NHS SCOTLAND






Scottish GP Patient Experience Survey 2009/10

Volume 2: Technical Report

An Official Statistics Publication for Scotland

Better Together
Scotland's Patient Experience Programme

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SCOTTISH GOVERNMENT

Scottish GP Patient Experience Survey 2009/10

Volume 2: Technical Report

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1. Introduction

1.1 Introduction

The Better Together Scottish GP Patient Experience Survey is a postal survey which was sent to a random sample of patients who were registered with a GP in Scotland in October 2009. The survey asked patients about their experience of accessing their GP Practice, making an appointment, visiting reception, seeing either a nurse and/or doctor at the surgery, receiving prescribed medicine and care provided overall by the practice. A copy of the questionnaire is available in Annex C

This report provides details of the technical aspects of the Scottish GP Patient Experience Survey 2009/10. It documents the way in which the survey was conducted and the survey data produced and should be read whenever using data from the survey. Specifically the report covers an overview of: the various outputs from the survey; the development of the survey materials and methodology; the fieldwork, data processing and handling; the survey response; and analysis, reporting and quality assurance.

1.2 Background to Better Together programme

Better Together, Scotland's Patient Experience Programme, has been designed to support NHS Scotland to deliver high quality, equitable, patient-centred care. The programme, in partnership with NHS Boards, GP practices, Information Services Division (ISD) Scotland and national improvement programmes, aims to equip staff and patients with the tools and techniques to embed experience into the design and delivery of continuous quality improvement – making patient experience an integral part of NHS Scotland's core business.

The programme collects feedback about experiences using approaches including surveys and qualitative techniques, to enable NHS Boards to make improvements through the use of practical techniques and tools.

The initial focus of the programme has been on three areas:

- GP services
- Inpatients
- Long Term Conditions – this work is currently being scoped out.

Prior to the development of the GP patient experience survey, GP practices around the country carried out different surveys of their patients to gather views about their experience of GP services. It was recognised that due to the variations in methodology and lack of aggregation of data, that it was difficult for GPs to see how they were doing in relation to others. Also, it was noted that if postal surveys were not used, people who were unable to travel to the practice or who were not frequent users were excluded. There was therefore demand for more co-ordination of patient experience information in Scotland, and also for a survey that took into account the needs and views of patients and practices in Scotland. In addition, in 2008/09 the GP access survey was carried out nationally for the first time, to inform payments in the quality and outcomes framework. It was agreed that it made sense to do one

large survey that addressed all of these needs, under the auspices of the Better Together programme.

Further information about the Better Together programme and results to date from the inpatient and GP surveys can be found at www.bettertogetherscotland.com

The Better Together work supports NHSScotland's Quality Strategy by providing a basis for the measurement of quality as experienced by service users across Scotland, in addition to support for local improvement as described above. The ultimate aim of the Quality Strategy is to deliver the highest quality healthcare services to people in Scotland, and through this to ensure that NHSScotland is recognised by the people of Scotland as amongst the best in the world. Further information about the Quality Strategy can be found at: http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality

1.3 Aims of the GP Patient Experience survey

The survey's specific objectives were to:

- Provide practices with structured feedback on their patients' experience of their service, relative to other practices in Scotland;
- Identify areas of best practice and areas for improvement
- Enable payment to GP Practices for Quality and Outcomes Framework (QOF)[1] indicators relating to patient experience of 48 hour access and advance booking[2];
- Explore if and how differences exist in terms of experiences between patients of different age groups, genders, ethnic groups, religious groups, sexual orientation, disability status and deprivation;
- Assess if and how the level of positive and negative experiences change over time, between GP Practices and between NHS Boards;
- Determine the key drivers for positive GP patient experience within Scotland.

1.4 Other outputs from this survey

This report focuses on the technical aspects of the Scottish GP 2009/10 Patient Experience Survey. The national results from the survey have been published and can been accessed from: www.scotland.gov.uk/gpsurveynationalreport

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[1] The Quality and Outcomes Framework (QOF) is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. See www.isdscotland.org/qof for more information.

[2] Results from the survey to inform the QOF payments for patient experience of access (indicators PE7 and PE8) were published on 18th May.
These can be found at www.scotland.gov.uk/publications/2010/05/GPAccess2010.

Supplementary tables and graphs, showing analysis of results for NHS Boards and Community Health Partnerships are available online at:
http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

Individual reports for each GP practice are available at:
http://surveyresults.bettertogetherscotland.com
Provisional reports for were first released on 27 April 2010, and these have now been updated.

The results to inform the Quality and Outcomes Framework indicators on patient experience of access were published on 18th May. The report can be found here: www.scotland.gov.uk/publications/2010/05/GPAccess2010.

Further analysis of the GP patient experience data will be undertaken to provide a series of topic reports, for example on long term conditions and on equalities.

2. Outputs of the Survey

2.1 Overview of the reporting

The various stages and levels of reporting the survey results are shown in table 1:

Table 1: Overview of reporting

Publication Date	Reporting
Tuesday 27 April 2010	• Individual Reports for GP practices publicly available on Scottish Government statistics and Better Together websites • An online results tool accessible to GP Practices, Community Health Partnerships (CHPs), NHS Boards and Scottish Government/ ISD.
Tuesday 18 May 2010	• GP patient experience access results for practices
Tuesday 27 July 2010	• The National Report containing national results. • The Technical report detailing the survey methodology • Online results tool updated
Summer 2010 onwards	• A series of national reports covering topics in more detail

2.2 GP practice reports

Reports for individual GP practices are available from a link on the page here: http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

The results are shown as the percentage positive. This means the percentage of people who answered in a positive way. For example, when asked if they could get through on the phone, if people said always or most of the time these have been counted as positive answers. See chapter 9.7 for more information about percentage positive.

An example of how results are reported is given below:

The bars illustrate the % positive as green, and the % negative as red. For example, if people said they could rarely or never get through on the phone, these have been counted as negative. Where answers are neither positive nor negative, the % is shown in yellow - for example if people answered sometimes to the question about getting through on the phone.

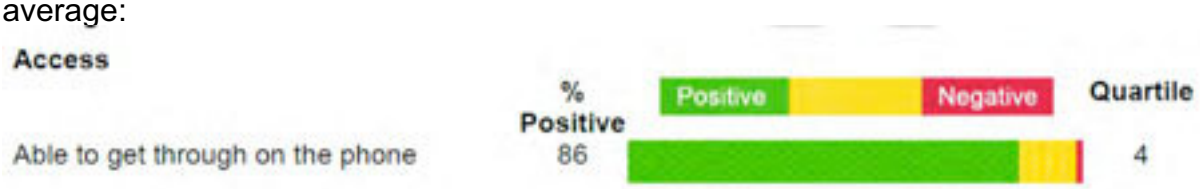
The number of respondents that answered positively and negatively for each question is displayed when the mouse cursor hovers over the bar charts. The

weighted national average is included so that a practice's results can be compared with the result for all patients in Scotland. The reports also showed the number of people who were sent a survey and number who responded. Breakdowns of age, gender and the percentage of respondents whose day-to-day activities were limited by a health problem or disability were provided.

Provisional versions of the reports were released on Tuesday 27 April. These reports were updated on Tuesday 27 July. A small number of changes were made to the reports.

The final reports included 3,272 responses received after the survey closed that could not be included in the provisional reports due to time constraints.

The provisional reports included the quartile instead of the national weighted average:



The quartile indicated how the % positive result for this GP surgery compared to all surgeries in Scotland. 1 indicated that the surgery was in the top 25% for that question, and 4 showed that the surgery was in the bottom 25%.

In response to user feedback, the definition of which answers were defined as positive was changed for two medicines questions to include "most of the time" as a positive answer instead of being neither positive or negative in the provisional results. The percent positive text was consequently changed to remove the word "always" from the two statements. The questions were:

- 16b. I know enough about what my medicines are for
- 16c. I know enough about how and when to take my medicines

2.3 Online reporting system

On the same day that the provisional reports were published an online reporting system went live for GP Practices, Community Health Partnerships (CHPs), NHS Boards and Scottish Government/ ISD. Each GP practice could download their own report and also see more detailed frequencies. NHS Board and CHP level users were able to download percent positive results for all of their practices into a single spreadsheet. Two new features have been developed for the online reporting system which will be available from 27 July 2010 onwards:

Benchmarking facility

The benchmarking facility allows users to compare a practice against the unweighted[3] average results for practices that are demographically similar. The system allows benchmarking by four variables:

[3] The unweighted average is calculated by summing the results for individual practices and dividing by the number of practices. For information on weighted averages see section 9.

- NHS Board unweighted average
- Practice size
- Urban / Rural classification (Scottish Government 6-fold was used)
- Deprivation (percentage of patients living in Scotland's 15% most deprived areas)

Question 20 text comments

Question 20 of the survey asked if patients had anything else that they would like to comment on. Over 45,000 patients chose to write a comment here. These comments were anonymised and coded into themes and reported back to GP practices, CHPs and NHS Boards on the online system. Several thousand longer comments will be included on the system once they have been anonymised. In the future a qualitative analysis will be undertaken at national level.

2.4 Access results

The results of the 48 hour and advance access questions in the survey were published on 18 May:
http://www.scotland.gov.uk/Publications/2010/05/GPAccess2010

They were available at GP practice level in the format of an excel spreadsheet:
http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPaccess2010xls

The Survey asked GP patients

- whether, in the last year, they had been able to obtain a consultation with an appropriate health professional within 2 working days; and
- whether, in the last year, they had been able to book an appointment with a GP more than 2 days ahead.

These results were published separately because they informed two indicators in the QOF. 48 hour access results inform the indicator PE7, and advance access results feed into PE8. Together these are worth 58.5 points out of a possible 1000 that GP practices can obtain. Points are calculated on a sliding scale depending on the percentage of surveyed patients obtaining access. For both indicators, all practices with 90% or more of patients answering positively will achieve full points; for PE7, no points are awarded for 70% or less and for PE8 the lower threshold is 60%.

The methodology used to calculate the percentage of patients obtaining 48 hour and advance access differs from that used in the national report. The methodology for the access results was:

48 hour access

Positive responses are those where either:

- the patient had a face-to-face or telephone consultation with a GP or nurse within 2 working days, or
- was offered an appointment within 2 working days but the exact day/time did not suit them or it was not with the person they preferred to see

Advance access

Positive responses are those where either:

- the patient was able to book an appointment in advance, or
- was offered an appointment in advance but the exact day/time did not suit them or it was not with the person they preferred to see

For the national report the only responses classed as positive are where the patient had a face-to-face or telephone consultation with a GP or nurse within 2 working days for 48 hour access and where the patient was able to book an appointment in advance for advance access.

