



Using The GP Patient Survey To Improve Patient Care:

A Guide For General Practices

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ABOUT THE AUTHORS



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Using The GP Patient Survey To Improve Patient Care:

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GLOSSARY

DES Directly enhanced service

GPAQ General Practice Assessment Questionnaire

GPPS GP Patient Survey

IPQ Improving Practice Questionnaire

QOF Quality and Outcomes Framework

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CHAPTER 1

INTRODUCTION & BACKGROUND

- 1.1 INTRODUCTION: THE NEW SURVEY AND QOF.**
- 1.2 WHY HAS A NEW SURVEY BEEN INTRODUCED INTO QOF?**
- 1.3 HOW THE GPPS WAS DEVELOPED.**
- 1.4 AREAS THAT ARE COVERED IN THE GPPS.**
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1.1 Introduction: the new survey and QOF.

The GP Patient Survey (GPPS) is being commissioned by the Department of Health and run by Ipsos MORI to assess patients' experiences of their local NHS services. The latest annual survey was sent to approximately 5,500,000 registered adult patients in January 2009, with results published in June 2009.

The Quality and Outcomes Framework (QOF) rewards practices on the basis of the responses of patients to two questions on access in GPPS.

When QOF was introduced in 2004, it contained incentives to ask patients their views using two approved questionnaires (GPAQ and IPQ) and allocated quality points relating specifically to access. Then in 2007, the Department of Health in England introduced a Directly Enhanced Service (DES) to reward practices which provided good access for patients, using a survey sent to random samples of patients registered with general practices. The access questions in the new GP Patient Survey are similar to those used in the DES questionnaire over the past two years, but now the payments have

been moved into QOF, thresholds and the payment formula have been changed, and the overall amount of money available has been increased from £40m to £68m. We describe these changes in more detail in section 3.2.

GPPS also contains a range of other questions about patient experience, many of which cover areas previously included in GPAQ and IPQ. The new survey also asks about out of hours care, though this is a PCT rather than a practice responsibility.

We have written this handbook as a practical guide to GPs and their staff to help them use the new GP Patient Survey (GPPS) to develop their practices. We hope also to help GP practices engage patients in that process.

This handbook focuses on what to do with the results of your survey.

• **Chapter 1 – Introduction & Background.**

Contains this introduction, background information about the GPPS and a section on Frequently Asked Questions.

• **Chapter 2 – Discussing the results.**

Provides guidance about receiving results and dealing with them within your practice.

• **Chapter 3 – Access, seeing a doctor of your choice.**

Addresses the results of questions about the patient's experience of the practice, including waiting times, ease of getting appointments, continuity of care.

• **Chapter 4 – Reviewing your consultations.**

Deals with the patient's experience of the doctor or nurse, in particular communication skills and inter-personal aspects of care.

• **Chapter 5 – Care planning for long term conditions.**

Asks about care planning for patients with long term conditions.

• **Chapter 6 – Making change happen.**

Offers advice about using surveys to improve care in your practice, and how to measure that change.

• **Chapter 7 – Involving patients.**

Concentrates on discussing your results with your patients, and involving them in improving care.

• **Chapter 8 – Appraisal and revalidation.**

Discusses the links between the survey results and appraisal and revalidation.

• **Appendix 1.**

The General Practice Patient Survey (GPPS).

• **Appendix 2.**

The GP Patient Survey Information for GPs and Practice Staff (flyer)

Each chapter includes a final section containing a list of useful links and references for further information on some of the key topics addressed.

Most GPs will have experience of using surveys, most likely from using either General Practice Assessment Questionnaire (GPAQ) or Improving Practice Questionnaire (IPQ), which were approved for use in the 2004 GP contract. These surveys have been replaced by the new GP Patient Survey, which was developed by the authors, who were able to draw on experience of developing and using other, similar surveys.

The BMA has also recently produced guidance for its members, based on a recent consultation on non-clinical aspects of general practice, and how these can be developed in response to patients' expectations and priorities. This guide, "Developing General Practice: Listening to Patients", includes many examples of small-scale changes which can be used to improve patient experience of general practice. It can be found at: www.bma.org.uk/images/listenpatient_tcm41-187204.pdf. This is supported by a practical guide recently developed by the NHS Practice Management Network, "Improving access, responding to patients", which describes the benefits and drawbacks of these different changes, how to implement them and where it has been done already by local GP practices. It has been developed in partnership with the NHS Alliance, BMA, RCGP, NAPC, AMSPAR, IHM and the Family Doctor Association and is available to download at www.practicemanagement.org.uk.

Our handbook also suggests how you can involve your patients in acting on the results of the survey.

We will be very pleased to receive feedback on the handbook, and any ideas you think it would be helpful to include in a future edition.

1.2 Why has a new survey been introduced into QOF?

Questionnaires which were approved for use in QOF were GPAQ (www.gpaq.info/) and IPQ (www.cfep.co.uk/default.aspx). A separate new questionnaire which acted as the basis for access payments was introduced in 2007.

The new GP Patient Survey extends the survey which has underpinned the DES (Directed Enhanced Service) since 2007. The access questions – which have been used for a DES in the past two years – have been combined with the areas that GPAQ and IPQ asked about. In addition, there are new sections on care planning and out of hours care.

GPPS is different from GPAQ and IPQ in that it's administered by post and not in the surgery. Some doctors are unhappy about this because they feel patients may not recall experiences accurately if they are asked about them weeks or months later. The advantage of sending the questionnaire by post is that a

consistent method is used for all practices. It also gets to patients who find access to the surgery difficult. As part of a three year ongoing research programme, we will be doing research to see how much difference is made by administering the questionnaire in the surgery or by post.

GPs' ability to communicate effectively with patients is a key part of what they do, and the importance of good communication has been recognised in the development of the new survey. It has been specifically developed to ensure that this, and other crucial elements of patient care, are not overlooked in favour of indicators focussed on chronic disease management.

1.3 How the GPPS was developed.

The development of the new questionnaire took place during the summer of 2008. As advisors to Ipsos MORI, Martin Roland and John Campbell started off by using the literature to identify the aspects of general practice which are most important to patients.

We used a variety of sources, including:

- Published reviews, e.g.

Cheragi-Sohi S, et al (2006)

What are the key attributes of primary care for patients: building a conceptual map of patient preferences

Health Expectations. 9(3):275-84.

<http://dx.doi.org/10.1111/j.1369-7625.2006.00395.x>

Chisolm A & Askham J (2006)

What do you think of your doctor: a review of questionnaires for gathering patients' feedback on their doctor

Retrieved 11/08/2009 from:

www.pickereurope.org/Filestore/PIE_reports/PCP/What_do_you_think_of_your_doctor_FINAL_greencover.pdf



Wensing M et al (1998)

A systematic review of the literature on patient priorities for general practice care: part 1: a description of the research domain

Social Science and Medicine 47(10):1573-88.

[http://dx.doi.org/10.1016/S0277-9536\(98\)00222-6](http://dx.doi.org/10.1016/S0277-9536(98)00222-6)

- Research where patients have been asked to rank the importance of different aspects of general practice care, e.g.

Cheragi-Sohi S et al (2008)

What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities

Annals of Family Medicine 6(2) 107-15.

<http://dx.doi.org/10.1370/afm.816>

Gerard K et al (2008)

Is fast access to general practice all that should matter?

Journal of Health Services Research & Policy 13 Suppl 2:3-10.

<http://dx.doi.org/10.1258/jhsrp.2007.007087>

Rubin G et al (2006)

Preferences for access to the GP: a discrete choice experiment

British Journal of General Practice 56(531):743-8

Turner D et al (2007)

Do patients value continuity of care in general practice: an investigation using stated preference discrete choice experiments

Journal of Health Services Research & Policy 12(3):132-7.

<http://dx.doi.org/10.1258/135581907781543021>

- Requirements for the survey outlined by Department of Health (who commissioned the survey).
- Specific issues which were linked to payments in the 2004 contract, ensuring that there was back-comparability with the payment questions in the previous Directed Enhanced Service.

As would be expected, there was very substantial overlap between these various sources of information on what patients value from their general practice care.

The draft questionnaire was then subjected to an iterative process of development over five months which included:

- Regular meetings of a Joint Review Group, containing representatives of the academic advisors, staff from Ipsos MORI and representatives of the Department of Health;
- Three meetings of a Stakeholder Review Group, including:
 - Patient representatives
 - British Medical Association
 - Royal College of General Practitioners
 - Royal College of Nursing
 - Healthcare Commission;
- Four waves of cognitive testing, including over

- 50 hours of interviews with patients to test their understanding of potential questions;
- A full pilot study, including 1500 patients.

This process resulted in progressive refinement of the questionnaire over a period of five months.

The final questionnaire was mailed to 5.6 million randomly selected patients from

GP lists in England in January 2009, with two postal reminders. The questionnaire could also be completed online and by phone in 13 non-English languages, and on the web in British Sign Language. Similar questionnaires were also sent to patients in Wales, Northern Ireland and the Isle of Man. Scotland produced its own questionnaire.

1.4 Areas that are covered in the GPPS.

The main aspects of care covered by the GP Patient Survey are:

- The surgery: access, privacy, cleanliness, reception arrangements;
- Telephone access;
- Access to the doctor – appointment arrangements;
- Waiting times in the surgery;
- Ability to see the doctor of your choice;
- Opening hours;
- Doctors' communication skills;

- Nurses' communication skills;
- Planning for long-term conditions;
- Out of hours care.

GPPS also contains information on the demographic and health characteristics of patients who respond. This is important in order to look at the way in which particular groups of patients experience GP services.

1.5 Frequently Asked Questions (FAQs).

1. How are patients selected for the survey?

A. The survey is sent to random samples of patients aged 18 or over who have been continuously registered with a general practice in England for at least six months. Non-respondents are sent reminders and additional questionnaires one month and two months after the initial mailing, unless they indicate that they want to opt out of the survey. Questionnaires can be completed in 13 non-English languages online or by telephone, and online in British Sign Language.

2. How many patients are sampled?

A. About 5.7 million adult patients registered with a GP in England are randomly selected. Each practice has a different number of people selected depending on the size of the surgery.

There are three key components that make up the sample size calculation for each practice: the number of cases required to deliver 95% confidence intervals of $\pm 7\%$ for key pay and incentive questions; the proportion of respondents who answer the key pay and incentive questions; and the overall response rate. These will be different for each practice and will result in a different issued sample size. For example, a practice that achieved a relatively low response rate in the previous year is likely to have higher issued sample

size this year compared with a practice that achieved a higher response rate last year.

More questionnaires were sent out in 2009 than in 2008 or 2007 and the confidence intervals on these questions are narrower than in previous years. Please note that if a practice was included in the 2007/08 survey, their actual response rate was used in the calculations described above. Furthermore, if a practice was not included in the 2007/08 survey, the average response rate for all practices in 2007/08 was used.

3. How long does it take for patients to complete the survey?

A. 10-15 minutes.

4. What questions are asked in the surveys?

A. The GPPS asks about the patient's experience in the consultation, as well as questions about the organisation of the practice, e.g. how easy it is to get appointments. The questionnaire used in January 2009 is reproduced in full in Appendix 1.

5. Doesn't the low response rate mean that the results will be biased?

The response rate is comparable to other surveys that use similar methodologies and was as expected. It is, however, slightly lower than last year. The lower response rate may in part be due to the questionnaire being eight pages long (compared with four pages long in 2007/2008). Our research shows that scores in practices with low scores have not been affected to any significant extent by non-response bias.

Roland M, Elliott M, Lyratzopoulos G, Barbieri J, Parker R A, Smith P, Bower P and Campbell J.

Reliability of patient responses in pay for performance schemes: analysis of national General Practitioner Patient Survey data in England.

British Medical Journal 2009; 339(7727): 955.
[DOI:10.1136/bmj.b3851]

6. Will the questionnaire be the same in future years?

A. No. The questionnaire is now being sent out in four quarterly rounds, but no patient is sampled more than once in any one year. The second year started in April 2009. There are likely to be small changes over time as the questionnaire develops. The current survey can be downloaded from: www.gp-patient.co.uk/download/questionnaire_example.pdf

7. Are the results confidential to the practice, and to me?

A. No. The full details of each practice's scores are published on the GPPS website: www.gp-patient.co.uk/surveyresults/ and some results will in future be published on the NHS Choices website.

8. When will next year's results be published?

A. Results from all four quarters will continue to be published in the summer of each year. The Department of Health may also publish cumulative results throughout the year, provided that the results are statistically significant, so practices can see how they are improving throughout the year.

9. Can doctors and other clinicians receive individual feedback?

A. No. GPPS only records results at practice level, except the questions on out of hours care which are reported at PCT level.

10. Will the practice results be available to the public?

A. Yes, all the information on GPPS scores is available to the public on the GPPS website: www.gp-patient.co.uk/surveyresults/ Results from previous years' surveys are available on the NHS Information Centre's website at www.ic.nhs.uk/pubs/gpps08.

