as shown in Table 2.2 below.

Table 2.2 Picker Principles Definitions

	Principle	Definition
1	Fast access to reliable healthcare advice	-Patients need to access care when it is required. Focusing on ambulatory care, the following areas were of importance to the patient: -Access to the location of hospitals, clinics and physician offices -Availability of transportation -Ease of scheduling appointments -Availability of appointments when needed -Accessibility to specialists or speciality services when a referral is made -Clear instructions provided on when and how to get referrals
2	Effective treatment delivered by trusted professionals	-Proper coordination of care can alleviate negative feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability: -Coordination of clinical care -Coordination of ancillary and support services -Coordination of front-line patient care
3	Continuity of care and smooth transitions	-Patient's ability to care for themselves after discharge. - Meeting patient needs in this area requires the following: -Understandable, detailed information regarding medications, physical limitations, dietary needs, etc. -Coordinate and plan ongoing treatment and services after discharge. -Provide information regarding access to clinical, social, physical, and financial support continuingly.
4	Involvement and support for family and careers	-This principle addresses the role of family and friends in the patient experience. Family dimensions of patient-centred care were identified as follows: -Providing accommodation for family and friends. -Involving family and close friends in decision-making. -Supporting family members as caregivers. -Recognising the needs of family and friends.

5	Clear information, communication, and support for self-care	-Patient informed about their condition or prognosis. To counter self-care fear, hospitals can focus on three kinds of communication: -Information on clinical status, progress, and prognosis. -Information on processes of care. -Information to facilitate autonomy, self-care, and health promotion.
6	Involvement in decisions and respect for preferences	-Involve patients in decision-making, recognising they are individuals with their unique values and preferences. -Treat patients with dignity, respect, and sensitivity to their cultural values and autonomy.
7	Emotional support, empathy, and respect	Emotional support and respect patient's personal choices and status. -Anxiety over physical status, treatment and prognosis. -Anxiety over the impact of the illness on themselves and their family. -Anxiety over the financial impact of illness.
8	Attention to physical and environmental needs	Physical comfort has a significant impact on patient experience. Three areas were reported as particularly important to patients: pain management, assistance with activities and daily living needs, hospital surroundings and environment.

The Picker Principles' emphasis enables us to understand the patient experience and self-care to enhance patient autonomy and decision for their treatment. The Royal Society of Medicine defines patient autonomy as "a patient has the ultimate decision-making responsibility for their treatment" (The Royal Society of Medicine, 2021). The doctor or staff member's main core concerns should be to explain the patient's medical condition, their options for treatment, and the advantages and disadvantages of those treatments fully. Also, they should be aware of the patient's ability to retain information, evaluate their options and arrive at a decision. The staff or the doctor should respect patient autonomy and provide them and their family with all of the information needed.

2.8 Current Healthcare Situation in Bahrain

As a result of regional pressure, stakeholder demands, requirements of Economic Vision 2030 and sustainability of the civil service, all Bahrain's government sectors have observed significant changes in the organisation's governance.

In 2016, the Bahraini parliament recognised and endorsed '*The National Health Plan (2016-2025)*' for the health sector in the Kingdom for the next 10 years. One of the main objectives of the National Health Plan (2016-2025) is to implement the Social Health Insurance

Program (SEHATI), which aims to develop the quality of the current health system and ensure sustainability (SCH, 2019).

This system meant revolutionising the local health sector by better utilising the available resources while overcoming pressing challenges. There is an increasing burden and demand for healthcare services because of the rapid increase in the population and shifting demographics.

All of this imposes a new way of management – and a new relationship between the main stakeholders of SMC, the patients and the administration. In a report, Barber (2017) argued that the government should implement a culture of continuous learning to bring about the needed change in the public sector, which may ultimately help to improve service quality, living standards and the economy in general.

The massive workload on the SMC and the increasing demand for healthcare services have negatively impacted patients' expectations, satisfaction, confidence and trust in SMC services. This has been repeatedly conveyed through the media. For example, in an article published in 2018 in Akhbar Al Khaleej, it was stated that healthcare services provided to patients in the SMC had begun to decline, day after day. Patients started complaining on social media, in print and via electronic media (Mamsei, 2018).

One of the main objectives of the National Health Plan is the adoption of the Social Health Insurance Program (SEHATI) to develop the quality of the current healthcare system and ensure its sustainability. Moreover, a significant factor to be considered is the current COVID-19 pandemic, which has had a considerable impact on the healthcare system. Recently, the health minister, Mrs Fayqah Al Saleh, reported that SMC was functioning under great pressure because it is regularly receiving more than 6,889 cases in outpatient clinics. Increased demand and high patient's expectations were the challenges that SMC is facing today (MOH, 2021). This was also highlighted during an interview with Dr Al-yousif, a leading team member for implementing autonomy in SMC, who stated that they were trying their best to cope with the increased demand and meet patients' expectations.

Conceivably, the significance of assessing the staff and patient experiences will drive the SMC administration to resolve the gaps and develop quality improvement initiatives. This means increasing the level of satisfaction and trust in healthcare services provided by SMC. Since SMC is moving towards automation, most government entities in Bahrain aim to enhance consumer interaction and prioritise SMC policies and future investment plans (MOH, 2021).

For this reason, there is an emergent need to determine how to improve the aspects of healthcare provision and gain confidence and trust in SMC accessibility to healthcare services.

By measuring the experiences of the two groups, staff and patients, a more meaningful indication of the quality of healthcare received can be obtained (Larson et al., 2019).

No previous studies have been conducted to investigate patients' views regarding their experiences and expectations in accessing healthcare in Bahrain, nor are there any studies examining the influencing factors and barriers these patients experience. Therefore, the study will assess and measure the level of accessibility to healthcare through major essential dimensions that will directly impact the services provided. This will highlight patients' expectations and trust in the facilities and influence the image and reputation of SMC's outpatient services.

The study's results could improve SMC's capacity to reach patients' expectations and create trust and confidence in the services at the operational and other levels. The findings can be used as a foundation to provide new insights and strategies for adoption by SMC administrative staff and the external hospital office directorate in the Ministry of Health, to increase patient and staff involvement in building a new accessible healthcare system and consequently reduce dissatisfaction and negative user experiences (Santana, 2017).

Future research could validate the feasibility of adapting innovative SMC practices, for example, virtual and remote medical services. The findings can also help develop a national-level consumer and employee experience policy or protocol for public service entities, especially in this extensive technological era.

Patient experience is recognised as one of the central elements of quality in the NHS in England (NHS, 2017). That triggered a strong interest in understanding the best ways to measure patient experiences regarding NHS trusts and their managers, clinicians and staff. The studies conducted in England mainly focused on the experiences of either primary care patients or inpatients, whilst outpatients' experiences have remained ignored or less frequently investigated (Jenkinson et al., 2002). The term 'patient's experience' can cover a vast range of aspects of the organisation and delivery of patient care – from making the appointment, through the experience of reception and waiting areas, care and treatment, to making the transition back to home or the community (Picker Institute Europe, 2021).

The research is concentrating on the outpatient clinics in SMC and the need to assess patient accessibility experience regarding different dimensions. The Picker Adult Outpatient Tool was selected to measure the healthcare provided by SMC's outpatient clinics. Moreover, staff perspectives, views and experiences were also considered to develop the quality of practices and services and improve the whole outlook of service delivery in health facilities (Farr & Gressey, 2015).

Chapter Three: Research Methodology

3.1 Introduction

The research aims to determine the level of accessibility in outpatient clinics in SMC according to patient experience and staff perspective and to experiment the hypothesis of the research. A combination of quantitative and qualitative methods was used in the data analysis and a triangulation process was utilised to validate the findings. There are two main sections in this chapter, the quantitative method presenting the survey and the qualitative methods. There are four sub-headings under each main section, i.e., method, sampling, data collection, and analysis & validation.

3.2 Research Design and Data Collection

The study presents an explanatory, analytical research approach to review the data provided to determine the level of healthcare accessibility according to staff and patient experience in outpatient clinics in SMC. The study design used a mixed methodology – quantitative and qualitative. As Ozawa and Pongpirul (2013) indicated, diverse methods are excellent for understanding a health system's performance in terms of social, economic and cultural contexts. This study is constructed on a survey directed to the patient and focus groups and interviews related to SMC's outpatient clinic staff. Combining different methods in studying social phenomena goes back to social science's beginnings (Hesse-Biber, 2010). Mixed methods potentially offer a depth of qualitative understanding with the reach of quantitative techniques.

The idea of having two groups (patient and staff) is to provide triangulation. Triangulation is often suggested as an excellent way to check legibility, i.e. get one analyst to analyse the data and then a second analyst to analyse the data. If they agree on the analysis, the study will have a higher level of reliability (Fielding, 2012). This way, if the study proves that patients think accessibility is a problem and the staff of SMC do not think accessibility to healthcare is a problem, a new conclusion is raised. The findings should contribute to developing reform recommendation in the SMC system, and more data investigation will be needed and considered. As Bazeley (2006, p.203) suggests, the combination of data types within an analysis means it needs to be analysed by applying the categorical or continuous variables for statistical analysis and to compare coded qualitative data. Because there is a clear rationale for using such analytic techniques as indicated previously, the outpatient clinic

situation in SMC and the health facilities are goal-oriented towards satisfaction and addressing patient experience, as an indicator of performance quality. The data were collected from three sources: the survey response, the focus group and the interview. Figure 3.1 shows the study design.

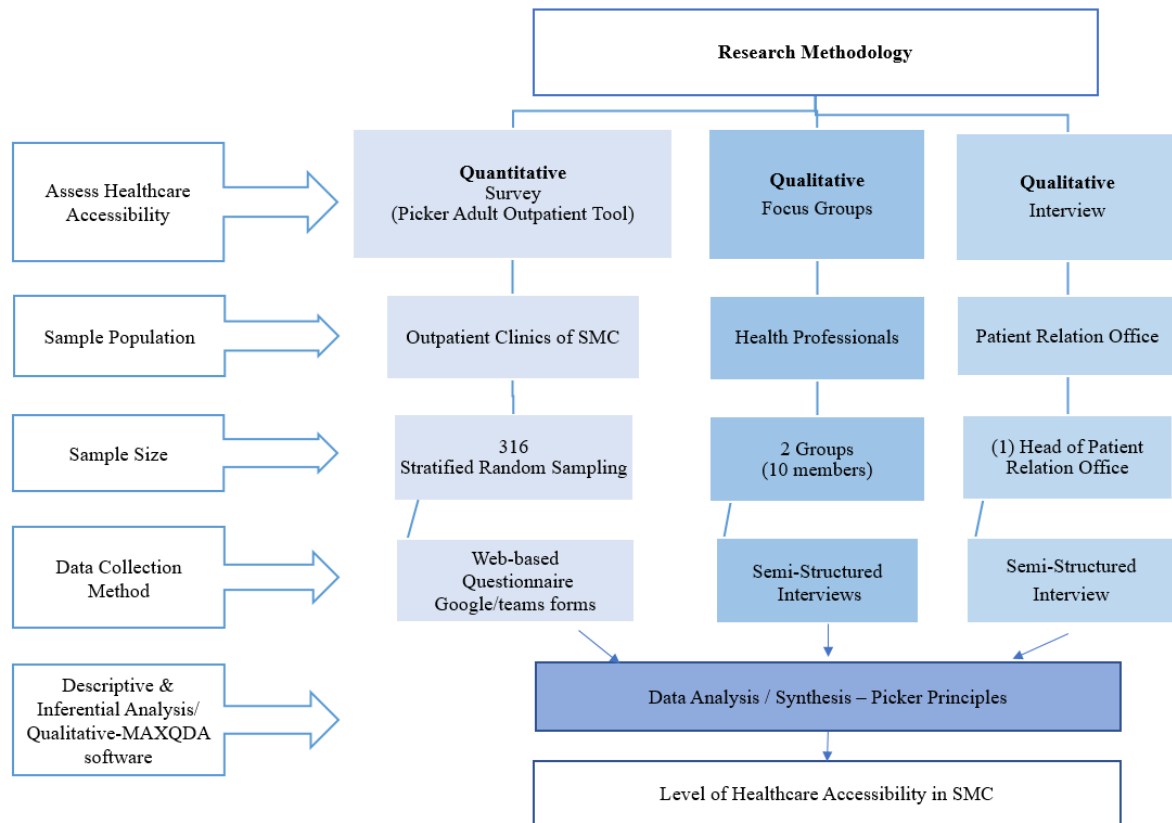


Figure 3.1 The Study Design

3.3 Conceptual Framework

The research model was established by the researcher employing a modified Picker Adult Outpatient Tool- Patient Experience. The principles are: 1) Fast access to reliable healthcare advice, 2) Effective treatment delivered by trusted professionals, 3) Continuity of care and smooth transitions, 4) Involvement and support for family and carers, 5) Clear information, communication and support for self-care, 6) Involvement in decisions and respect for preferences, 7) Emotional support, empathy, and respect, 8) Attention to physical and environmental needs.

Accessibility to healthcare according to patient and staff experience was measured using the eight dimensions as the research framework illustrated in Figure 3.2 and research questions and hypothesis:

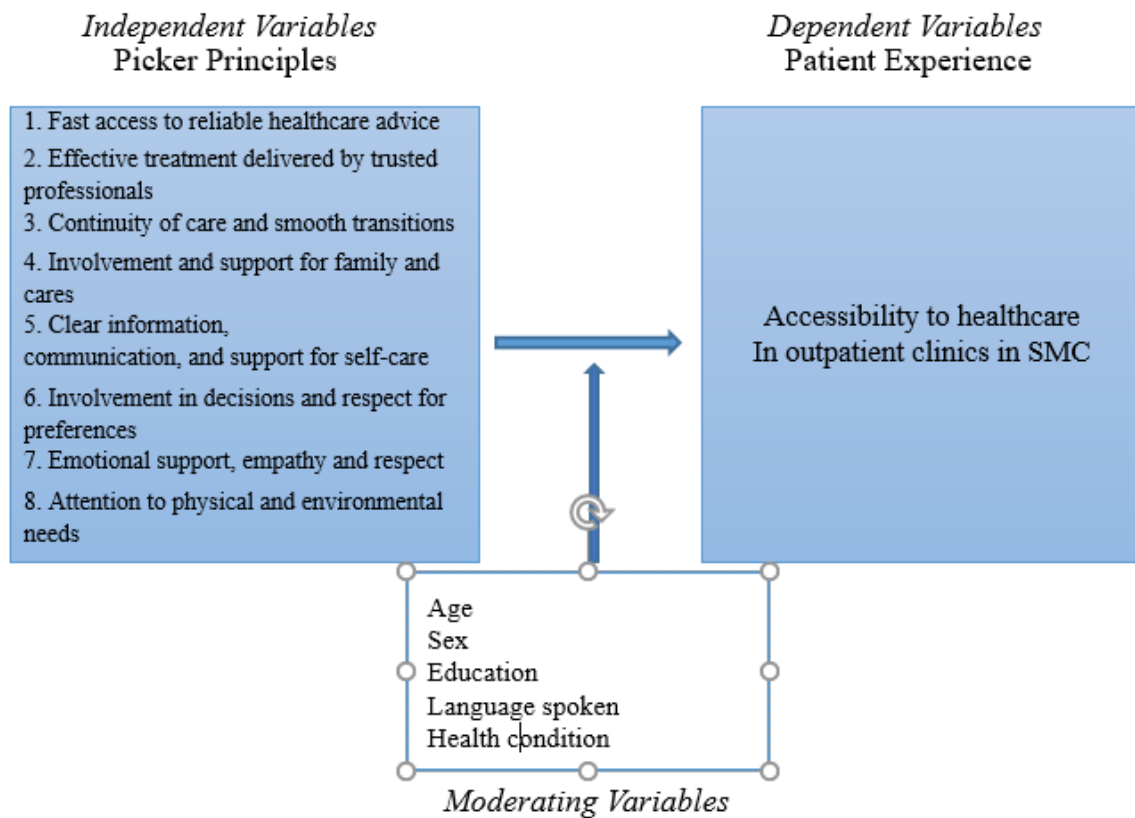


Figure 3.2 Theoretical Framework Adopted from the Picker Institute Questionnaire

3.4 Research Questions

The main question of the research is:

To what extent are accessibility to healthcare dimensions (as per Picker Principles) implemented in outpatient clinics in SMC based on staff and patient experience?

The sub-questions are:

1. What are the main patient complaints about healthcare accessibility in SMC outpatient clinics?
2. How do staff members view accessibility to healthcare in SMC outpatient clinics?
3. What are the key differences between patient and staff experiences of healthcare accessibility at SMC outpatient clinics as per the Picker Principles?

Figure 3.3 below presents the objective and the research questions.

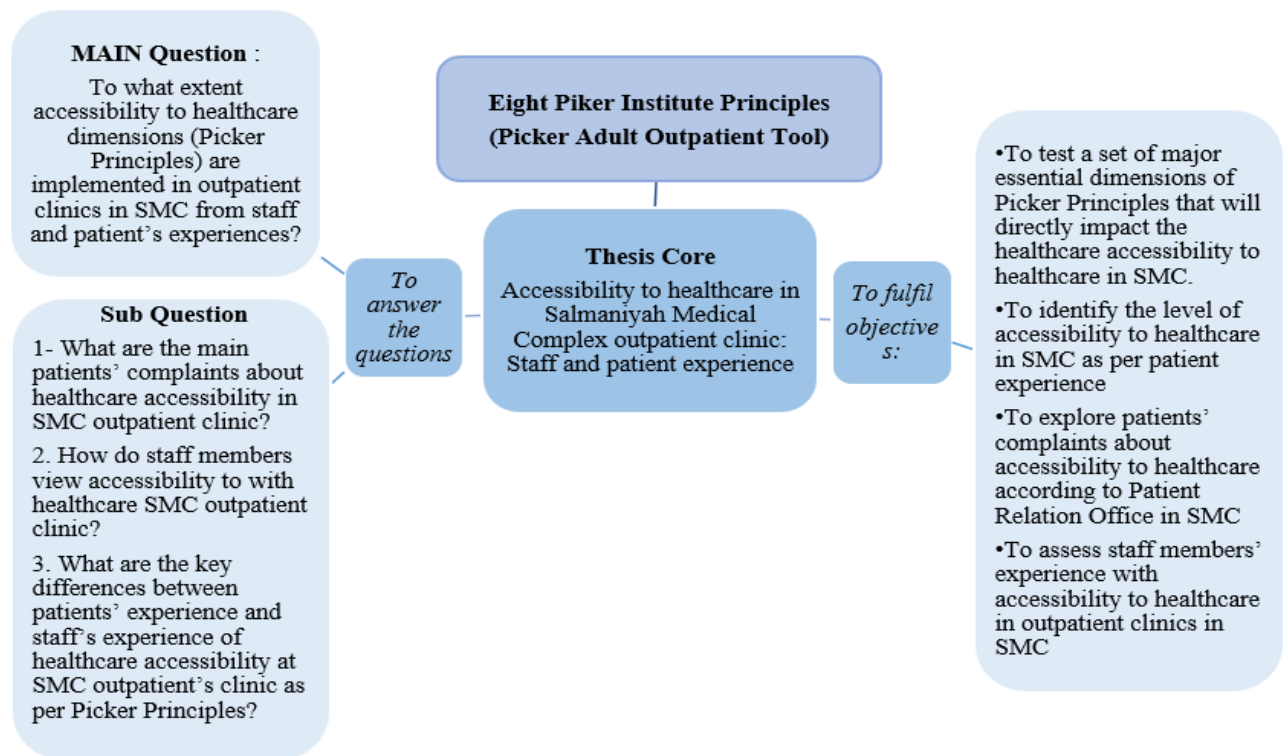


Figure 3.3 Main Research Questions and Hypotheses

3.5 Quantitative Method

3.5.1 Questionnaire Design

The Picker Outpatient Adult Tool was designed based on sections asking patients about their condition, demographic details, and aspects of their healthcare experience. The questionnaire was redrafted and piloted extensively before the final version was produced by in-depth interviews with patients in different countries to test comprehension.