2.5 National report

The national report was released on 27 July, 2010. The report presents national weighted results for each survey question. There are also sections covering results by GP practices and NHS Boards, and results by practice and patient characteristics.

2.6 Community Health Partnerships (CHP) level reporting

Results at CHP level are available in an excel spreadsheet tool that presents results for each question by CHP in the format of percentage positive or negative. More detailed spreadsheets showing individual question responses are also available.

2.7 NHS Board level reporting

Results at NHS Board level are available in an excel spreadsheet tool that presents results for each question by NHS Board in the format of percentage positive or negative. More detailed spreadsheets showing individual question responses are also available.

2.8 Topic reports

It is anticipated that some topic reports will be published in due course. These reports will look at particular topics in more detail such as patients with long term conditions.

2.9 Availability of data for further research

An anonymised dataset will be made available for further research through the Essex data archive (http://www.data-archive.ac.uk/). No survey ID numbers or other patient identifiers will be included. Other data items that could potentially identify patients (for example age) will only be available in summarised form.

3. Survey design

3.1 Introduction

This section provides detail on the development stages of the 2009/10 survey of patient experience of GP services and the accompanying survey pack.

The survey pack (Annexes C-G) contained the following:

- Questionnaire;
- A language sheet;
- Introductory/Cover or reminder letter; and
- FREEPOST envelope in which to return the survey.

All of these materials were drafted, amended and ultimately finalised in a staged process consisting of a number of research activities, discussions and consultation with stakeholders groups.

An overview of these development activities is presented in the paragraphs that follow, with further detail contained in annexes. The survey materials were finalised in late summer 2009, with a reformat by the survey contractors Picker Europe, including clearer front cover page .

3.2 Survey development

The development process involved collaboration between the Scottish Government and Price Waterhouse Coopers LLP (PwC)[4], with input from the GP Measuring Experience Research Advisory Group, which included key stakeholders from the Scottish General Practitioners Committee (SGPC), Royal College of General Practitioners (RCGP) and NHS Scotland.

Initial work began in 2008 and the materials were developed over the following year. The work built upon evidence gathered from national and international literature, and research on public priorities in Scotland with respect to GP services. The following design principles were adopted to guide the development of the survey:

- Issues important to patients in Scotland would form the core of the survey content;
- GP practices and Health Boards would be able to use the information outputs of the survey to inform improvement actions;
- The survey should be grounded in the national and international literature; and
- The survey should focus on the patient journey, inclusive of interactions with GP staff.

Taking into account the above principles, the questionnaire design was also informed by a number of information gathering, review and consultation activities. These activities are listed below and can be classified as having two purposes; the

[4] PricewaterhouseCoopers role was to develop the survey tools and methodologies for capturing data.

early activities were focused around development of content, while subsequent work centred on testing and refining the questionnaire.

Early activities to support survey content

These activities included:

- A review of patient experience literature;
- Survey on public priorities with respect to GP services (GP Importance Survey);
- Focus groups on what is important to GP patients;
- Collecting GP practice views on existing surveys;
- Workshop with stakeholders to prioritise survey content;
- Consideration of response scales;
- Consumer Panels.

Subsequent activities to test and refine survey content

These activities included:

- Cognitive testing;
- Independent peer reviewer; and
- Piloting.

Further information on these activities is outlined below.

3.3 Initial survey content

Literature review

A search of relevant literature on patient experience (in general) and patient experience in general practice (more specifically) was conducted across the internet using online bibliographic databases such as: British Nursing Index, Cinahl, Medline, Health Management Information, Consortium and Science Direct.

Additionally, members of the research team identified papers that were of relevance to the review, and other relevant documents were identified from the bibliographies of papers found through the online search strategy.

Types of documents reviewed included:

- Strategy / consultation documents
- Literature reviews
- Development of questionnaire / survey / models to measure patient satisfaction
- Exploratory / research / evaluative studies into patient satisfaction / experience

The review identified a wide range of factors that influence patient experience, ranging from consultation time and access to skills and expertise of staff, and patient characteristics. The work also identified good practice in measuring patients' experience of services. A summary of the key findings can be found at annex H

Public Priorities with Respect to GP Services (Importance Survey)

The survey was undertaken in August 2008 as part of MRUK's omnibus survey and included questions on views of GP services and what was important to patients.

Approximately 1,040 in-home interviews were conducted with adults across Scotland aged 16+ years.

Respondents were asked to provide a ranking of items across a number of categories that related to patients' experience of GP practices covering: contacting the GP surgery; visiting the GP surgery; seeing a health professional; talking to a health professional; and prescribing of medicines.

The following issues were identified as priorities:

- Ability to get an appointment (either on same day, or another day);
- The surgery being easy to get to;
- Being able to speak to a health professional with knowledge of the patients' medical history;
- Have enough time to talk to a health professional and for health professional to listen to patient; and
- Have enough information provided about prescribed medicines, the side effects and how and when to take them.

The full report from MRUK is available here:
http://www.bettertogetherscotland.com/bettertogetherscotland/files/GPUsers.pdf

Qualitative research on what is important to patients

To complement the importance survey, qualitative research was carried out in Glasgow and Stirling by Patient Perspective. Two focus groups were organised and they explored individual experiences of General Practice. An additional four telephone interviews were carried out with people in remote Western Isles locations. A total of 18 people were included, 13 women and 5 men. The participants were aged from 24 to 75 years.

The findings mostly agreed with the survey, for example the ability to get an appointment was identified as important, but other items ranked as very important generally related to medical care, including – the doctor giving clear explanations of treatment, being open with patients, confidence in doctors, getting the best treatment available.

> *It's most important that they take time to listen, can talk to you, examine you thoroughly.* GP Focus group participant

The full report for the qualitative research can be found at:
http://www.bettertogetherscotland.com/bettertogetherscotland/files/NHSPatients2.pdf

The findings from both the importance survey and qualitative research were used as a 'starting point' for the development of the content of the GP Patient Experience survey, whilst the literature review and feedback from GPs and practice staff was used to inform and flesh out the detail of the questions.

GP practice views on existing surveys

In July 2008, questionnaires were sent to GPs, practice nurses and practice managers about their views on the surveys that they were already using as part of the Quality and Outcomes Framework. The questions asked were:

1. What survey(s) do you currently use in your practice?
2. What information that is collected in the survey(s) you currently use do you find useful, or have you found useful in the past?
3. What questions in the current surveys would you prefer not to ask patients, or do you think are not relevant?
4. Are there any questions in your current survey which you think could be more useful to you if they were changed in any way?
5. Are there any other specific topics, that are not covered in your current survey, on which you would like to receive feedback from patients?

A range of feedback on these questions was received. For example some GPs felt it was unreasonable to ask questions about opening hours as their hours were contractual and therefore was something they felt they could not readily change or influence. There was demand for questions specifically about nurses to be included. This feedback was taken into consideration in the subsequent drafting process for the GP survey both in terms of content and how questions were structured.

Workshop

A workshop was held on 16th December 2008 to consult stakeholders on the content of the survey. This included representatives from SGPC, RCGP, practice managers, practice nurses, NHS Boards and academia.

At the workshop, participants were asked to consider 64 potential statements for inclusion in the survey questionnaire. These were based on the outputs from the literature review, importance survey, patient focus groups and the feedback from GP practices about existing surveys.

The results of this prioritisation were discussed in conjunction with what's important to patients and what would be useful information for improvement, and a list of 24 statements for potential inclusion in the questionnaire was identified. Examples of some of the statements that were rejected at this stage included:

- Ease of getting to the practice (e.g. transport/ parking) – it was felt that this was not in control of the practices.
- Cleanliness of the practice – while this is important, there was a response from stakeholders that this was difficult for patients to judge in a GP practice environment
- Accessibility (e.g. wheelchair access) – this was excluded as it was decided to make the survey relevant to as many people as possible, and also is covered by The Disability Discrimination Act (DDA).

A review of the literature was inconclusive on whether a seven, five or three point scale should be used, however did show the advantage of odd number scales in preference to even number scales as they allowed for the inclusion of a 'middle' response category. Literature also showed the advantages of using more than one positive scale specifically when exploring satisfaction and that scales with more than seven points are difficult for the majority of people to use.

Discussion was also held at this workshop around options for question layout and on types of response scales. It was agreed that scales would be driven by individual statements, but there was a preference amongst the group for the 5 point scales e.g.

never – always, and strongly disagree – strongly agree. It was also agreed that there should be limited bespoke scales.

It was considered that with reference to many patient experience items included within this survey, asking the patient to note if something did or did not happen would be less useful than an assessment using a scale with more than two or three points. The three main scales[5] (as well as other response scales) adopted in the survey were discussed in detail with the GP Measuring Experience Advisory Group and then cognitively tested.

Consultation with Research Advisory Group

Following on from the above workshop, in January 2009, a draft questionnaire was sent to the Advisory Group and other interested people for comment. The feedback from this consultation was incorporated prior to the cognitive testing work.

3.4 Activities to test and refine survey content

Once the early activities exploring survey content had been achieved, work then focused on testing the draft survey and related materials. These activities included: cognitive testing, peer review and piloting.

Cognitive testing

In order to robustly test the GP survey (and accompanying cover letter), a series of cognitive test interviews were organised with health service users across three NHS Boards in Scotland[6]. A phased approach to cognitive testing was adopted in order to facilitate revisions to the survey and cover letter and testing of the revised versions. Table 2 outlines the aims of the cognitive testing.

Table 2: Aims of the cognitive testing process

Aims of Cognitive Testing
• Explore the thought processes of participants as they responded to the questions, to understand if their interpretation of the statements and/or questions was in line with the designated purpose/objective;
• Explore the usability of the survey, exploring whether participants, including those with low literacy levels, found it easy to read and navigate and their visual impression of the survey as well as the views about length of time to complete and potential user burden;
• Discuss the relevance of the topics contained in the survey to the experience of the participant; and

[5] Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree; excellent, good, fair, poor, and very poor; and always, most of the time, sometimes, rarely and never.

[6] Cognitive testing took place in NHS Greater Glasgow and Clyde (Glasgow) and NHS Highlands (Inverness) and NHS Grampian (Aberdeen)

Aims of Cognitive Testing
• Seek to identify any potential problems in how the statements and/or questions were framed.

There were three rounds of cognitive testing for the GP survey. The first took place in February 2009, with round two following two weeks later. These two rounds were undertaken with members of the public who were recruited through on-street interviewing on the basis that they had been in contact with their GP surgery in the past 12 months and on their background characteristics. Fifteen participants were recruited (nine in round one and six in round two) from a range of age groups, gender type, socio-economic groups and urban and rural locations.

Round three of the cognitive testing took place over a week in August 2009. This round was specifically aimed at testing the GP survey and cover letter with individuals who had low levels of literacy, an approach suggested by the peer reviewer (see next section) The six individuals who participated were recruited from adult literacy programmes in Glasgow.