11. Why is the survey being done by post?

A. Sending it by post makes it more likely that the sample selected will be more representative of all patients in the practice. However, payments to practices are only based on results from patients who have seen their GP in the past six months. When previous surveys (i.e. GPAQ and IPQ) were given out by practices, it was hard to know who got them.

12. Surely patients will have forgotten if they get a questionnaire several months after they saw the doctor?

A. This is certainly a potential problem. We will be investigating how much it matters as part of our research. When patients haven't seen a GP for over six months, the survey asks them why, and practices may be interested in the answers to this question.

13. Can we compare our performance with other practices?

A. Yes, by looking at:

www.gp-patient.co.uk/surveyresults/

The website includes a tool for practices to compare and benchmark their results against PCT and national averages and to analyse the data according to the demographics profile of their population.

14. How many surveys are approved for use for the GMS Contract?

A. GPPS is the only survey approved in England, Wales, Northern Ireland and the Isle of Man. Scotland has produced its own questionnaire.

15. What has happened to GPAQ and IPQ?

A. Practices can still use GPAQ (www.gpaq.info/) and it's freely available. IPQ (www.cfep.co.uk/default.aspx) is copyright. However, neither of these questionnaires count for QOF points from 2009/10.

16. How do I set about discussing the results with patients?

A. Chapter 7 in this handbook provides information and guidance about discussing survey results with your patients.

17. Will doctors need to present patient feedback data for revalidation and appraisal in future?

A. Yes. Chapter 8 in this handbook contains information about how you can use the results of the survey for appraisal and revalidation.

18. Where can I find out more information about the validity and reliability of the questionnaires?

A. We have so far published two papers on the development and validation of GPPS with others in preparation:

Campbell J et al (2009)

Development of the national GP Patient Survey for use in primary care in the National Health Service in the UK.

BMC Family Practice.

www.biomedcentral.com/1471-2296/10/57

Roland M, Elliott M, Lyratzopoulos G, Barbiere J, Parker R A, Smith P, Bower P and Campbell J.

Reliability of patient responses in pay for performance schemes: analysis of national General Practitioner Patient Survey data in England.

British Medical Journal 2009; 339(7727): 955.

[DOI:10.1136/bmj.b3851]

Ipsos MORI has also published a technical report which includes details of the development of the survey, including piloting, cognitive interviewing, sampling, sample size calculations and details of response rates. This report can be found at: www.gp-patient.co.uk/results/England%20Technical%20Report%2008-09.pdf

1.6 Links & references.

Chisolm A & Askham J (2006)

What do you think of your doctor: a review of questionnaires for gathering patients' feedback on their doctor
www.pickereurope.org/Filestore/PIE_reports/PCP/What_do_you_think_of_your_doctor_FINAL_greencover.pdf

*Developing General Practice:
Listening to Patients*

http://policy.helptheaged.org.uk/NR/rdonlyres/9A099B6D-E4AD-42A9-B9C7-1B7DF996AFC1/0/BMA_GP_consultation.pdf

General Practice Assessment Questionnaire
www.gpaq.info/

GP Patient Survey Technical Report
www.gp-patient.co.uk/results/England%20Technical%20Report%2008-09.pdf

GPPS website
www.gp-patient.co.uk

Improving Practice Questionnaire
www.cfep.co.uk/default.aspx

Quality and Outcomes Framework
www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/DH_099079

NHS Information Centre
www.ic.nhs.uk/pubs/gpps08

Improving access, responding to patients
www.practicemanagement.org.uk

Cheragi-Sohi, S, et al (2006)

What are the key attributes of primary care for patients: building a conceptual map of patient preferences.
Health Expectations. 9(3):275-84
<http://dx.doi.org/10.1111/j.1369-7625.2006.00395.x>

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What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities
Annals of Family Medicine 6(2) 107-15
<http://dx.doi.org/10.1370/afm.816>

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Is fast access to general practice all that should matter?
Journal of Health Services Research & Policy 13 Suppl 2:3-10.
<http://dx.doi.org/10.1258/jhsrp.2007.007087>

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Preferences for access to the GP: a discrete choice experiment
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Turner D et al (2007)

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A systematic review of the literature on patient priorities for general practice care: part 1: a description of the research domain
Social Science and Medicine 47(10):1573-88
[http://dx.doi.org/10.1016/S0277-9536\(98\)00222-6](http://dx.doi.org/10.1016/S0277-9536(98)00222-6)

CHAPTER 2

DISCUSSING THE RESULTS

- 2.1 PUBLISHING THE RESULTS OF THE SURVEY.**
- 2.2 DISCUSSING THE SURVEY RESULTS IN YOUR PRACTICE.**
- 2.3 COMPARING YOURSELF WITH OTHER PRACTICES – USING BENCHMARKS.**
- 2.4 LINKS & REFERENCES.**

2.1 Publishing the results of the survey

The results of the GPPS have been published on the GP Patient Survey website (www.gp-patient.co.uk/surveyresults/) and may be discussed by your PCT as part of your annual QOF visit. You could choose to invite a representative of your patient group to this or a separately convened meeting, to discuss issues arising from the survey, though this no longer attracts QOF payments. Chapter 7 Involving Patients provides guidance on how to set up a patient group to look at your survey results with you. The NHS Centre for Involvement has also been established to support and encourage patient and public involvement in health and social care (www.nhscentreforinvolvement.nhs.uk/).

If you appear to have very low scores in some areas, it may be wise for you to discuss them proactively with the PCT, and seek its support in addressing issues that have come up.

“ ”

What we then decided to do, was that we wanted to meet to discuss the results, as a team. We found getting the time to do that difficult to organise, and we eventually did it by an away morning and actually put it on the agenda. And it proved to be very useful... we would like to do it again... (we) found the comments constructive and we didn't feel terribly pressurised by the comments. We thought they were probably truthful, it was a good learning aid to us. And that's why we would really like to do it again, to see if any of the things we're hoping to change because of the results have actually made a difference.

Practice Manager, small practice, small town.



2.2 Discussing the survey results in your practice.

This needs to be planned carefully, and it is always wise to agree the process well in advance. The results are everybody's business and so all the practice staff should be involved. In most cases the ideal situation would be an open discussion of the results with the entire practice team.

Everyone should be asked to contribute their own reflections on the data. Whoever is responsible for leading the meeting should be careful to stop people rushing to conclusions or blaming individuals or groups for shortcomings. Shortcomings are rarely the fault of one person or group of staff. Receptionists, in particular, are easily and wrongly blamed by patients for problems. The meeting may be a valuable opportunity for practice staff and clinicians to improve their understanding of the pressures faced by either group, and their appreciation of the important role played by each member of the team in the smooth running of the practice. It is also a good idea to record contributions in a summary of the meeting.

Multi-disciplinary group meetings are usually best for this type of discussion. Chairing the meeting is an important responsibility which may well be the role of the practice manager. Whoever chairs the meeting needs to feel empowered to challenge contributions from all staff, including doctors, who otherwise tend to dominate meetings and can suppress useful debate!

Here are some suggestions for maximising the benefits of a multi-disciplinary group meeting to discuss results:

- **Celebrate success first.** Most practices have achieved very high scores on GPPS;
- **Don't accept being average** as the best that

you can do. Even if having average scores may take you off the PCT's radar, you may want to be more ambitious for your own practice;

- Where there are scores which are below average, steer the meeting to **look for the "low hanging fruit"**. These are problems for which it is easy to find consensus about the cause, and agree things to do about it. Solving these problems may be very simple, and will help to build confidence within the team for addressing larger concerns;
- Try and identify **a small number of manageable issues** to address, and delegate a small team to produce an action plan to bring back to a future meeting;
- Address **major concerns** immediately, especially as half of the rounds of the 2009/10 survey will probably already have happened by the time you get round to discussing the results;
- Identify **major challenges** that you cannot address immediately, and decide how these could be addressed in future. Maybe you need help from the PCT or another agency in thinking about these problems, e.g. problems caused by unfilled GP vacancies and long waiting times;
- Once priority areas are agreed with your staff, **stop and reflect** – consider how you can get **patients' views** on this. Patients can be your experts and can often help you find solutions. Look at how to engage with your patients and discuss your results and proposals.

2.3 Comparing yourself with other practices – using benchmarks.

You may want to compare yourself to other practices. You will be able to do this using the information on the GP Patient Survey website (www.gp-patient.co.uk/results/).

- If your scores are lower than other practices, does it matter?
- How big a difference is important?

There is no simple answer to this – it is a matter of professional judgement, though practices are likely to be most interested in scores on the access questions which link to payments. On the whole, you should be more concerned if your scores across a whole range of questions are low, than if just one or two scores are low. We would generally recommend that you don't concentrate too heavily on small differences.

Comparing your practice results to other

practices' scores is one way to focus attention on areas needing improvement. Since this is only the first year of the survey, there are no published benchmarks. However, you can compare your practice's scores with others at: www.gp-patient.co.uk/results/

It will also be possible to use this website to compare your practice with others with similar demographic profiles.

2.4 Links & references.

GP Patient Survey results website
www.gp-patient.co.uk/results

Local Involvement Network
www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_076366

National Association for Patient Participation
www.napp.org.uk

NHS Centre for Involvement
www.nhscentreforinvolvement.nhs.uk/

The NHS Information Centre
www.gpps.ic.nhs.uk/results08/



The chairperson must be empowered to ensure that no individual or individuals dominate the meeting and discourage others from having their say!

CHAPTER 3

ACCESS, SEEING A DOCTOR OF YOUR CHOICE

- 3.1 IMPROVING ACCESS.**
- 3.2 SEEING A DOCTOR – THE PAYMENT QUESTIONS.**
- 3.3 GETTING THROUGH TO THE PRACTICE ON THE PHONE.**
- 3.4 SPEAKING TO A DOCTOR OR NURSE ON THE PHONE.**
- 3.5 SEEING THE DOCTOR YOU PREFER.**
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- 3.9 OPENING HOURS.**
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- 3.11 OUT OF HOURS CARE.**
- 3.12 LINKS & REFERENCES.**

3.1 Improving access.

Patients expect very high standards of access to their general practice, as well as very high standards of continuity of care, and it's hard to provide the two at the same time.

Since the 2004 GP contract, the NHS has put most attention on access targets, but for GPs and their patients, it's very important that the importance of continuity of care is still recognised, especially as research shows that continuity of care for patients has got worse in recent years. Many people believe that, at a time when primary care risks getting fragmented with new types of care (e.g. walk-in centres, etc), it is all the more important that patients are able to engage in a long term relationship with their GP.

So GPPS includes questions on access (including the payment questions), and also questions on whether patients prefer to see a particular doctor in their practice and if so, whether they are able to.

GPPS recognises that patients are concerned with other aspects of their general practice too, such as the way in which they are treated by reception staff, physical features of the practice premises, opening hours and the importance of privacy within the reception area. The BMA report *Developing General Practice: Listening to Patients*, and the supplementary guide "Improving access, responding to patients" from the NHS Practice Management Network includes sections on these and other aspects of care which can help you improve the overall experience of patients in your practice (www.bma.org.uk/images/listenpatient_tcm41-187204.pdf and www.practicemanagement.org.uk).

3.2 Seeing a doctor – the payment questions (Qs 6-7, 9-10).

These questions in the GPPS address the issue of the time it takes to get an appointment to see the doctor. They include the payments questions, which are similar to the questions used for GP payments in the Directed Enhanced Service (DES) in 2007 and 2008. Question 6 asks whether patients have tried to see a doctor 'fairly quickly' in the past six months, and for those who responded 'Yes', question 7 asks them whether they were able to see a doctor "on the same day or in the next two weekdays that the surgery was open" (QOF indicator PE7)

The second payment question (Q9) asks if patients have tried to book ahead in the last six months, and for those who responded 'Yes', asks whether they were able to book ahead (Q10) (QOF indicator PE8).

In 2009, the lower payment thresholds below which no payments were made were increased compared to the DES which had been operating for the previous two years, from 50% to 70% for PE7, and from 40% to 60% for PE8.

There was an additional change in that under the DES payment rules, practices received 50% of available payment if they reached the 50% target, so the sliding scale of payments went from 50% to 90% for PE7 (and 40% to 90% for PE8). QOF payment rules are different, and practices which just cross the payment threshold now start at 0% of available payments, so there is now a sliding scale from 0% to 90% for each of the indicators. This change is illustrated graphically in the figure (right). The steep incline in payments increases the impact of the margin of error that inevitably rises from using a survey as a performance incentive.

So, the change in the payment system between 2008 and 2009 has resulted in changes in payments to practices for three reasons:

- Increases in the minimum payment thresholds for PE7 and PE8 by 20%;

- Changes in the sliding scale of payments;
- Increased impact of random variation on practice payments;
- Increase in the overall amount of money available from £40m to £68m.

The effect of these changes is that some practices will have less income in 2009 with no change in performance: however others will have gained.

Despite these problems, access issues are important to patients. In fact the confidence intervals – indicating the reliability of these questions – were narrower in 2009 than in 2008, because more patients were surveyed. So it is likely that these results do act as useful pointers to areas where you might think about the way you provide access to your practice. Don't just dismiss them!