The tool helps organisations with quantitative research and to understand patients' experiences visiting outpatient clinics in any health facilities with different services. Adapting the Picker tool aims to determine the level of accessibility to healthcare in outpatient clinics and provide valuable feedback to the hospital board, staff, commissioners, patients and the public. Not to mention that Picker encouraged the researcher to obtain a licence to adopt and use the tool in the current research.

The Picker Adult Outpatient Tool consists of 13 sections. The original version of the questionnaire comprises 55 items plus six demographic questions, which measure eight core dimensions as listed in the table. Each item or question of the survey is coded for statistical analysis.

For the study's requirement, the questioner consists of 32 items. The tool includes 24 multiple-choice questions distributed in 13 sections; the other eight questions are the demographic questions that include an open-ended question.

The questions were selected based on the research objectives. The 32 items were selected based on the area of accessibility to healthcare.

The table below shows the SMC-BH Picker Adult Outpatient Tool and the 32 items. The table is about the eight main principles or the core of the questionnaire representing the main factor of accessibility to healthcare.

Table 3.1 Picker Adult Outpatient Tool Principles

Code	Picker Principles
FA	Fast access to reliable healthcare advice
ET.	Effective treatment delivered by trusted professionals
CC	Continuity of care and smooth transitions
IS.	Involvement and support for family and careers
CI	Clear information, communication and support for self-care
ID.	Involvement in decisions and respect for preferences
ES.	Emotional support, empathy and respect
AN	Attention to physical and environmental needs
FQ	Filter question

Table 3.2 below provides the questions or the items selected for the research. Questions are categorised in the questionnaire according to the patient's pathway through their visit to an outpatient clinic. The sections where they receive the services need to be evaluated according to each question coded by the Picker Institute for their research and benchmarking purposes.

Table 3.2 SMC-BH. Picker Adult Outpatient Tool Questionnaire Version

Q.No.	Section Heading	Theme	UK full code	BAHRAIN question set
1.	Before the appointment	FA	OP-UK-FA-2	From the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for your appointment?
2.	Waiting in the hospital	FA	OP-UK-FA-8	Did you have to wait at the clinic to see the doctor or medical staff, or were they on time?
3.	Waiting in the hospital	FA	OP-UK-FA-9	Were you told how long you would have to wait?
4.	Hospital environment and facilities	AN	OP-UK-AN-10	In your opinion, how clean was the Outpatients Department?

Q.No.	Section Heading	Theme	UK full code	BAHRAIN question set
5.	Hospital environment and facilities	AN	OP-UK-AN-11	How clean were the toilets at the Outpatients Department?
6.	Tests and treatment	CI	OP-UK-CI-15	Did a member of staff explain the results of the tests in a way you could understand?
7.	Tests and treatment	CI	OP-UK-CI-18	Did anyone at the Outpatients Clinic explain to you the pros and cons of the treatment or examination?
8.	Seeing a doctor	ES	OP-UK-ES-20	Did you have enough time to talk to the doctor or other staff members about your illness or problem?
9.	Seeing a doctor	CC	OP-UK-CC-21	Did the doctor or other member of staff know what was written in your medical records?
10.	Seeing a doctor	CI	OP-UK-CI-24	If you had important questions to ask the doctor, did you get answers that you could understand?
11.	Seeing a doctor	ET	OP-UK-ET-25	Did you have confidence and trust in the doctor examining and treating you?
12.	Overall, about the appointment	ES	OP-UK-ES-31	Did the staff treating and examining you introduce themselves?
13.	Overall, about the appointment	ES	OP-UK-ES-32	Did doctors and/or other staff talk in front of you as if you weren't there?
14.	Overall, about the appointment	ES	OP-UK-ES-34	Were you given enough privacy when discussing your condition or treatment?
15.	Overall, about the appointment	ES	OP-UK-ES-35	Sometimes at the Outpatient Clinic, members of staff will say different things Did this happen to you?
16.	Overall, about the appointment	ID	OP-UK-ID-36	Were you involved in the decisions at the Outpatients Clinic about your treatment or examination?
17.	Overall, about the appointment	ID	OP-UK-ID-39	Did your appointment help you to feel that you could better manage your condition or illness?
18.	Leaving the outpatients department	CI	OP-UK-CI-42	Did a staff member explain the purpose of the medications you were to take at home in a way you could understand?
19.	Leaving the outpatients department	CI	OP-UK-CI-43	Did a member of staff tell you about possible side effects you could have from any new medication?
20.	Leaving the outpatients department	ET	OP-UK-ET-49	In general, are you satisfied with the healthcare provided in the Outpatient Clinic for your case?
21.	Leaving the outpatients department	ES	OP-UK-ES-50	Overall, did you feel you were treated with respect and dignity while you were at the Outpatients Department?
22.	Leaving the outpatients department	FQ	OP-UK-FQ-51	Overall how would you rate the care you received at the Outpatients' Department?
23.	Leaving the outpatients department	ES	Netherlands	Were the staff at the Outpatients Clinic reception friendly?
24.	Leaving the outpatients department	IS	Netherlands	Was there a family member or someone close to you involved in your treatment or examination decisions?
25.	Demographic Questions			Are you male or female?
26.				Age range?

Q.No.	Section Heading	Theme	UK full code	BAHRAIN question set
27.				What is your educational level
28.				Do you have any of the following long-standing conditions?
29.				Does this condition cause you difficulty with any of the following
30.				What is your nationality?
31.				What is your native language?
32.				Any comments regarding outpatient clinics

The researcher adopted qualitative and quantitative research designs to provide a holistic understanding of the accessibility of healthcare by involving the main stakeholders in this process: the users – patients – and the leading providers – staff. The research data were drawn from three primary sources: (a) Picker Adult Outpatient Tool; (b) The staff focus group; and (c) an interview with the head of the Patient Relations Office.

Squires (2014) indicates that the translation of structural and institutional differences that shape HSR remain inconsistent and largely untested in most healthcare research. For that reason, the researcher made sure to adopt Picker guidelines while preparing the survey correctly.

For the researcher to apply the quantitative data collection via the Picker Survey, a licence agreement [small-scale usage] for the Picker Adult Outpatient tool was adopted⁶. Moreover, it was necessary to make changes to the survey to ensure that it was acceptable and appropriate for the research settings by considering the recipient patients' demographic characteristic, ages, education and abilities.

The survey adaptation guidance was applied when making the changes. Figure 3.4 illustrates the adaptation process.

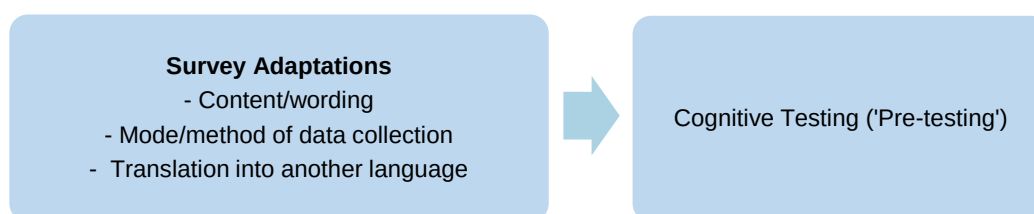


Figure 3.4 Adaptation Process⁷

⁶ Refer to Annexes A and D

⁷ Source: Survey Adaptation Guidance, Picker (2017)

The process was implemented in four stages:

Stage One: Changes to the survey content or question wording; for example, amending questions or sections that are not relevant to our case, change of wording or phrases which were not clear, shortening the length of questions.

Stage Two: Adaptations to the mode/method of data collection. Due to the current pandemic circumstances, online surveys were the best choice. This implies receiving approval from the keepers of the medical records to provide the patient's mobile phone number. Extracting all the numbers to upload them to an SMS service website and send SMS messages with the survey link was challenging. When selecting the population, the researcher tried to choose patient samples from different departments and make sure to avoid redundant patient information. Eventually, the survey was sent with a clear letter on the first page explaining that some might have difficulties accessing the internet, especially older people who are in need of healthcare services.

Stage Three: Translation into another language: by following the Language Translation Framework which aims to achieve different language versions of the English questionnaire that are conceptually equivalent. Picker Institute Europe emphasised the cross-cultural and conceptual rather than the linguistic/literal equivalence. Therefore, the forward-translation and back-translation methods were used.

Application of this method includes the following steps:

1-Forward translation by a formal English translator to Arabic, emphasising conceptual rather than literal translations and using natural and acceptable language for the vast audience.

2-Expert panel: checked by another professional expert English translator and a doctor of linguistics. This was in order to obtain maximum comprehension of the Arabic language use, and ensure that the questionnaire was suitable for all ages and backgrounds, and reflected the culture of SMC and patients.

3- Back-translation: emphasising the literature concept. Therefore, the Arabic survey draft was checked by a doctor of linguistics and approved.

Stage Four: Cognitive testing, or 'Pilot testing,' was conducted with 20 patients, with around 55 questions, 13 sections and patient background⁸. This was conducted to receive their feedback regarding comprehension, retrieval of information, evaluation of question, response

⁸ Refer to Annexe E.

match the responses. Overall, the structure was found to be adequate and the language use was proper; the only comment was that the length and number of questions needed to be minimised. An amendment was made according to the comments received. Accordingly, 32 questions were selected based on the outcome of the adaptation process and the feedback gathered, plus the type of patient in SMC and the services available. Finally, the last version of the questionnaire presents 22 questions related to Picker Principles and six demographic questions.

A request was forwarded to the Medical Records team at the end of November asking for around 10,000 patients' contact numbers in order to send them a link to the questionnaire form through an SMS service⁹. The patient numbers were randomly selected using a stratified sampling method to allocate patients from all of SMC's 21 departments who had visited SMC in 2019 and 2020; teleconsultation was implemented. Patients were selected by applying the stratified sampling process. The researcher selected a number of patients from each department in certain days of the month. The population sample represents patients from more than 16 departments in SMC.

In August 2020, a request was sent to the Picker Institute for a licence to adopt the Picker survey tool for the quantitative method. Eventually, after fulfilling all the requirements, the permit was approved by the end of September. The questionnaire was adopted and translated through a formal translator panel as requested in the guidelines provided by the Picker Institute (Picker Institute Europe, 2021).

In November, the survey was translated into Arabic. Two copies of the survey, Arabic and English, were ready for pilot testing. The link to the questionnaire draft was sent to 20 volunteers. The test's main goal was to receive feedback on the conceptual questionnaire, meaning the language used, the time needed to fulfil the questionnaire, relevance to Bahraini culture and patient experience in SMC.

The feedback was positive and the comments received were used to improve the overall question selection and presentation and reduce the number of questions from 61 to 32, including the demographic questions. The language and phrases were clear and organised, and easy to understand.

3.5.2 Survey Sampling Design

Outpatient clinic patients who were eligible to complete the questionnaire were defined as patients who had visited an SMC outpatient clinic in 2019 or 2020, visited the facilities more

⁹ Refer to Annexes B and C.

than twice, stayed in the hospital for more than four to five hours, and used more than two facilities in SMC (pharmacy, registration desk, toilets, etc.).

The sampling method used is the probability stratified random sampling technique. SMC's medical records provided information on 10,000 patients, presenting the research population as requested. Then, a filtration process was conducted and redundant patients and those with insufficient phone numbers were excluded; 8,650 patients were eligible to receive the web-based form, and 1,350 were excluded.

The survey was uploaded to the website for one month. During the first week of March 2021, forms were sent directly to the patients via the SMS service website. The targeted population revealed a sample of 313 respondents. As a researcher, we expected a higher number, but most of the literature indicates that 300 is a significant number for clinical research (Jenkinson et al., 2002).

3.5.3 Survey Data Collection

At the end of February 2021, the patient contact numbers were received from the Medical Records Department. Then, the survey form was uploaded onto an SMS service website. The survey was kept open for receiving responses for one month. Due to a low response rate and time constraints, the target was reduced to targeting to receive at least 300 responses for research purposes.

A total of 316 responses were received, 303 to the Arabic version and 13 to the English version. The target sample was completed for the study.

3.5.4 Survey Analysis

Data management and analysis were performed by applying descriptive statistics and using Microsoft Excel by calculating the frequency and the percentage of each action patient experienced in an SMC outpatient clinic. Plus, inferential statistical analysis was conducted for the quantitative method applying the chi-square analysis to test the research hypothesis and to study the factors' extent and the correlation between variables. Using the **Statistical Package for Social Sciences** (SPSS) version 23, during the preparation of the raw data for the chi-square test, the researcher found some variables had expected counts less than five or more variables set in each question from Excel 5x7 table. As questions have many possible responses but only a few possible answers per person, a different coding scheme was used. The researcher combined the categorical variables in some questions to 2x2 or 3x3 tables so the p-value will be corrected. This approach is commonly used in the social sciences (Kass, 1980).

Descriptive and inferential analysis determines the level and describes the accessibility to healthcare in outpatient clinics in SMC. Throughout the analysis, relationships and differences are painted by considering different variables and responses. And some elements are correlated with others.

3.6 Qualitative Method

3.6.1 Discussion Guide

The focus group questions guideline was based on the eight dimensions from the Picker Adult Outpatient Tool survey and aimed to answer the research questions related to staff experience. It mainly aimed to investigate their point of view relating to the accessibility to healthcare in outpatient clinics.

Variation of the sample encouraged the researcher to set different types related to explaining patient experiences during their visits to the outpatient clinics in SMC. The language was set to be professional and the mood was set to be semi-formal to extract the most reliable information.

In general, the discussion topic motivated the staff because the research and the formulated points encouraged the speaker to highlight their experience and present valid examples and explain solutions to some problems that were encountered regarding accessibility. A summary of the discussion points and the transcription is attached in the annexes¹⁰.

3.6.2 Sampling Design

The second category was the SMC outpatient staff. The staff may include the physicians, nurses, allied medical care staff and medical secretaries covering outpatient clinics interacting directly with patients. The total number of participants was 10, divided into two focus groups. The table below indicates the distribution and the speciality of each participant.

¹⁰ Refer to Annex G.

Table 3.3 Focus Group Professionals

Participants	Group A	Group B
Allied Medical Care focus	2	1
Nurse	1	4
Medical Secretary	1	0
Physician	1	0

While forming the focus groups, the researcher followed the instruction and guide of Dr Lesley Curry, a senior research scientist at Yale School of Medicine (Curry, Fundamentals of Qualitative Research Methods: Focus Groups, 2015). Also, a guided consultation was provided by researcher analyst Ms Katie Daly from the Picker Institute. In her lecture, she emphasised focus group standards, and that a group size of 5-10 is a fair number of participants which will provide good momentum and freedom of speech and discussion. As for the strata, it is preferable to have 3-5. However, coronavirus restricted social and physical gatherings, but the researcher managed to organise two strata and one interview for the qualitative data gathering. An essential point that was kept under consideration during the focus group assembly was the composition, to have a group with common ground and experts. Thus, members were selected based on those criteria.

The third data source was a semi-structured interview with the head of the Patient Relations Office. This was to verify the actual patient challenges and their opinion regarding the complaints or appraising the services and healthcare accessibility in outpatient clinics in SMC.

3.6.3 Qualitative Data Collection

In January, a semi-structured interview with the head of the Patient Relations Office, Mrs Ghaith, was conducted. She provided all the data and information about patient experience and her office's efforts to increase the accessibility to healthcare regardless of all the complaints and challenges observed and reported in the case study received in the office. The interview was audio-taped and lasted around 25 minutes.

By the end of February, two focus groups had been set up. Each group consisted of five members of SMC staff. All interviews were audio-recorded. The first group lasted for about 52 minutes and the second for about 57.

3.6.4 Method of Data Analysis

MAXQDA software was used to organise and manage the focus group and interview transcription. This was to help in analysing and organising the interviews and, most importantly, to code the interviews according to Picker Principles and the sections or the pathway that patients experience while visiting an outpatient clinic in SMC. Through the software, the outcome of the analysis was visually presented in order to observe relationships and any negative and positive impacts of the accessibility. In addition, the solutions and suggestions will help to promote accessibility in the outpatient clinics in SMC.

The three qualitative data transcriptions are: 1) the two focus groups, 2) the interview with the head of the Patient Relation Office, and 3) the open-ended question from the survey reflecting patient comments and recommendations for the SMC clinics.

The MAXQDA software functions were used to illustrate the main codes of the research principles and organise the respondents' answers. The following steps were used:

In the first step, all files were imported to the software and categorised accordingly in separate sheets with the audio-recording of the interviews.

Second, all the codes that were related to the eight Picker Principles and the survey were listed and the sub-categories were added under each principle related to the concept. Below each main principle code, the participants' reflections and answers were provided. They could agree/disagree, explain (WHY), and recommend improving the process (HOW). As for the interview with the head of the Patient Relation Office, the interview's main objective was to highlight the challenges of the main complaints and the administration's view regarding the accessibility to healthcare principles. The main codes used were: complaints and problems, solutions provided, recommendation. The survey questions' code was the recommendation and further complaints, and other comments.