Interviews in all three phases of the cognitive testing were conducted by means of semi-structured interviews with participants. A combination of think aloud and verbal probing techniques were used to achieve the aims, which promoted a focused approach to the discussion. In round three, facilitators were also able to observe the participant as they completed the survey; this was particularly useful as it provided an insight into participant reaction and approach to completing the survey.

The findings from all three rounds and the resultant actions on the content of the survey are summarised in tables 3 (rounds one and two) and 4 (round three). After each round of cognitive testing, the results were discussed with the GP Measuring Experience Advisory Group and decisions made about changes to the survey based on the feedback from the cognitive testing.

More information on the methods used for cognitive testing and a summary of the results can be found in annex J

Table 3: Examples of findings from the first and second rounds of cognitive testing

Area Explored	Cognitive Testing Findings	Agreed Action Post Cognitive Testing
GP survey instructions that completion was for those who had attended their surgery in the last 12 months – there was no specific survey question asking participants to identify if they had attended their surgery in the last 12 months	• In Round 1, participants tended to navigate towards the boxes in the survey where they had to take action e.g. cross a box rather than reading instructions. • For Round 2, the formatting was amended so that the instructions relating to the 12 month timeframe became the first question and a response action was required, to increase the likelihood of recipients noticing this. **Cognitive testing feedback:** • *'It is defining the duration in which you have seen your GP and therefore if you have not seen your GP within the 12 months then you don't qualify to fill it in. That is the way it is.'* (Male, 38)	Question one was changed between Round 1 and 2 to: Q1: This survey is about contact with your surgery in the last 12 months. Have you had contact with your GP surgery in the last 12 months?
First version of survey to be cognitively tested had the following question: Q8. The last time you attended your GP surgery, did you… ▪ have an appointment ▪ attend an open access session ▪ other (e.g. fitted in as an emergency?)	There were varying interpretations of 'open access session' **Cognitive testing feedback:** • *'I was thinking that was it like a group meeting, a group discussion? It doesn't mean anything to me, maybe go to any doctor?'* (Male, 44) • *'Open Access? I've never heard of it, don't know that term...It's just a term that's not used here, it's maybe used in other areas but I've certainly never heard of it'* (Female, 64)	This question was removed from the survey following Round 1 of cognitive testing due to confusion around the term 'open access session'.

Q9. The last time you attended your GP surgery, how did you feel about how long you had to wait to be seen after you arrived?	'How long you had to wait to be seen after you arrived' is interpreted as waiting time from appointment time onwards and participant comments suggested that they thought of their summative experience here rather than 'the last time.' **Cognitive testing feedback:** • *'From the time of my appointment I would take it from'* (Female, 31-45) • *'Anything between 15-20 minutes after my appointment time is normal I would say. Very rarely do you get taken on time…I was thinking in general (i.e. summative experience).'* (Male, 47)	Following Round 1, reference to 'the last time' was removed since most people chose their answer based on their summative experience.
Round 1 testing included both 'Don't know' and 'Not relevant' answer options in the response scale. In Round 2, the 'Don't know' option was removed from the scale to explore if its absence impacted on the ability of participants to select an option that they felt accurately reflected their experience.	**Cognitive testing feedback:** • *'(Not relevant) I don't think there is anything there that isn't relevant, it's all pretty well described there…Everything that you need is there.* (Male, 65+) • *'I think you're probably better off leaving it (don't know) out, don't know is not going to help you any, so fair enough leave it out."* (Male, 26-30)	Following Round 2, Don't know response scale was removed from response options.

Table 4: Examples of findings from the third round of cognitive testing

Area Explored	Cognitive Testing Findings	Agreed Action Post Cognitive Testing
Cover letter to GP survey	**Cognitive testing feedback:** • *'I would automatically fill it in because medical treatment is important…It's asking about my GP and how they treat me, myself I go to the doctor all the time.'* (Male, 46-64) • *'The letter is informative. Tells me everything you need to know about the survey. It's confidential so straight away you feel to answer honestly'.* (Female, 31-45)	Generally participants were clear about what the letter was asking them to do – no changes were recommended to it post cognitive testing.
Q7. In the last 12 months, have you tried to book a doctor's appointment 3 or more days in advance?	**Cognitive testing feedback:** • *'If I phoned on the Monday it would be the Thursday before I could get an appointment. I don't think I've ever needed an advance appointment."* (Male, 31-45) • *'Surgery works by phoning up in the morning between 8 and 9am and get an appointment that day. Cant advance book.'* (Female, 31-45)	On balance, comments on this question suggested there was an issue with participant interpretation of the question. Therefore, explanation added to the question to explain why individuals may want to book in advance, to enhance patient understanding of the question. In addition, replace reference to "3 or more days in advance" with "in advance" to avoid confusion relating to "3 days".
Q13.3. I was bothered or threatened by other patients	**Cognitive testing feedback:** Reaction to "I was" and "I felt" for use in this question • 'There is a difference between 'I was' threatened and 'I felt' threatened…but If the question was changed to 'I felt' bothered or threatened, I would still say never'. (Female, 31-45)	Question was changed to 'I felt bothered or threatened by other Patients'.

Consumer panels

Both before and after the cognitive testing, the survey materials were reviewed by members of the public with recent experience of receiving healthcare services. This was carried out through a series of "Consumer Panel" meetings organised by the Scottish Health Council. The panel meetings took place in Inverness, Edinburgh, and Glasgow and included 32 members of the public from throughout Scotland meeting twice a year over a two year period. Members included those with disabilities, those whose first language was not English, and those who had carers and needed assistance completing the survey.

Panel members were asked to review the poster, covering letters, and complete the GP survey. Panel members were then asked their views about their interpretation of the questions, whether they had any difficulties in completing the questionnaire and any suggested improvements.

Over 40 detailed suggestions were made by the panel members to improve the GP survey materials. These included how participants should be addressed on the covering letters; use of the term reminder on the follow-up letter; using images for the helpline rather than text to highlight how people could contact the survey helpline; moving instructions such as "please turn over" to a more prominent position; simplifying the letters and question text; and pointing out questions where there was a lack of clarity or where the order could be changed. For example, the initial version had a question about people attended an open access practice – but people did not understand what this meant. Within the doctor and nurse questions, the patient groups agreed that the question about listening to them should be first so that the order made more sense. The consumer panel also suggested that the scales should be ordered from the more positive answer on the left to the more negative on the right, rather than the other way round as it was in early drafts.

Peer review

The survey materials and proposed methodology were peer reviewed by a leading academic. The aims of the peer review process were to:

- Assess whether the methodology was appropriate to the project
- Assess the robustness of the proposed methodology
- Assess the research instruments
- Assess whether ethical considerations have been adequately addressed
- Provide a view on whether the study is feasible and achievable

There were three key issues raised by the peer reviewer in relation to the GP survey:

- Methodology – Psychometric properties and utility of survey (for example the survey giving respondents the opportunity to provide adequate feedback to reflect their actual experience) to be assessed further.
- Cognitive testing – Suggested testing to have greater representation; such as for people where English was not their first language and individuals with reading and writing difficulties.

- Reliability of survey – To be tested in terms of inter-item correlation (e.g. are some items uninformative); and can the survey meaningfully distinguish between practices?

In order to respond to these comments, a third phase of cognitive testing was carried out with those with lower levels of literacy and non-English speakers (as described above).

Pilot

The survey was then piloted to test the suitability of the proposed methodology and the operation of the survey. The pilot took place in the summer of 2009. Fieldwork commenced on 10 July 2009 with data collection/field period finishing on 5 August 2009.

A random sampling approach was used. The sample was constructed from household population data (electoral roll) and checks were made by postcode and gender to ensure that a spread of sample all of the 14 Health Board areas was achieved.

A total of 2,000 survey packs were distributed. As well as including all the survey materials, the packs also included a feedback form to allow respondents to comment on the survey and provide suggested improvements.

A freephone 0800 helpline number was set up and details were included in the introductory letter in order to allow potential respondents to request assistance with completion of the survey.

Of the 2,000 survey packs distributed, 581 were returned representing a response rate of 29%. Survey returns were entered and quality assured by PwC and analysis and interrogation of the data took place using industry standard SPSS software.

A series of reliability tests were used to measure internal consistency within the survey tool on the basis of the pilot exercise and the feedback forms which most (97%) respondents returned with their completed questionnaire. These feedback forms provided valuable insight into the views of respondents on how they found completion of the questionnaire. Results from the feedback forms were as follows:

- 98% of respondents indicated that questions were not difficult to understand:
- 90% noted that they felt able to choose a suitable answer for questions;
- 93% felt comfortable that the length of survey was about right; and
- 99% agreed that the instructions on how to complete the survey were easy to follow.

Annex K provides more details of the pilot methods and the recommended changes to the survey design and methods. These recommendations included:

- The helpline should be operated on an answer message basis as all queries to the helpline number were easily resolved and the volume of calls was low.

- To control for missing data use an option such as 'I did not see a doctor/nurse' should be considered within Question 12.
- Further development of Question 13 should be considered to ensure that participants are clear on which answer option most clearly expresses their view.
- Whilst there were a small number of instances of incorrect question completion due to routing error, within feedback forms 99% of respondents felt that instructions were easy to follow.
- An option to complete the survey online should be provided in the future, as 13.8% would have preferred to complete the survey by this method.

3.5 Summary of rationale behind the final questionnaire

The questionnaire follows the patient journey by looking firstly at the patient's ability to make contact with the GP surgery and how they found that initial contact. The questions then move on to ask about the patient's experience in the last 12 months right through from the receptionist, doctor, nurse, to their medicines and involvement. The penultimate section asks about the patient's overall experience in the last 12 months and the survey closes with a section on demographics.

The first question in the survey is a filter question to help ensure only those who had contact with their GP surgery in the last 12 months completed the survey. This was added following feedback from consumer panels who thought the instruction could be missed, and a decision that people should not send back the survey if they had not contacted their practice.

Access section

Following on from the filter question, the first two questions are about phoning the GP surgery. These were positioned at the start of the survey as a telephone call is often the first point of contact with the GP surgery for the patient. There was significant discussion regarding the meaning of "getting through" on the phone and whether it means the same to different people, e.g. how many times should you try to phone. However in cognitive testing it was felt that this question was clear when the response options were taken into consideration.

The GP Patient Experience Survey built on the Scottish GP Patient Access Survey questionnaire, which was used to establish payment for GP practices for the Quality and Outcomes Framework (QOF) the previous year. The questions on patient experience of access were therefore included to be used to establish payment for GP Practices for the two relevant QOF indicators These were tested thoroughly the previous year by IPSOS Mori[7], so changes to these were minimised. Q9 (which covered the reasons for not being able to get an advance appointment) was an additional question developed following feedback from SGPC and General

[7] The original Scottish GP Patient Access Survey questions (Q4-Q8) were tested by IPSOS MORI and used in the GP Access Survey 2008/09. Report at: http://www.scotland.gov.uk/Publications/2009/05/18142136/0

Practitioners. Additional feedback on these questions in the context of the new questionnaire was accounted for – which meant shortening some of the explanations as the questions were considered too long.

