Report on the feedback received from the patient groups following publication of the results from the 2012 patient survey

Introduction – methodology used with the survey

There have been a few queries about the methodology used in running the survey and hence I have written a short introduction to clarify our approach.

The Department of Health lay down a set of guidelines that Practices must follow if the survey is to be recognised. These guidelines cover the way in which the survey is managed throughout the entire process, from construction through to analysis and publication of findings.

Initially we asked the patient group to identify the topics that that felt were important to cover in the survey. This identified a clear priority as regards the opening times of the practice as this topic received twice as many votes as the next category, however the rest were within one to two points of each other.

The agreed final list was as follows:

- Opening times (clear priority to all)
- Ability to get an appointment when you want one
- Ability to contact the practice easily
- Continuity of care
- Quality of care

The patient group also felt that they survey should be much shorter and simpler than in previous years. Also there was a desire to use plain English and to keep the questions simple. The final survey was also agreed with the patient group.

The practice is required to ask the patient group for their comments on the results from the survey and to agree the subsequent action plan with them. Once the action plan has been agreed a copy of the results together with the plan is sent to the local Primary Care Trust and published on the Practices website.

Regarding specific points about the questionnaire and the responses, of course I am disadvantaged by coming to this without prior knowledge of how the format and content of the questionnaire were determined. It is all very well for me to wonder, for example, why a certain question was not asked, or why another was framed in such a way, when it may well have been the case that the questions were chosen and laid out according to a priority that is invisible to me and which has been determined by or in consultation with the Patient Participation Group. I hope you will forgive me, therefore, if I mention in the following some points that perhaps were not covered in the survey or covered differently because neither the PPG nor the staff considered them a priority for the University of Reading Medical Practice.

On a related topic, could I ask whether the design of the questionnaire is in any sense approved by the PCT/CCG or notified to them? Similarly, could

you let me know whether the results of the survey are shared with the PCT/CCG and/or with other GP practices?

Queries raised by members of the patient group during feedback of results process

1. I note that almost half of the respondents are under 25, with only 9% over 65. Given the unusual patient-age profile of UoRMP, this is not surprising, but it does mean that drawing conclusions particularly relevant to a more mature patient cohort might be dangerous, and that comparison with patient surveys from other practices (where, typically, those numbers might be reversed) could be misleading. (NB: the specific age 25 was included in *two* age bands – a typo, presumably.)

   We tend to follow trends within our own surveys rather than compare with other practices as the questionnaires are now individual to each practice and their PPG. We will take into account national and local benchmarks where published results are similar to our questions.

2. Close to half of the respondents identify themselves as having a long-standing illness or disability or infirmity. I find this surprising in view of the age profile mentioned above. Was this a surprise to the practice staff?

   Initially yes, but this same statistic presents year on year and is consistent with other practices. One of the anomalies yet to be explained as the statistic is not supported by clinical evidence.

3. While on the demographics of the respondents (gender, age, ethnicity, etc), it would be useful for me to see how these compare with the demographics of the patient cohort as a whole, where such information is available.

   Our turnover sits at 66% because of our close association with the University and hence the churn associated with the student population. We do look at the demographics every so often but this must be born in mind with the rate of change as next years figures could be notably different. The reports are also quite cumbersome and take some time to run. We cannot unfortunately produce statistics on ethnicity with our system at present.

Figures as off 7th January 2013

Total patient list size	17495
Under 16	918
Aged 16-30	12919
Aged 30-74	3292
Over 75	366
Females	8900
Males	8596

4. The question about staff being friendly and approachable did not permit differentiation between doctors, nurses, and administrative staff. I can understand why, when the practice is working as a team, you might wish for your performance under this heading to be judged as a whole, rather than categorised. However, in taking this line, it is possible that valuable information is hidden. The three categories of staff that I mentioned have very different training pathways with respect to this question, both within the professional qualification and in-post. Thus, it is unlikely that one will find a perfectly uniform 'friendliness and approachability image' across all categories of staff in any GP practice. And nor is any remedial action likely to be the same across all categories of staff. For example, the 'additional comments' section of the survey reveals a number of positive comments about the friendliness of reception staff, but also three negative comments under this heading. I could not find any negative comments about the nursing staff or the doctors in that section. This is not to disparage the reception staff, who sometimes have a difficult job in fielding front-of-office pressures applied by those who turn up late for appointments and so on.