Third, memos and code memos were created with the definitions and information related to the transcription findings.

In the fourth step, the outcome of the coding was presented by visual tools, MAXmaps and MAXstat. The data were organised to conduct and analyse the respondents' answers from the transcription.

3.7 Data Validity and Reliability

The validity and reliability of the research tools and instruments was based on a triangulation process. The data were gathered using a mixed method approach, quantitative and qualitative,

to validate the findings. The quantitative method is based on the Picker Adult Outpatient survey, a tool developed by Picker Institute Europe. This survey provides a set of questions, based on eight Picker Principles related to patient-centred care and patient experience as the first research sample. It consists of 13 sections and 31 questions. To increase the level of reliability, a pilot test was performed before the actual survey distribution and remarks and notes were taken. As for the qualitative data, was collected by face-to-face interview and discussion group with staff as the second research sample. As the researcher is an allied medical specialist working in an outpatient clinic in SMC, she is involved in daily routine clinics and recognises the workload and the duties of staff, and patient experience. This offers broad knowledge and experience with the matter and encouraged the focus group members to provide reliable answers and reflect their experience and concerns.

Chapter Four: Findings

4.1 Introduction

This chapter provides the results of the Picker Adult Outpatient Tool Survey and the qualitative data findings. The finding of the quantitative analysis is divided into two sections, the demographics and the Picker Principles results. The interview transcription is presented in the third section based on the type of data collected, i.e. the focus group discussion, the interviews, and patient comments and remarks.

4.2 Descriptive Analysis Finding

In this section, the descriptive statistical analysis is performed using Excel (2016) to analyse the responses to 31 questions. The last question, which was an open-ended question, is interpreted in the qualitative analysis section. By the end of the survey period, responses were collected from 316 individuals who replied to the web-based survey, out of which 303 responses were to the Arabic version and the rest were to the English version.

In this section, the questions are categorised and listed according to the independent variables of the conceptual framework, which is presented as the eight principles of the Picker survey tool to measure and determine the level of accessibility to healthcare in outpatient clinics in SMC from the patient's perspective. Each principle consisted of several items (questions)¹¹.

4.2.1 Demographic Information

Respondents to this study had quite diverse characteristics. The personal data gathered from the respondents included gender, age, educational level, long-standing condition, any difficulties with the health condition, nationality and native language, as reported in Table 4.1.

The majority of the respondents were female (56.6%) and between 31-40 years old (27.5%). The data showed that 36.1% of participants hold a bachelor's degree and almost the same percentage are high school certificate holders. The long-standing condition question showed that 59.2% did not have a long-standing condition, whereas 28.5% of the respondents stated that they did have long-standing illnesses such as cancer, HIV, diabetes, etc.

¹¹ Refer to Annex F.

Accordingly, in the answers to the question related to whether the conditions caused any difficulties from the listed activities, 45.3% of the respondents said they had no difficulties. On the other hand, 54.6% indicated that they did face difficulties in their daily activities such as access to buildings, education problems, people's attitudes, and communication and socialising problems. Almost all (99.4%) of the survey respondents were Bahraini by birth, and 94.9% indicated Arabic as their native language, with only 5.1% being English/other language speakers.

Table 4.1 Participants' Demographic Information

Variable		Frequency	Percentage
Gender			
	Male	137	43.4
	Female	<u>179</u>	<u>56.6</u>
Age			
	21-30	62	19.6
	31-40	<u>87</u>	<u>27.5</u>
	41-50	71	22.5
	51- 60	61	19.3
	61 and more	35	11.1
Education			
	High School	111	35.1
	Diploma	65	20.6
	Bachelor's Degree	<u>114</u>	<u>36.1</u>
	Master's Degree	21	6.6
	PhD degree	5	1.6
Condition			
	Deafness or severe hearing impairment	11	3.5
	Blindness or partially sighted	15	4.7
	A long-standing physical condition	10	3.2
	A learning disability	1	0.3
	A mental health condition	2	0.6
	A long-standing illness, such as cancer, HIV diabetes, etc.	<u>90</u>	<u>28.5</u>
	No, I do not have a long-standing condition	<u>187</u>	<u>59.2</u>
Difficulties			
	Everyday activities that people your age can usually do	51	16.1
	At work, in education, or training	15	4.7
	Access to buildings, streets or vehicles	26	8.2
	Reading or writing	16	5.1
	People's attitudes to you because of your condition	13	4.1
	Communicating, mixing with others, or socialising	32	10.1
	Any other activity	20	6.3
	No difficulty with any of these	<u>143</u>	<u>45.3</u>
Nationality			
	Bahraini	314	99.4
	Other	2	0.6
Language			
	Arabic	300	94.9
	English	11	3.5
	Other	5	1.6

4.2.2 Picker Principles Question Results

Principle One: Fast access to reliable healthcare advice

The first set of questions aims to identify the fast access to reliable healthcare advice dimension. This was measured by three questions such as the assessment reflected the patient's experience before the appointment and his or her waiting time in the hospital. Duration of waiting time for the appointment was more than 12 months but no more than 18 months ranked first with 39.2%, as shown in Figure 4.1. The second question is related to waiting time to see the doctor and initiating treatment. Most of the respondents (26.3%) said they waited 31-60 minutes. The last question confirms that many patients had a disappointing experience (72.2%) as they were not informed about how long they would have to wait to see the doctor.

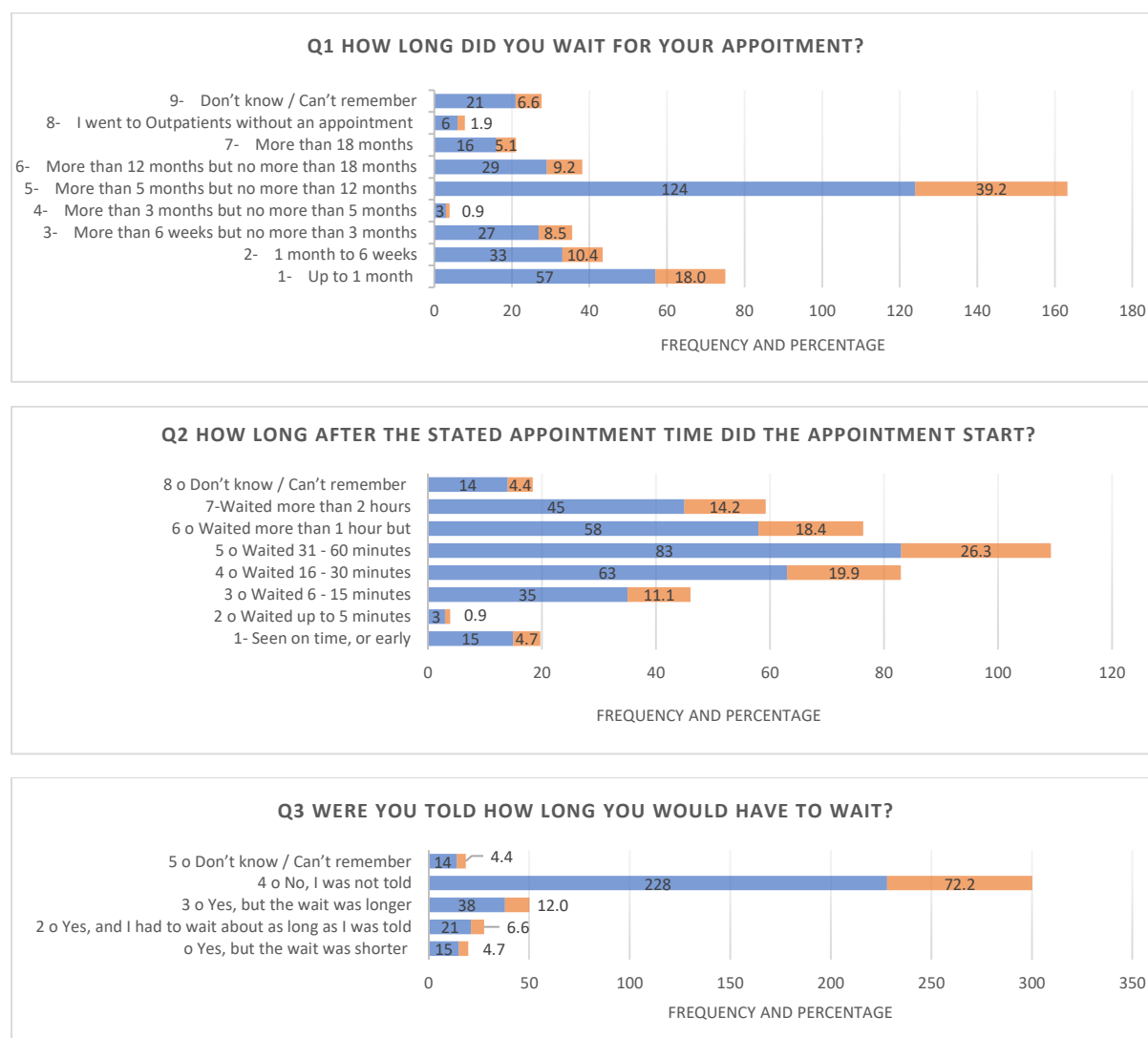


Figure 4.1 Participants' Opinions on the Speed of Access to Reliable Healthcare Advice

Principle Two: Effective treatment delivered by trusted professionals

The results of the two questions related to the second principle revealed that the majority (46.5%) of the respondents do have, to some extent, confidence and trust in the doctor's treatment. Just over half of the sample (54.1%) stated that they were satisfied with the treatment received for their crucial health issue. Figure 4.2 presents the results.

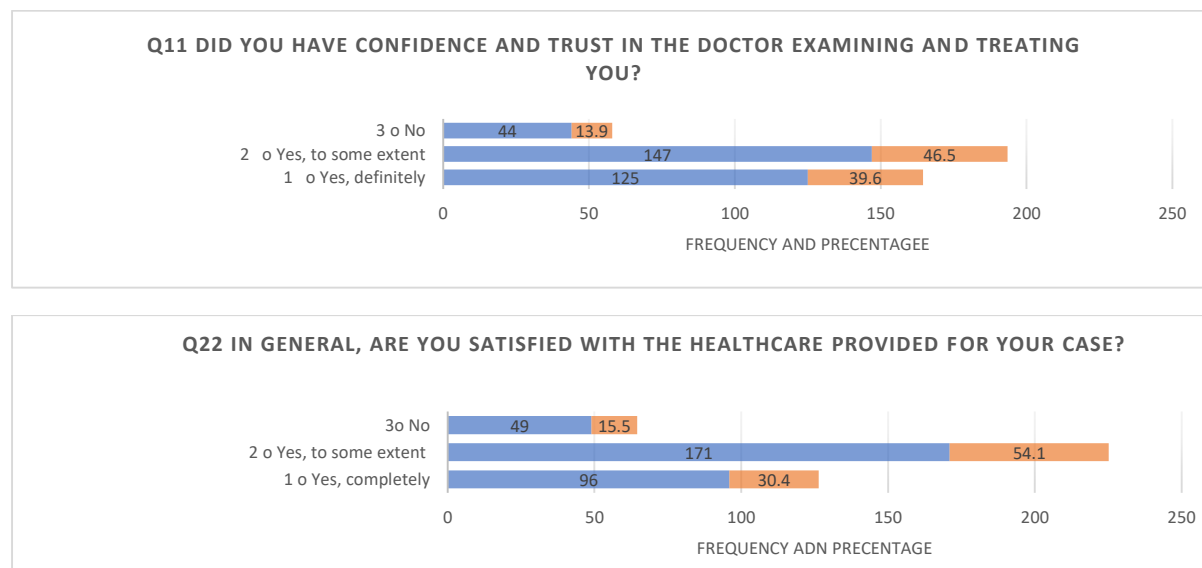


Figure 4.2 Participants' Opinions on the Effectiveness of Treatment Delivered by Trusted Professionals

Principle Three: Continuity of care and smooth transitions

When it comes to continuity of care and smooth transition, most of the respondents (35%) stated that the doctor knew something but not enough about their medical history. In contrast, 32% said that the doctor knew enough about their medical history. Although only 25.6% believed that the doctor knew little or nothing about their medical history, this may be an important issue to highlight. The results are shown in Figure 4.3.

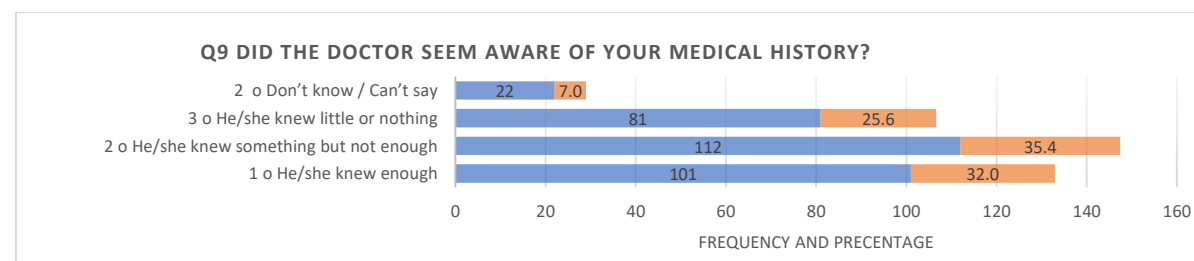


Figure 4.3 Participants' Opinions on the Continuity of Care and Smooth Transition Results

Principle Four: Involvement and support for family and careers

This principle was measured by one question related to family member involvement in patient treatment and examination decisions. The responses showed that 61.4% of the participants did not have any close family member involved (SD 0.96). Figure 4.4 presents the results.

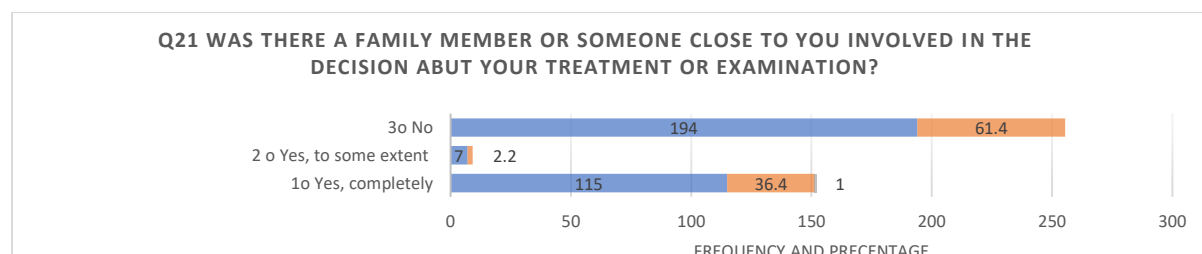


Figure 4.4 Participants' Opinions about the Involvement and Support for Family and Carers Results

Principle Five: Clear information, communication and support for self-care

Five questions measured this variable. The principle focused on reflecting patients' experience regarding clear information and timely communication provided by the staff members at the SMC outpatient clinic. From Table 4.5, the response to the first four items illustrates that the respondents believed that doctors and staff members provided clear information about their current health condition. The descriptive statistics revealed that 28.8% of the respondents agreed, to some extent, that the staff members explained the results of the tests in a way that the patient could understand. Moreover, 42.4% confirmed that staff members explained the risks and/or benefits of the treatment. Additionally, 42.1% stated that, to some extent, they received answers to their questions, which reflects a piece of clear information and communication.

However, the last item indicated that the side effect of the medication was not clarified to the patients, although 40.5% of respondents stated that the staff members did explain the purpose of the medication and 60.1% mentioned that staff members did explain medication side effects.