The remaining access questions (see Table 5) were included in the survey. As on the basis of the desk review and consultation activities, it was felt that it was important to establish how patients got in touch with their GP, if they encountered any problems getting appointments and the length of time they had to wait for an appointment/to be seen. Table 5 provides detail for these access questions on the background and rationale for their inclusion in the survey.

Table 5: Background and rationale for access questions

Access Questions	Rationale
Q2: In the last 12 months, when you have phoned your GP surgery, could you get through on the phone?	This area was indicated by patients in the omnibus survey as one of the most important factors when contacting the GP survey, and is an area that is of interest to practices to know whether improvement is required.
Q3: When you have phoned your GP surgery, was the person who answered polite and helpful?	Feedback suggested that a statement was needed to capture how patients feel about the initial point of contact within their GP surgery. The routing to only answer this when you have got through on the phone was proposed by consumer panel.
Q10: When you arrange to see a doctor at your GP surgery can you *usually* see the doctor you prefer?	Continuity of care is important to patients. An option was added to the answers following testing to allow for practices with only one doctor.
Q11: How do you feel about how long you usually have to wait to be seen after you arrive at your GP surgery?	This question was introduced as research activities had highlighted the importance of determining how patients feel about length of time patient they had to wait. Also feedback from patient panels in Edinburgh and Glasgow were positive about the inclusion of this question. This question went through several stages of development, as initial versions referred to an appointment time – which added complication if some people had not had specific times.
Q12 Overall how would you rate the arrangements for getting to see a doctor and/or nurse in your GP surgery	This statement was included based on feedback from the GP Access Survey and was positioned after the other access questions to allow the patient to reflect on overall arrangements. Initial options of "not relevant" were simplified to "I did not try to see a doctor/ nurse" following patient feedback.

The remaining questions gather information on non access related experience and have been split into two sections – firstly, specifics about the GP surgery such as

the receptionist/reception area; doctors; nurses; medicines and patient involvement, and secondly patients' overall experience at their GP surgery.

Question 13

The statements in question 13 cover:

- the receptionist being polite and helpful;
- the patient being worried about other people overhearing them;
- and feeling bothered or threatened by other patients.

These statements were included as the topics were identified as important in the initial research. The wording of these statements went through several iterations. For example, the intital concept for the third item was about patients feeling safe in their GP practice. However it was felt that there were too many possible interpretations for this and it had to be explained more clearly. This question was originally in the overall experience section, but was moved to here as it was felt it was more relevant to the questions about reception area.

Questions 14 and 15

The next stage in the patient journey after the reception is the time spent with the doctor or nurse. The statements in Q14-Q15 relate to the patient's experience with the doctor/nurse at the GP surgery. The nurse questions followed directly on from the doctors as the patient can either visit the doctor or the nurse when at the GP surgery. At the beginning of the nurse question there was a filter question in place, this gave those who had not visited the nurse in the last 12 months the opportunity to be routed to the next question.

The nurse statements were the same as those used for the doctor question, as it was believed that the same statements applied to both the doctor and the nurse. This also kept the statements consistent to allow comparisons between the two questions.

Statements such as the doctor/nurse listening, showing consideration, talking in a way that patients can understand and having enough time with the doctor were areas that were highlighted in the importance (omnibus) survey as being important to patients and were therefore included in the survey.

The remaining statements in these questions (having all the information they need, consideration for personal circumstances, and confidence in the doctor's ability) were suggested for inclusion by the GP Measuring Experience Advisory Group and were also agreed by patient panels.

Some discussion took place about what patients would understand by the word "nurse", and whether or not this should say "practice nurse". It was agreed that at times the boundary may not be clear cut and that specifying a particular nursing role may complicate the issue. Also, that in general patients would be answering about

the practice nurse. If feedback represents the general ethos of nursing at the practice it is still useful and could be explored further by the practice if necessary.

Question 16

Towards the end of the consultation, the patient may be prescribed some form of medication and therefore the next logical step in the patient journey was medicines. At the beginning of the medicines question there was a filter question added. This allowed those who had not been prescribed medicines in the last 12 months to be routed to the next question, and negated the need for a "not relevant" option. The initial versions of these questions that were tested were:
I understand what my medicines are for
I understand how [and how often] to take any medicines I have been prescribed
I understand what to do if I have any side effects or other concerns about taking my medicines.

The word understand here caused some difficulties as some people would interpret this as having to know everything including for example how the drugs worked. This was changed to "know enough" to account for the fact that people only need to know enough for their own requirements and that this can vary. Under the third initial question above, this was considered to be two separate things so was split into "I know enough about possible side effects of my medicines" and "I would know what to do if I had any problems with my medicines". There was initially a "don't know" option on this question, however because patients were on occasion interpreting this as the answer to not knowing about their medicines rather than not knowing the answer, this option was discarded.

Question 17
The final question (Q17) in the "At the GP Surgery" section related to patient involvement in care and treatment. There was some mixed feedback around the inclusion of this question, but it was finally agreed it would be helpful to have this included – if an option about not wishing to be involved was provided. This did not come out as being of particular importance to patients relative to other statements in the same category in the Importance Survey, however, the consumer panels felt that this was an important statement to include within the questionnaire.

Overall experience section

The final statements asking about experience were fairly general and were placed at the end of the survey as part of an "overall experience" section. The patient was therefore able to reflect on previous questions to provide their overall opinion on their GP surgery. Feedback from General Practices and from patients had indicated that overall experience questions are very useful

The final experience question asked the patient if there is anything else they would like to add about their experiences at their GP surgery. This was an open ended question with a large box for the patient to write any comments about their

experiences. It was decided that it was best to keep this to the end so that patients could comment about all aspects of the survey rather than individual sections.

Demographic questions

The demographic questions in the "about you" section were included in order to capture further details on patients. The purpose of having these questions was to discover if different groups of people in Scotland had different experiences of treatment at their GP surgeries.

The literature review suggested that factors outside of the patient journey such as demographics and health status may have an impact on the attitude expressed regarding that journey. In order to understand if patient demographics or health status may influence patient experiences, questions to establish gender, age, ethnic group, religion, sexual orientation and health status were asked.

In addition, it was also necessary to help ensure that the survey captured a cross-section of views from across the population in Scotland including the equality groups within Scottish society to cover the six *Fair for All*[8] strands and comply with statutory requirements.

As a result, the demographic questions were agreed by the Scottish Government for inclusion. As some of these questions asked for sensitive information, it was made clear to patients that they could skip any questions which they preferred not to answer.

These questions are in the main the standard recommended questions for equalities. Some development of the disability / long term condition terminology was carried out following feedback from the consumer panels and the pilot that "chronic" condition was not an appropriate term so long term condition was used.

Cover letters

The cover letters that were sent out with the questionnaire were checked by the Plain English Campaign (http://www.plainenglish.co.uk) to ensure that they were clear and concise. They were given a crystal mark which is the seal of approval for the clarity of a document.

[8] Fair for All was developed by the Scottish Executive Health Department. It sets out the agenda for Scotland's NHS Board's to ensure they provide a 'culturally competent service' that meets needs from the black and minority ethnic community. Fair for All covers the six equality strands covered in legislation i.e. age, disability, gender, religion, belief and sexual orientation.

4. Sample Design

4.1 Sampling frame

Patients eligible to be sampled for the survey were those who were registered to a Scottish GP practice at 20 October 2009 and aged 16 or over at that date. Eligible patients were identified by ISD Scotland, using an October 2009 extract from the Community Health Index (CHI) database.

A small number of special practices, run by NHS Boards to provide primary care services to particular small groups of patients (e.g. practices for homeless people) were excluded from the survey.

4.2 Sample size calculation

Sampling was done within GP practice lists, to aim for sufficient responses to achieve a reasonably reliable result for each practice. The reliability of the result depends on the number of questionnaires returned, and also the variability of the responses.

The sample size that was calculated for each practice was based on the minimum number of responses that would be required to achieve an estimate of a percentage that has a 95% confidence interval with width +/- 7 percentage points, sampled from a finite population. This level of acceptable uncertainty was agreed with stakeholders.

The formula for the minimum sample required is
$M = B/(1+(B-1)/N)$

Where:
N is the number of patients in a practice on the sampling frame (i.e. the number of patients aged 16 and over)

$B = z^2p(1-p)/c^2$

p = the proportion answering in a certain way (assume 0.5 as this gives maximum variability)

z is 1.96 for a 95% confidence interval (from standard normal distribution)

c gives maximum acceptable size of confidence interval, in this case 0.07 (7 percentage points).
Based on the above, B=196

The table below shows examples of this minimum number of responses required (M)
based on the assumptions above for some example practice population sizes.

Table 6: Minimum sample size required for different practice list sizes

Practice Population[9]	**200**	**500**	**1,000**	**2,000**	**5,000**	**10,000**	**20,000**
Minimum sample required	99	141	164	179	189	192	194
Percentage of population	50%	28%	16%	9%	4%	2%	1%

In practice, if the underlying proportion is actually higher, or lower, than 0.5, then these numbers of responses would give narrower confidence intervals (or fewer responses would be required for the same accuracy).

The above minimum sample required (M) was increased to account for two factors:

1. Non contact
   Recipients of the questionnaire may not have contacted their GP practice in the last year. It was assumed that 80% of registered patients would have contacted their GP in the last year. This is based on estimates derived from ISD Practice Team Information www.isdscotland.org/pti , and was also found in the survey of what is important to GP patients carried out for the Better Together programme http://www.scotland.gov.uk/Publications/2009/12/04110138/0 , and

2. Response rate
   Allowance for people not returning the questionnaire. This allowance was made in one of two ways:

   - For practices that were open in both 2009/10 and 2008/09, the response rates from the 2008/09 access survey was taken as the expected response rate for this 2009/10 GP patient experience survey.

   - For the small number of practices that opened in 2009/10, the expected response rates for this survey were based on experience from other surveys and whether a high proportion of practice patients were identified as living in deprived areas. There is evidence that people living in more deprived areas are less likely to respond to surveys. For practices with more than half of their patients living in Scotland's most deprived areas, a response rate of 30% was assumed. A deprived area was defined as a patient residing in one of the 15% most deprived data zones as defined by the Scottish Index of Multiple Deprivation (SIMD) [10] 2006. For practices not classed in this way as serving a deprived population, a response rate of 44% was assumed, based on a similar survey previously carried out in England.