Flexibility is needed to provide for the different needs of different patients. Some patients need to be seen as soon as possible, and may not be too bothered about the particular doctor or nurse they see, while others will find it inconvenient only to be offered an

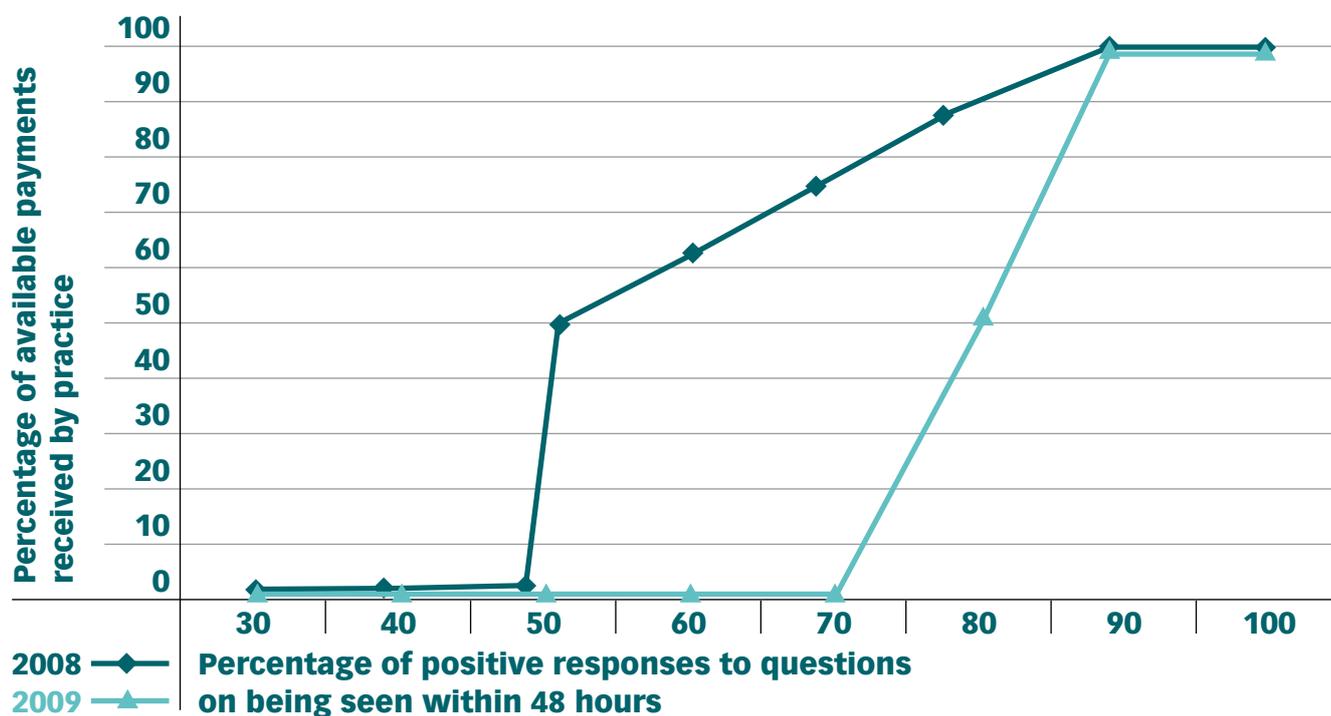


Figure: Relationship between practice payment and patient response to question on being seen within 48 hours: effect of change in payment system between 2008 and 2009

appointment ‘on the day’. The key is to find a balance which reflects these different needs.

Various systems have been proposed to organise appointment systems so that patients can be seen without delay, including ‘Advanced Access’ which aims to avoid patients having to wait for appointments. However, if appointments are only offered ‘on the day’, patients may not be able to book ahead, and it was this problem that led the original patient experience points in QOF being changed to include those in the access DES. Nevertheless, the principles behind Advanced Access can still be useful for improving waiting time, and more detailed guidance for practices has recently been provided by the NHS Practice Management Network (www.practicemanagement.org.uk/uploads/access_guide/090702_improving_access_responding_to_patients_final.pdf).

The NHS has also published guidance to PCTs on improving access (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102121.pdf)

A step-by-step guide to understanding your demand and matching capacity against it can be found in section one of “Improving access, responding to patients” (www.practicemanagement.nhs.uk).

This considers the following principles:

- Understanding the pattern of demand for appointments in the practice;

- Matching the capacity of the practice to that demand;
- Providing alternatives to seeing the doctor.

Other approaches which may help include:

More booked telephone consultations.

Increasing booked telephone consultations, both for minor illness and follow up of chronic disease. Section two of “Improving access, responding to patients” provides more information on how to implement telephone consultations in your practice and to hear some of the experiences of practices who have been operating such systems for some time.

Encouraging self-help for patients.

Patients can be encouraged to engage in more self-help by their general practices if they are provided with good information, both in printed form (in the surgery) and by maintaining a

clear, up-to-date web site. Good examples are:

- Marple Cottage Surgery (www.marplecottage.co.uk/)
- Manor House Surgery (www.manorhousesurgery.co.uk/).

Section eight of “Improving access, responding to patients” contains a range of simple marketing techniques that practices may wish to consider including how to set up a website and what it might include.

Email consultations.

Email consultations will not suit all patients and situations, but may be used in some circumstances. It’s probably fair to say that most GPs feel pretty anxious about opening email up to patients, but some GPs who have tried it say they find it a valuable additional way to communicate with patients. General practice as a discipline hasn’t really thought clearly about how best to embrace this new technology.

No follow-up appointments on Monday.

GPs are well aware that Monday is a particularly busy day. It therefore makes sense to ask patients who come on Monday and need follow up in a week to be asked to come back on Tuesday or Wednesday.

Monitoring waiting times.

One method for monitoring progress with waiting times, is to measure the time to the third next available appointment. Other ways of measuring the availability of appointments have been reviewed by researchers from Swansea University in “Measuring access to primary care appointments: a review of methods” (Jones W et al 2003. BMC Family Practice 4:8 <http://dx.doi.org/10.1186/1471-2296-4-8>)



“ ”

I think the use of telephone consultations must be something that's in everyone's interest, because presumably that does keep down the time the doctor gives, and the need for the patient to get to the surgery. So it's knowing that you can ring up and have a chat with the doctor – that might dispose of the need for some appointments.

Patient, large practice, city location.





There's two doctors there that seem to be the popular ones, because they've been there the longest, and they're a bit older. And they get full very quickly. And people ring up and want the appointment, but they want it with that doctor and won't have it with another one.

Patient, large practice, small town.

3.3 Getting through to the practice on the phone (Q5).

If your scores are low on this question, think about the pattern of calls coming into the surgery. Do you have sufficient staff to answer the telephone at peak times? Do you need more phone lines? There is a formula (developed by Agner Erlang, a Danish mathematician

– see www.primarycarefoundation.co.uk/page9/page19/files/gp-urgent-care-report.pdf) to help you calculate the number of receptionists necessary for answering a given number of calls per hour, which you can find on the Primary Care Foundation website.

3.4 Speaking to a doctor or nurse on the phone (Q5).

Patients value being able to speak to a doctor or nurse on the phone, and if organised effectively, this can reduce your workload. Phone consultations should be booked into regular surgeries like other consultations (though shorter), and the patient given an approximate time when the doctor or nurse will phone them. This makes the workload from phone consultations predictable for doctors, and

patients know when to be available.

By offering a range of access options – including phone consultations and same day appointments – you will be able to respond promptly and effectively to your patients needs. Some practices are now making extensive use of phone appointments as a way of reducing the demand for surgery appointments.

3.5 Seeing the doctor you prefer (Qs 15-16).

Continuity of care is a core value of general practice, and is highly valued by patients. It has been under threat from an increasing emphasis on team working, with larger teams being employed by practices, and in part due to an increased focus on access.

Several books and articles have been written about continuity of care and the importance of this mutual “therapeutic relationship” between doctor and patient (e.g. *The Human Effect in Medicine* by Michael Dixon and Kieran Sweeney. 2000. Radcliffe Medical Press ISBN 9781857753691).

However, not everyone wants to see the same doctor each time. GPPS acknowledges this by first asking patients whether there is a particular doctor they prefer to see (Q.15), and only for patients answering ‘Yes’ to this, does that survey ask how often they actually

get to see the doctor of their choice (Q.16)

If you want to monitor progress in providing continuity of care, the best way is probably by repeating the survey, or part of it to include the continuity question. You can also measure continuity directly from the notes. One way to do this is to take a sample of notes and measure the proportion of consultations that occurs with the doctor seen most frequently. If you use this method, you need to be careful that the number of times the patients you sample have seen the doctor is roughly the same in the two time periods.

3.6 Waiting time in the surgery (Qs 13-14).

The survey asks about patients’ experiences of waiting in the surgery. Demand fluctuates, as does the type of problem seen in each surgery. So you won’t necessarily be able to avoid some times when patients wait a long time. Under those circumstances, patients find it very helpful if they are kept informed about possible or probable delays, including the reason (for example, if a doctor has been called out on an urgent visit).

If your patients regularly wait a long time or if your waits are much worse than those in local practices, then you should think about how to reduce the waits. As well as providing a better service for patients, any improvement here will reduce the stress on doctors and other staff if they are not always running late. The following are possible remedies:

- Increase the appointment booking interval. If you book at 7.5 minute intervals, and the doctors in your practice spend an average of ten minutes with patients, then a two-hour booked surgery will always end up running 40 minutes late. Acknowledge reality!
- Break up long surgeries with administrative/ coffee time. For example, a three-hour surgery



session may be better booked as two one-and-a-half hour surgeries with a half-hour break in the middle. That admin or coffee time is going to be taken sometime anyway, and if the break is there, it allows the doctor to catch up, greatly reducing his or her stress

when running behind. Again, acknowledge reality, and don't make life difficult for yourself. Putting breaks into long surgeries is one of the easiest ways of providing better patient care and reducing everyone's stress;

- Allow patients to book longer appointments if they think they need more time. When patients ring some practices to get an appointment, a recorded message routinely tells them they can ask for a longer appointment if they need. It's valued by patients, but not taken up all that frequently.

The experience of waiting is affected by the general ambience in the surgery, and this can be enhanced by providing sufficient appropriate seating (in particular for elderly and disabled patients), clean toys and up-to-date information and magazines. GPPS asks both how long patients waited to see the doctor and how they felt about the wait.

3.7 Care given by receptionists (Q4).

Receptionists sometimes get a bad press in general practice. Yet they are the first point of contact with the practice – whether on the phone or at the reception desk. It's often not the fault of the receptionists. They are caught between the patients who want to be seen and the doctors who need their time to be protected. So, if there are problems with how your patients see receptionists, perhaps you should first consider your part in how friendly or otherwise they appear to be. Are you embarrassed but secretly pleased when you are very busy and you hear a receptionist giving a patient who wants an appointment a hard time at the desk?

Patients value being able to speak to a doctor or nurse on the phone, and if organised effectively, this can reduce your workload. Phone consultations should be booked into regular surgeries like other consultations

(though shorter), and the patient given an approximate time when the doctor or nurse will phone them. This makes the workload from phone consultations predictable for doctors, and patients know when to be available.



I think it's very important that the atmosphere is right at front of house. Because you immediately get a sense of the people that are there, whether they greet you with a smile, or say "good morning" or their manner is civil.

Practice Nurse, large practice, small town.

By offering a range of access options – including phone consultations and same day appointments – you will be able to respond promptly and effectively to your patients needs. Some practices are now making extensive use of phone appointments as a way of reducing the demand for surgery appointments. So the first step is for the practice to discuss what sort of front-end they want to present to patients. This means a meeting between doctors and reception staff. They may want to think about:

- What messages does the practice want receptionists to give out?
- What types of phrasing and language should be used or avoided?
- How should receptionists handle patients whose problem can't be resolved – e.g. when there just is no appointment at the time the patient wants?

Receptionists and doctors may also benefit from training designed to defuse conflict. Patients often feel stressed and anxious when they are ill. Receptionists need to know how to deal with stressed or angry patients without increasing the risk of conflict or an escalated response. In some inner city areas, receptionists are frequently subjects of verbal, or even physical, abuse. Training and discussion are essential for receptionists to handle such situations (see Box 3.1 for some useful techniques). Where incidents of abuse have occurred, it's very important that someone senior

VERBAL TECHNIQUES FOR DEFUSING ANGRY PATIENTS

BOX 3.1

- **I shall do my best...**
- **I understand what you are saying but...**
- **I'm glad you checked up with me as...**
- **Thank you for bringing this to my attention...**
- **What is it you would like me to do?**
- **I am here to help you....**
- **Can I ring you back about this?**

in the practice discusses it with the member of staff, so that they feel supported in what can otherwise be a very traumatic experience.

Courses for receptionists and other practice staff are widely available. Your PCT may be able to offer guidance about this, or you can contact the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR – www.amspar.co.uk). Box 3.2 contains a list of available courses.