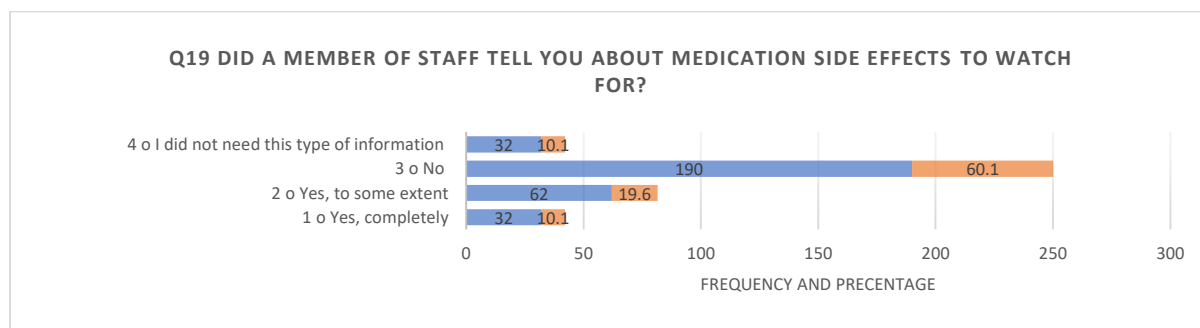
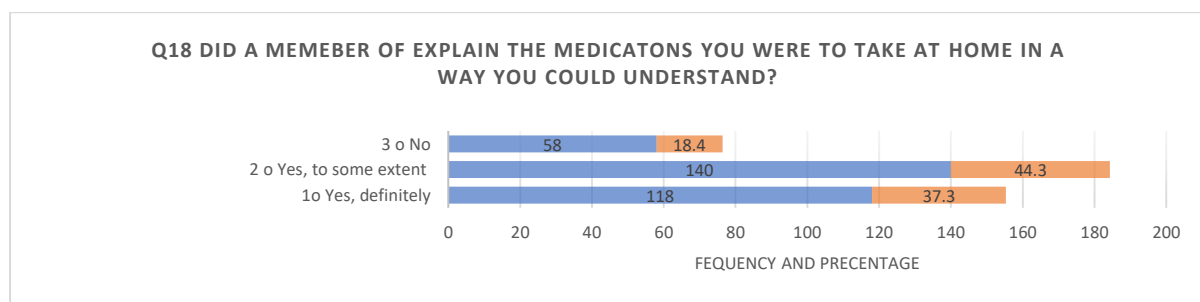
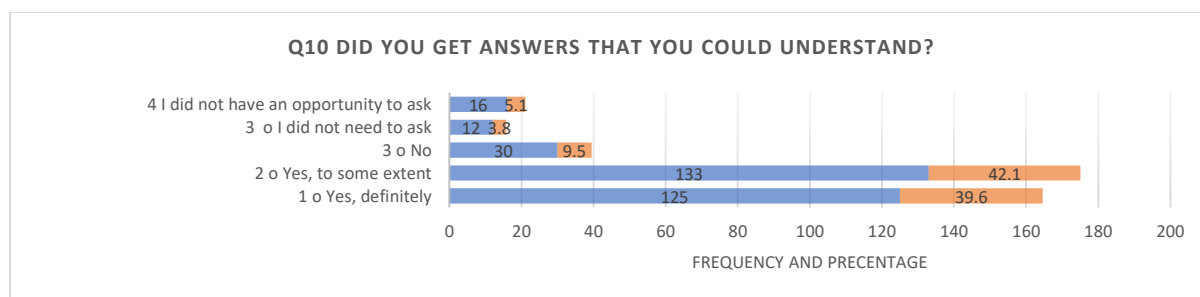
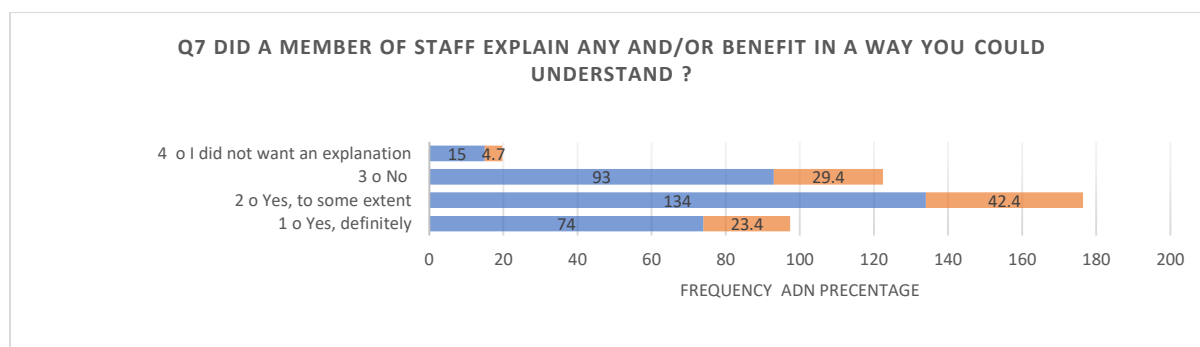
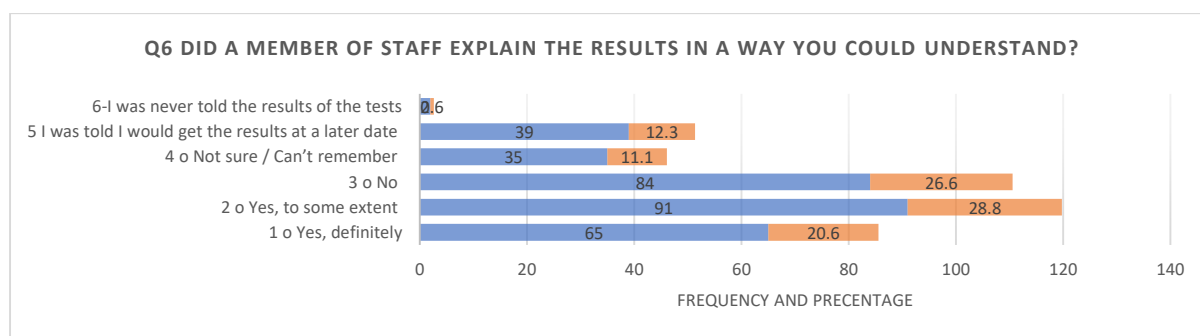


Figure 4.5 Participants' Opinions on the Clarity of Information, Communication, and Support for Self-care

Principle Six: Involvement in decisions and respect for preferences

Two questions assessed this variable. The assessment reflected the patient's involvement in decisions and the staff's respect for preferences. The results show that 45.9% agreed that they were involved in decisions about their care and treatment, which indicates a reliable rate. As for the second question that enquires if the appointment helped the patients feel that they could better manage their condition, 44% said that it did help to some extent. Figure 4.6 below shows the results.

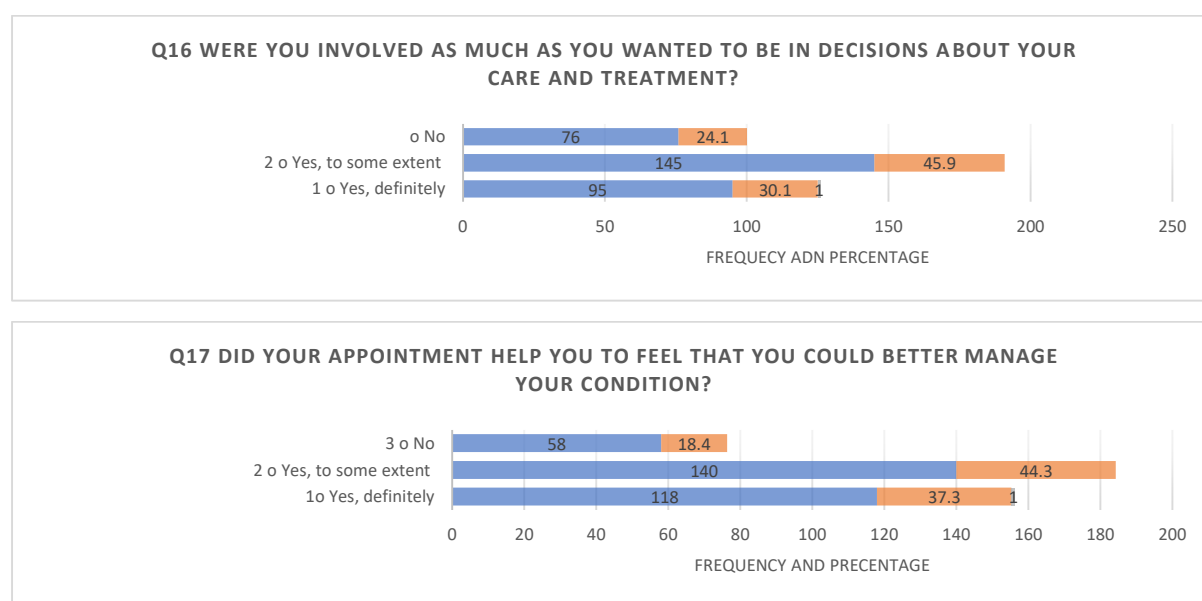


Figure 4.6 Participants' Opinions on their Involvement in Decisions and Staff's Respect for their Preferences

Principle Seven: Emotional support, empathy and respect

Seven questions measured this principle of patient experience. The overall concept of emotional support, empathy and respect indicated, to some extent, positively. The responses revealed that 42.1% of the patients confirmed that they had enough time to discuss their health or medical problems with the doctor. The second question was whether the staff treating and examining patients introduced themselves or not. Responses to this question had a striking result, with 63.9% of the participants indicating that very few or none of the staff introduced themselves. The third item was questioning if a doctor and/or other staff talked in front of the patients as if they were not there, and 45.6% said no, it did not happen. The fourth question was about whether the patients were given enough privacy when discussing their condition or treatment or not, to which 49.1% said, to some extent, yes. The fifth item asked whether the patients experienced that one staff member said one thing and another member said something

quite different, and 44.0% of the participants said yes, to some extent. The sixth question about this principle was about the reception staff members, and it asked if they were friendly or not, to which 54.1% responded that yes, to some extent, they were friendly. The last item was whether the patients felt they were treated with respect and dignity or not, and to this question, 48.7% of patients said yes, to some extent, they felt that they were treated with respect and dignity. Figure 4.7 shows the results.

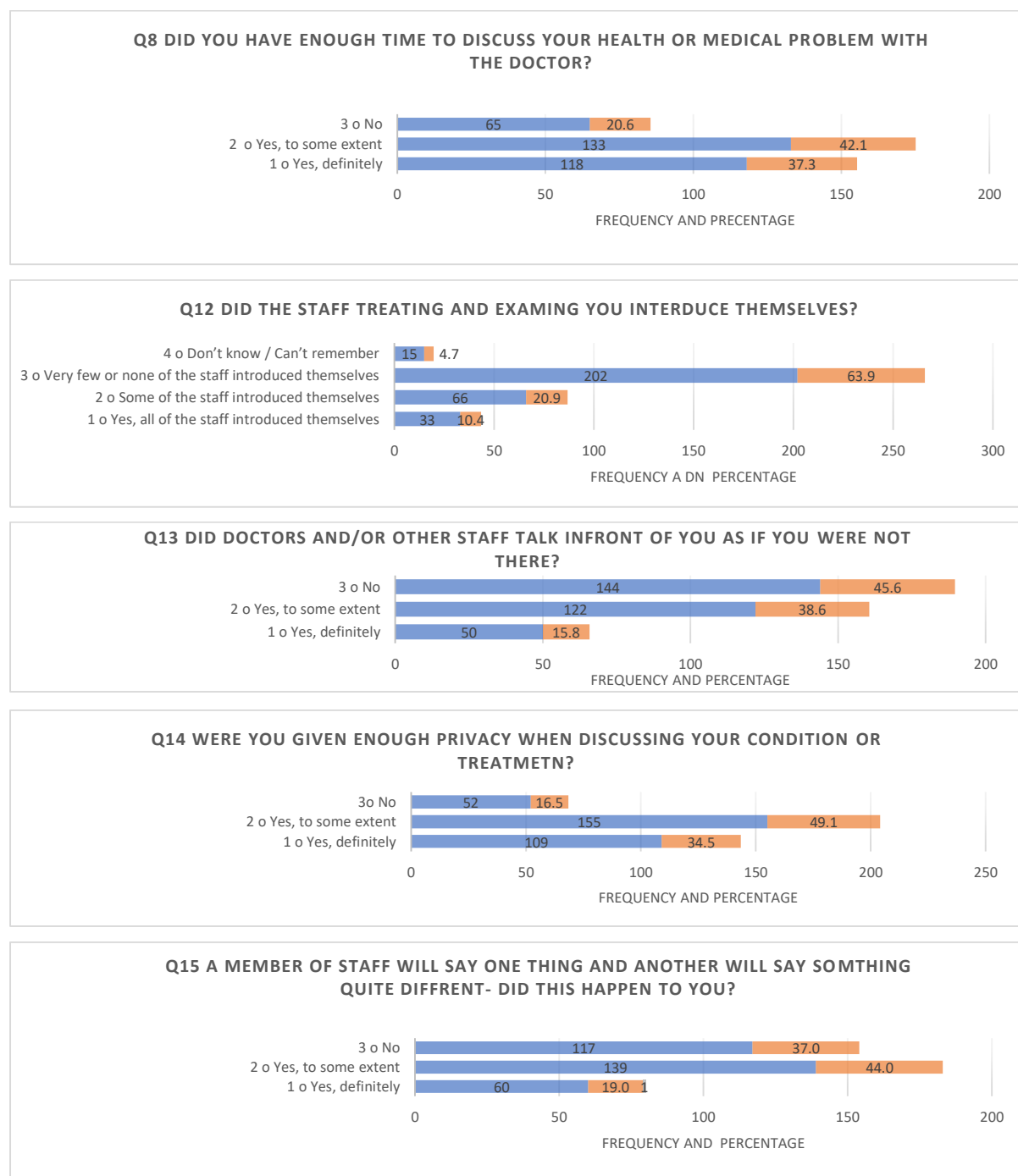


Figure 4.7 Participants' Opinions on Emotional Support, Empathy and Respect

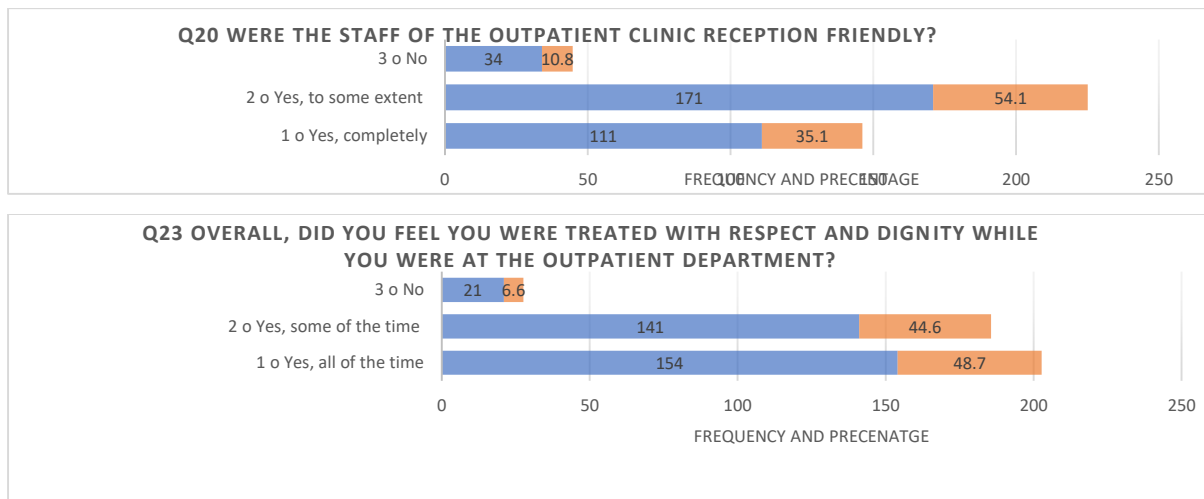


Figure 4.8 Participants' Opinions on Emotional Support, Empathy and Respect

Principle Eight: Attention to physical and environmental needs

To measure this variable, two questions were proposed. The answers reflected the patients' experience towards if the management paid attention to their physical and environmental needs. Half (50.3%) of the respondents indicated that the outpatient clinics in general were fairly clean, and only a third (33.9%) said that the toilets are also fairly clean. That indicates that management should pay more attention to the physical and environmental needs of the patients as the rate of satisfaction is quite low. Figure 4.9 below presents the results.

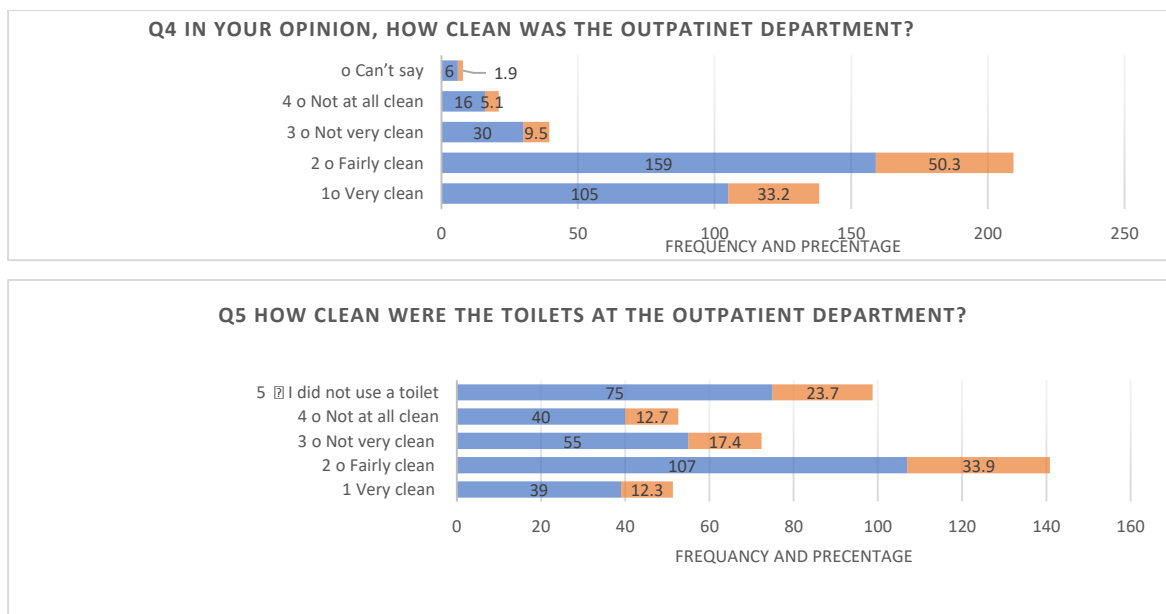


Figure 4.9 Attention to Physical and Environmental Needs Results

Filter Question

Finally, when the participants were asked to provide their opinion on their overall rate of care at the outpatient clinics, the majority (30.7%) said very good. In contrast, 7% said poor. In second rank was good, with 26.6%, and 19% rated it as fair. Only 19% rated it as excellent. These findings indicate that the overall rate of care in outpatient clinics is very good. The results are presented in Figure 4.10.

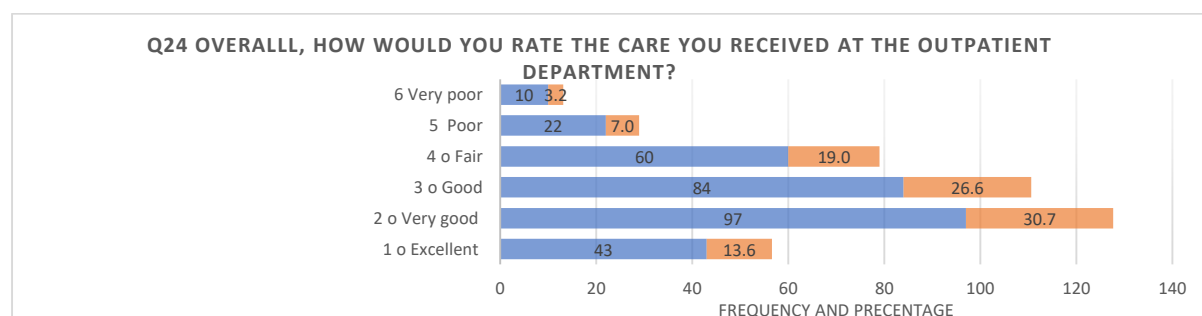


Figure 4.10 Filter Question Result

4.3 Inferential Analysis

4.3.1 Chi-square Test

The chi-square test was performed to test if the factors correlate to the rate of overall satisfaction with healthcare received in outpatient clinics. The responses to Q-24 were measured as the outcome (dependent) variable, “Overall, how would you rate the care you received at the outpatient department?” Patient satisfaction is measured based on this question. The predictor (independent) variables were measured through the responses to the following questions as presented in Table 4.2 below:

Table 4.2 Independent and Dependent Variables Questions

Independent Variables				Question
1	Picker Principles	Fast access to reliable healthcare advice		Q1. How long did you wait for your appointment?
2		Effective treatment delivered by trusted professionals		Q.11 Did you have confidence and trust in the doctor examining and treating you?
3		Continuity of care and smooth transitions		Q.9 Did the doctor know what was written in your medical records?