[9] The practice population here is the total number of eligible patients which excludes those aged less than 16. The percentage of population therefore is the minimum percentage of eligible patients required to be sampled.
[10] http://www.scotland.gov.uk/Topics/Statistics/SIMD

Therefore the required sample size (S) for each practice, i.e. the number of patients to be sampled for the questionnaire, was calculated as

$S = M/(0.8 \times R)$

Where R is the assumed response rate based on the above.

This resulted in a total sample size of 485,380 patients.

4.3 Patient selection

For the majority of practices in Scotland, a random sample of the required number of patients (S) from each practice was taken from the sampling frame by ISD Scotland, using the "sample" function within the R software package. For some practices (six in total) with very small numbers of eligible patients, all these patients were included in the survey in order to meet the minimum sample size requirements identified from the calculation above.

The R software is free software and we acknowledge the following source:
(R Development Core Team (2007). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. ISBN 3-900051-07-0, URL http://www.R-project.org.

Further references for this methodology are:
Becker, R. A., Chambers, J. M. and Wilks, A. R. (1988) The New S Language. Wadsworth & Brooks/Cole.

Ripley, B. D. (1987) Stochastic Simulation. Wiley.

5. Fieldwork

The Scottish Government contracted the Picker Institute Europe[11] to administer the survey. Picker Institute Europe is an independent, not for profit research and development institute with charitable status, and has provided support for other patient experience survey work elsewhere in the UK. ISD Scotland provided day-to-day support for the administration of the survey along with Scottish Government staff.

The fieldwork began on 20 November 2009. In total 485,380 surveys were initially posted out in batches between 20 November 20 and 4 December 2009. An initial reminder was sent in batches between 13 January and 21 January 2010 to all patients who had not responded.

A second reminder was sent out in batches between 8 March and 17 March 2010. This reminder was not sent to patients at all practices in order to reduce costs and respondent burden. There were three types of practices whose patients were not sent second reminders:

- Open Access practices that therefore were not eligible for the advance access questions for the QoF PE8 payment, and achieved highly last year in PE7.
- Small practices that achieved 100% on both access indicators in the previous year's GP Access Survey.
- Small practices (<1000 patients) with over 95% achievement in PE7 and PE8 last year

Before the initial survey and each reminder were issued, an extract was taken from the Community Health Index (CHI) database to identify patients who had recently died to minimise the risk of the survey going to dead patients' addresses.

The survey closed on 31 March 2010. However, a greater than expected number of responses were received after that date, probably delayed by bad weather at the end of March. These additional responses were not included in the provisional GP practice reports due to time constraints but have been included in the final GP practice reports and national reporting on 27 July 2010, and in the GP access results, which were released on 18 May 2010.

Data was collected in the form of hardcopy returns and online returns (including online returns completed by people using JAWS readers[12]). For more information on the format of returns refer to chapter 8.5.

The survey asked people to only respond if they had contact with GP surgery in the past 12 months. This meant that people who did not have contact in the past 12

[11] Picker Europe used Ciconi Ltd as part of the contract to assist with data entry and reporting
[12] JAWS is a screen reading software product that is accessible to the visually impaired.

months and as instructed did not respond will have received reminder letters. However these people may have had contact with their GP surgery between them originally receiving the survey and them receiving their reminder which would have allowed them to complete the survey based on their experience of that contact.

During the fieldwork a freephone helpline answered queries from patients surveyed. In total 3,688 telephone enquires were received.

6. Data Entry and fieldwork quality control

6.1 Scanning process

Once the survey was issued, paper copies of questionnaires received were scanned on a daily basis by staff at Ciconi Ltd. A verification process was then carried out for each batch scanned and a number of checks were undertaken to ensure that the scanning process had worked correctly.

6.2 Data capture

To ensure clarity of information and ultimately accuracy, the following were set up and tested before the data entry began:

- Data structure
- Data entry spreadsheet
- Data capture instructions
- Capture questionnaire

The people entering the data were required to enter data into a test environment prior to commencing work. The test data files were individually checked, matching each questionnaire to each record, to ensure accuracy. Once the test files had been verified and approved, the person was allowed to commence work. A number of formal procedures were used to help increase accuracy including name of the person who entered the data recorded against each entry and the unique reference numbers that link a survey to a patient were entered twice.

6.3 Verification & upload process

The data entry system ensured that only valid answer codes for each question could be entered and that the correct data appeared in each field. Other checks included ensuring that numeric data was the correct format and that fields were not truncated in error.

6.4 Secure disposal

Once confirmation had been received that the scanned batch of completed surveys had been verified; trays containing the hardcopy forms were tipped into a locked cage and stored for collection. Periodically the cages were collected and sent for secure shredding. Batches that were destroyed were logged and a certificate of destruction was received.

6.5 Free text coding

Where patients ticked “other” in response to questions on religion and/or ethnicity, free text responses for were coded using lists published by the ISD Data Dictionary.[13]

Where patients contacted the survey helpline to complete the questionnaire in a language other than English, the language of completion was recorded. Some free text responses that do not appear in the ISD data dictionary will be retrospectively coded.

[13] http://www.datadictionaryadmin.scot.nhs.uk/isddd/CCC_FirstPage.jsp

7. Data Security and Confidentiality

7.1 Information Governance Framework

Data to support the survey were provided by ISD Scotland and Practitioner Services Division (PSD) (both divisions of NHS National Services Scotland). NHS National Services Scotland (NSS) staff adhere to an NHS Scotland Information Governance Framework, which brings together all of the statutory requirements, standards and best practice that apply to the handling of personal information. This includes requirements set out in the Data Protection Act. Similarly, as the appointed survey contractors, Picker Europe and Ciconi Ltd were required to comply with the principles covered by the Scottish Information Governance Toolkit (published at http://www.scotland.gov.uk/Publications/2008/07/01082955/5)

7.2 Application for use of data

The Community Health Index (CHI) is a NHS Scotland database containing personal information about every patient registered with a General Practice in Scotland. ISD submitted an application to the CHI Advisory Group seeking authorisation to obtain the necessary CHI information to be used as a sampling frame for the Survey. ISD's Head of Primary Care Programme appeared before the Group to answer a range of questions and provide assurances to the Group on the nature of the survey and the use of the data.

7.3 Data sample

The sample of patients to whom the survey was sent was drawn randomly from CHI. The sampling method and process are described in more detail in chapter 4. Each patient selected for the survey was allocated a survey-specific unique ID number. This ID number was shown on the questionnaire sent to each patient, and used to link individual survey responses back to the original list of sampled patients.

7.4 Data transfer

The names, addresses and survey-specific unique ID numbers of sampled patients, along with the code, name and location of their registered GP practice, were sent electronically by secure ftp (File Transfer Protocol) link to Picker Europe.

On completion of survey fieldwork and data capture (described in more detail in chapters 5 and 6), the coded questionnaire responses were sent electronically by secure ftp from the survey contractors to ISD Scotland.

7.5 Access to data

Only named personnel within ISD and the survey contractors had access to the name and addresses of the people who were sent the questionnaire and of those who responded. All personnel are governed by the previously mentioned Information Governance Framework. No access to patient name and address details has, or will be given to General Practices, Community Health Partnerships, NHS Boards, the Scottish Government or any other organisation or individual.

8. Survey Response

8.1 Overview

The response rate for the survey is the number of forms returned as a percentage of the number of people in the sample. In total 485,380 surveys were sent to patients and 185,989 were returned completed giving an overall response rate of 38 per cent. Patients were only asked to respond to the survey if they had contact with their GP surgery in the last 12 months.

The expected number of returns was 184,622 which is a response rate of 38 per cent. The chapter on sampling (chapter 4) contains more information on the sample size and expected response rates.

8.2 Overall response rates for NHS Board areas

The highest response rate for an NHS Board was Orkney (49%) and the lowest response rate was for Greater Glasgow and Clyde (33%).

The calculations for the expected response rates are detailed in chapter 4.

Table 7: Response rate by NHS Board

NHS Board	Total forms sent out	Number of Responses	Response Rate (%)	Expected Response Rate (%)
Ayrshire And Arran	26,749	11,220	42	41
Borders	10,163	4,812	47	45
Dumfries And Galloway	13,863	6,533	47	46
Fife	26,693	10,772	40	40
Forth Valley	26,849	10,771	40	39
Grampian	36,397	15,049	41	42
Greater Glasgow And Clyde	150,412	50,189	33	33
Highland	37,024	16,944	46	46
Lanarkshire	49,746	18,376	37	36
Lothian	65,822	23,714	36	35
Orkney	3,522	1,726	49	53
Shetland	3,519	1,539	44	47
Tayside	30,479	12,439	41	42
Western Isles	4,142	1,905	46	48
Scotland	**485,380**	**185,989**	**38**	**38**

8.3 Response rates for GP Practices

The information on the Scottish Government website shows the details of response rates for each GP practice.

Patients at smaller practices were more likely to respond than those at larger practices.

Table 8: Response rate by practice list size

GP Practice List Size	Total forms sent out	Number of Responses	Response Rate (%)
< 2,500	85,820	35,618	42
2,500 - 4,999	145,708	55,740	38
5,000 - 7,499	116,951	44,397	38
7,500 - 9,999	83,321	30,422	37
10,000+	53,580	19,812	37
Scotland	**485,380**	**185,989**	**38**

8.4 Response rate by patient characteristics

As expected the response rate was lower for patients living in deprived areas. This was taken into account when the sample sizes were calculated (see Chapter 4 on Sample Design). The response rate ranged from 31 per cent for the patients living in the most deprived areas to 43 per cent for patients living in the least deprived areas.

Table 9: Response rate by deprivation[14] quintile[15]

Deprivation	Total forms sent out	Number of Responses	Response Rate (%)
1 - Most deprived	112,567	35,086	31
2	101,024	36,857	36
3	103,338	42,301	41
4	88,497	38,116	43
5 - Least deprived	77,145	32,892	43
Scotland	**485,380**	**185,989**	**38**

The response rate ranged from 33 per cent of patients living in large urban areas to 48 per cent of patients living in remote rural areas.

[14] An error has been found in the income domain of SIMD 2009. This affects the SIMD 2009 income domain and overall SIMD 2009. The effect of this error is expected to be minimal and is unlikely to change the key messages. The results by patient deprivation will be updated when SIMD 2009 is revised. For further information on this error see: http://www.scotland.gov.uk/Topics/Statistics/SIMD/

[15] Total Forms sent out and number of responses will not sum to the national total because for some patients it was not possible to match their address to an SIMD datazone

Table 10: Response rate by patient urban rural[16]

Urban Rural	Total forms sent out	Number of Responses	Response Rate (%)
Large Urban Areas	215,692	71,645	33
Other Urban Areas	113,764	44,116	39
Accessible small towns	33,585	13,925	41
Remote Small Towns	14,198	6,246	44
Accessible rural	52,688	24,092	46
Remote Rural	50,860	24,571	48
Scotland	**485,380**	**185,989**	**38**

The response rate was higher for older age groups. A response rate of 66 per cent was achieved for 65-74 year olds compared to one of just 16 per cent for those aged 16-24.