   In the past we separated this question out and received consistent scores with high scores across the board but Reception scoring slightly lower and getting the odd negative comment. As the results have been very consistent and as the PPG wished to shorten the format from last year it was an obvious set of questions to be streamlined.

   The PPG also recognises that it is the practice team that deliver the service and that different disciplines have different experiences with the patients. I feel that is fair to say that the Reception /patient relationship is the trickiest one to manage within the practice and the slightly lower scores reflect this together with the negative comments.

   Unfortunately some patients have overly high or even incorrect expectations of the service and it falls to Reception in most instances to make them aware of this. This is not always received well and indeed Reception are also more likely than any other discipline to receive abuse from patients.

5. I note there was no attempt to seek views on patients' satisfaction with the Out-of-Hours service. I know this is contracted out, and so not under the direct control of the UoRMP, but I think the general principle of primary care is that the GP practice has oversight of the health and well being of its patients, so whether or not the patients feel they are receiving a good OOH service should be of interest to every GP practice.

   This point was not identified when we discussed the content but it's something we're happy to consider should the PPG feel that it would be of benefit next year. It would however perhaps be best surveyed seperately as the vast majority of patients have no experience of the OOHs service and hence the response could be meaningless statistically speaking. A survey of the actual patient accessing OOHs would be far more meaningful but technically the PCT should undertake this work as they commission the service.

6. I wonder whether a question about referrals to hospitals and clinics and choose-and-book might have been useful.

   Again for the PPG to consider – but again the vast majority of patients are not referred. We could target this specific group though if needs be

7. I thought the responses on questions concerned about being able to get an appropriate appointment with a doctor were very good. In my view this is a very positive attribute of the UoRMP, and I am sure that many a GP practice would struggle to meet such a standard. Appointments with nurses were not asked about.

   Again a question that was streamlined so that access to nurses was a separate service was removed. But thank you for your comments about access as we have seen that this is of high importance to patients and hence strive to maintain a very high standard in this regard. It is not always possible but we aim to meet demand as far as costs allow. This is of course a delicate balance but we try to manage the appointment system proactively and to fully utilise the tools available to us.

8. I see that more than half of the respondents use the online booking system. The system is brilliant, but, perversely and notwithstanding the untypical demographic of the UoRMP, it worries me slightly that such a large fraction of the respondents are techno-savvy. I wonder how this compares to the practice as a whole. I guess you could easily say what fraction of appointments are made online.

   For the period Jan – Dec 12 17% of appointments were made on line. Many of our patients still prefer the personal touch or have a query as to the best course of action for their particular concern and hence they need to speak to a Receptionist. Also many follow up appointments are made whilst the patients are still at the surgery.

9. Some patient surveys ask about the wait-time in the waiting room and about difficulty in seeing the doctor that you prefer to see and how important this is thought to be. Would this information have been useful in your case?

Whilst patient perception of their experience is interesting, our appointment system can tell us exactly what waiting times patients experience over a given period. We can also split this down by clinician, days of the week etc. We look at this every so often to ensure no outliers in performance, by comparing individual performance against the average.

10. Given that, in recent times, a notice has appeared in the waiting room asking the second person in line to stand back from the reception desk in order to aid patient confidentiality, I had expected to see a question about confidentiality in the reception area.

    This has indeed come up in previous surveys in that we do not achieve a high mark in this regard. However we have looked at the layout of the area many times and have had experts in also to conduct feasibility studies.