Independent Variables		Question
4	Involvement and support for family and careers	Q.21 Was there a family member involved in the decisions about your treatment?
5	Clear information, communication and support for self-care	Q.7. Did anyone explain to you the risk and benefit of the treatment or examination in a way you could understand?
6	Involvement in decisions and respect for preferences	Q.16 Were you involved in the decisions about your treatment or examination?
7	Emotional support, empathy and respect	Q.8 Did you have enough time to talk to the doctor or other members?
8	Attention to physical and environmental needs	Q.4 In your opinion, how clean was the Outpatients Department?
9	Demographic Question	Q28. Do you have any of the following long-standing conditions?
	Dependent Filter Questions	Q.24 Overall, how would you rate the care you received at the Outpatients Department?

The following section examines the first research hypothesis:

(H01): There is no statistically significant relationship of healthcare accessibility (eight Picker Principles) to staff and patient experiences at outpatient clinics at SMC. The nine factors are listed with the respective hypothesis, and the results of the chi-square test are presented next.

1- Fast Access to Reliable Healthcare Advice

(H01): There is no relation between the overall care and waiting time for a patient appointment.

A chi-square test of independence showed a p-value of 59% ($X^2(3, N = 313) = 1.90, p = .59$), suggesting that we fail to reject the null hypothesis that “there is no association between overall care and waiting time for a patient’s appointment”. In other words, overall care is not related to waiting time for a patient’s appointment.

2- Effective Treatment Delivered by Trusted Professionals

(H02): There is no statistically significant relationship between the overall care and confidence and trust in the doctor examining and treating the patient.

The chi-square test results showed a statistically significant relationship between overall care and confidence and trust in the doctors. The p-value is less than 5% ($X^2(1, N = 313) = 5.52, p=.019$), suggesting that we can reject the null hypothesis that states “there is no statistically significant relationship between overall care and confidence and trust in

doctors”; rather, we can accept the alternative hypothesis that states “there is a statistically significant relationship between overall care and confidence and trust in doctors”.

3- Continuity of Care and Smooth Transitions

(H03): There is no statistically significant relationship between patient medical records and overall care.

The chi-square test results showed a statistically significant relationship between patient medical records and overall care. The p-value is less than 5% ($\chi^2(2, N = 313) 6.94, p = .03$), suggesting that we can reject the null hypothesis that states “there is no statistically significant relationship between patient medical records and the overall care”; rather, we can accept the alternative hypothesis that states “there is a statistically significant relationship between patient medical records and the overall care”.

4- Involvement and Support for Family and Careers

(H04): There is no statistically significant relationship between the overall care and involvement of family members in patient treatment decisions.

The chi-square test results showed a statistically significant relationship between the overall care and involvement of family members in patient treatment decisions. The p-value is less than 5% ($\chi^2(1, N = 313) = 6.06, p = .014$), suggesting that we can reject the null hypothesis that states “there is no statistically significant relationship between the overall care and involvement of family members in the decisions about the patient’s treatment”; rather, we can accept the alternative hypothesis that states “there is a statistically significant relationship between the overall care and involvement of family members in the decisions about the patient’s treatment”.

5- Clear Information, Communication and Support for Self-care

(H05): There is no statistically significant relationship between overall care and communication and self-care support.

The chi-square test results showed a statistically significant relationship between overall care and communication and self-care support. The p-value is less than 5% ($\chi^2(1, N = 298) = 5.47, p = .019$), suggesting that we can reject the null hypothesis that states “there is no statistically significant relationship between the overall care and communication and self-care support”; rather, we can accept the alternative hypothesis that states “there is a

statistically significant relationship between the overall care and communication and self-care support”.

6- Involvement in Decisions and Respect for Preferences

(H06): There is no statistically significant relationship between overall care and the patient’s involvement in decision-making about their treatment or examination.

The chi-square test results showed no statistically significant relationship between overall care and the patient’s involvement in decision-making about their treatment or examination. The p-value is greater than 5% ($X^2(1, N = 313) = 1.28, p=.26$), suggesting that we cannot reject the null hypothesis that states “there is no statistically significant relationship between overall care and the patient’s involvement in decision-making about their treatment or examination”.

7- Emotional Support, Empathy and Respect

(H07): There is no statistically significant relationship between overall care rate and emotional support, empathy and respect.

The chi-square test results showed a statistically significant relationship between overall care and emotional support, empathy and respect. The p-value is less than 5% ($X^2(1, N = 313) = 5.21, p = .02$), suggesting that we can reject the null hypothesis that states “there is no statistically significant relationship between overall care rate and emotional support, empathy and respect” and accept the alternative hypothesis that “there is a statistically significant relationship between overall care rate and emotional support, empathy and respect”.

8- Attention to Physical and Environmental Needs

(H08): There is no statistically significant relationship between overall care rates and physical environment needs (hygienic and cleanness).

The chi-square test results showed a statistically significant relationship between overall care and physical environment needs. The p-value is less than 5% ($X^2(1, N = 307) = 4.24, p = .04$), suggesting that we can reject the null hypothesis that states “there is no statistically significant relationship between overall care rates and physical environment needs” and accept the alternative hypothesis that “there is a statistically significant relationship between overall care rates and physical environment needs”.

9- Demographic Question

(H09): There is no statistically significant impact of patient health condition as listed and the overall care rate.

A chi-square test of independence showed that the hypothesis failed to reject that there is no association between the patient's health condition as listed and the overall rate of care, $X^2(2, N = 313) = 1.244, p = .53$.

4.3.1.1 Phi and Cramer's Value

The correlation strength was indicated by the Cramer's Phi, which presents the strength of the relationship between variables' values (Akoglu, 2018). Thus, the factors can be categorised and sorted as follows in Table 4.3 below

Table 4.3 Summary of Correlation Analysis

Correlation Strength	Cramer's Phi	Factors
Strong Correlation (Greater or equal to 0.15)	.15	Continuity of care and smooth transitions
Moderate Correlation (Less than 0.15)	.13	Effective treatment delivered by trusted professionals
	.14	Involvement and support for family and careers
	.12	Attention to physical and environmental needs
	.14	Clear information, communication and support for self-care
	.13	Emotional support, empathy and respect
Not applicable (chi-square test indicated that the hypothesis was not rejected)	--	Fast access to reliable healthcare advice Involvement in decisions and respect for preferences Demographic question

The results show that some factors did not affect the overall care rate even though descriptive analysis reported a significant impact on the patient's experience. For example, the accessibility dimensions related to Fast Access to appointment and waiting time, Involvement in decisions and respect for preferences, and the Demographic question showed no correlation. In contrast, other dimensions like Effective Treatment Delivered, Involvement and support for family and carers, Attention to physical and environmental needs, Clear information, communication and support for self-care, Emotional support, empathy and respect showed a strong correlation.

That may indicate that other factors, in general, could affect the accessibility of healthcare. In general, the outpatient clinic experience at SMC was acceptable, and patients have good experiences of accessibility regardless of the weak and insignificant relationship reported by inferential analysis. On the other hand, the sample size might affect the result to some degree on inferential statistics; therefore, the descriptive analysis results may be considered more reliable in describing the study results and reflecting all the accessibility dimensions that affect patient experience.

4.4 Qualitative Analysis Findings

4.4.1 Introduction

The following section reviews the analyses of the transcription of the staff interview, the interview with the head of the Patient Relations Office, and the last question of the patient experience survey¹². The first main headings follow the structure of the theoretical framework that is used for the study, the Picker Principles, to analyse the staff's responses and reflections on the accessibility to healthcare in outpatient clinics in SMC. In addition, it details staff explanations and recommendations regarding some phenomena that can be resolved or improved in SMC in general.

The second main heading is the analysis of an interview with the head of the Patient Relation Office, and her elaboration regarding the patient complaints, and the factors affecting the accessibility and her recommendations for improvement and mitigating the challenges and the obstacles. The last section will analyse patient responses and comments on opportunities for improving the services in outpatient clinics in SMC.

MAXQDA software was used to facilitate the transcription of the interview and the answers to the questions by managing and organising the outcomes and the results. The qualitative data will be used to validate the result of the survey outcome and enhance the impact of the discussion. Most importantly, it will fulfil the objective of the research and answer the second, third and fourth questions regarding the patient experience and complaints, staff experience regarding the accessibility to healthcare, and the differences between them.

4.3.2 Staff Experience Responses

The word cluster from the transcription of the focus group answers is presented in Figure 4.10. This visual tool indicates that the staff's main concern is always the patient, and the factors

¹² Refer to Annex H.

affecting accessibility are shown in bold (appointments, awareness, understand, doctor, information, privacy, explain, think). It highlights the main topic that concerns the staff in order to promote the accessibility to healthcare in clinics. Figure 4.11 shows the codes and frequency of the focus group used for analysis.



Figure 4.11 Focus Group Word Cluster

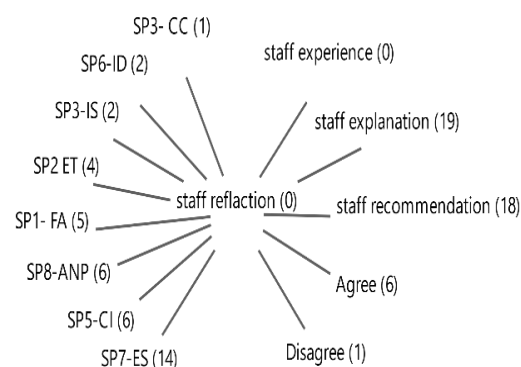


Figure 4.12 Focus Group Codes and Frequency

Table 4.4 summarises the answers of staff working in the outpatient clinics. The citations are formed according the eight Picker Principles.

Table 4.4 Focus Group Citations According to Picker Principles

Picker Principles (Variables)/ CODES	No. of Citation	Citation	Agree/ Disagree	Explanation	Recommendation
1 Fast access to reliable healthcare advice	23	-Waiting time -Late appointment -Late seeing the doctors	Agree there is a problem	-Patients don't stick to their appointment timing -Doctors take long time with patient -Starting the clinic late due to overload	-Introduce new calling system especially for emergency clinics - Increase patient awareness - Increase manpower - Decrease overload on doctors
2 Effective treatment delivered by	11	-Trust in doctor and treatment	To some extent	-Patients trust some doctors - In general they are satisfied	- Promote awareness - Promote the services and good marketing

Picker Principles (Variables)/ CODES	No. of Citation	Citation	Agree/ Disagree	Explanation	Recommendation
trusted professionals		- Satisfied with healthcare provided		-Unpleasant image in media, reputation of SMC staff -Cultural issues: patient seeks other opinion always	for SMC and staff in general - Doctors and staff training -Public relations workshop
3 Continuity of care and smooth transitions	5	Medical record and the I-Seha system	Agree	-Information is clear -System used by some doctors efficiently	-Improve the data entry for I-Seha Takes a long time -More training and involvement of staff to develop the system
4 Involvement and support for family and careers	5	-Decision -Help	Agree	Always there will be a member to consult and help -Cultural effect	-May interfere with treatment and delay the procedures
5 Clear information, communication and support for self-care	26	-Information -Instruction -Medication -Test result -Side effect - Provide understandable information	To some extent	-Some doctors are not that transparent and not clear -Depends on doctor's experience and communication skills - Sometimes the patient doesn't pay that much attention during the treatment	- Need communication skills workshop -Aware of patient culture and language use Doctors should be patient and use aided guide if possible
6 Involvement in decisions and respect for preferences	6	-Patient involvement in decisions about treatment	To some extent, yes	-Doctors provide the option and explain -Cultural interferences	-Need more awareness from patient side and family to eliminate any doubts

	Picker Principles (Variables)/ CODES	No. of Citation	Citation	Agree/ Disagree	Explanation	Recommendation
7	Emotional support, empathy, and respect	48	-Time given to patient -Staff introduce themselves -Talk in front of patient -Patient privacy -Friendly reception - Patient treated with dignity	To some extent	-Doctors are overloaded in clinics, not enough time -10 min not enough for each patient as recorded -Privacy always respected -Patient is treated with dignity - Doctors do talk in front of patient not related to their case	-Decrease number of patients on the list - Instruct staff in the reception - Provide a guided aided instruction in SMC facilities (smart screens, information desks, site application) - Instruction to doctors how to provide best clinical setting possible for patient comfort
8	Attention to physical and environmental needs	15	-Cleanliness of clinical facility	To some extent	-Some clinics need to redesign and re-allocate their settings and equipment -Some building rooms and toilets need to be reconstructed. - Hygienic and clean procedures are not applied with the same level of efficiency	- The cleaning hygiene providers should be instructed and use the best materials and detergent possible.

4.4.3 Patient Relations Office Responses

The interview was with the head of the Patient Relations Office (PRO), to elaborate on the factors affecting the accessibility to healthcare in outpatient clinics in SMC, according to the recodes and the complaints they receive daily in their office. The PRO provides a service for patients and their families to help them have a positive experience at SMC, and to achieve the highest level of patient satisfaction. The PRO covers concerns from both inpatients and those

attending outpatient clinics. There are six employees in the office covering all the cases in SMC departments. They receive any report regarding a patient's situation from different channels, whether from the patient directly, wards, departments, administration, media or international affairs.

The codes that were introduced to the transcription of the interview highlighted three main elements were discussed regarding patient experience in accessing the healthcare in outpatient clinics, as Figure 4.12 shows.

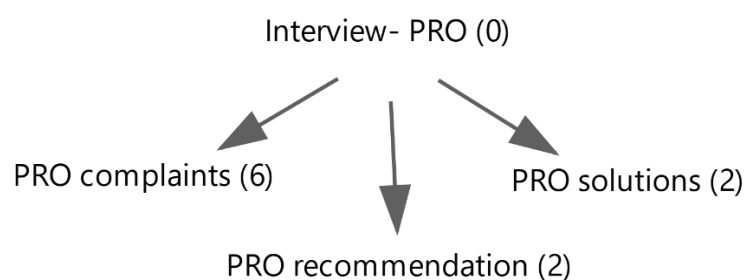


Figure 4.13 Patient Relations Office Interview Codes and Frequency

Table 4.5 below summarises the main discussion points from the interview and the three elements that were highlighted: 1) Patient complaints, 2) Solution provided, 3) Recommendation.

Table 4.5 Patient Relations Office Interview Elements

Element	Questions	Citation
1 Complaints	What are the main complaints that you receive?	The first main complaint is the Appointment: very late appointment given, even on times for emergency access, and delay in operation procedures. More than 60 complaints on one department were recorded in the last 11 months. Plus, doctors were not available. It is a daily basis issue. The second issue is Pharmacy, as the statistics indicated in the last 11 months, the number of cases reported are: 1) Medication Prescription Expiration, around 600 cases, 2) Suspended Medicine, around 40 cases, 3) Drug Control, around 410 cases, 4) Out of Stock Medicine, around 100 cases. The third issue is Changing the doctor, due to miscommunication or gender preference.

		Other issues like there is demand for sleep study, which most patients require as part of their treatment but unfortunately is not provided in SMC for now.
2	Solutions	How do you solve those problems? What are the solutions? For the appointment issues, we try to manage by contacting the medical record directly and booking appointments after doctor's approval, depending on how urgent the case, is or refer them to another doctor with less waiting [time]. Pharmacy issue is complicated, because lot of departments are involved – the financial, the purchasing, the supplying stores – but we do our best to investigate and explain to the patient. As for changing the doctor, we do our best to solve the problem between the doctor and the department in charge to solve any personal issues.
3	Recommendations	In general, these issues are expected in any government hospital with overloaded [staff] and serving large numbers of the population. But to minimise the complaints, financial support is needed, and training. [We need to i]ncrease the awareness among patients and professionals about services and any changes in the information system, which will prevent any delay in service.

4.4.4 Question No. 32 of the Picker Outpatient Tool Survey

The question was: are there any comments regarding outpatient clinics? The main objective of this question was to understand the record and comments on the eight dimensions of Picker along with patients' remarks and recommendations for SMC administration to improve the accessibility to healthcare in outpatient clinics. There were approximately 114 remarks. The word cluster in Figure 4.13 codes the structure as it is shown in Figure 4.14 and 4.15. They are followed by Table 4.16, which provides the codes and patients' comments and recommendations.

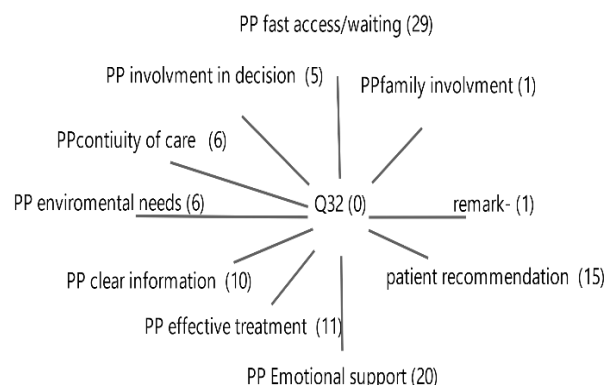


Table 4.6 below presents the main responses and recommendations from Question 32.

	Piker Principles (Variables)	No. of citation	citation	Recommandation
1	Fast access to reliable healthcare advice	55	- Appointment system need to be consider -Long waitings to see the doctor - Xray appointment very Far - Long waitings Q in Pharmacy - Sickle cell patiets need to be concidered -Uncomfortable waiting area , chairs - unable to hear the nusrses ,when calling to see the doctors. - Waitign time affecting the health condition , make us concider to go to privet clinics	- Concider chronic disesse - Instruction to medical records staff - Change the calling system in the clinics.
2	Effective treatment delivered by trusted professionals	10	- Not satisfied with some doctors treatment -	-New experts and Training needed for all staff especilly doctors

3	Continuity of care and smooth transitions	2	-Not knowing my case, file not read - No any contact number to call in case enquirers to clinics -changing the doctors and we are not informed	- Provide phone numbers or contact to contact in case of enquiries - Doctors should read files
4	Involvement and support for family and careers	-	-	-
5	Clear information, communication, and support for self-care	5	-Patient need to have enough time with doctor to describe his condition -Un arabic speaker doctors confuse the patient and may cause embarrassment -Non arabic doctors effect patient psychology and explain his illness -Remote calling effect communication , and medication description and treatment	- Sometimes need a translator when speaking to non arabic doctors.
6	Involvement in decisions and respect for preferences	-	-	-
7	Emotional support, empathy, and respect	5	- Doctors lack of respect for the patient	-
8	Attention to physical and environmental needs		-No place to set , large number of patients - the Cleanliness scared me - Privacy needed laboratory while blood taking - Bathroom unsanitary - Some department are clean.	-More attention to cleanliness especially bathrooms.