Table 11: Response rate by age group

Age	Total forms sent out	Number of Responses	Response Rate (%)
16 - 24	70,803	11,614	16
25 - 34	81,873	17,046	21
35 - 44	88,093	27,658	31
45 - 54	84,735	34,724	41
55 - 64	69,428	38,845	56
65 - 74	49,715	32,569	66
75 and over	40,733	23,533	58
Scotland	**485,380**	**185,989**	**38**

The response rate was higher for females (45%) than it was for males (32%).

Table 12: Response rate by gender

Gender	Total forms sent out	Number of Responses	Response Rate (%)
Male	242,763	77,151	32
Female	242,617	108,838	45
Scotland	**485,380**	**185,989**	**38**

[16] Total Forms sent out and number of responses will not sum to the national total because for some patients it was not possible to match their address to an urban rural area

8.5 Types of response

Of the 185,989 respondents 178,246 sent their surveys back in the post, 7,414 completed their survey online and 329 completed the survey using a JAWS[17] reader.

Of the patients included in the sample 1,513 were identified as having died and were not sent a survey. 108 surveys were returned informing us that the patient had died.

27,782 surveys (less than six per cent) were returned as 'undeliverable'.

[17] JAWS is a screen reading software product that is accessible to the visually impaired.

9. Analysis and Reporting

9.1 Introduction to analysis

The survey data collected and coded by Picker and Ciconi Ltd were securely transferred to ISD Scotland, where the information was analysed using the statistical software package SPSS version 17.0.

9.2 Reporting age and gender variables

Analysis of survey response rates by gender was done using the gender of the sampled patients, according to their CHI record.

For all other analyses by gender, where survey respondents had reported a valid gender in response to question 21, this information has been used in reporting. Where the respondents did not answer the question or gave an invalid response, gender information from the sampled patient's CHI record was used.

Self-reported gender was used where possible as in a small proportion of responses the reported information and the information on CHI differed. The most likely reason for this is that the questionnaire was sent to one patient but was completed by or on behalf of another one registered to the same practice (e.g. a recipient passing their questionnaire to a spouse).

In total, 182,382 responders (98.1%) provided a valid response to the question on gender (Q21). Of these, there was a difference between self-reported gender of the respondent and the gender of the originally sampled patient in 2,581 cases (1.4%). Amongst this group it was more frequently the case that a survey questionnaire originally sent to a male was responded to by a female (n = 1,662), than it was that a questionnaire sent to a female was answered by a male (n = 919). As practice contact rates are generally higher in females than males, one possible reason for this is that some male survey recipients may not have been to their practice in the past 12 months and passed their questionnaire to a female member of their household.

9.3 Reporting patient age

Analysis of survey response rates by age was done using the age of the sampled patients, according to their CHI record at the time of data extraction (20th October 2009).

For all other analyses by age where survey respondents had reported a valid age in response to question 22, this information has been used in reporting. Where the respondents did not answer the question or gave an invalid response, age information from the sampled patient's CHI record (as at 20th October 2009) was used.

Valid age was taken to be anything between 16 and 108 years. A small proportion of cases where age was reported as less than 16 were treated as invalid responses to the question, although it is likely that in at least some of these instances the respondents were giving their feedback about their experience at the practice when making an appointment for their child, and in doing so reported the child's age rather than their own.

Self-reported age was used where possible in preference to age derived from the CHI record as in a proportion of responses the reported information and the information on CHI differed. Reasons for this include the questionnaire being sent to one patient but being completed by or on behalf of another one registered to the same practice (e.g. a recipient passing their questionnaire to a family member or spouse). In some of these instances, where the survey recipient and another member of their household had the same name (e.g. a father and son), the questionnaire may have been answered by the namesake of the individual sent the questionnaire.

In total, 177,512 responders (95.4%) provided a valid response to the question on age at last birthday (Q22). Of these, the self-reported age and the age calculated from the CHI record differed by two or more years in 5,291 cases (3.0%). In a further 36,703 cases (20.7%) there was a difference of one year. This is not unexpected, however, as many recipients would have had a birthday between 20th October 2009 and the date they responded to their questionnaire (November 2009 – March 2010).

In many instances where the age calculated from the CHI record differed from the age reported by the survey respondents, the associated age group used in the national report remained the same, whether based on CHI or based on the survey response. In 7,181 cases the record was however counted under a different age group for response rate analysis to the one used for all other analyses. Of these, 5,481 (76.3%) were in an older group for the main analysis of results than for analysis of response rates. Some of this relates to individual recipients having a birthday and "moving up" by a single age group. In other instances this reflects the respondent being a different individual to the person sent the questionnaire and being more likely to be somewhat older than the originally sampled patient; older people were more likely to respond to the survey than younger people.

Table 13: Where reported age and CHI age groups are different

Age group calculated from survey responses (Nov 2009 – Mar 2010)	Age group calculated from CHI record as at 20th October 2009							Total
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 and over	
16 - 24	0	79	37	59	15	19	4	213
25 - 34	341	0	149	36	30	9	12	577
35 - 44	128	451	0	224	71	96	24	994
45 - 54	421	169	676	0	285	57	108	1716
55 - 64	151	310	148	789	0	163	38	1599
65 - 74	33	88	222	73	746	0	185	1347
75 and over	20	18	43	89	41	524	0	735
Total	1094	1115	1275	1270	1188	868	371	7181

9.4 Reporting deprivation and urban/rural status

Patient postcodes were used to match records to deprivation and urban/rural status information as defined by the Scottish Government. The versions used were:-

- The Scottish Government urban rural classification 2007/08 (see Annex B). Further information on the classification is published at http://www.scotland.gov.uk/Publications/2008/07/29152642/0

- The Scottish Index of Multiple Deprivation 2009. Further information on the index is published at http://www.scotland.gov.uk/Topics/Statistics/SIMD

A small minority of records were not matched to deprivation or urban/rural information, for example because the postcodes were not valid or recognised by the reference files used in the matching. Table 9 below shows the numbers and percentages of records that were not assigned to a deprivation or urban/rural category.

Table 14: Patients that could not be assigned urban/rural or deprivation categories

	All responders		**Sampled patients**	
	n	**%**	***n***	**%**
Urban/Rural: Patient not assigned to a classification	1,394	0.75	4,593	0.95
Deprivation: Patient not assigned to a quintile	737	0.4	2,809	0.58
Total	**185,989**	**100**	**485,380**	**100**

9.5 Number of responses analysed

The number of responses that have been analysed for each question is often lower than the total number of responses received. This is because not all of the questionnaires that were returned could be included in the calculation of results for every individual question. In each case this was for one of the following reasons:-

- The specific question did not apply to the respondent and so they did not answer it. For example if they did not see a nurse in the previous 12 months and therefore did not answer questions about their experience with the practice nurse(s)

- The respondent did not answer the question for another reason (e.g. refused). Patients were advised that if they did not want to answer a specific question they should leave it blank

- The respondent answered that they did not know or could not remember the answer to a particular question

- The respondent gave an invalid response to the question, for example they ticked more than one box where only one answer could be accepted.

9.6 Weighting

Estimates for Scotland NHS Boards and CHPs are weighted. Weighted results are calculated by weighting each GP Practice result for each question by the relative practice size. The weight is calculated as the practice patient list size (of patients aged 16+ and therefore eligible for survey) as a proportion of the entire population (Scotland, NHS Board or CHP) patient list size (of patients eligible for survey). Weighting the results in this way provides results more representative of the population (at Scotland, NHS Board or CHP level).

The national report also has national weighted results by patient characteristics (age, gender, urban/rural and deprivation). These results were weighted by taking the results for patients with a certain characteristic at a particular practice, and weighting them by the total number of eligible patients with that characteristic at that practice as a proportion of the total number of eligible patients nationally with that characteristic.

9.7 Percentage positive and negative

Percentage positive is frequently used in the reporting. This means the percentage of people who answered in a positive way. For example, when asked if they could get through on the phone, if people said always or most of the time these have been counted as positive answers. Similarly those patients who said they could rarely or

never get through on the phone have been counted as negative. Annex A details which answers have been classed as positive and negative for each question.

Percentage positive is mainly used to allow easier comparison rather than reporting results on the five point scale that patients used to answer the questions. There is also a belief that differences between answers on a five point may be subjective. For example there may be little or no difference between a person who "strongly agrees" and one who "agrees" with a statement. In fact some people may never strongly agree or disagree with any statements.

9.8 Confidence intervals

It should be kept in mind that because they are based on a survey of sampled patients and not the complete population of Scotland, the results are subject to sampling variability. More information on sampling can be found in the chapter on sampling (chapter 4).

GP Practices

The reported results for the percentages of patients in GP practices answering positively have been estimated from a random sample of patients. As with any sample, if we had asked a different group of patients, we could have ended up with a different result. How different this result might have been depends on (a) the number of people asked (we can be more sure with higher numbers) and (b) the variation in reported experience from that practice (if nearly everyone we asked had answered positively, we could be more confident that this would be the experience of most other people in the practice than if only half had answered positively).

Confidence intervals provide a way of quantifying this sampling uncertainty. A 95% confidence interval gives a range that we can be 95% sure contains the "true" result i.e. the results we would have obtained had we asked the entire practice. 95% confidence intervals have been published on the Scottish Government website for the estimates of the percentages of patients in each GP practice answering each question positively.

If, for example, the percentage positive result for a practice for a particular question is 80% and the confidence interval is 5%, this means we are 95% sure the result should be between 75% and 85%.

Confidence intervals for the results of all percentage positive questions have been published on the Scottish Government website for each GP Practice. The 95% Confidence Intervals for each practices were calculated using the following formula[18]:

[18] Lohr, Sharon L., 1999. *Sampling Design and Analysis*. Duxbury Press

$$CI = 1.96 \times SE$$

where $SE = \sqrt{(1 - n/N)} \times \sqrt{(p \times (1-p))/(n-1)}$

n=number of responses the practice result was based on

N= number of patients on the sampling frame for the practice

Example of calculation of confidence interval for a GP practice's result

For practice A, where the result (proportion of patients answering positively for a particular question) is equal to 84%, with a denominator of 195, and the total number of patients in the practice eligible for the survey was 5,066.