The Medical Defence Union (www.the-mdu.com/) and Medical Protection Society (www.medicalprotection.org/uk) also run training

courses in this area, because they know that a good front desk in a practice reduces the risk of complaints against doctors. Medical Defence Union practice seminars address topics that are relevant to all members of the practice team, including GPs, nurses, practice managers and receptionists. The Medical Protection Society runs courses for practice staff, including risk management, which focus on improving communication skills, reducing complaints and generally increasing the quality of one's practice. The Medical and Dental Defence Union of Scotland (www.mddus.com/mddus/home.aspx) also runs a receptionist development programme, which includes topics such as risk management, patient rights and working as a team.

AMSPAR works with City & Guilds to provide a range of nationally recognised qualifications suitable for delivery as either full or part time study programmes.

BOX 3.2

- **The Certificate/ Diploma in Primary Care Management, Level 5.**
- **The Advanced Diploma for Medical Secretaries, Level 3.**
- **The Intermediate Diploma in Medical Reception, Level 2.**
- **The Award in Medical Terminology, Level 2.**
- **The Certificate in Medical Terminology, Level 3.**
- **The AMSPAR Certificate in Health Service Administration.**

3.8 Privacy and confidentiality (Q3).

GPPS asks about privacy and confidentiality. It is not always easy, but practices may want to think how they could provide some area where patients could talk to a receptionist in private if they wish. Partly because reception areas can often be overheard, responses to this question may indicate that more care needs to be taken when discussing patients in the reception area.

3.9 Opening hours (Qs 17-19).

GPPS asks about patients' rating of the practice's opening hours, and also asks patients what additional hours they would like the practice to be open. These can be useful questions to use if you are thinking about how to respond to your PCT's requests for extended opening hours. There's no point in providing extended opening hours when your patients don't want to come.

You also need to have clear explanations of the arrangements for out of hours care – these are very important in reducing patients' anxiety about this issue. Over England as a whole, a third of patients responding to the GP Patient Survey said they didn't know how to contact out of hours services.

3.10 Urgent care.

Some patients need urgent advice. Here are some examples of solutions implemented by general practices and described in greater detail in a recent report about urgent care in general practice, accessible from the Primary Care Foundation website (www.primarycarefoundation.co.uk/).

Dedicated, integrated urgent care team.

This is a rather elaborate title used by the Primary Care Foundation to indicate that practices need a clear plan for how to deal with urgent requests. They suggest a model in which:

- Patient telephones or presents at surgery with an urgent request;
- Request is passed on to a doctor or nurse who makes an immediate assessment;
- Patient is directed to most appropriate clinician for full assessment;
- Discussion between urgent care team members to decide on patient's care;
- Doctor implements care pathway.

A key organisational issue for practices is to decide how to plan the workload of the doctor or nurse who is going to screen urgent requests. It may be preferable but it's clearly not always possible for them not to have a fully booked surgery when they are taking this role.

Nurse-led emergency clinics.

Nurses can take the pressure off doctors, leaving them time to spend with patients with ongoing, chronic conditions. Success depends on effective communication between the nurses and the GP. You also need to be sure that your nurses are adequately trained to recognise patients who might be seriously ill, and that they are provided with robust systems and arrangements to support them in this role.

Training reception staff to recognise and act on urgency and emergency.

This requires allowing reception staff the time to learn the difference between an emergency and a situation that is urgent (i.e. requiring prompt action). This is not easy to learn "on the job", as genuine emergencies occur rarely. It includes knowing the correct questions to ask the patient, and an awareness of straightforward list of presentations, including chest pain, haemorrhage and breathlessness.

Acute visiting service.

Some small practices have collaborated with other practices to provide a visiting service in which those patients who are unable to go to the surgery receive a visit from a GP or nurse. However, these may well be patients with multiple long term conditions who most need to see their regular doctor. For these patients, a request for a visit doesn't always mean they want to see a doctor the same day, and they may prefer to wait a day or two to see their own doctor. This can be discussed on the phone.



3.11 Out of hours care.

Out of hours care is a PCT rather than a practice responsibility, and so these results aren't reported at practice level. Patients are more negative about out of hours care than most other aspects of the GP Patient Survey, and you may well be interested in what sort of care your patients are receiving out of hours.

The questions on out of hours care in GPPS are brief, and if your PCT or out of hours provider is interested in carrying out a more detailed survey of patients, we have developed a questionnaire specifically for out of hours care which is being administered by CFEP-UK (www.cfep.co.uk/ooh.aspx).

The feedback on the extended opening hours was generally excellent although some people feel we should provide croissants and coffee in the morning and a little late supper in the evening!



3.12 Links & references.

Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR)

www.amspar.co.uk

Client-Focused Evaluations Program (CFEP)

www.cfep.co.uk/

*Developing General Practice:
Listening to Patients*

www.bma.org.uk/images/listenpatient_tcm41-187204.pdf

Manor House Surgery

www.manorhousesurgery.co.uk/

Marple Cottage Surgery

www.marplecottage.co.uk/

Medical Defence Union

www.the-mdu.com/

Medical Defence Union of Scotland

www.mddus.com/mddus/home.aspx

Medical Protection Society

www.medicalprotection.org/uk

Primary Care Foundation

www.primarycarefoundation.co.uk/

Quality and Outcomes Framework

www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/DH_099079

Urgent Care: a practical guide to transforming same-day care in general practice

www.primarycarefoundation.co.uk/page9/page19/files/gp-urgent-care-report.pdf

Dixon M & Sweeney K (2000)

The human effect in medicine.

Oxford: Radcliffe Publishing.

ISBN13: 9781857753691

Jones W et al (2003)

Measuring access to primary care appointments: a review of methods

BMC Family Practice 4:8

<http://dx.doi.org/10.1186/1471-2296-4-8>

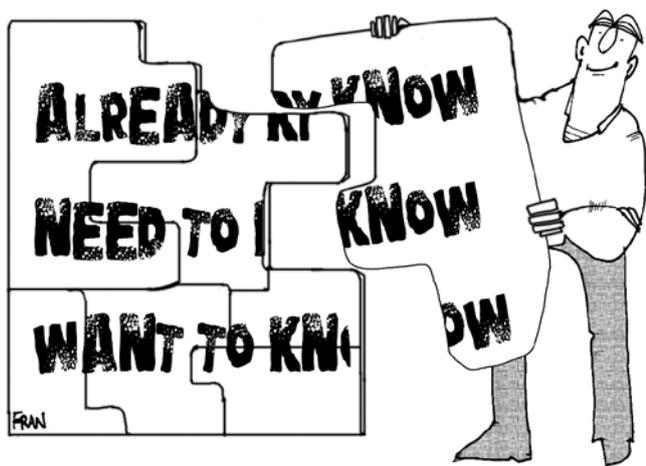
CHAPTER 4

REVIEWING YOUR CONSULTATIONS.

- 4.1 COMMUNICATING WITH PATIENTS.
- 4.2 HOW TO IMPROVE YOUR CONSULTING SKILLS.
- 4.3 RECORDING YOUR CONSULTATIONS.
- 4.4 REVIEWING YOUR CONSULTATIONS.
- 4.5 REVIEWING VIDEOS OF CONSULTATIONS.
- 4.6 REVIEWING YOUR CONSULTATIONS WITH COLLEAGUES.
- 4.7 LINKS AND REFERENCES.
- 4.8 FURTHER READING.

4.1 Communicating with patients.

Part of GPPS (Qs 20 and 21 for GPs, and Q.24 for nurses) addresses the way in which you communicate with patients. This is a key part of general practice, and relates to the issue of establishing an effective therapeutic relationship as mentioned in the previous chapter.



If your scores are not as good as you would like (and they are generally very high for most doctors and nurses), it's worth spending some time thinking about the following aspects of communication which are specifically addressed in GPPS.

Giving enough time (Qs 20a & 24a).

Time is always a controversial topic. Some doctors are naturally 'slow consulters' and always run over time. Others are the opposite. But there is a lot that you can do in a short consultation, and long consultation length is not necessarily synonymous with efficiency or greater patient satisfaction. Wilson and Childs (The effect of interventions to alter



... if we can make simple, small changes to our styles and our communication skills... I think the experience of health care is probably more important than people's health itself, and the health services are the thing that need sorting out, not people's health. People have health needs, but the health service needs are greater.

GP, large practice, city location.

the consultation length of family physicians British Journal of General Practice. 2006. 56(532):876-82) undertook a systematic review of studies on this topic, and concluded that the actual length of the consultation may be less important than other qualities, such as having a good patient-centred consulting style. What matters for the patient is that they feel that they have had good value, but it is difficult to achieve that in less than 7½ minutes. Nurses generally got slightly higher scores than GPs in the GP Patient Survey. This may be because they book longer appointments in many practices.

Asking about the patient's symptoms (Qs 20b & 24b).

How well have you clarified the patient's problem? We know from research into the consultation that doctors and patients often don't agree what the presenting problem actually is, but where they do achieve agreement, this significantly contributes to patient satisfaction. In order to clarify problems effectively you need to be able to pick up on both verbal and non-verbal cues (see box 4.1 for some

examples). Cues are clues to what the patient's problems are – use of particular words, change in tone of voice or posture. Being able to recognise and respond to cues is particularly important in detecting emotional problems, and emotional reactions to physical problems.

Listening carefully to the patient (Qs 20c & 24c).

Research has shown the importance of listening to patients' opening statements without interruption. Doctors too often focus on the first issue mentioned by their patients, yet this might not be what is concerning the patient most. Once the doctor has interrupted, patients rarely introduce a new issue. If uninterrupted, and especially if the doctor maintains eye contact, the great majority of patients do stop talking within 60 seconds, and often well before. Active listening is a vitally important skill made up of various different component skills (see box 4.2 for some examples).

Explaining tests and treatment (Qs 20d & 24d).

When you provide information you have to consider the three key questions:

- What does the patient already know?
- What does the patient want to know?
- What does the patient need to know?

The first question emphasizes the importance of building on the patient's existing



RESPONDING TO CUES – E.G. AFTER A PATIENT HAS MENTIONED FEELING TIRED AND FED UP

BOX 4.1

Ways of using verbal cues:

Repeating the patient's own words: 'So you feel completely tired and fed-up...'

Asking an open question: 'Can you tell me a bit more about feeling fed-up?'

Seeking clarification: 'What do you mean by completely tired and fed-up?'

Asking for an example: 'Tell me about the last time this happened...'

Responding to non-verbal cues:

Commenting on what you observe: 'You do look pretty exhausted'

Asking a question to: 'You look exhausted – how has all this been affecting you?'

USING ACTIVE LISTENING SKILLS

BOX 4.2

Open ended questions: questions that cannot be answered in one word:

e.g.: Would you like to tell me a bit more about the problems you've had eating?

Checking: repeating back to the patient to make sure that you have understood:

e.g.: So you didn't vomit at all yesterday?

Facilitation: encouraging patient both verbally ('go on...') and non-verbally (nodding)

Legitimizing patient's feelings:

e.g. by saying: 'this must worry you a great deal.'

Surveying the field: indicating you would like to hear more:

e.g. by saying 'Is there anything else you'd like to talk about?'

Empathic or supportive comments:

e.g. 'It must have been tough for you lately'

Offering support:

e.g. 'I'm trying to work out what we can do to help'

Negotiating priorities: if there are several problems ask which one needs to be addressed first.

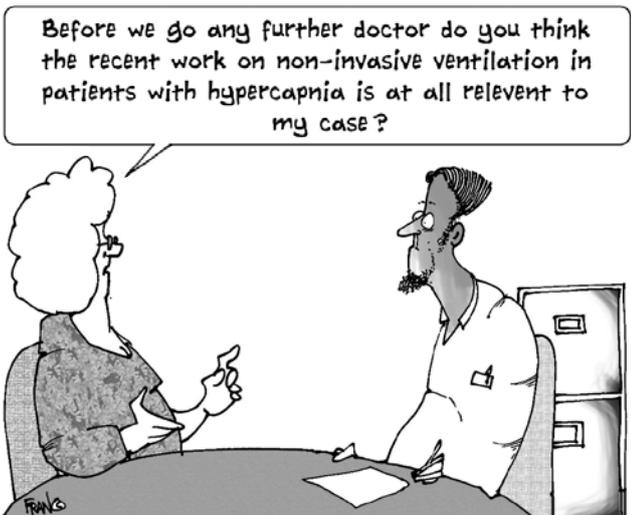
Summarizing: summarize what you have been told so far. This indicates that you are listening and can also help to control the flow of the interview if there is too much information. It also gives you a chance to get your thoughts together.

understanding, adding to what he or she already knows, and correcting inaccuracies. The second and third reflect the need to address two often quite different agendas, the patient's and the doctor's. You cannot provide effective reassurance unless you have first explored the precise nature of the patients' worries and concerns. For the patient, reassurance is often more about the doctor being on their side or having their best interests at heart, rather than assuring the patient that all will be OK.

Involving the patient in decisions about his/her care (Qs 20e & 24e).

Patients vary considerably in how much they want to be involved in decisions. At one end of the spectrum is the person who wants the doctor to advise them what to do. At the other end is the person who wants to be fully informed about the options and come to their own decision.