Chapter Five: Discussion

5.1 Introduction

In this chapter, the findings will be presented to answer the research questions and fulfil the study's objectives. The next section will discuss the findings of the descriptive analysis by discussing accessibility to healthcare in outpatient clinics as per patient and staff experiences. The second research question will be answered in the third section exploring patient complaints and experiences. The fourth section will answer the third question by assessing staff experience. In section five, the fourth research question will be answered regarding the differences between patient and staff experiences regarding accessibility to healthcare. The last four sections discuss current coexisting studies, practical implications of the study, managerial recommendations, and limitations of the study and future research directions.

, practical implications of the study, managerial recommendations, and limitations of the study and future research directions.

5.2 Patient Experience of Accessibility to Healthcare in the Outpatient Clinics of SMC

This section aims to summarise the descriptive and inferential statistics of the Picker Adult Outpatient Survey, which will answer the first question of the research:

To what extent is accessibility to healthcare dimensions (Picker Principles) implemented in outpatient clinics in SMC from staff and patient experience?

It will also fulfil the research objective: To test a set of major essential dimensions of Picker Principles that will directly impact the accessibility to healthcare in SMC.

The descriptive analysis consisted of 31 questions, which provided insights regarding the patients' characteristics. Descriptive statistics revealed that about 56.6% of the respondents were female. The participants' ages varied from 21 to 61 and above, and the majority are between 31 and 50 years. Most of them were educated to high school or bachelor's level. Three hundred and fourteen were Bahraini nationals, out of which 300 were Arab speaking. In general, there was no long-standing illness in the sample; 28% indicated that they had chronic medical issues and there were 39 cases of disabilities. This indicates that most follow-up cases were for a specific and acquired condition that a specialist needs to solve. The patients expressed their concerns that their medical condition affects their communication, socialising, and access to buildings and vehicles. The majority answered that the main difficulties were the everyday activities that people at their age should be doing.

These results suggest that the patients sampled in the research are educated and able to evaluate their condition and the healthcare provided.

As for the core analysis of the eight dimensions, the results are discussed accordingly:

5.2.1 Fast Access to Reliable Healthcare Advice

The three questions related to access highlighted the long wait for appointment dates. For instance, 39% waited for more than 12 months, and only 18% were able to book appointments in one month but not more than six weeks. The patients expressed their concerns in the survey because their condition was deteriorating. Hence, they visited private clinics for treatment.

Waiting to see the doctors negatively impacted patient satisfaction; the majority answered that they waited about 30 or more minutes to see the doctor. A few, around 11%, had to wait for less than 15 minutes. In addition, 72.2% indicated that they were never told that they must wait that long to see the doctor. The patients were frustrated and explained their frustration in the survey remarks section.

In contrast, staff endorsed the patients' concerns about the delay in appointments and reported that it is mainly because of workload, general procedure, and an increasing number of patients. There is a need to hire more doctors and adjust the daily rota distribution to reduce doctors' workload and minimise patient waiting time. A high respondent rate revealed that it is one of the significant issues that SMC management needs to correct/resolve. This was also reported by Menu (2020), that a long waiting time is a barrier to healthcare accessibility.

5.2.2 Effective Treatment Delivered by Trusted Professionals

Trust is one of the essential features of relationship building (Pearson,, 2000). Respondents showed a moderate level of confidence and trust in doctors; 39.6% stated that they have complete faith and trust in doctors, while 46.5% showed comparatively little trust in doctors. In contrast, only 15.5% of respondents showed dissatisfaction with and lack of trust in doctors, whereas 54.1% showed satisfaction with the healthcare services received at outpatient clinics. Although a small lack of trust element was observed, it was not significant. On the other hand, when the staff and the doctors were asked about the trust issue, they replied that it is a cultural influence because most patients always seek another opinion.

5.2.3 Continuity of Care and Smooth Transitions

The patients' remarks regarding the transition were quite disappointing, and they were complaining about pharmacy services, x-rays and the laboratory. Although the survey did not

include a section regarding the detailed evaluation of the transition services, the patients complained about the transition of care after discharge or were referred to another section. On the other hand, when the staff were asked about the transition issue, they reported that this might occur because of missing information in the I-Seha system, causing disruption for patients and even for doctors who were following the case.

5.2.4 Involvement and Support for Family and Carers

The inclusion of families and caregivers in planning and organising care is essential for patients, especially the elderly and patients with disabilities (Javed, 2017). Most patients may feel lonely and, indeed, need support. The survey statistics reported that 36.4% of the patients' families were involved in organising care at the SMC. The staff also believe that the families' involvement level needs to be increased for outpatient patients.

5.2.5 Clear Information, Communication and Support for Self-care

A patient has the right to receive information about their condition because self-efficiency is when a person believes that they can see success in accomplishing a certain task, especially in caring for their health (Paterick, 2017). This dimension has five different aspects. The main question was whether the staff and doctors explained the risks and benefits of the treatment so the patients could understand. Statistics revealed that 42.2% of the respondents agreed with the statement that doctors explained everything to them. In contrast, patients showed a little dissatisfaction on the part of the staff: 60.1% of the respondents stated that staff did not explain/guide them properly.

On the other hand, staff stated that they could not explain everything to every patient. However, they did explain to the patients who were seeking guidance or when there was a high risk of any side effects.

5.2.6 Involvement in Decisions and Respect for Preferences

The patients' involvement was positively answered, enhancing the treatment outcome. Most of the literature emphasises that greater patient involvement will reflect better outcomes and provide better patient experiences and satisfaction (Cox & et, 2007). Seventy percent of the respondents were involved to some extent in the decision, whereas 24.1% indicated that they were not. This was followed by a majority of 81% who reflected that the appointment helped them to feel better and they were able to manage their condition.

Staff stated that most of the patients have the right to accept or refuse the treatment. Some patients do not ask or give their decision immediately. They prefer to consult with a friend or someone else to understand their condition, and then they can decide.

5.2.7 Emotional Support, Empathy and Respect

The patients answered seven questions related to this dimension; the most important question was if a patient had enough time to discuss their problem with the doctor: 79.4% of the respondents said yes, they had enough time to discuss their health issues with the doctors. In contrast, only 20.6% answered no. Naturally, a doctor should provide enough time for a patient, to listen to all their worries and complaints. Physicians are always too busy, especially in the overloaded clinics of SMC, to provide emotional support and full attention to patients and deliver care (Dugdale, 1999). A study by the NHRA (2021) concluded that emotional support, attention and respect for patients were important elements during treatment. The patients also acknowledged other elements like dignity, respect and privacy. But two striking results need to be mentioned: that 63% of respondents indicated that very few or none of the staff introduced themselves, and more than 54.4% felt that staff talk in front of patients as if they were not there.

It is an important ethical issue that needs to be addressed because familiarising staff and introducing their specialities will reduce patients' anxiety and fear of treatment. This will ease the acceptance of and increase trust and confidence in healthcare services (Gordon, 2016). It is a positive step towards ensuring that a good patient experience is an integral part of patient care.

Staff were not sure how to explain why doctors and nurse were not introducing themselves to patients and the reason why it occurred. But they explained that yes, it might happen, and not all staff nurses or doctors were practising like this. This might be corrected by issuing a circular, reminding them to introduce themselves to the patients, as it is one of the patients' rights. As for talking in front of a patient, they justified it by stating that it might sometimes happen in the case of an emergency, but, generally, staff do not discuss issues in front of patients. The Universal Statement of Human Rights (USHR) also advocates respect, dignity and equality should be recognised, and it is healthcare providers' responsibility to meet the recipients' needs (WHO, 2021).

5.2.8 Attention to Physical and Environmental Needs

In general, the environment and physical needs imply all aspects of pain management, assistance with activities and daily living needs, and hospital surroundings and environment,

as the Picker Institute states. The outpatients were questioned about the general environment and cleanness of the SMC facility; 50.3% answered that, to some extent, it was clean. But some patients added remarks at the end of the survey that the administration should pay more attention to make facilities more hygienic in some clinics.

Staff implied that some departments need to be renovated and all the utilities and equipment replaced. Strict rules and protocols need to be implemented to improve hygiene and cleanness.

The descriptive analysis summarised the collected data, followed by the inferential statistics, which indicated a strong relation between dimensions and was validated in the interviews with the staff and PRO head:

- 1- Fast access to reliable healthcare: The main concern was to ease scheduling appointments and availability of appointments when needed.
- 2- Emotional support, empathy and respect: provide emotional support and respect for patients' personal choices and status; staff, or other health workers should introduce themselves to the patient to reduce anxiety and create effective healthcare.
- 3- Clear information, communication and support for self-care: the patient needs to be informed about their health condition, most importantly how to facilitate autonomy, self-care and health promotion, especially in the current COVID-19 situation.

Those are the main three dimensions highlighted by patients and staff regarding accessibility to healthcare in an outpatient clinic in SMC.

5.3 Exploring Patients' Complaints and Experience

This section aims to answer the first sub-research question: What are the main patient complaints about healthcare accessibility in SMC outpatient clinics?

In addition, it aims to achieve two objectives: to explore patients' complaints and experience with accessibility to healthcare according to the Patient Relations Office in SMC. and assess the overall accessibility level to healthcare in SMC as per patient experience.

In reviewing the data provided in Figure 5.1, the two major complaints were delay in appointment date and the pharmacy and medication issues. As a result of better healthcare facilities and advanced medical technology, high life expectancy and increasing population offer a possible explanation, as a high life expectancy and increasing population are associated with more healthcare issues and medical treatment requirements.

Therefore, as the office indicated, there is a need to address appointment and medication access to meet the increasing demand. One of the suggestions was redesigning the rescheduling system and adding new categories like walk-in patients, who doctors see without an appointment. As the recent pandemic has influenced the telehealth process, a virtual appointment should improve patient access and reduce the worries and concerns of patients regarding the appointment and medication issues. Effective use of the new alternative will promote healthcare in the long term.

As for the miscommunication issue, a well-structured awareness of communication skills needs to be promoted to avoid any misunderstanding, especially regarding doctors' rights and responsibilities and patients' rights.

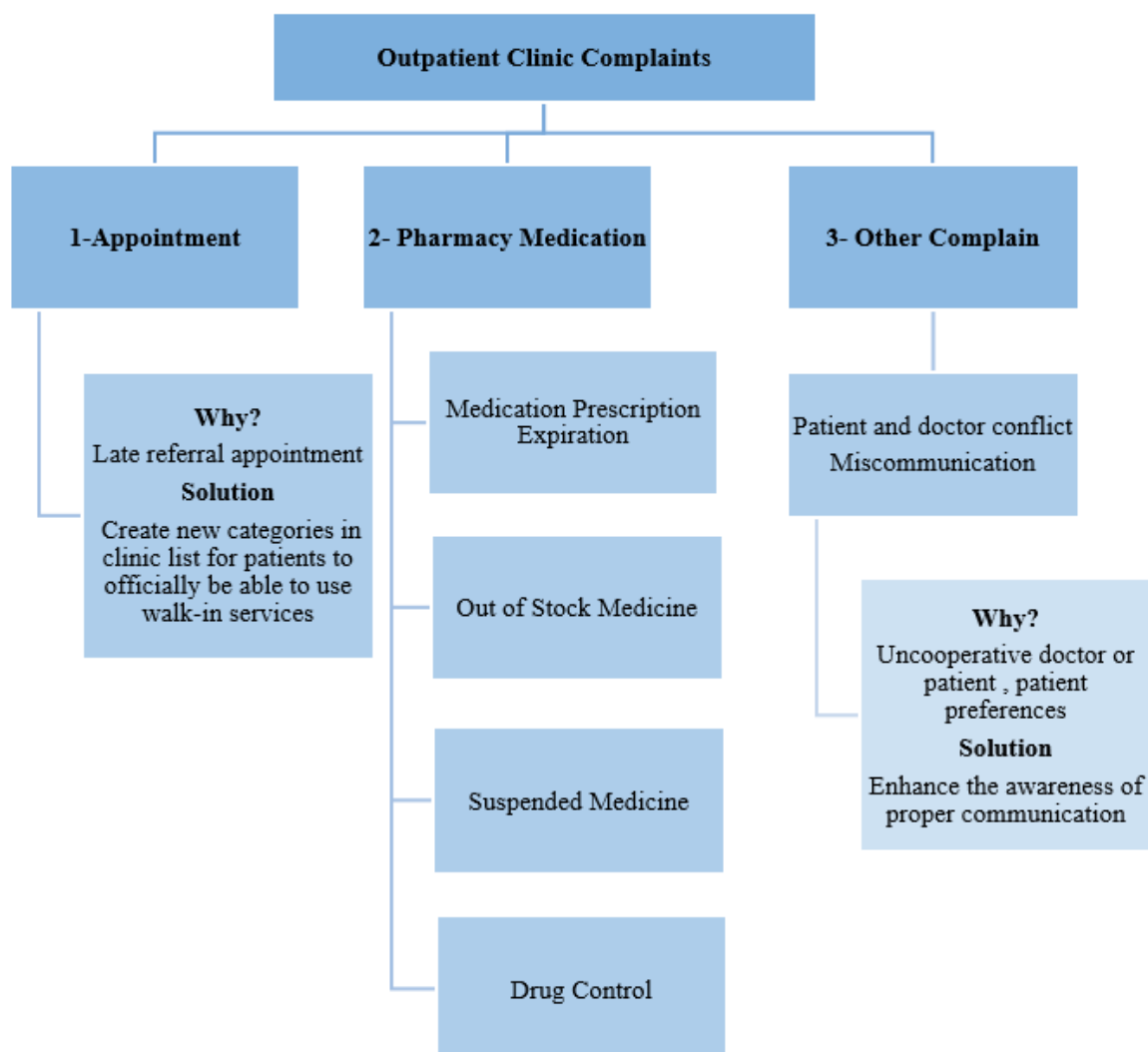


Figure 5.1 Patient Relations Office Feedback

In order to enhance the understanding of patient complaints and experience, the Patient Relations Office should improve its performance and evaluation process. Bendall-Lyon (2001) presented a complaint management process that SMC may adopt, as presented in Figure 5.2. SMC needs to become more customer-oriented by elevating patients' experiences and autonomy, and increase the transparency and build more effective communication channels, which will enhance the level of trust in SMC services and experience.

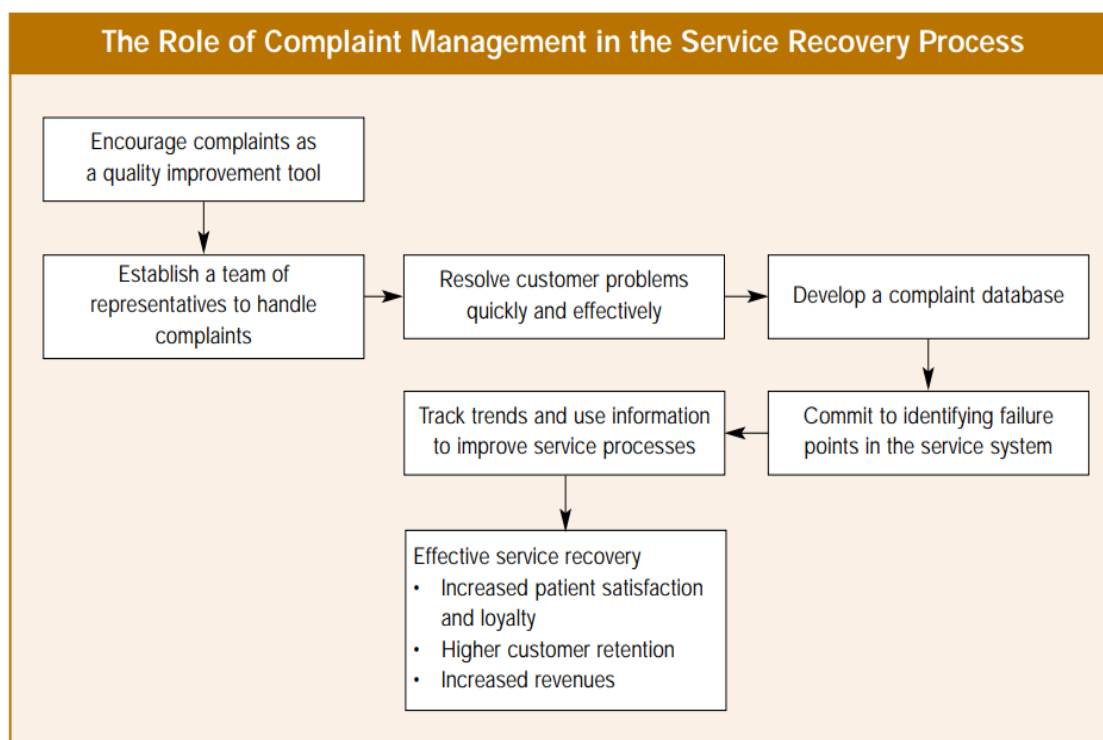


Figure 5.2 The Role of Complaint Management in the Service Recovery Process¹³

In comparison with other research findings, an interesting systematic study prepared by (Reader, 2014) about patient complaints in healthcare systems indicated that 113,551 issues were analysed using 205 different analytical codes, which presented 29 sub-categories of complaint issue. The finding was that the most common issues were 'treatment' (15.6%) and 'communication' (13.7%). The findings of the current study indicated that the following were the main complaints received by the Patient Relationship Office and from patients' remarks that were summarised from the office data and open-ended question in the questionnaire:

- 1- Late appointments and long waiting to see doctors in the clinics.

¹³ Source: Bendall-Lyon (2001)

- 2- Availability of medication, especially for chronic cases.
- 3- Some staff members and doctors did not provide clear and accurate information about the patient's treatment and prognosis.
- 4- Concerns regarding their health issues, especially in the pandemic situation.
- 5- Doctors did not fully explain the medication's side effects.
- 6- Ensure doctors and nurses introduce themselves to the patient when starting the treatment.
- 7- The patients requested a way to communicate with the clinic via a hotline to reduce the appointment system and waiting process.
- 8- Give more attention to the SMC infrastructure maintenance, cleaning and overall environment.
- 9- Communication barriers mainly occurred because of non-Arabic speaking staff.