Then p = 0.84, n = 195, N = 5066

$SE = \sqrt{(1 - n/N)} \times \sqrt{(p \times (1-p))/(n-1)}$

$= \sqrt{(1 - 195/5066)} \times \sqrt{(0.84 \times (1 - 0.84))/(195 -1)}$

$= \sqrt{(0.9615)} \times \sqrt{((0.84 \times 0.16)/194)}$

$= 0.026$

$CI = 1.96 \times SE$

So, $CI = 1.96 \times 0.026 = 0.05$

Expressed as a percentage (x100) is 5%

The 95% confidence interval for practice A, where the proportion is 84%, is 79% - 89%. We can be 95% confident that the result would be in this range if we were to survey the patients from practice A again.

National weighted averages

The survey used a stratified sample design with weights applied to estimate national averages. One of the effects of using stratification and weighting is that standard errors for survey estimates are generally higher than the standard errors that would be derived from an unweighted simple random sample of the same size.

Confidence intervals have been calculated for the results of question 19 (the overall rating of care provided by the GP surgery) by NHS Board in the table below. This provides an example of the accuracy of the estimates in the national report.

In the table below the true standard errors used to calculate the confidence intervals have been calculated using a Taylor Series expansion method to take into account the weighting and stratification.

The SAS procedure surveyfreq was used to calculate the confidence intervals.

Table 15: Percentage of patients rating the overall care provided by their GP surgery as good or excellent by NHS Board with confidence intervals

NHS Board	Overall rating of care provided by GP Surgery	95% confidence interval	
		Lower Limit	Upper Limit
Ayrshire And Arran	90	89.0	90.3
Borders	94	93.2	94.7
Dumfries And Galloway	92	91.7	93.2
Fife	90	89.4	90.6
Forth Valley	91	90.4	91.6
Grampian	90	89.3	90.5
Greater Glasgow And Clyde	91	90.7	91.3
Highland	92	91.7	92.8
Lanarkshire	88	87.6	88.7
Lothian	89	88.6	89.5
Orkney	98	96.9	98.2
Shetland	88	85.0	90.3
Tayside	91	90.4	91.6
Western Isles	94	92.2	95.3
Scotland	**90**	**90.2**	**90.5**

9.9 Quality assurance of the national report

Members of the GP Measuring Experience Advisory Group were sent a draft version of the national report for quality assurance. Feedback included suggestions on ways in which to report data as well as comments about the context for the survey. These were taken into account in finalising the national report. In addition ISD Scotland carried out quality checks of all figures used in the report.

ANNEX A Percent Positive and Negative Results

The table below shows which answers were classed as positive and which were classed as negative for each question. The "Percent Positive text" column shows how each question was rewritten for the GP surgery report.

The answers "neither agree nor disagree", "fair" or "sometimes" have been included as being neither positive nor negative. Other answers such as "Not relevant" or "can't remember or don't know" have been excluded.

Qu. No	Question	Percent Positive Text	Positive	Negative
2	In the last 12 months, when you have phoned your GP surgery, could you get through on the phone?	Able to get through on the phone	Always, Most of the time	Rarely, Never
3	When you have phoned your GP surgery, was the person who answered polite and helpful?	Person who answered phone was polite and helpful	Always, Most of the time	Rarely, Never
5	The last time this happened, did you see or speak to a doctor or nurse within 2 working days?	Could see or speak to a doctor or nurse within 2 working days	Yes	No
8	The last time you tried to book in advance, were you able to get an appointment?	Able to book an appointment in advance	Yes	No
10	When you arrange to see a doctor at your GP surgery can you usually see the doctor you prefer?	Can usually see preferred doctor	Yes	No
11	How do you feel about how long you usually have to wait to be seen after you arrive at your GP surgery?	Time waiting to be seen at GP surgery	It is reasonable	It is too long
12a	Overall how would you rate the arrangements for getting to see a doctor in your GP surgery?	Overall arrangements for getting to see a doctor	Excellent, Good	Poor, very poor
12b	Overall how would you rate the arrangements for getting to see a nurse in your GP surgery?	Overall arrangements for getting to see a nurse	Excellent, Good	Poor, very poor

13a	The receptionist was polite and helpful	The receptionist was polite and helpful	Always, Most of the time	Rarely, Never
13b	I was worried because other people could overhear me talking to the receptionist	People were not worried that they could be overheard talking to the receptionist	Rarely, Never	Always, Most of the time
13c	I felt bothered or threatened by other patients	People did not feel bothered or threatened by other patients	Rarely, Never	Always, Most of the time
14a	The doctor listens to me	The doctor listens to the patient	Strongly Agree, agree	disagree, strongly disagree
14b	I feel that the doctor has all the information they need to treat me	Patients feel that the doctor has all the information they need to treat them	Strongly Agree, agree	disagree, strongly disagree
14c	The doctor shows consideration for my personal circumstances in treating me	The doctor shows consideration for the patient's personal circumstances when treating them	Strongly Agree, agree	disagree, strongly disagree
14d	The doctor talks in a way that helps me understand my condition and treatment	The doctor talks in a way that helps the patient to understand their condition and treatment	Strongly Agree, agree	disagree, strongly disagree
14e	I am confident in the doctor’s ability to treat me	Patients have confidence in the doctor's ability to treat them	Strongly Agree, agree	disagree, strongly disagree
14f	I have enough time with the doctor	Patients have enough time with the doctor	Strongly Agree, agree	disagree, strongly disagree
15b	The nurse listens to me	The nurse listens to the patient	Strongly Agree, agree	disagree, strongly disagree

15c	I feel that the nurse has all the information they need to treat me	Patients feel that the nurse has all the information they need to treat them	Strongly Agree, agree	disagree, strongly disagree
15d	The nurse shows consideration for my personal circumstances in treating me	The nurse shows consideration for the patient's personal circumstances when treating them	Strongly Agree, agree	disagree, strongly disagree
15e	The nurse talks in a way that helps me understand my condition and treatment	The nurse talks in a way that helps the patient to understand their condition and treatment	Strongly Agree, agree	disagree, strongly disagree
15f	I am confident in the nurse's ability to treat me	Patients have confidence in the nurse's ability to treat them	Strongly Agree, agree	disagree, strongly disagree
15g	I have enough time with the nurse	Patients have enough time with the nurse	Strongly Agree, agree	disagree, strongly disagree
16b	I know enough about what my medicines are for	Patients always know enough about what their medicines are for	Always, Most of the time	Rarely, Never
16c	I know enough about how and when to take my medicines	Patients always know enough about how and when to take their medicines	Always, Most of the time	Rarely, Never
16d	I know enough about possible side effects of my medicines	Patients know enough about side effects of medicines	Always, Most of the time	Rarely, Never
16e	I would know what to do if I had any problems with my medicines	Patients know what to do if they have any problems with their medicines	Always, Most of the time	Rarely, Never

17	How do you feel about being involved in decisions about your care and treatment?	Patients are involved as much as they want to be in decisions about their care and treatment	I am involved as much as I want to be	I am involved more than I want to be; I am not involved enough
18a	I am treated with dignity and respect	Patients are treated with dignity and respect	Strongly Agree, agree	disagree, strongly disagree
18b	My personal values and beliefs are respected	Patients' personal values and beliefs are respected	Strongly Agree, agree	disagree, strongly disagree
19	Overall, how would you rate the care provided by your GP surgery?	Rating of overall care provided by GP surgery	Excellent, Good	Poor, very poor

ANNEX B Scottish Government urban rural classification

The Scottish Government classifications of urban and rural areas are based on the following definitions.

Large urban area: settlements with population of 125,000 or more
Other urban areas: settlements with population of 10,000 – 125,000
Small towns: settlements with population of 3,000 – 10,000
Rural area: any settlement of less than 3,000 people

Small towns and rural areas can be split into accessible and remote, based on distance from an urban area:

Remote area: more than 30 minutes drive from a settlement of 10,000 people or more
Accessible area: less than 30 minutes drive from a settlement of 10,000 people or more.

All analysis is shown using the SG 6-fold urban rural classification.

The urban / rural splits shown in this publication show rural areas compared with urban areas including small towns. GP practices are classified depending on their location. There are 225 rural practices in Scotland, compared with 790 urban by this classification. Patients have been classified by their postcodes.

Please see the published classification for full details.
http://www.scotland.gov.uk/Publications/2008/07/29152642/0

Better Together

Scotland's Patient Experience Programme

GP Patient Experience Survey

Please read the enclosed letter for more information about this survey.

If you would prefer, you can complete this survey online at **www.gpsurvey.org.uk**

To do this, you will need to enter this ID:

Instructions

Please answer all questions, unless the instructions ask you to skip a question.

For each question, please place a tick in the box next to the answer that most closely matches your own experience at your GP surgery.

For example, if your answer is yes, write in a tick as below:

☑ Yes

☐ No

Don't worry if you make a mistake. Simply cross it out and tick the correct answer.

Most of the questions are about your whole experience over the last 12 months, but some will ask you to think specifically about the most recent time you had contact with your GP surgery.

Helpline
0800 783 2896

healthier scotland
SCOTTISH GOVERNMENT

NHS SCOTLAND

Q1 This survey is about contact with your GP surgery in the last 12 months. **Have you had contact with the GP surgery named on the enclosed letter in the last 12 months?**

1 ☐ Yes → Go to Question 2

2 ☐ No → Please **do not** fill in this form

If you have any questions about filling in the survey please phone the helpline on **0800 783 2896**

Section 1: Access

Q2 In the last 12 months, when you have phoned your GP surgery, could you get through on the phone?

*Please tick **ONE** box only*

1 ☐ Always → Go to Question 3

2 ☐ Most of the time → Go to Question 3

3 ☐ Sometimes → Go to Question 3

4 ☐ Rarely → Go to Question 3

5 ☐ Never → Go to Question 4

6 ☐ I haven't tried to phone → Go to Question 4

7 ☐ I can't remember or I don't know → Go to Question 3

Q3 When you have phoned your GP surgery, was the person who answered polite and helpful?

*Please tick **ONE** box only*

1 ☐ Always

2 ☐ Most of the time

3 ☐ Sometimes

4 ☐ Rarely

5 ☐ Never

6 ☐ I can't remember or I don't know

Q4 **In the last 12 months**, have you contacted your GP surgery because you needed advice **fairly quickly** because you felt unwell or were worried about something? (*Please include contacting your GP surgery for **someone else**, for example a child or elderly person who is registered at the **same surgery**).*

*Please tick **ONE** box only*

1 ☐ Yes → Go to Question 5

2 ☐ No → Go to Question 7

Q5 **The last time this happened**, did you see or speak to a doctor or nurse **within 2 working days?**

*Please tick **ONE** box only*

1 ☐ Yes, I saw a doctor or nurse **face-to-face** → Go to Question 7

2 ☐ Yes, I spoke to a doctor or nurse on the **telephone** → Go to Question 7

3 ☐ No → Go to Question 6

Q6 Why did you not see or speak to a doctor or nurse **within 2 working days**?