You have to use your consulting skills to work out the extent to which each patient wants to be actively involved in decision-making. Are you getting the balance right? Look at how individual patient responses to this question compare with other ratings in order to try and work out where you are going wrong. Difficulties here may be related to how thoroughly you



Before we go any further doctor do you think the recent work on non-invasive ventilation in patients with hypercapnia is at all relevant to my case?

Some patients may want to know more than others!

assess the problem, your listening skills, how well you explain problems, and your patience in dealing with questions or worries.

Treating the patient with care and concern (Qs 20f & 24f).

We demonstrate our concern using the skills discussed above but also by saying things to patients that show we understand, or think we understand, how they're feeling. How often do you make empathetic or supportive comments? (See box 4.2) How do you respond when people demonstrate strong emotions such as anger or fear? You may feel concerned – but unless you find ways of showing this to the patient you may come over as cold or uncaring.

Getting the consultation off to a good start often has an impact on what happens afterwards. What do you say to the patient? How often are you still looking at the notes of the last patient? How appropriate is your form of greeting?

Taking the patient's problems seriously (Qs 20g & 24g).

How good are you at really addressing the patient's agenda? Do you give patients an opportunity to ask questions or express their worries and fears when you have given them information or advice? When people come to the doctor they often have ideas about their problems and anxieties and concerns that reflect these ideas. They are also likely to have hopes and expectations concerning the care that they will receive. Do you give them space to express these? At the end of the consultation, have you checked that the patient has understood your advice (especially important for older patients).

We know from research that if something goes wrong, patients are much more likely to make a formal complaint if they feel that the doctor has been disinterested.

4.2 How to improve your consulting skills.

There are many online and other resources that will help you understand what is meant by good communication or consulting skills. One example is Communication Skills, a useful guide published originally in GP Registrar magazine by the Medical Protection Society (available to download:

www.medicalprotection.org/uk/gp-registrar-magazine).

A good way to approach the topic of improving communication skills is to take an online course. e-Learning for Healthcare (e-LfH), in collaboration with the Royal College of General Practitioners, has developed online modules to support General Practice education. The programme, e-GP ([www](http://www.e-lfh.org.uk/projects/egp/index.html).

[e-lfh.org.uk/projects/egp/index.html](http://www.e-lfh.org.uk/projects/egp/index.html)), includes modules on consulting skills and clinical governance. Other organisations offer workshops to help you improve your communications skills, e.g. Client-Focused Evaluation Programs (www.cfep.co.uk/).

4.3 Recording your consultations.

The most effective way to change the way that you consult is to record your consultations and review them.

Setting up the surgery to record consultations.

You can use either sound or video recording and training practices will be used to video recording consultations as reviewing recorded consultations is a standard part of GP training. If you are using video recording, it helps if you can see both doctor and patient, though in a small room it isn't always easy to get both in the shot. If this is not possible, ensure that you can see yourself so that you can observe your own behaviour in the consultation when you come to look at the recording.

You need to get patients' consent before you record their consultations. Box 4.3 shows a standard consent form overleaf.

A word about camcorders:

Many people now own digital camcorders for home video recording. Most digital camcorders record on to a small digital video tape which lasts for about two hours on long play, but we would recommend that you use short play (one hour) for better quality. The tape can be played back through television, or can be edited and transferred to DVD using software on a computer.

Recording consultations.

Plan to record at least one surgery and do the following:

- Let people know when they are booking an appointment that you will be recording;
- Put a sign up in reception and/or ensure that all

PATIENT CONSENT TO RECORDING FOR ASSESSMENT PURPOSES

BOX 4.3

Date _____

Patient's name _____

Name(s) of person(s) accompanying patient _____

Dr _____,

whom you are seeing today, is hoping to make recordings of some consultations. (This may be audio or video). The recordings are being used to help the doctor improve the way that he or she consults.

The recording is ONLY of you and the doctor talking together. Intimate examinations will not be recorded and the equipment will be switched off at any time if you wish. All recordings are carried out according to guidelines issued by the General Medical Council and will only be used to assess the doctor whom you are consulting. The recording will be securely stored and is subject to the same degree of confidentiality as your medical records. The recording will be erased as soon as practicable and in any event within three years. The security and confidentiality of the recording are the responsibility of the doctor.

You do not have to agree to your consultation with the doctor being recorded. If you do not want your consultation to be recorded, please tell Reception. This is not a problem, and will not affect your consultation in any way. But if you do not mind your consultation being recorded, we are grateful to you. If you wish, you may listen to or view the recording before confirming your consent.

If you consent to this consultation being recorded, please sign where shown below. Thank you very much for your help.

TO BE COMPLETED BY THE PATIENT

I have read and understood the above information, and give my permission for my consultation to be recorded.

Date _____

Signature of the patient BEFORE THE CONSULTATION

Date _____

Signature(s) of any person(s) accompanying the patient

After seeing the doctor I am still willing / I no longer wish my consultation to be used for the above purposes.

Date _____

Signature of patient AFTER THE CONSULTATION

Date _____

Signature of any person(s) accompanying the patient

- patients are informed that you are recording;
- Get your receptionist to ask all patients if they are willing to be recorded and to fill in a consent form;
- Check that patients have consented as they come in to see you, and record consecutive attendees;
- After the consultation ensure that the patient signs again that they are willing to let you keep the recording for the purposes of your education (but it should be wiped immediately after you have watched it);

- Ensure that you record on a simple diary sheet which patients have agreed to be recorded – this helps you to find your way around the recording!
- Ask patients to fill in a questionnaire about the consultation. You may use the GPPS again so that you can focus on how your perceptions of the consultation compare with the patient's own views. Make sure that the patient understands that you will be seeing their individual responses.

4.4 Reviewing your consultations.

Reviewing recordings of your consultations.

If patients have completed the GPPS as part of a separate exercise to look at your own consultations, you can look through the responses (having ensured that you have their permission) and have these to hand as you listen to or look at the recording. Just listening/looking through the recording on your own and reading what your patients have written will be helpful in beginning to understand your strengths and weaknesses.

However, in order to really try and improve what you do, you need to be more systematic. This means either trying to audit your behaviour in a series of consultations against a predetermined checklist of 'good' behaviours or reviewing your recording in a group setting where you get feedback from colleagues who have also agreed to show their recording.

Auditing your own consultations.

You can audit your consultations against a checklist of 'good' behaviours that have been developed as a result of extensive research

into the consultation. The RCGP criteria for MRCGP can be useful for this – full information is contained in the MRCGP video assessment of consulting skills workbook (available at www.rcgp.org.uk/default.aspx?page=5775).

These criteria are summarized in Box 4.4: We know from research that self-audit can be effective – but it needs to be focused. And it's much better if you do it with a colleague.



Discover the reasons for a patient's attendance

Elicit the patient's account of the symptom(s) which made him/her turn to the doctor

- the doctor encourages the patient's contribution at appropriate points in the consultation
- the doctor responds to cues

Obtain relevant items of social and occupational circumstances

- the doctor elicits appropriate details to place the complaint(s) in a social and psychological context

Explore the patient's health understanding

- the doctor takes the patient's health understanding into account

Enquire about continuing problems

- the doctor obtains enough information to assess whether a continuing complaint represents an issue which must be addressed in this consultation

Define the clinical problem(s)

Obtain additional information about symptoms and details of medical history

- the doctor obtains sufficient information for no serious condition to be missed
- the doctor shows evidence of generating and testing hypotheses

Assess the condition of the patient by appropriate physical or mental examination

- the doctor chooses an examination which is likely to confirm or disprove hypotheses which could reasonably have been formed OR to address a patient's concern

Make a working diagnosis

- the doctor appears to make a clinically appropriate working diagnosis

Explain the problem(s) to the patient

Share the findings with the patient

- the doctor explains the diagnosis, management and effects of treatment

Tailor the explanation to the patient

- the doctor explains in language appropriate to the patient
- the doctor's explanation takes account of some or all of the patient's elicited beliefs

Ensure that the explanation is understood and accepted by the patient

- the doctor seeks to confirm the patient's understanding

Address the patient's problem(s)

Assess the severity of the presenting problem(s)

- the doctor differentiates between problems of differing degrees of severity and manages each appropriately

Choose an appropriate form of management

- the doctor's management plan is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice

Involve the patient in the management plan to the appropriate extent

- the doctor shares management options with the patient

Make effective use of the consultation

Make efficient use of resources

- the doctor makes sensible use of available time and suggests further consultation as appropriate
- the doctor makes appropriate use of other health professionals through investigations, referrals, etc
- the doctor's prescribing behaviour is appropriate

Establish a relationship with the patient

- the patient and doctor appear to have established a rapport

Give opportunistic health promotion advice

- the doctor deals appropriately with at-risk factors within the consultation

4.5 Reviewing videos of consultations.

Try to set aside times to do this exercise when you are unlikely to be disturbed, and are not too tired. You will need your full attention to get the best from the material.

You can take as much or as little time as you want, but complete the review of one consultation in one session. You may want to listen to or watch the consultation more than once, but don't spend too much time trying to classify your actions.

The outline for reviewing the consultation is a guide only. Focus on the areas which it addresses, but it is fine to reflect on other areas as well (e.g. your choice on management). The patient's behaviour is of course relevant and you will find reference to their records and any questionnaire they filled at the time of the consultation helpful too.

Starting the recording.

- Let the recording run for about 30 seconds and then STOP.
- What have you already noticed about the patient?
- Make a brief note of the following:
 - How did you greet the patient?
 - Eye contact at start?
 - Any comments on the seating arrangements?
 - The patient's first statement?
 - Your response?
- What have you noticed so far about how YOU were feeling at the time?

What happened next?

Try to notice as much as possible, both about what you see happening on the recording and how it makes you feel. Classifying your words and actions may seem difficult, but it will help you to get a clear sense of what you did. It's easy to be too hard on yourself, or to ignore subtle aspects of your behaviour.

Pay particular attention to the following:

- How you helped the patient to talk;
- The type of questions that you asked;
- How you made sure you had understood;
- How you structured the consultation.

To help you focus, try to write down an example of:

- An OPEN question;
- A CLOSED question;
- Something you SAID or DID that showed you were interested in how they were feeling?
- Something you SAID or DID that helped the patient to show their feelings?
- A way you showed understanding (of their concerns or feelings?)
- Anything else about this interview that strikes you—your own behaviour, the patient's response?

Overall observations.

Use Box 4.5 to mark your assessment of your performance:

Anything else which strikes you about this consultation?

Finally think about how you feel...

(focus on the feelings that you have now listening to/watching the recording):

- Anything you liked about what you did?
- Anything that got in the way of how you wanted to be?
- Any strong feelings? About yourself? About the other person? About what you wanted out of the situation? About their expectations of you?
- Anything you would like to say or do differently given the chance?
- What might you say/do instead (be specific!)?

SELF ASSESSMENT

BOX 4.5

Did I:

1. Seem to be in a hurry?

Very good Good Neither good nor poor Poor Very poor

2. Look at the patient?

Very good Good Neither good nor poor Poor Very poor

3. Have a good rapport with the patient?

Very good Good Neither good nor poor Poor Very poor

4. Listen to what the patient said or asked?

Very good Good Neither good nor poor Poor Very poor

5. Explore psychosocial aspects of the patient's problem?

Very good Good Neither good nor poor Poor Very poor

6. Achieve a balance between 'open' and 'closed' questions?

Very good Good Neither good nor poor Poor Very poor

7. Control the consultation?

Very good Good Neither good nor poor Poor Very poor



4.6 Reviewing your consultations with colleagues.

Probably the most effective way to improve your consulting skills is to look at recordings in a group setting. Your local GP trainer group may be a good source of expertise in how to do this, as they will be regularly working with GP registrars.

You may decide to set up a small group in your practice or with other colleagues locally to look at consultations. It's important to have ground rules for such a group so that is experienced as constructive and not overly critical. This simple method is based on Rules (in Pendleton D et al 2003. *The new consultation: developing doctor-patient communication*. Oxford: University Press. 2nd revised edition. ISBN13: 9780192632883) and is a good starting point:

- The person showing the recording begins by saying what they think went well in the consultation;
- Other people in the group say what they think went well;
- The person showing the recording says what they might have done differently to make the consultation more effective;
- The other people in the group comment on those parts of the consultation which could have been done differently. It's important that they make specific suggestions about how the consultation could have been improved upon.