In a nutshell, the Picker Adult Outpatient Tool presented a detailed patient experience pathway in SMC clinics. Past studies emphasised evaluating “the sum of all interactions, shaped by an organisation’s culture, influences patient perceptions across the care continuum” (Ilevala, 2014 p.4). Thus, question number 24 indicated the overall patient evaluation for the care received by the outpatient department. From the results, one may infer that the level of healthcare accessibility at SMC is very good (see Figure 5.3).

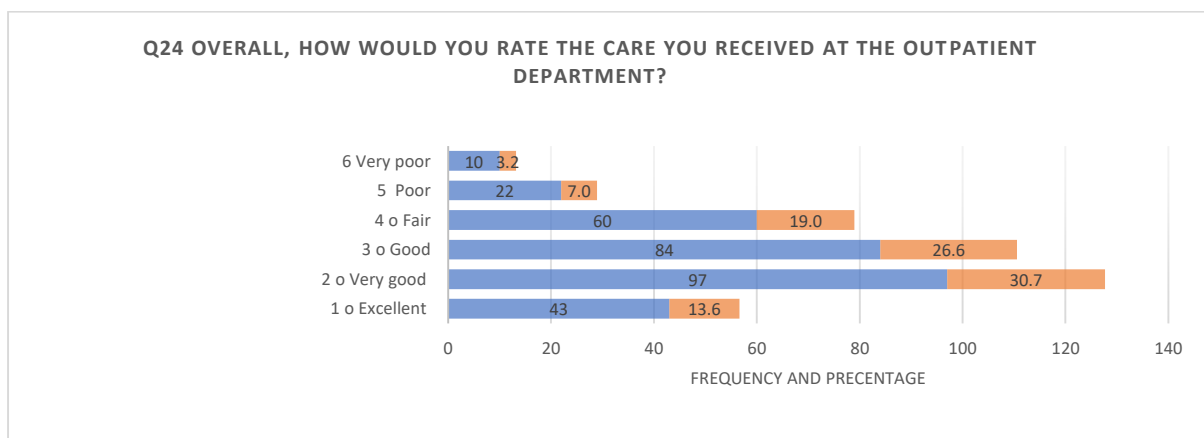


Figure 5.3 Findings from Q.24: Overall, How Would You Rate the Care You Received at the Outpatient Department?

5.4 Assessing Staff Experience

The following section will answer the second sub-research question: How do staff members view accessibility to healthcare in SMC outpatient clinics?

It achieves the fourth objective: To assess staff members' experience with accessibility to healthcare in outpatient clinics in SMC.

The research showed that improving patients' experience is positively associated with staff's experience. Literature reported that motivated staff would provide better care, leading to better patient experiences (Locock , 2020). The staff's main concern was appreciation by the top management. They emphasised that, if management takes their comments seriously, they may be more motivated, and it will be reflected in their performance and positive patient experiences.

Their reflection on the patients' experience highlights very important aspects that need to be considered. Staff agreed and had the same perspective on the same major dimensions that need to be enhanced as the descriptive analysis indicated. They had some remarks regarding the dimensions in general.

For the first dimension about access to healthcare, the staff reported that patients do not stick to their appointment timing, and some doctors take a long time with each patient. Doctors also sometimes start the clinic late due to overload. According to the group nurses, an automated calling system may help to improve the waiting system, appointment issues and registration. They need to address patient concerns regarding the time given by the doctor and explain that long waiting times are because of workload, as many nurses and doctors at SMC avail themselves of the government's early retirement scheme, thereby creating a gap in the workforce to be filled.

Communication and clear information are part of the treatment session of a patient, as most staff emphasised. But they have recommended that there be regular training and awareness workshops by the quality assurance department to enhance staff's skills.

As for the environment and physical attention, there are some special areas for a patient with mobility problems, but more consideration should be taken, especially with regard to toilet doors/entrances.

Confidence in doctor and treatment is present, as group B indicated. The lack of clear information might be an issue to consider improving the I-Seha information system.

Culture is an essential element in a patient's life; family and friends play a vital role in a patient's decisions, and they are always part of a patient's treatment.

The staff's overall impression regarding accessibility was good, regardless of the obstacles that lead to some misconceptions or discomfort for patients.

These findings contribute to our understanding of staff experience and engagement and provide a basis for more staff engagement in the process of change at SMC at all levels, especially in promoting and enhancing patient centre care, which is the core element of any healthcare facility.

5.5 Differences between Patient and Staff Experience in Accessibility to Healthcare

The following discussion answers the fourth sub-research question: What are the key differences between patient and staff experience of healthcare accessibility at SMC outpatient clinics as per Picker Principles.

According to their experience and observation, the findings reported here shed new light on how staff explain the levels and accessibility to healthcare at SMC. They were the key experts in explaining and providing insightful information on accessibility to healthcare services at SMC.

To summarise the outcomes and the key differences in the two samples (patients & staff), Figure 5.4 illustrates the key agreement points that need to be changed or improved by evaluating patient experiences during their treatment pathway.

Both sample groups agreed on four key dimensions that need to be mitigated to enhance patient satisfaction, trust, confidence and accessibility to healthcare. However, both groups indicated that patient and family involvement in treatment is one of the essential elements influenced by culture, although family and friends' involvement to some extent affects a patient's treatment plan and prognosis, as the majority of staff indicated in the interview. Therefore, this factor needs to be highly addressed and promoted via awareness workshops and campaigns. Reducing the workload for doctors and nurses was another key point that staff pointed out to enhance efficiency and effectiveness. The staff's contribution was different so that they presented the patient experience as a holistic view and reasoning, which provided in-depth knowledge on how to understand the patient experience and how to manage the improvement. For example, introducing a new waiting system in the waiting area will promote patient autonomy, especially in self-care and healthcare workshops in SMC departments. Figure 5.4 shows the common aspects and the differences of accessibility dimensions between staff and patient experience.

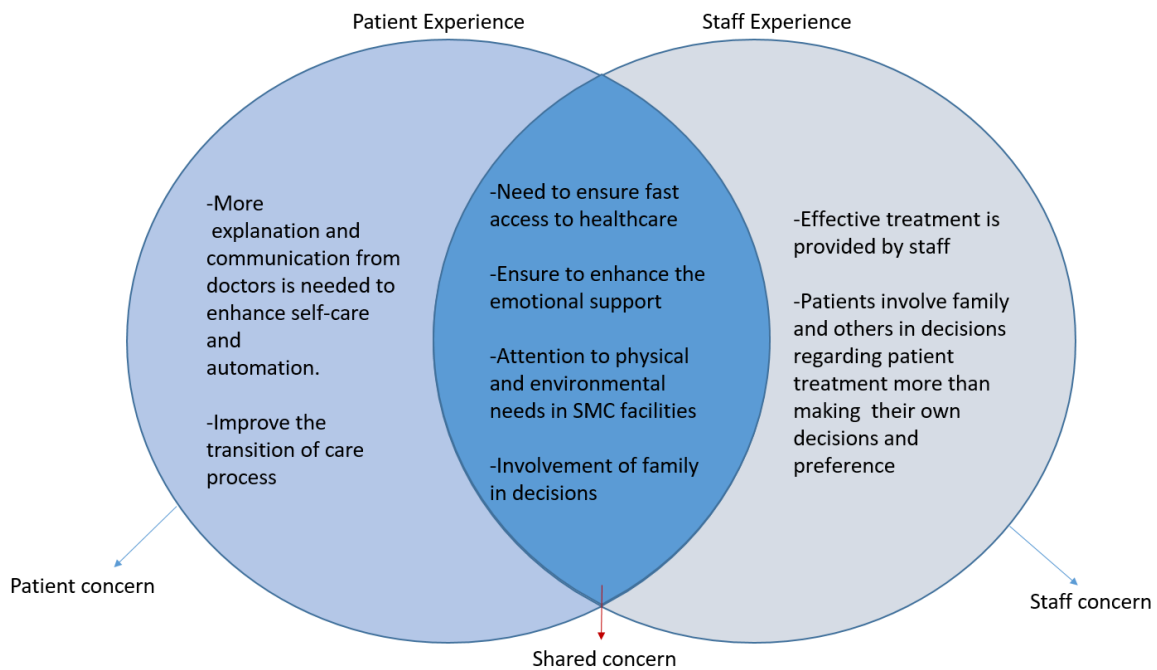


Figure 5.4 Differences between Patient and Staff Experience in Accessibility to Healthcare

5.6 Current Coexisting Studies

In this section, the author has tried to link the findings of this study with past studies that adopted the same Picker questionnaire as adopted in this study. The Picker Institute indicated that the same questionnaire is currently adopted in the Netherlands, and the outcomes are not finalised (Piker Institue Europe, 2021). Although the comparison is not applicable due to sample variations and the number of healthcare providers involved, it provides insights into how patient experience varies in different countries from a general perspective. In addition, the study is the first of its kind to establish a national survey regarding patient experiences, especially in the new era of transformation and change management in government healthcare entities.

In general, the results of previous studies regarding the Picker Outpatient Tool indicated that the waiting time for appointments was patients' main issue: 37% waited up to six weeks for their most recent outpatient appointment, with 22% waiting between six weeks and three months, and 9% having to wait more than three months. And overall the rate of care varied between very good, excellent and good (Tallett, 2015).

It is important to mention that similar questions were used in the SMC Bahrain version (SMC- BH) used in the Netherlands and the UK to validate and enrich the best practices. The researcher also included two questions from the Netherlands version that were not included in

the UK version. It can be used as an additional resource for future benefit to understand Bahrain's data.

5.7 Practical Implication of the Study

The impact of the research was the first thing that drove the researcher to challenge herself, as she was very keen to find enriching tools to meet the study's objectives, challenges and concerns.

Authors like Barber have argued in his book that "if you want evidence-based or evidence-informed policy, there is no alternative but to collect good data" (Barber, 2015). Data collection is essential; it strengthens the delivery chain and provides accurate and reliable results. This explains the need to evaluate and assess the accessibility to healthcare in terms of patient-centred care based on two aspects of how the service is delivered and how the care was performed. The core of providing healthcare to a patient is the time given and the information about treatment.

One of the most reliable data collection strategies to understand and judge the implantation process was interviewing at different levels. Due to the current pandemic situation and social and physical distance that needs to be considered, it was a challenge to conduct direct interviews with the patients to express their experiences and needs. Therefore, the most suitable alternative was a web-based survey, which was utilised to collect data from patients.

Another important aspect highlighted by Nutt (2008) in his article entitled 'Investigating the success of decision-making processes' was that the success for any process of decision-making must be documented by constructing an action theory. He further added that, throughout the decision-making analysis, the discoveries along the documentation are more essential than the planned ideas and process (Nutt, 2008). For example, the finding and the results of the data analysis revealed an amount of information and discoveries that enhanced the outcome and the impact of the research and the objective that was intended.

The evidence presented here based on the data analysis provides valuable inputs for SMC and the health ministry in general. It provides a lot of explanation and a comprehension overview of very important aspects of healthcare provided to a patient. The results are in line with the findings of the literature review. Reporting key concerns and challenges from a patient's perspective and validating the concerns/issues raised earlier with staff may significantly enhance the reliability of the study's findings.

The detailed survey questions regarding the factors of accessibility that assess a patient's experience are expected to be useful for monitoring the efficiency and the effectiveness of healthcare services provided at SMC. The data here indicate what areas or actions need to be changed or improved. This will help the administration and decision-makers pinpoint the issues to consider. For example, whether something is an obstacle that needs to be eliminated or a process needs to be improved by utilising descriptive statistics and inferential statistics to conclude and predict the outcomes from the data.

5.8 Managerial Recommendations

The findings of this study have several important managerial implications. One of the strategic goals for SMC outpatient clinics should be to improve patient and staff experiences.

A recommended managerial project was adopted to enhance patient and staff experiences of accessibility based on descriptive analysis and prospective staff analysis results. But, on the other hand, SMC clinics revealed that the project fails to resolve some of the fundamental issues which might significantly impact a patient's experience. Strong management support coupled with stakeholder involvement & coordination (patients, staff, doctors, administrative & media) is required to address these issues. Moreover, overcoming staff shortages, implementing performance incentives, offering training programmes, and sharing knowledge may help to boost employee motivation and to reduce workload, which eventually results in better patient care (Ciasullo, 2017). Lastly, a strong electronic system needs to be implemented to achieve higher efficiency of the new process of change management.

A brief SWOT analysis of SMC outpatient clinics, as presented in Figure 5.5, is conducted to focus on the areas that may promote or hinder the managerial application to increase the level of accessibility to healthcare at SMC.

Strength Resources • Experienced medical staff • Overloaded with patient appointments • I-Seha system • The ability of the medical staff to continue under pressure at work • Training Centre	Weakness Need Improvement • Shortage of professional staff • Lack of incentives and rewarding system • Ineffective appointment system • Unclear information and instruction • Unable to promote patient self-autonomy efficiently
Opportunities Chances • Creative innovative ideas and processes • Electronic application • Enhance the level of patient and staff awareness • Utilise the internal professional expert in training workshops	Threats Challenges • Demographic changes • Increase the prevalence of communicable and non-communicable diseases • Elevate the level of patient and staff experience in healthcare accessibility • Increase number of complaints • Competition with other private healthcare facilities • Attracting professional medical staff to join other facilities

Figure 5.5 Salmaniya Medical Complex Outpatient Clinics SWOT Analysis

Traditional public administration is the standard model in most public servant entities in the Kingdom of Bahrain, where bureaucracy is common. As SMC is also a public entity, it may also have significant entry, exit and other management procedures.

Accordingly, the governance process conducive to achieving higher efficiency of accessibility to healthcare at SMC ensured an efficient service delivery and promoted good patient and staff experience. More consideration should be given to integration. Planning is highly needed for a typical process and successive tasks where all services are linked together and affected by any mismanagement at any stage of application. Therefore, accountability is essential in all stages of service delivery to overcome malfunctioning (Benghozi, 2020).

Figure 5.6 simplifies each stage needed to implement the managerial model that the researcher adopted. Communication with stakeholders and documentation were the most important element that needed to be considered throughout all stages to enhance accountability and reference purposes. Figure 5.6 illustrates the governance process.

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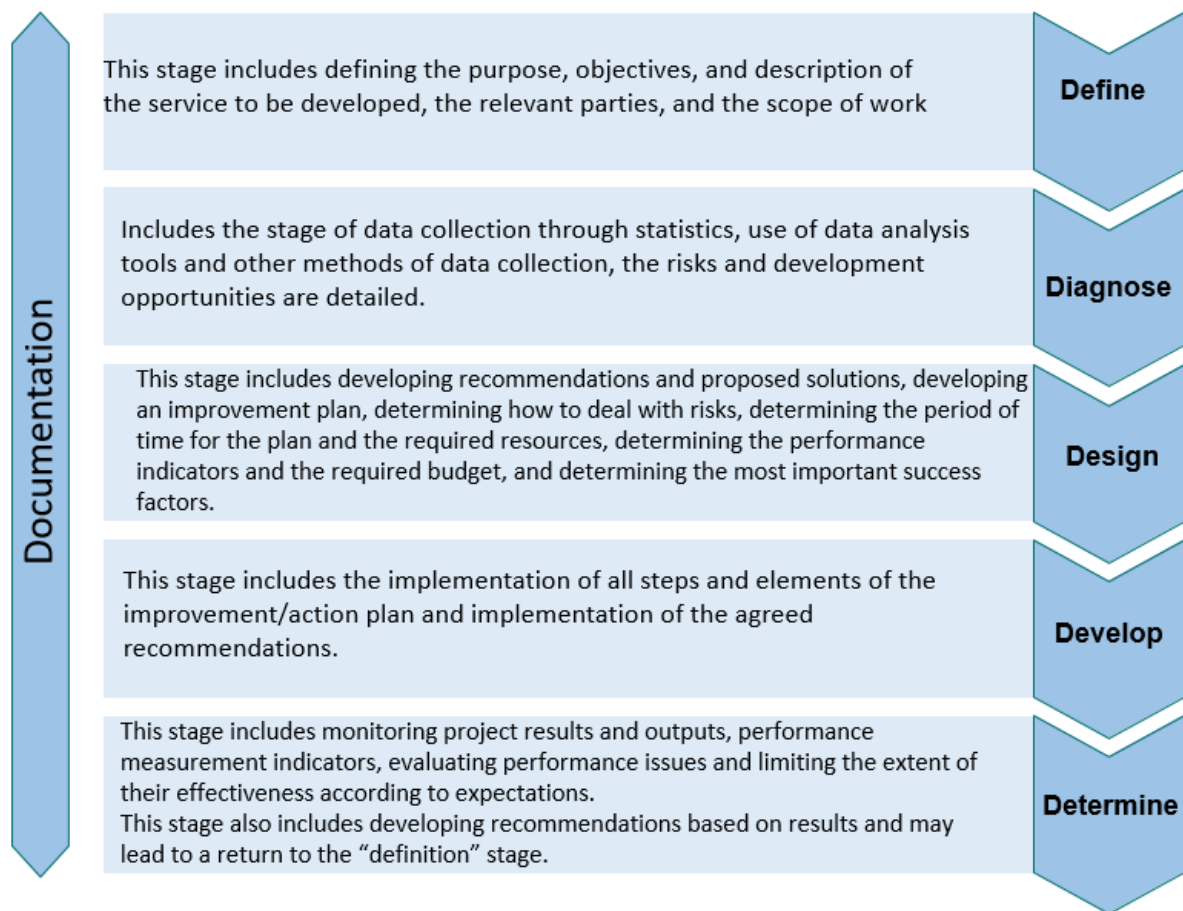


Figure 5.6 Governance and Redesigning Process

5.8.1 Recommending Process

The research results suggest very broad managerial changes that need to be implemented to enhance the effectiveness of the eight dimensions to achieve a balance between the major needs and the most feasible and applicable contribution in developing accessibility to healthcare and promotes the patient experience. A holistic view of the input and outcome with the recommended project is illustrated in Figure 5.7 below.

