Reviewer’s report

Title: Evaluating patient experiences in decentralised acute care using the Picker Patient Experience Questionnaire; methodological and clinical findings

Version: 0 Date: 20 Jun 2017

Reviewer: Andrew Garratt

Reviewer's report:

1. Translation and testing of the PPE-15 should be made clear in the abstract.

2. Background, first sentence. Patient experiences often include evaluations of structure and even outcomes.

3. The authors include several references to the Norwegian questionnaires developed by the Norwegian Knowledge Centre for the Health Services. These questionnaires have been developed and tested for measurement properties in Norwegian patients. Why did they choose to use a questionnaire that was not developed in Norway, had not been translated and validated with Norwegian patients? Was there not an appropriate questionnaire available that had been developed with input from and testing with Norwegian patients?

4. Data collection. I am not familiar with the Brislin reference from 1970. International standards now exist for the translation of patient-reported questionnaires (Wild, Value in Health 2009; COSMIN checklist; CAHPS have their own guidelines). How many translators were involved each way, did they work independently, how was disagreement dealt with (for example, was there a meeting)?

5. EQ-5D. Most Norwegian EQ-5D-3L studies use the UK Measurement and Valuation of Health value set (Dolan, Medical Care, 1997) with EQ-5D scores that range from -0.59 to 1. This value set is based on the time trade-off which is the most widely used and accepted method for the EQ-5D. Reference 24 for the "Europe VAS value set" does not include the development of the value set but rather a clinical study relating to construct validity. King et al (ref 24) also assessed Cronbach's alpha which is inappropriate for a preference weighted instrument such as the EQ-5D. King et al also state that the scores range from 0 to 1 which is not correct. What about states worse than dead? Justification for the choice of weightings is needed in a single sentence together with an appropriate reference.

6. Patient ratings of experiences are affected by data collection methods including where the data are collected. Better ratings of experiences have been found when questionnaires are administered where care is received. The patients completed questionnaires at home but where were they returned to - the hospital? What are the potential implications of this? This point might be taken up in the discussion.
7. Was it the study nurses who telephoned the patients? Please state.

8. How were patients selected for inclusion in the study? The results state that 1235 patients out of 2182 admitted patients received a questionnaire. Were the included patients representative of the 2182 patients? There was considerable variation in the proportions receiving questionnaires across the five MAWS and yet in the methods it is stated that a "standardised inclusion procedure" was used. The different proportions receiving a questionnaire at each of the MAWS more than suggests that this was not the case across the MAWS. This issue may relate to inclusion or recruitment but either way it makes comparisons of the five MAWS highly problematic.

9. 68 patients responded to the retest questionnaire but how many were selected to randomly receive a questionnaire? Were reminders used?

10. What were the data collection procedures for the test-retest questionnaire? Approximately 3 weeks but what was the SD and range in days. Did the authors include a question to assess whether patients had received further health care in the period between test and retest, which might have influenced their responses to the second questionnaire?

11. Methods, statistical analysis. Please be more precise about the nature of testing for face validity (see COSMIN checklist) which should come before the Statistical methods. Content validity is a qualitative judgement about the degree to which an instrument adequately reflects the construct being measured. This is a widely accepted definition (See COSMIN checklist).

12. Did the authors consider assessing structural validity by means of factor analysis or better still, confirmatory factor analysis? The PPE-15 has a unidimensional structure based on earlier work and hence it is important that this is demonstrated in Norwegian patients. After content validity, this is arguably the most important measurement property because it underpins dimensionality and hence scoring procedures and further testing including Cronbach's alpha. The level of Cronbach's alpha is related to the number of items in a scale and hence for a lengthy scale such as the PPE-15, a high level of alpha is expected. This highlights the importance of testing for structural validity, the results of which show whether it is appropriate to sum the 15 items.

13. The test-retest reliability of individual questions should also be considered by means of kappa/weighted kappa as appropriate.

14. Table 1. EQ-5D/CCI - give the score ranges and meaning of lowest and highest scores as footnotes.

15. Table 2. A short summary of item content alongside the item number is recommended rather than the footnote. Eg NORPEQ "1 Understanding doctors".
Minor comments

16. Abstract "scarce".


18. Abstract. Replace "negatively influenced" with "negatively associated" which is more appropriate given the limitations of the study design.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Unable to assess

Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

No

Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review?
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I am able to assess the statistics

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