4.7 Links & references.

e-Learning for Healthcare (e-GP)

www.e-lfh.org.uk/projects/egp/index.html

Client-Focused Evaluations Program (CFEP)

www.cfep.co.uk/

Medical Protection Society basic guide to communication skills

www.medicalprotection.org/uk/gp-registrar-magazine

MRCGP video assessment of consulting skills workbook

www.rcgp.org.uk/default.aspx?page=5775

Howe A (1996)

Detecting psychological distress: can general practitioners improve their own performance?
British Journal of General Practice 46(408):407-10

Pendleton D et al (2003)

The new consultation: developing doctor-patient communication
Oxford: University Press. 2nd revised edition.
ISBN13: 9780192632883

Wilson A & Childs S (2006)

The effect of interventions to alter the consultation length of family physicians
British Journal of General Practice 56(532):876-82

4.8 Further reading.

Dixon M and Sweeney K (2000)

The human effect in medicine
Oxford: Radcliffe Publishing
ISBN13: 9781857753691

Mitchell A and Cormack M (1998)

The therapeutic relationship in complementary healthcare
Edinburgh: Churchill Livingstone. ISBN 0442053197

Silverman J et al (2004)

Skills for communicating with patients. 2nd rev ed
Oxford: Radcliffe Medical Press
ISBN13 9781857756401

Tate P (2006)

The Doctor's Communication Handbook. 5th rev ed.
Oxford: Radcliffe Medical Press, 5th revised edition
2006 ISBN13 9781846191381

CHAPTER 5

CARE PLANNING FOR LONG TERM CONDITIONS

5.1 PLANNING CARE FOR PATIENTS WITH LONG TERM CONDITIONS. 5.2 LINKS & REFERENCES.

5.1 Planning care for patients with long term conditions.

Care plans may be helpful to patients, especially those with long term conditions. Although there is no agreed definition of what a 'care plan' is, the Department of Health aims for most people with long term conditions to have care plans by 2010. This is to encourage doctors and nurses to involve patients in planning their care, including encouraging patients to do things which will help them to manage their own conditions.



Care planning isn't necessarily something that GPs will be responsible for. If a patient with a complex long term condition routinely sees a specialist, it will be the specialist who helps to plan his or her care. Nevertheless, for most patients with long term conditions, this responsibility will fall to GPs.

When we set out designing questions to address this issue, most patients didn't know what a 'care plan' was. So we phrased the questions around 'having a discussion with a doctor or nurse about managing your long term condition'. Of people who replied to that question, most said they had had such a discussion, but a few said they didn't want one.

However, the question in the second year of GPPS is being changed to ask



about a written plan, and this is likely to require more change to what GPs do.

In our view, there is a lot to be gained by discussing with patients how their future care is going to be organised, and what part they are expected to play in it. The risk is that what many would see as a normal part of general practice (and have been doing for years) becomes another box to be ticked. Avoiding that will, to a large extent, depend on GPs'

and nurses' professionalism in using this as an opportunity to plan patients' care and involving patients in that planning process.

An NHS Choices web page describes to patients what they can expect from a care plan – www.nhs.uk/YourHealth/Pages/CarePlans.aspx. It includes related articles on 'Making a care plan', and a video from a community matron, in which she describes how she goes about producing a care plan.

5.2 Links & references.

NHS Choices

www.nhs.uk/YourHealth/Pages/CarePlans.aspx

CHAPTER 6

MAKING CHANGE HAPPEN

- 6.1 USING SURVEYS TO PRODUCE CHANGE.**
- 6.2 MEASURING CHANGE: HOW TO TELL IF THINGS HAVE IMPROVED.**
- 6.3 PDSA CYCLES.**
- 6.4 DOING AN ANNUAL SURVEY.**
- 6.5 LINKS & REFERENCES.**

6.1 Using surveys to produce change.

Remember that a survey is only a tool for gaining useful information: the challenge is how to translate this into visible change and produce improvement. This process is essentially a social one and, as discussed elsewhere, to be most effective, it needs to involve your patients.

At the very best, surveys offer the opportunity for really significant change in your practice. Where practices have energetically embraced involving patients in the design of services, both staff and patients have been able to see clear improvements. This has been the clear experience of practices who responded to the BMA nationwide consultation, *Developing General Practice: Listening to Patients*, (www.bma.org.uk/images/listenpatient_tcm41-187204.pdf), and of the practices in North & East Devon Healthcare Community (Greco and Carter 2006. *Impact of patient involvement in general practice. Education for Primary Care* 17:486-496). See Chapter 7 *Involving Patients* for more details.

Patients consistently record the highest levels of satisfaction with primary care services, the highest in any public organisation. So practices don't have much to fear. Yet patients still find things that need improvement. Issues such as waiting times for appointments, waiting times in the surgery and getting the doctor of choice all feature highly in patients' wish-lists. These may not all be achievable in these days of part-time working and targets for waiting times. However, patients can be included in discussions about trade-offs between these various elements, and involved in analysing the impact on further satisfaction ratings.

“ ”

There were quite a few things that needed to get changed and get settled in. Hopefully we've addressed the things which caused most distress... we didn't want to do it again before they were up and running... It is a problem with having made changes.

GP, large practice, large town.



6.2 Measuring change: how to tell if things have improved.

If you have tried to make changes in your practice, you will want to know if they have made a difference. It's not likely, however, that just doing a survey will have been sufficient to bring about future improvement in scores. Greco and Carter (2004) looked at this issue in detail, in Does a patient survey make a difference? (Education for Primary Care 15:183-189). Such improvement may occur only when there is a concerted effort by the practice staff to put into action strategies targeted at specific areas in need of change.

Often, you will want to know whether changes you have made (e.g. making phone appointments available) have been successful. You may want to develop your own way of auditing that. Choose simple things that you can measure, and can measure easily. You need rapid feedback for

you or your staff about the differences you are making. The GPPS is repeated annually so you can keep a check on progress by comparing results from year to year. There is also no reason why you should not use all or part of GPPS for your own audit purposes if you wish.

6.3 PDSA cycles.

The model for improvement adopted and promoted by the Improvement Foundation website at www.improvementfoundation.org/ (formerly National Primary Care Development Team) consists of two parts that are of equal importance:

PART 1 is the **thinking part** and includes three fundamental questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

PART 2 is the **doing part**, consisting of PDSA cycles, which assist with making rapid change:

• **Plan** • **Do** • **Study** • **Act**

The basic premise of the model is that a planned approach to improvement ensures a better chance of success. The PDSA cycles allow you to test out ideas developed from question 3 above. It is advisable to try out a small scale change to begin with, perhaps based on one aspect or question of the GPPS, and rely on using many consecutive cycles to build up information about how effective your change is. Box 6.1 contains an example PDSA cycle.

It is important to remember that PDSA cycles cannot be too small, and it is best to

EXAMPLE OF A PDSA CYCLE

BOX 6.1

Objective: To assess views of patients regarding privacy in the surgery reception area.

PLAN:

Give out a very short questionnaire about privacy to patients attending the surgery over a week.

DO:

120 questionnaires given out.

STUDY:

Out of 120 questionnaires:

- 80 said that privacy in the reception area was acceptable.
- 38 said that improvements could be made to privacy in the reception area.
- 2 said that privacy in the reception area was very poor.
- 84 weren't aware that there is a room available (on request) for confidential conversations.

ACT:

Practice Manager will put up a notice asking patients to request use of a separate room if they need more privacy. This issue to be reviewed at the next practice meeting.

apply them to a series of linked, small-scale changes. Measuring and recording the results of these small-scale changes is essential, as this will help you learn from the experience. You will then be in a position to share your learning among your own team and beyond. Improvement is nearly always a team endeavour – try to ensure that you involve the right people in your work. In future, some results from the GP Patient Survey may be published quarterly to help you keep a check on your progress.

6.4 Links & references.

Developing General Practice:

Listening to Patients

www.bma.org.uk/images/listenpatient_tcm41-187204.pdf

GP Patient Survey Technical Report

www.gp-patient.co.uk/results/England%20Technical%20Report%2008-09.pdf

Improvement Foundation

www.improvementfoundation.org/

Greco M et al (2004)

Does a patient survey make a difference?

Education for Primary Care 15:183-189

Greco M et al (2006)

Impact of patient involvement in general practice

Education for Primary Care 17:486-496

CHAPTER 7

INVOLVING PATIENTS

7.1 DISCUSSING RESULTS WITH PATIENTS.

7.2 INVOLVING PATIENT GROUPS.

7.3 OTHER PATIENT AND PUBLIC REPRESENTATIVES.

7.4 LINKS & REFERENCES.

7.1 Discussing results with patients.

We know a lot about how patients want to receive information about their practice. From our experience and our research work, we have found that:

- Patients like to see survey information about their practice. They want to know what people like them think about their practice. They find survey information more useful than information on clinical indicators;
- Patients like to know that the data have been collected reliably, and that the practice has been involved in some way in the data collection;
- It is easy to engage patients in discussion about care in practices;
- Patients are positive and constructive and want to help practices get better;
- Patients like histograms and bar charts. They don't like lots of tables of raw data;
- Patients also like narrative descriptions of problems, and like to understand the context in which the practice is working (especially if comparing with other practices).

For previous rounds of the GPPS, in addition to a poster thanking patients for taking part in the GPPS, many practices have produced for the reception area an eye-catching and informative display of the headline results. Patient surveys also provide a good opportunity to engage positively with patients in thinking about improving the care in your practice. One way of doing this is to form a Patient Group.

7.2 Involving Patient Groups.

One way of achieving ongoing communication with patients is the establishment of a Patient Participation Group (PPG) attached to a particular general practice. The National Association of Patient Participation (NAPP, www.napp.org.uk) is the umbrella organisation for such groups and provides practical advice and support on how to establish and maintain a PPG. In 2007, NAPP surveyed GP practices in England and found that 37% had a PPG (although this may be an overestimate for the country as a whole, as practices with a PPG were probably more likely to respond). 44% of practices with a PPG felt that their group was 'quite or very influential' in the life of the practice. PPGs can be initiated by doctors, practices or patients.

The BMA provides a useful resource, Patient Participation Groups in Primary Care (www.bma.org.uk/patients_public/ppgintro.jsp), which focuses primarily on those PPGs initiated by GPs and aims to provide practical advice on setting up and running a successful group, such as how to obtain funding, self-evaluation of PPGs, and links to practices with established PPGs.

The Impact of Patient Involvement, an article by Greco and Carter (2006) reports on a project conducted in Devon with a number of general practices. The study investigated the impact of a patient-practice partnership group (in this case called a "Critical Friends Group") on the general practice's ability to act on the results of systematic patient feedback in making patient-focused changes to their services. We've described their findings in some detail as they give a useful guide to what other practices could do in this area.

The experience of getting a Critical Friends Group together.

It was the responsibility of the practice to select a small group of patients for participation in discussions with practice staff. Practitioners

were encouraged to select patients with whom they felt comfortable, and who, they believed, would make a constructive contribution to quality improvement.

Some practices found selecting patients to participate quite difficult, and it was important that this responsibility was shared among practice staff. If possible, the group needed to contain a mix of men and women, different ages and people with and without chronic problems. Between three and five patients was found to be best for a Critical Friends Group.

This study also found that it was important for a cross-section of practice staff to be involved in discussions with patients, including practice manager, GP, receptionist and practice nurse. Some patients remarked that they would prefer the group to include more than one GP, as this provided reassurance that involving patients was part of an ethos embraced by the entire practice, not simply by one individual.

A pre-meeting with the patients invited to join the group was held about two weeks prior to the first full meeting.

These meetings were organised and run by an experienced facilitator who was familiar with the concept of partnership working, and



The group mentioned that they wanted other doctors to come, so that they don't feel it's just the Dr V bandwagon! They'd like some reassurance that it's got backing.

GP, large practice, large town.

ARE PATIENT REPRESENTATIVES REALLY REPRESENTATIVE?

BOX 7.1

This is a question often asked about patients' groups of all kinds. Critical Friends Groups were developed with this issue in mind. The patients were not invited so that they could bring their own concerns to the meeting. The agreed agenda for discussion was based purely upon the result of the systematic feedback provided by the approximately 250 patients per practice who responded to the survey. The Critical Friends are there simply to discuss the results presented to them.

It made sense to encourage practice staff to select patients whom they felt able to work with. The partnership had to be based on mutual trust, and that trust had to be positively nurtured by all the participants.

with the format of the patient feedback results received by the practice. Members of the group were encouraged to introduce themselves, to be open about their feelings about joining the group and to say what they hoped to get out of it. Having given every patient sufficient time to introduce themselves, the facilitator next explained the process of gaining patient feedback, and then distributed the practice results for the patients to look at. Participants were given the results to take away with them for further perusal. The facilitator needed to make sure that all participants know the agenda for the full meeting, i.e. discussing the practice results, and he or she cautioned against individuals raising their own particular concerns or hobby horses as that was not the purpose of the group.

Although it was very important for an individual within the practice to be a key contact for the group, it was equally important for everyone involved to be well-informed and prepared for sharing and discussing results with the patients. Some staff were unfamiliar with the feedback process and the format of results, and so a pre-meeting with staff was a useful opportunity to ensure that all practice participants felt comfortable with the process. This session took no more than an hour.

The first meeting of the partnership group was chaired either by the trained facilitator mentioned above or, in some cases, the Practice Manager or other practice member who felt comfortable adopting this role. First, each member of the new group introduced him/

herself. Each member of practice staff took the opportunity to describe his or her role within the practice – this was not always be understood by patients. Participants were encouraged to give their view of the group’s role and objectives.

Then the group looked at the practice’s survey results, and identified areas of concern.



The group discussed each issue, each bringing their own perspective and interpretation (see box 7.2 for the top 10 topics for discussion).

Practice staff benefited from an opportunity to describe various aspects of the surgery, together with an explanation of restrictions and constraints it faced. The patients had a chance to speak from the patient perspective, and clarify scores and comments contained within the results.