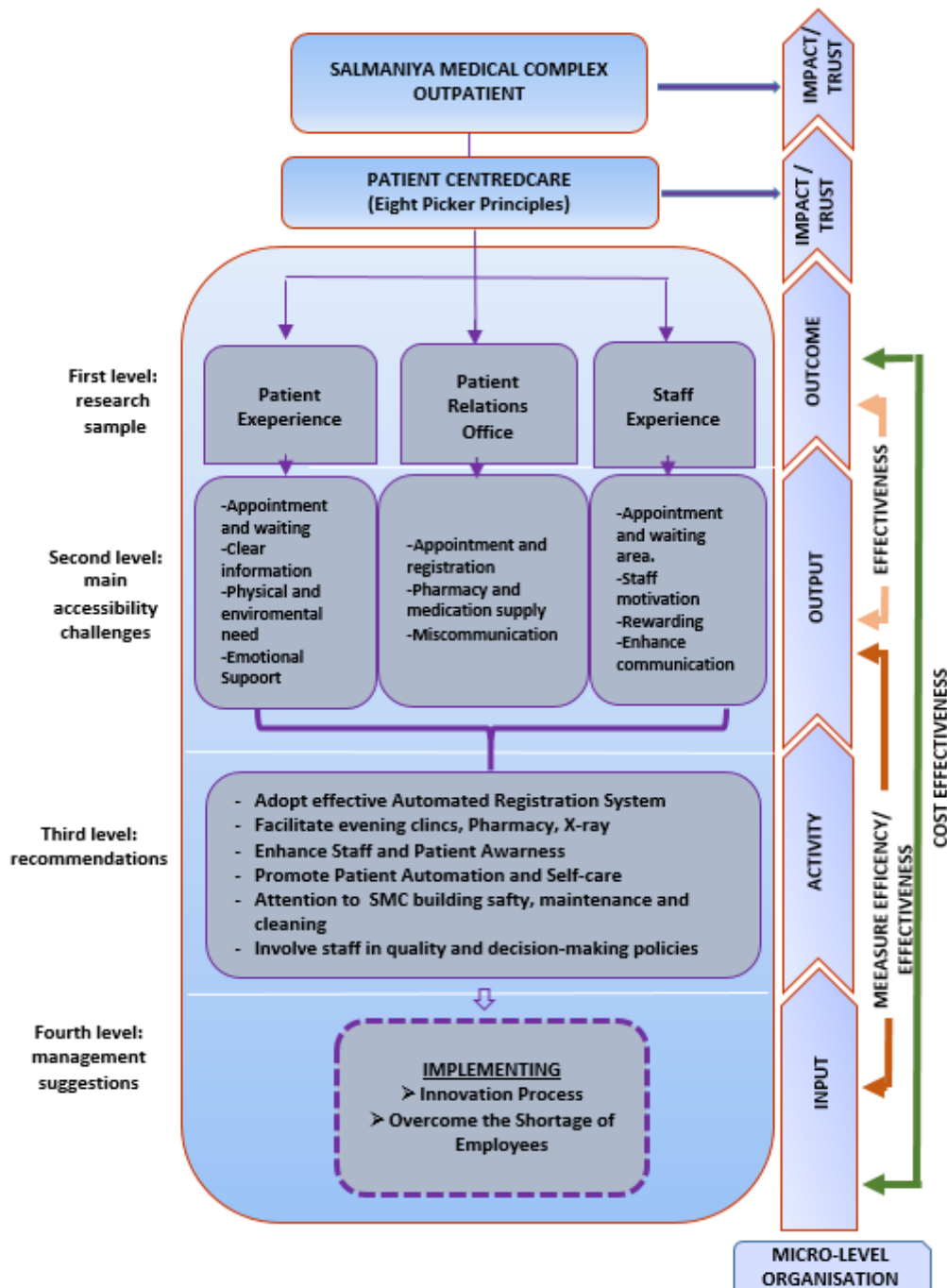


Figure 5.7 The Recommended Process Outline

The process outline levels are divided into four main aspects, based on the research results and interpretation.

First level: the sample population, which resembles the main stakeholders of the project and the beneficiaries

Second level: the main concerns regarding accessibility to the healthcare according to patients' experience in each sample are in five key dimensions: Fast access to reliable healthcare advice,

Clear information, communication, and support for self-care, Attention to physical and environmental needs, Emotional support, empathy, and respect, Involvement in decisions and respect for preferences.

Third level: recommendations and suggestions adopted from the research outcomes.

Fourth level: the managerial suggestions to SMC administration to develop and promote accessibility to healthcare.

An integrated system needs to be implemented to link all the systems and help allocate the resources to enhance performance management. SMC administration and the clinic's top management should focus on productivity, efficiency and effectiveness. As Bouckaert and Halligan (2006) emphasise, an organisation can turn its resources into outputs and outcomes termed as 'the span of performance' or the analytical framework of performance in the public sector. Not to mention that applying the performance model to the project will enhance the performance of SMC as the NPM reform is focused on performance analysis at the organisational level, which is considered to be the micro level (Vincenzo, 2018). As the outcome and the impact of the process occur, a high level of accessibility to healthcare for patient and staff experience will enrich the trust in SMC in general.

There are lots of innovative processes that can be formalised and presented. Still, according to the emergent need and the feasibility of the project, the most suitable and visionary recommendations are:

- 1) To implement an Innovative Patient Self-care Automated Process
- 2) To overcome the Shortage of Employees in outpatient clinics in SMC.

These two innovative suggestions are described briefly to understand the impact of the project on the results and the research outcome.

5.8.1.1 Innovative Patient Self-care Automated Process

The innovative process in the outpatient clinics at SMC aims to achieve higher efficiency and less costly services through a patient self-care automation system. This will take place by adopting new regulations and designing a new atmosphere or ecosystem of the department stakeholders. Additionally, the processes were developed and planned within the rationalisation of SMC resources. The table below presents the innovative process and the outcome:

Table 5.1 Innovative Patient Self-care Automated Process and Outcomes

Innovative process	Outcomes /Results
Improve registration system by moving towards online registration.	To select suitable appointment time and the doctor. To reduce waiting time for appointment. To avoid errors in the recorded patient data.
Establish a new waiting list management system that includes screens ,the times and waiting times are shown for each clinic room.	To expect the waiting time in any department or facility.
Develop a media plan to raise awareness and educate patients on how to use the online facilities more efficiently and obtain the information needed.	To reduce the number of patients coming to the SMC outpatient clinics.
Launch of a smartphone application that will guide patients to buildings, departments and facilities. And provide all the instructions, policies, contact information, appointment registration, test results, etc.	Clear information and easy access to contact numbers. Trusted source and accuracy of information.

5.8.1.2 Overcoming the Shortage of Employees

The objective is to overcome the shortage of qualified professional staff because of the voluntary retirement scheme. Moreover, it will overcome the complaints about the increase in workload and shortage of staff. But in responding to the complaints the SMC administration must give great consideration to feasibility and effectiveness when applying the recommendations (Addicott, Maguire, Honeyman , & Jabbal, 2015). The proposal suggests that SMC offers an action plan to overcome the problems and is illustrated in Figure 5.8:

- 1- Reliance on a temporary workforce: part-time contract.
- 2- Retention: preservation of existing staff allows for greater continuity of care.
- 3- Collaborative work: develop shared roles, a more flexible range of transferable skills, and flexible changes in a different care setting. This can be enhanced and successful through training schemes. Figure 5.8 outlines the proposal to overcome the workforce shortage.

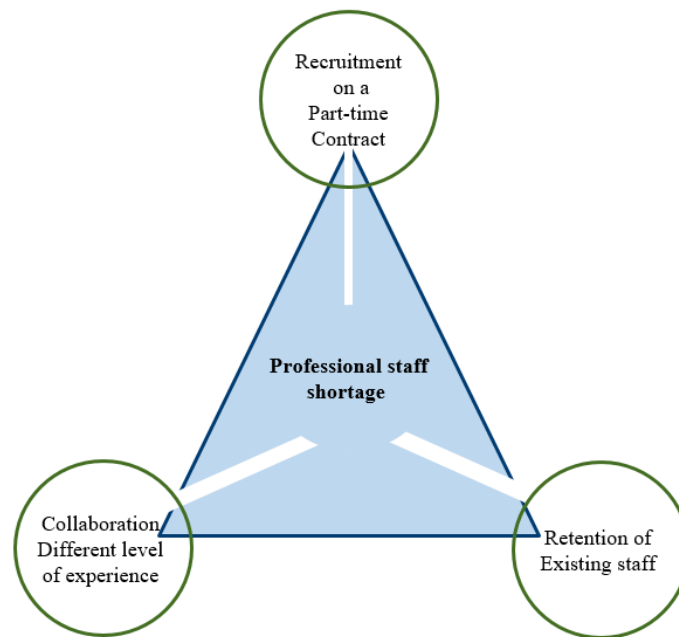


Figure 5.8 Overcome the Shortage of Employees

5.9 Limitations and Future Studies

The major limitation of this study is that the data were collected during COVID-19, which led to a web-based survey that affected the sample size. The survey respondents were almost 2-3% of the population group, collected during one month. This suggests that future research is required to prepare an online survey to be completed during a patient's visit to the hospital to ensure their participation.

The second limitation is the research focused on the conceptual model of the survey, not on the demographic characteristics and other dimensions, which are conceded to be a rich source of data. Knowledge management should be applied to utilise the data in the most efficient and effective way in public management and decision-making.

The third limitation was that the Picker Adult Outpatient Tool did not include items related to the mobility challenges that the patients experience in the facility, the pharmacy and allied services. For future research, this aspect needs to be discretely used with the Picker Institute.

Despite its limitations, the study certainly adds to our understanding of the accessibility dimension that needs to be considered and promoted according to patient and staff experience. In addition, future research on inpatient experience and other healthcare professionals is required.

What is now needed is a cross-national study involving outpatient clinics of government sectors in primary and secondary care to promote a general perspective and comprehensive analysis, especially since the Bahrain health system moves towards autonomy and health insurance. In addition, it is necessary to benchmark the results with other countries' findings for future studies. The study advocates for more studies on clinical management precisely. To overcome the challenges and complaints regarding patient experience, a regular quality assurance and performance measurement should be applied continuously to promote the effectiveness and efficiency of service delivery.

Chapter Six: Conclusion

Bahrain's health system has made significant achievements and witnessed an enormous and comprehensive health renaissance, despite the insufficiency and lack of resources. Recently, the Supreme Council of Health (SCH) in the Kingdom of Bahrain targeted all the government health entities to move forward towards autonomy and health insurance schemes (BSDG, 2021). Therefore, it is important to evaluate the current accessibility to healthcare at various departments and wards at SMC and point out how healthcare delivery could be improved. Healthcare needs have increased because of the increasing population and higher life expectancy in Bahrain. Literature reported that several factors such as an appointment system, physical environment, empathy, respect, accurate information sharing, trust and confidence in doctors might help to enhance access to healthcare.

A mixed-method approach was applied in this research. The data for this study were collected from 316 patients utilising the Picker Adult Outpatient Survey to assess the accessibility to healthcare in outpatient clinics from the patients' perspective. Moreover, 10 semi-structured interviews were also conducted with staff members to gain their views and perspective. The mixed methodology approach helped the researcher present various stakeholders' experiences and offer a rationale on the extent of the eight Picker Principles of accessibility to the healthcare system at SMC clinics.

Descriptive statistics revealed that about 56.6% of the respondents were female. The participants' ages varied from 21 to 61 and above, the majority belonging to the ages between 31 and 50 years. Most of them were educated with to either high school or bachelor's level. Three hundred and fourteen were Bahraini nationals, out of which 300 were Arab speaking. In general, 59.2% of the sample had no long-standing illness; 28% indicated that they had chronic medical issues; and there were 39 cases of disabilities. Descriptive statistics further revealed that 39% waited for more than 12 months for an appointment, and only 18% were able to book appointments by one month but not more than six weeks. About 11% had to wait for less than 15 minutes, and 72.2% indicated that they were never told that they must wait that long to see the doctor while they were at the hospital. The majority of the respondents showed a moderate level of confidence and trust in doctors: 39.6% stated that they have complete faith and trust in doctors, while 46.5% showed comparatively little trust in doctors. In contrast, only 15.5% of respondents showed dissatisfaction and lack of trust in doctors. The survey statistics reported that 36.4% of the patients' families were involved in organising care at the SMC. Similarly, about 70% of the respondents were involved to some extent in the decisions regarding their

health, whereas 24.1% indicated that they were not. Statistics further revealed that 42.2% of the respondents agreed that doctors explained everything to them. In contrast, patients showed a little dissatisfaction on the part of the staff: 60.1% of the respondents stated that staff did not explain to/guide them properly. In addition, descriptive statistics also revealed that 79.4% of the respondents said yes, they had enough time to discuss their health issues with the doctors. In contrast, only 20.6% answered no.

Inferential analysis results strongly emphasised three key aspects: involvement in decisions and respect for preferences, effective treatment delivered by trusted professionals, clear information, communication and support for self-care. The Patient Relationship Office also highlighted the same concerns, i.e. delayed appointments and the miscommunication between patients and staff.

Staff, on the other hand, believe that more acknowledgement of their efforts would be motivating. Another shared concern is improving the waiting areas in both the clinics and the pharmacy. However, when it comes to patients' family involvement in decision-making, the patients want more of it while the staff recommend reducing it. The patients request a clearer explanation from doctors to enhance self-care and a smoother transition of continuity of care.

In general, studies show that the integration between patient and staff experiences will help to understand as much as possible the processes needed to design and enhance the delivery of the services. Based on the study's findings, a number of managerial recommendations were proposed; emphasis has been placed on redesigning processes to enjoy greater efficiency and effectiveness. To put the actual research in perspective with Public Management studies, it is useful to mention that Pollitt and Bouckaert described changes and reforms as "Deliberate attempts to change the structure, process and or cultures of public sector organisation to get them (in the same sense) to run better" Pollitt & Bouckaert (2017, p.2).

The research findings generated a productive data information and knowledge that allow the development of ideas to overcome many of the encountered issues. Therefore, according to the SMC's current situation and emergent needs, two practical managerial recommendations were highlighted 1) implement of Innovative Patient Self-care Automated Process, 2) Overcome the Shortage of Employees .in outpatient clinics in SMC. Innovative solutions will help raise the department's efficiency in two key aspects of healthcare: its delivery of services and its handling of patients' complaints.

Many staff members at SMC suggested potentially innovative ideas to improve the local healthcare system and patients' experience. In the case the SMC, the administration finds value in these innovative ideas and decides to take them into account, it must elaborate and spread a

new and, somehow, disruptive culture of innovation. The latter will put the SMC healthcare facility in the necessary conditions to work on increasing the standard of delivery of healthcare to patients.

Finally, it may be worth mentioning that the data findings will offer access to additional resources and possibly opportunities to formulate new research questions and present the practical usefulness of SMC's work. Furthermore, another opportunity is to expand the research scope in the future to benchmark and compare the findings with other countries. The study's key limitation is that the sample size is considered to be numerically limited to benchmark with other countries outcomes and apply abroad statistical analysis and provide a clear relationship between the variables. Yet, the data was managed and revealed very interesting findings which give ground to a broader spectrum of future studies.

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Abstract

Patient and staff experience is significantly crucial to assess the accessibility to healthcare in outpatient clinics in any health facility. However, the correlation between the two in Salmaniya Medical Complex (SMC) in Bahrain has not been measured by a proper tool. This study assesses the level of accessibility to healthcare in SMC according to patient and staff experience. The study adopts a mixed method. First, 316 patients' opinions are surveyed using an adopted web-based version of the Picker Adult Outpatient Tool. Second, a semi-structured interview is used with 10 staff members from outpatient clinics to probe their experience, in addition to one interview with an administrator. The results show that healthcare accessibility has a significant impact (eight Picker Principles) on staff and patient experiences at outpatient clinics in SMC. The most important concern to both the patients and staff is fast access to healthcare, particularly the appointment system and waiting time. A total of 42.1% of patients stressed the need for further emotional support and respect. At the same level, the staff believe that more acknowledgement of their efforts would be motivating. Another shared concern is improving the waiting areas in both the clinics and the pharmacy. However, when it comes to patients' family involvement in decision-making, the patients want more of it while the staff recommend reducing it. The patients request clearer explanation from doctors to enhance self-care, and also continuity of care and smooth transition of medical cares. The research recommends introducing innovative applications to enhance patient autonomy and overcome the shortage of staff and provide tailored training courses that address the issues.

Keywords

Accessibility, patient experience, outpatient clinics, administrative autonomy, patient autonomy, Picker Adult Outpatient Tool, mixed methods

Abstract (French)

Résumé

L'expérience des patients et du personnel est cruciale pour évaluer l'accessibilité des soins de santé dans les cliniques ambulatoires de tout établissement de santé.

Cependant, la corrélation entre les deux dans le complexe médical de Salmaniyah (SMC) à Bahreïn n'a pas été, à ce jour, mesurée par un outil approprié.

Cette étude a pour but d'évaluer le niveau d'accessibilité des soins de santé du SMC en fonction de l'expérience des patients et du personnel.

L'étude adopte une méthode mixte. Premièrement, les avis de 316 patients sont étudiés à l'aide d'une version adaptée de l'outil Picker Adult Outpatient Tool. Deuxièmement, un entretien semi-structuré est utilisé avec 10 membres du personnel des cliniques externes pour sonder leur expérience, en plus d'un entretien avec un administrateur.

A la lumière de l'analyse des résultats de l'étude, il apparaît qu'il existe un impact significatif de l'accessibilité des soins de santé (les 8 principes de Picker) sur l'expérience du personnel et des patients dans les cliniques ambulatoires du SMC.

La préoccupation la plus importante pour les patients comme pour le personnel hospitalier est l'accès rapide aux soins de santé, en particulier le système d'accueil en général et la prise de rendez-vous et le temps d'attente en particulier. Au total, 42,1% des patients ont souligné le besoin d'un meilleur soutien émotionnel et d'un comportement plus respectueux des personnels hospitaliers. Parallèlement, le personnel pense qu'une plus grande reconnaissance de leurs efforts de la part des patients serait motivante.

Une autre préoccupation partagée est l'amélioration des zones d'attente tant dans les cliniques que dans la pharmacie. Dans un registre plus large et inclusif, celui de l'implication de la famille des patients dans la prise de décision, les patients en veulent plus tandis que le personnel recommande de la réduire. Les patients demandent des explications plus claires aux médecins pour améliorer les soins personnels et également une transition plus douce de la continuité des soins entre les différents services.

En conséquence, l'étude recommande d'introduire des applications innovantes pour améliorer l'automatisation de la gestion des patients et surmonter la pénurie de personnel et de proposer des cours de formation sur mesure aux personnels qui abordent les problèmes que l'étude a pu faire ressortir.

Mots clés

Accessibilité, expérience du patient, cliniques externes, autonomie administrative, autonomie du patient, outil de sélection ambulatoire adulte, méthodes mixtes