    Unfortunately we are constrained by the size and layout of the building in this regard. We have however taken various measures to improve confidentiality in this area eg moving the phones from the office adjacent to the desk to a small room beyond. This means that the waiting room is a quieter more pleasant area but that also the conversations on the phone cannot be heard. We have also considered background music but in general patients are against this.

11. I know that the ten-minute GP appointment is a national standard (agreed with the RCGP, I guess), but, as a round number, it appears suspiciously arbitrary, and it is not impossible to imagine that long-term patient throughput and care could both be improved by a slightly longer standard appointment time, if this led to fewer patient re-visits. Perhaps some GP practices are trialling longer (or shorter!) appointments, but I doubt it. In the light of this, perhaps the patients' view of the ten-minute appointment time should be sought. What do you think?

    10 mins is the accepted average time and statistics show that in general the GP keeps surgery reasonably to time. A small number of patients are identified as having special needs and as such are allocated a double appointment. Patients are also asked to remember 1 problem – 1 appointment and to ask for a double if they have more than one problem to discuss with the doctor. We also offer telephone consultations for certain issues which are scheduled for just 5 minutes.

    To give a longer appointment in general could prove very wasteful of time and would inevitably reduce the number of appointments and hence ease of access. When a complex situation presents the doctor will have to spend longer with that patient and hence will run late with the surgery. Generally this is balanced by a number of 'easy' patients or even patients who do not attend, all of whom allow the GP to balance the workload. There are many variables involved though which is precisely why we cannot guarantee to run surgery to time, nor to cope with patients who unfortunately run late themselves.

12. There was no question about how easily patients could obtain test results. I had expected to see such a question, although I am not suggesting that it is a problem area.

    Indeed previous surveys have not indicated this to be a problem and hence question axed in the streamlining

13. One of the comments referred to a difficulty with the new patient paging system. A question in the survey on satisfaction with patient paging would have been helpful, I think. It's not ideal, in my view.

    We are asked to be non –discriminatory and hence to cater for patients will all needs. Our old system was an auditory one and hence we fell short on this requirement for those with poor hearing. We therefore implemented the new system but continue to audibly call known patients with visual problems. The patient simply needs to ensure that we are aware of the problem and then we can flag this up in their notes so that all clinicians are aware as they will then call you on the old system.

14. Banning the use of mobile phones in the waiting area? [one comment asked for this.] Given the place that mobile phones and smart phones have in the modern culture, particularly with young persons, I can only say good luck with that one! I think you would get more votes for providing free WiFi in the waiting area.

    We do ask patients to refrain from using mobile phones within the practice but as you recognise it is a hard matter to effectively police and one that distracts staff from more important aspects of patient care. We will consider more signage and other initiatives and do indeed have a Wi-fi trial about to start as part of a PCT initiative.

<u>Feedback on results</u>

Overall the PPG seemed to be very happy with the results of the 2012 patient survey and pleased to see the staff and service regarded so highly. The comments raised about incidences with Reception have however given rise to some concern understandably and this is the main issue that we need to look at.

There are also a few comments about the wish for ordering prescriptions on line. We cannot currently do this with our clinical system, but we will be changing this over the next six months and this is a facility that we will try to incorporate in our replacement system.

There are also several mentions of the provision of water coolers in the waiting areas. We have looked at this before and have not progressed due to both cost and lack of space in the rooms (without loosing one or more chairs). However I am happy to get updated quotations and to discuss further with the PPG

As regards the Reception team we are aware as stated above that the Reception / patient relationship is the most challenging one in the practice.

They also work under immense pressure during busy periods but we move them around different duties during the day to give them a break from the 1-1 patient contact at times. We have identified a training session on customer service within a medical practice that we propose to run at our next Team Day. This is a 3 hour session and would involve the whole team. After some discussion it was felt appropriate to run with the entire team and not just Reception, as it is a team effort and we did not feel that Reception would be encouraged by being singled out