The group then identified a number of remedial strategies (where needed). These were usually small-scale, but with the potential to make a real difference to patients’ experience of the practice (see box 7.3 for the top 10 actions agreed). The date of the second meeting was set for approximately 8-10 weeks later, and the agenda agreed (see next paragraph).

The basis of the second meeting of the group was a review of the strategies discussed and agreed at the first meeting. By this time

WHAT DO CRITICAL FRIENDS GROUPS DISCUSS?

BOX 7.2

Top 10 topics

- Methods of communicating key information to patients
- Telephone systems
- Reception arrangements
- Waiting room arrangements
- The role of practice nurses (e.g. nurse-led clinics)
- Appointment systems (including “advanced access”)
- Systems for repeat prescriptions
- Seeing the doctor of your choice
- Waiting times (in the surgery)
- Out of hours systems

Experience of North & East Devon Healthcare Community, Active Patient Involvement in Primary Care project, 2001-03 (Greco and Carter 2006)

the group often wanted to clarify its remit, and draw up more specific terms of reference – participants sometimes decided to review and extend membership. Many groups also addressed the issue of disseminating the results of the group’s discussions to a broader constituency of practice patients, and identified the most effective means of communicating information. These methods varied from practice to practice, and included leaflets/newsletters/website available within the surgery or sent

to patients, a group notice board, or possibly a regular time at which a group member was present in the surgery to answer queries.

Many groups decided to hold meetings on a quarterly basis, giving the practice sufficient time to implement some of the strategies agreed at the initial meetings. Some groups decided that they needed a mechanism for communicating developments or concerns in a timely manner – i.e. not waiting until the next scheduled meeting of the partnership group.

7.3 Other patient and public representatives.

If the practice does not have a Patient Participation Group, you might choose to discuss the results of the GPPS with a non-executive director of your PCT, another lay person nominated by the PCT, or perhaps a patient representative from your Practice Based Commissioning Group. Where the lay person has already held meetings with other practices, they may be able to offer useful comparisons, and ideas for improvement based on what others have included in their forward plans. However, these meetings don’t any longer attract QOF points.

If the meeting is arranged by the PCT, they may specify the format of the meeting; any paperwork they want you to provide, and who they would like to attend from the practice. Where possible, as in the case of Critical Friends Groups, it is generally appreciated if a GP attends the meeting. However positive the results of the GPPS for your practice, be prepared to admit that there is room for improvement and provide a suggested action plan for discussion. Minutes of a practice meeting where the GPPS results were discussed provide evidence that the practice takes patient feedback seriously. You can also provide a copy of the poster or leaflet you are using to report results to your patients. Where the PCT has nominated a lay person or

non-executive director to talk to you, it is their responsibility to ensure that this individual is suitably prepared and supported for the role.

Each area now has a Local Involvement Network (LINK), the replacement body for the PCT and NHS Trust Patient and Public Involvement Forums (PPIFs). Under certain conditions, and with due regard to patient privacy and dignity, LINKs are able to enter GP premises to view services. You may wish to cultivate a positive relationship with your LINK: they could be helpful in commenting on your GPPS results, and you might want to pro-actively engage them in this. In addition, they should be able to provide useful feedback on patient experience in your area, not just of

“”

“I felt that the people who came in were being constructive, and I think it’s good from our point of view too. Because we get so busy, don’t we, that it’s nice to have a balanced view from a broader area”.

Receptionist, large practice, large town.



WHAT ACTIONS ARE AGREED?

BOX 7.3

A selection of outcomes of Critical Friends Groups

- **Information for patients:**
 - Clear information about all services offered at practice.
 - Improved use of notice boards.
 - Production of newsletter and leaflets.
 - Reception and other practice staff reinforcing information with word-of-mouth messages to patients.
- **Appointments systems**
 - Changes to balance between book-able and same-day appointments.
- **Telephone systems**
 - Clear answer-phone messages.
- **Waiting room arrangements**
 - Improved safety for elderly patients (e.g. sensible storage of children's toys).
- **Practice nurse roles**
 - Renaming of nurse-led clinic to reflect patients' perceptions and concerns from "Minor Illness" to "Urgent Access".
 - Group members (patients) taking responsibility for spreading the word among fellow patients about the extended role of nurses within the practice.

the services you provide but also of those you commission, or which are commissioned on your behalf. The NHS Centre for Involvement Web site provides more information on LINKs (www.nhscentreforinvolvement.nhs.uk/).

Local Authority Health Overview and Scrutiny Committees (HOSCs) have the power to call in PCT officers, but not GPs, to answer questions about the health service in their area, and they can also review any aspect of health and social care commissioning or delivery. It is possible that a HOSC may choose to review GPPS results for their local practices and they might invite you to attend a meeting. The Centre for Public Scrutiny (www.cfps.org.uk/) is the main body providing information about, and support for, health scrutiny.

7.4 Links & references.

Centre for Public Scrutiny
www.cfps.org.uk/

National Association for Patient Participation
www.napp.org.uk/

NHS Centre for Involvement
www.nhscentreforinvolvement.nhs.uk/

Patient participation groups in primary care
www.bma.org.uk/patients_public/ppgintro.jsp

Greco M et al (2006)
Impact of patient involvement in general practice
Education for Primary Care 17:486-496

“ ”

“I think it’s really valuable... to actually talk to patients in a calm environment, not at the front desk, when they may be furious, because they’ve waited. I think also in that environment they can ask you ‘why?’, and maybe that helps.”

Practice Manager (small practice, urban location)



CHAPTER 8

APPRAISAL & REVALIDATION

- 8.1 LINKING TO APPRAISAL AND REVALIDATION.**
- 8.2 GOOD MEDICAL PRACTICE.**
- 8.3 LINKS AND REFERENCES.**

8.1 Linking to appraisal and revalidation.

Although GPPS doesn't provide results at an individual practitioner level, information from the survey may well prove useful for individuals undergoing appraisal and revalidation.

GPs have an annual appraisal, and this includes an opportunity to reflect on their consulting skills. The Royal College of General Practitioners website includes useful, detailed information and guidance about what is expected of GPs (www.rcgp.org.uk/_revalidation.aspx), and provides a detailed outline of the evidence currently proposed to be appropriate for the revalidation of GPs as well as an outline timetable relevant to collecting that evidence.

GPs' appraisal forms include space to comment on relationships with patients. You can get information about these and related aspects of care from patient surveys. You can therefore use the results of patient questionnaires to provide information for your appraisal about what patients think of your attitude and care.

Practice accreditation (Primary Medical Care Provider Accreditation – PMCPA) is also on the horizon. This will focus on organisational issues at a practice level. Information from the GPPS will no doubt form an important

part of the assessment of each practice's performance. The criteria for assessment were developed by stakeholder groups, which included the RCGP's patient partnership group. More information is available on the RCGP website: www.rcgp.org.uk/practising_as_a_gp/team_quality/pmcpa.aspx.

Although GPPS can be used as evidence in your annual appraisals, it is not yet clear how surveys will be used in revalidation. The current survey will not fulfil all of a doctor's needs for revalidation as it is entirely based at practice level, and it's very likely that a periodic survey of the GP's own patients will be needed in future as part of obtaining information from a range of people who can comment on a doctor's professional practice and behaviour. The GMC has been testing their own questionnaires for this purpose, and relevant research by Campbell et al (2008) has recently been published about the potential role for these questionnaires.

8.2 Good Medical Practice.

The General Medical Council website includes a section on Good Medical Practice (www.gmc-uk.org/guidance/good_medical_practice/).

This will form the basis for judgements about revalidation. Good Medical Practice sets out the duties of a doctor which are that:

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern;
- Protect and promote the health of patients and the public;
- Provide a good standard of practice and care;
 - Keep your professional knowledge and skills up to date
 - Recognise and work within the limits of your competence
 - Work with colleagues in the ways that best serve patients' interests.
- Treat patients as individuals and respect their dignity;
 - Treat patients politely and considerately;
 - Respect patients' right to confidentiality;
- Work in partnership with patients;
 - Listen to patients and respond to their concerns and preferences;
 - Give patients the information they want or need in a way they can understand;

- Respect patients' right to reach decisions with you about their treatment and care;
- Support patients in caring for themselves to improve and maintain their health;
- Be honest and open and act with integrity;
 - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk;
 - Never discriminate unfairly against patients or colleagues;
 - Never abuse your patients' trust in you or the public's trust in the profession.

As mentioned earlier in this handbook, there are many resources, including e-Learning for Healthcare – e-GP (information from www.e-lfh.org.uk/projects/egp/index.html), available to help you maintain and develop good medical practice. While these aren't directly linked to the GP Patient Survey, critical responses to the survey could indicate that the practice has problems in areas identified as important by the GMC.

8.3 Links & references.

e-Learning for Healthcare (e-GP)
www.e-lfh.org.uk/projects/egp/index.html

Guide to the Revalidation of General Practitioners
www.rcgp.org.uk/revalidation/revalidation_guide.aspx

General Medical Council, Good Medical Practice
www.gmc-uk.org/guidance/good_medical_practice/

Primary Medical Care Provider Accreditation (PMCPA)
www.rcgp.org.uk/practising_as_a_gp/team_quality/pmcpa.aspx

Campbell J L et al (2008)
Assessing the professional performance of UK doctors: an evaluation of the utility of the General Medical Council patient and colleague questionnaires
Quality and Safety in Health Care 17:187-193
<http://dx.doi.org/10.1136/qshc.2007.024679>

APPENDIX

GPSS and staff flyer

- APPENDIX 1. THE GENERAL PRACTICE PATIENT SURVEY (GPSS).**
 - APPENDIX 2. THE GP PATIENT SURVEY INFORMATION FOR GPs AND PRACTICE STAFF (FLYER)**
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THE GP PATIENT SURVEY

Thank you for taking the time to answer these questions. Please answer the questions below by putting a ✓ in ONE BOX for each question. We will keep your answers completely confidential.



If you would prefer to complete the survey online, please go to www.gp-patient.co.uk and follow the instructions.



Reference/Username:

1234567890



Online password:

ABCDE

A. ABOUT YOUR GP SURGERY OR HEALTH CENTRE

Q1 How easy do you find it to get into the building at your GP surgery or health centre?

- Very easy
- Fairly easy
- Not very easy
- Not at all easy

Q2 How clean is your GP surgery or health centre?

- Very clean
- Fairly clean
- Not very clean
- Not at all clean
- Don't know

Q3 In the reception area, can other patients overhear what you say to the receptionist?

- Yes, but I don't mind
- Yes, and I am not happy about it
- No, other patients can't overhear
- Don't know

Q4 How helpful do you find the receptionists at your GP surgery or health centre?

- Very helpful
- Fairly helpful
- Not very helpful
- Not at all helpful

B. GETTING THROUGH ON THE PHONE

Now please think about times you have phoned your GP surgery or health centre in the past 6 months.

Q5 In the past 6 months, how easy have you found the following? Please put a ✓ in one box for each row.

	Haven't tried	Very easy	Fairly easy	Not very easy	Not at all easy	Don't know
Getting through on the phone	<input type="checkbox"/>					
Speaking to a doctor on the phone	<input type="checkbox"/>					
Speaking to a nurse on the phone	<input type="checkbox"/>					
Getting test results on the phone	<input type="checkbox"/>					

C. SEEING A DOCTOR

Q6 In the past 6 months, have you tried to see a doctor fairly quickly?
By 'fairly quickly' we mean on the same day or in the next 2 days the GP surgery or health centre was open.

- Yes..... Please go to Q7
- No Please go to Q9
- Can't remember.... Please go to Q9

Q7 Think about the last time you tried to see a doctor fairly quickly. Were you able to see a doctor on the same day or in the next 2 days the GP surgery or health centre was open?

- Yes..... Please go to Q9
- No Please go to Q8
- Can't remember.... Please go to Q9

Q8 If you couldn't be seen within the next 2 days the GP surgery or health centre was open, why was that?

Please tick all the boxes that apply to you

- There weren't any appointments
- The times offered didn't suit me
- The appointment was with a doctor I didn't want to see
- I could have seen a nurse but I wanted to see a doctor
- Another reason
- Can't remember

Q9 In the past 6 months, have you tried to book ahead for an appointment with a doctor?
By 'booking ahead' we mean booking an appointment more than 2 full days in advance.

- Yes..... Please go to Q10
- No Please go to Q11
- Can't remember.... Please go to Q11

Q10 Last time you tried to, were you able to get an appointment with a doctor more than 2 full days in advance?

- Yes
- No
- Can't remember

Q11 When did you last see a doctor at your GP surgery or health centre?

- In the past 3 months Please go to Q13
- Between 3 and 6 months ago..... Please go to Q13
- More than 6 months ago..... Please go to Q12
- I have never been seen at my present GP surgery or health centre Please go to Q12

Q12 If you haven't seen a doctor in the past 6 months, why is that?

Please tick all the boxes that apply to you

- I haven't needed to see a doctor
- I couldn't be seen at a convenient time
- I couldn't get to the GP surgery or health centre easily
- I didn't like or trust the doctors
- Another reason

D. WAITING TIME IN THE GP SURGERY OR HEALTH CENTRE

Q13 How long after your appointment time do you normally wait to be seen?

- I don't normally have appointments at a particular time
- I am normally seen at my appointment time
- Less than 5 minutes
- 5 to 15 minutes
- 16 to 30 minutes
- More than 30 minutes
- Can't remember

Q14 How do you feel about how long you normally have to wait?

- I don't normally have to wait too long
- I have to wait a bit too long
- I have to wait far too long
- No opinion

E. SEEING THE DOCTOR YOU PREFER

Q15 Is there a particular doctor you prefer to see at your GP surgery or health centre?

- Yes..... Please go to Q16
- No Please go to Section F
- There is usually only one doctor in my GP surgery or health centre Please go to Section F

Q16 How often do you see the doctor you prefer to see?

- Always or almost always
- A lot of the time
- Some of the time
- Never or almost never
- Not tried at this GP surgery or health centre

F. OPENING HOURS

In the next few questions, think about the times your GP surgery or health centre is open for you to see a doctor or a nurse.

Q17 How satisfied are you with the hours that your GP surgery or health centre is open?

- Very satisfied
- Fairly satisfied
- Neither satisfied nor dissatisfied
- Fairly dissatisfied
- Very dissatisfied
- I'm not sure when my GP surgery or health centre is open

Q18 Would you like your GP surgery or health centre to open at additional times?

- Yes..... Please go to Q19
- No Please go to Section G

Q19 Which one of the following additional times would you **most like** the GP surgery or health centre to be open? Please pick **one** answer showing the time you would **most like** it to be open.

- Before 8am
- At lunchtime
- After 6.30pm
- On a Saturday
- On a Sunday

G. SEEING A DOCTOR IN THE GP SURGERY OR HEALTH CENTRE

Please answer these next questions about the last time you saw a doctor at your GP surgery or health centre.

Q20 **Last time** you saw a doctor at your GP surgery or health centre, how good was the doctor at each of the following? Please put a ✓ in one box for **each** row.

	Very good	Good	Neither good nor poor	Poor	Very poor	Doesn't apply
Giving you enough time	<input type="checkbox"/>					
Asking about your symptoms	<input type="checkbox"/>					
Listening to you	<input type="checkbox"/>					
Explaining tests and treatments	<input type="checkbox"/>					
Involving you in decisions about your care	<input type="checkbox"/>					
Treating you with care and concern	<input type="checkbox"/>					
Taking your problems seriously	<input type="checkbox"/>					

Q21 Did you have confidence and trust in the doctor you saw?

- Yes, definitely
- Yes, to some extent
- No, not at all
- Don't know/can't say

H. SEEING A PRACTICE NURSE IN THE GP SURGERY OR HEALTH CENTRE

Q22 Have you seen a practice nurse at your GP surgery or health centre in the past 6 months?

- Yes..... Please go to Q23
- No Please go to Q25

Q23 How easy is it for you to get an appointment with a practice nurse at your GP surgery or health centre?

- Haven't tried
- Very easy
- Fairly easy
- Not very easy
- Not at all easy
- Don't know

Q24

Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at each of the following? Please put a ✓ in one box for each row.

	Very good	Good	Neither good nor poor	Poor	Very poor	Doesn't apply
Giving you enough time	<input type="checkbox"/>					
Asking about your symptoms	<input type="checkbox"/>					
Listening to you	<input type="checkbox"/>					
Explaining tests and treatments	<input type="checkbox"/>					
Involving you in decisions about your care	<input type="checkbox"/>					
Treating you with care and concern	<input type="checkbox"/>					
Taking your problems seriously	<input type="checkbox"/>					

I. YOUR OVERALL SATISFACTION

Q25

In general, how satisfied are you with the care you get at your GP surgery or health centre?

- Very satisfied
- Fairly satisfied
- Neither satisfied nor dissatisfied
- Fairly dissatisfied
- Very dissatisfied

J. PLANNING YOUR CARE

The next few questions are about a discussion you may have had with any doctor or nurse.

Q26

Do you have any long-standing health problem, disability or infirmity? Please include anything that has troubled you over a period of time or that is likely to affect you over a period of time.

- Yes..... Please go to Q27
- No Please go to Section K
- Don't know/can't say.....Please go to Section K

Q27

In the past 6 months, have you had a discussion with a doctor or nurse about managing your long-standing health problem?

- Yes..... Please go to Q28
- No, I didn't want a discussion Please go to Section K
- No, I would have liked a discussion..... Please go to Section K
- Can't remember Please go to Section K

Q28

Following this discussion, did a doctor or nurse agree a plan about how you wanted to manage your long-standing health problem?

- Yes
- No
- Can't remember

Q29

Do you think that having a discussion or plan has helped improve the care you receive?

- Yes, definitely
- Yes, to some extent
- No, not at all
- Don't know

K. OUT OF HOURS CARE

The next few questions are about contacting an out-of-hours GP service when your GP surgery or health centre is closed outside normal working hours (for example, in the evening, at night or at the weekend).

These questions are not about NHS Direct, NHS walk-in centres or Accident and Emergency (A&E) or Casualty services.

Q30 If you wanted to, would you know how to contact an out-of-hours GP service when the surgery or health centre is closed?

- Yes
- No

Q31 In the past 6 months, have you tried to call an out-of-hours GP service when the surgery or health centre was closed?

- Yes, for myself Please go to Q32
- Yes, for someone else Please go to Q32
- No Please go to Section L

Q32 How easy was it to contact the out-of-hours GP service by telephone?

- Very easy
- Fairly easy
- Not very easy
- Not at all easy
- Don't know

Q33 Were you prescribed or recommended any medicines by the out-of-hours GP service you contacted?

- Yes Please go to Q34
- No Please go to Q35
- Don't know/doesn't apply Please go to Q35

Q34 How easy was it to get these medicines?

- Very easy
- Fairly easy
- Not very easy
- Not at all easy

Q35 How do you feel about how quickly you received care from the out-of-hours GP service?

- It was about right
- It took too long
- Don't know/doesn't apply

Q36 Overall, how do you feel about the care you received from the out-of-hours GP service?

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know/doesn't apply

L. SOME QUESTIONS ABOUT YOURSELF

The following questions will help us to see how experiences vary between different groups of the population.

Q37 Are you male or female?

- Male
 Female

Q38 How old are you?

- Under 18 55 to 64
 18 to 24 65 to 74
 25 to 34 75 to 84
 35 to 44 85 or over
 45 to 54

Q39 What is your ethnic group?

Choose one section from A to E below, then select the appropriate option to indicate your ethnic group

A. White

- British
 Irish
 Any other White background

→ Please write in

B. Mixed

- White and Black Caribbean
 White and Black African
 White and Asian
 Any other Mixed background

→ Please write in

C. Asian or Asian British

- Indian
 Pakistani
 Bangladeshi
 Any other Asian background

→ Please write in

D. Black or Black British

- Caribbean
 African
 Any other Black background

→ Please write in

E. Chinese or other ethnic group

- Chinese
 Any other ethnic group

→ Please write in

Q40 Which of these best describes what you are doing at present?

If more than one of these applies to you, please tick the main ONE only

- Full-time paid work (30 hours or more each week) Please go to Q41
 Part-time paid work (under 30 hours each week) Please go to Q41
 Full-time education at school, college or university
 Unemployed
 Permanently sick or disabled
 Fully retired from work
 Looking after the home
 Doing something else

Please go to Q43

Q41 In general, how long does your journey take from home to work (door to door)?

- Up to 30 minutes
 31 minutes to 1 hour
 More than 1 hour
 I live on site

Q42 If you need to see a doctor at your GP surgery or health centre during your typical working hours, can you take time away from your work to do this?

- Yes
 No

Q43 In general, would you say your health is...?

- Excellent
 Very good
 Good
 Fair
 Poor

Q44 Do you have any of the following long-standing conditions? Please include problems which are due to old age.

Please tick all the boxes that apply to you

- Deafness or severe hearing impairment
- Blindness or severe visual impairment
- A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying
- A learning difficulty
- A long-standing psychological or emotional condition
- Other, including any long-standing illness
- No, I do not have a long-standing condition

Q45 Are you a deaf person who uses sign language?

- Yes
- No

Q46 Are you a parent or a legal guardian for any children aged under 16 currently living in your home?

- Yes
- No

Q47 Do you have carer responsibilities for anyone in your household with a long-standing health problem or disability?

- Yes
- No

Thank you for your time.

Please return this questionnaire in the reply paid envelope provided.

This questionnaire has been developed in conjunction with the National Primary Care Research and Development Centre, The University of Manchester and Peninsula Medical School.



THE GP PATIENT SURVEY



Information for GPs and Practice Staff

THE GP PATIENT SURVEY

The Department of Health (DH) is running a GP Patient Survey again this year to assess patients' experiences of their local NHS services. Survey specialist Ipsos MORI continues to run the survey on behalf of DH and this year has worked with primary care academics to develop a new questionnaire. Around 5.7 million patients in England are invited to give their experiences.

Why is this happening?

The GP Patient Survey continues to be developed as part of the Government's commitment to make the NHS more responsive to patients' needs. The Survey underpins a range of policies to improve the patient experience. This includes supporting assessment of practice achievement of the patient experience indicators in the Quality and Outcomes Framework covering 48-hour access and advance booking. Primary Care Trusts (PCTs) will also be assessed on their record on patient experience of GP services using the survey data, which will help to improve standards. The findings of the GP Patient Survey will also provide valuable information for patients about what other patients think about local services.

What does the survey cover?

The new survey questionnaire covers a range of issues that are important to patients including questions on:

- The surgery environment and helpfulness of reception staff
- Getting through on the Phone
- Accessing GP appointments
- Patient satisfaction with practice opening hours
- Consultations with healthcare professionals
- Patient satisfaction with overall care and planning care
- Accessing local out of hours care

How have patients been selected?

A random sample of patients registered at your practice has again been drawn from the NHAIS (Exeter) Registration systems by the Department of Health. The sample is being used by Ipsos MORI on behalf of the Department, under the terms of a Data Processor Agreement the Department has put in place with Ipsos MORI. The sample is being used for survey administration purposes only. Once Ipsos MORI has completed its analysis of the responses, all sample data will be securely destroyed.

The following personal data are being collected:

- Patients' NHS number: provides a unique identifier
- Name: for personalised letters
- Address: to conduct a postal survey
- Date of birth: to exclude patients under 18 years of age
- Gender: for data analysis and non response bias analysis, e.g. to ascertain if certain groups are less likely to respond to the survey

No other personal data will be collected from the NHAIS system. Ipsos MORI has not been given access to any NHS systems, nor has it been provided with any clinical information about patients' health or consultations.

What happens next?

- Patients selected to take part in the survey will be sent a questionnaire in the week commencing 5 January 2009
- Reminder questionnaires will be sent out in February and March to people who do not return a questionnaire, unless they have opted out following the initial questionnaire (see below)
- Analysis and reporting will be undertaken in April and May 2009
- PCTs will receive results data in May so that they can calculate achievement of QOF indicators PE7 (patient experience of 48-hour access) and PE8 (patient experience of advance booking) and finalise payments to practices by the end of the first quarter of the 2009/10 financial year

Taking part in the survey is voluntary. If patients do not wish to take part, they do not need to return their questionnaire and can disregard the reminders. If there are patients you know who should not receive mailings to their address or who have registered an objection with their GP to receiving mailings, practices should email the names and NHS numbers of these patients to gppatientsurvey@dh.gsi.gov.uk.

As there is a possibility that some patients could receive a questionnaire at an inappropriate time, please note that we will always continue to withdraw patients from survey mailings wherever possible. Cut-off dates for patient opt outs from the 2008/09 survey are 28th November for the main mailing, 19 January 2009 for the first reminder mailing and 23 February 2009 for the final reminder mailout. For future surveys please continue to notify the mailbox as soon as you can.

Confidentiality

We are aware that the confidentiality of patient details will be a major concern for GPs and the public. This has been taken very seriously and the administration of the survey will ensure that the survey is conducted within the law, that the requirements under the Data Protection Act 1998 are upheld, and that the Caldicott Principles are adhered to. For more information about this please see the website address below.

Accessibility

To assist patients who may find it difficult to complete the questionnaire, Ipsos MORI is putting in place various measures to help these respondents. These include:

- A website (www.gp-patient.co.uk) with a detailed Frequently Asked Questions section. These will be available in English and in the 13 other languages most commonly used by NHS Direct
- The website will be fully compatible with W3C Standards which means that users will be able to use Screen Reader software and it will be possible to change the font size of the text
- The questionnaire will also be available on the website in British Sign Language
- Alternative versions of the questionnaire, such as large print and Braille will be available on request
- It will be possible to complete the questionnaire online or over the telephone, including in the 13 languages most commonly used by NHS Direct
- There will be a telephone helpline which will be able to answer respondents' queries and help with completing the questionnaire if necessary

For more information

Please visit the following web pages for more information about the survey, including a detailed Frequently Asked Questions section:

www.pcc.nhs.uk/201.php

www.dh.gov.uk