*Please tick **ONE** box only*

1 ☐ I **was** offered the chance but the time offered did not suit me

2 ☐ I **was** offered the chance but the person I wanted was not available

3 ☐ I **was not** offered the chance

4 ☐ I can't remember or I don't know

5 ☐ Other reason

Q7 **In the last 12 months**, have you tried to book a doctor's appointment **in advance**? (For example, have you tried to book an appointment for when you get back from a holiday or to fit in with other commitments)

*Please tick **ONE** box only*

1 ☐ Yes → Go to Question 8

2 ☐ No → Go to Question 10

Q8 The last time you tried to book **in advance**, were you able to get an appointment?

*Please tick **ONE** box only*

1 ☐ Yes → Go to Question 10

2 ☐ No → Go to Question 9

3 ☐ Can't remember → Go to Question 10

Q9 Why did you not get an appointment in advance?

*Please tick **ONE** box only*

1 ☐ There were no advance appointments available for booking

2 ☐ I was offered an appointment, but not at a time that suited me

3 ☐ I was offered an appointment, but not with the doctor I wished to see

4 ☐ I can't remember or I don't know

5 ☐ Other reason

Q10 When you arrange to see a doctor at your GP surgery can you *usually* see the doctor you prefer?

*Please tick **ONE** box only*

1 ☐ Yes

2 ☐ No

3 ☐ I don't have a doctor I prefer to see

4 ☐ There is usually only one doctor in my GP surgery

Q11 How do you feel about how long you *usually* have to wait to be seen after you arrive at your GP surgery?

*Please tick **ONE** box only*

1 ☐ It is reasonable

2 ☐ It is too long

3 ☐ I can't remember or I don't know

Q12 Overall how would you rate the arrangements for getting to see a doctor and/or nurse in your GP surgery?

*Please tick **ONE** box in each list*

Getting to see a doctor	Getting to see a nurse
1 ☐ Excellent	1 ☐ Excellent
2 ☐ Good	2 ☐ Good
3 ☐ Fair	3 ☐ Fair
4 ☐ Poor	4 ☐ Poor
5 ☐ Very poor	5 ☐ Very poor
6 ☐ I did not try to see a doctor	6 ☐ I did not try to see a nurse

Section 2: At the GP Surgery – based on your experience in the last 12 months

Q13 When you attended your GP surgery, how often did you experience each of the following?

*Please tick **ONE** box on each line.*

	Always	Most of the time	Some-times	Rarely	Never	Not relevant
The receptionist was polite and helpful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I was worried because other people could overhear me talking to the receptionist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I felt bothered or threatened by other patients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Q14 How much do you **agree or disagree** with each of the following about the **doctor or doctors** you have **seen** at your GP surgery?

*Please tick **ONE** box on each line.*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The doctor listens to me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I feel that the doctor has all the information they need to treat me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
The doctor shows consideration for my personal circumstances in treating me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
The doctor talks in a way that helps me understand my condition and treatment	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I am confident in the doctor's ability to treat me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I have enough time with the doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q15 Have you seen a **nurse** at your GP surgery in the last 12 months?

1 ☐ No → Please go to Question **16**

2 ☐ Yes → How much do you **agree or disagree** with each of the following about the **nurse or nurses** you have seen at your GP surgery?

*Please tick **ONE** box on each line.*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The nurse listens to me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I feel that the nurse has all the information they need to treat me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
The nurse shows consideration for my personal circumstances in treating me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
The nurse talks in a way that helps me understand my condition and treatment	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I am confident in the nurse's ability to treat me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I have enough time with the nurse	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q16 Have you been prescribed **medicines** at your GP surgery in the last 12 months?

1 ☐ No → Please go to Question **17**

2 ☐ Yes → How often have you experienced the following?

*Please tick **ONE** box on each line.*

	Always	Most of the time	Some-times	Rarely	Never
I know enough about what my medicines are for	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I know enough about how and when to take my medicines	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I know enough about possible side effects of my medicines	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I would know what to do if I had any problems with my medicines	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q17 How do you feel about being involved in decisions about your care and treatment?

*Please tick **ONE** box only*

1 ☐ I am **involved more** than I want to be	4 ☐ I do **not wish to be involved**
2 ☐ I am **involved as much as** I want to be	5 ☐ Not relevant
3 ☐ I am **not involved enough**	

Section 3: Overall Experience – based on your experience in the last 12 months

Q18 How much do you **agree or disagree** with each of the following about how you generally feel about your GP surgery?

*Please tick **ONE** box on each line.*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I am treated with dignity and respect	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My personal values and beliefs are respected	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q19 **Overall, how would you rate the care provided by your GP surgery?**

*Please tick **ONE** box only*

1 ☐ **Excellent**	2 ☐ **Good**	3 ☐ **Fair**	4 ☐ **Poor**	5 ☐ **Very poor**

Q20 If there is anything else you would like to tell us about your experiences at your GP surgery, please write your comments in the box below.

Section 4: About you

This information will help us to find out if different groups of people in Scotland have different experiences of treatment at their GP surgeries. Nobody at your GP surgery will be able to see your answers. If you would prefer not to answer a particular question then you should skip it and go to the next question.

Q21 Are you male or female?
*Please tick **ONE** box only*

1 ☐ Male

2 ☐ Female

Q22 What was your age on your last birthday?
Please answer in full years only

Q23 Which of the following options best describes how you think of yourself?
*Please tick **ONE** box only*

1 ☐ Heterosexual / straight
2 ☐ Gay / Lesbian
3 ☐ Bisexual
4 ☐ Other

Q24 What **religion**, religious denomination or body do you belong to?
*Please tick **ONE** box only*

1 ☐ None
2 ☐ Church of Scotland
3 ☐ Roman Catholic
4 ☐ Other Christian
5 ☐ Muslim
6 ☐ Buddhist
7 ☐ Sikh
8 ☐ Jewish
9 ☐ Hindu
10 ☐ Pagan
11 ☐ Another religion, please write in:

Q25 What is your **ethnic group?**
*Choose **ONE** section from A to E, then tick **ONE** box which best describes your ethnic group or background*

01 **A White**
1 ☐ Scottish
2 ☐ English
3 ☐ Welsh
4 ☐ Northern Irish
5 ☐ British
6 ☐ Irish
7 ☐ Gypsy / Traveller
8 ☐ Polish
9 ☐ Other, please write in:

02 **B Mixed or multiple ethnic groups**
10 ☐ Please write in:

03 **C Asian, Asian Scottish or Asian British**
11 ☐ Pakistani, Pakistani Scottish or Pakistani British
12 ☐ Indian, Indian Scottish or Indian British
13 ☐ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
14 ☐ Chinese, Chinese Scottish or Chinese British
15 ☐ Other, please write in:

04 **D African, Caribbean or Black**
16 ☐ African, African Scottish or African British
17 ☐ Caribbean, Caribbean Scottish or Caribbean British
18 ☐ Black, Black Scottish or Black British
19 ☐ Other, please write in:

05 **E Other ethnic group**
20 ☐ Arab
21 ☐ Other, please write in:

Q26 Do you have any of the following?
*Please tick **ALL** that apply*

1 ☐ Deafness or severe hearing impairment

2 ☐ Blindness or severe vision impairment

3 ☐ A physical disability

4 ☐ A learning disability (such as Down's Syndrome)

5 ☐ A learning difficulty (such as dyslexia)

6 ☐ A mental health condition (such as depression or schizophrenia)

7 ☐ A long term condition (such as diabetes, cancer, HIV, heart disease or epilepsy)

8 ☐ Other, please write in:

Q27 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?
(Include problems related to old age).
*Please tick **ONE** box only*

1 ☐ Yes, limited a lot

2 ☐ Yes, limited a little

3 ☐ No

Q28 Do you need an **interpreter** or other **help to communicate**?
*Please tick **ONE** box only*

1 ☐ No

2 ☐ Yes – what type of help do you need?

Thank you for taking the time to complete this form. Please return it in the envelope provided. If you have no envelope please post it (no stamp needed) to:

PICKER INSTITUTE EUROPE
FREEPOST NATW1240
AIRFIELD INDUSTRIAL ESTATE
WARBOYS
HUNTINGDON
PE28 2BR

ANNEX D Survey Materials – Language Sheet

translations

For help filling in the survey in any other language, please call our free helpline on 0800 085 8535. You can also ring this number to request other formats e.g. large print. It also works with text phones.

Ma tha ceistean agaibh mun sgrùdadh seo, no ma tha sibh ag iarraidh cuideachadh airson a' cheisteachan a thig na chois a lionadh, cuiribh fòn an asgaidh gun loidhne-cuideachaidh airson bruidhinn ri eadar-theangair beò ann an Gaelic ☎ 0800 085 8535

আপনার যদি এই সার্ভের বিষয় কোন প্রশ্ন থাকে অথবা আপনি যদি সংশ্লিষ্ট প্রশ্নাবলি পূরণ করবার জন্য কোন সাহায্য চান, তাহলে দয়া করে এই ফ্রিফোন হেল্পলাইনে ফোন করুন যেখানে আপনি একজন বাংলা জানা দোভাষী বা ইন্টারপ্রিটারের সাথে কথা বলতে পারবেন। ☎ 0800 085 8535

如果你對此調查有何疑問，或需要協助來完成所附上的問卷，請撥打此免費電話，你將會獲得廣東話口譯員的協助。☎ 0800 085 8535

اگر در مورد این زمینه یابی سؤالی دارید و یا در پر کردن این پرسشنامه به کمک احتیاج دارید، لطفاً با تلفن مجانی کمک تماس بگیرید و مترجم فارسی در اختیار شما گذارده خواهد شد. ☎ 0800 085 8535

આ પ્રશ્નો વિષે તમને કંઈ પણ જાણવું હોય કે પછી પ્રશ્નોના જવાબ દેવા માટે મદદ જોઈએ તો ફ્રી ફોન કરી શકો અને તમને ગુજરાતીમાં અમે મદદ કરી શકીશું. ☎ 0800 085 8535

यदि आपने सर्वेक्षण के बारे में कोई प्रश्न पूछने हैं, या साथ दी प्रश्नावली को भरने में आपको सहायता चाहिए, तो कृपया फ्रीफ़ोन हेल्पलाइन ☎ 0800 085 8535 पर टेलिफ़ोन कीजिए जहाँ आप एक दुभाषिया से हिन्दी में बातचीत कर सकत ह।

ئەگەر هەر پرسیارێکت هەبوو لەبارەی لێکۆڵینەوەکە یاخود یارمەتیت پێویست بوو بۆ پرکردنەوەی ئەو راپرسینەی پاشکۆ کراوە، تکایە تەلەفۆن بکە بۆ هێڵی یارمەتی لەسەر ئەم ژمارەیە بەخۆڕایی و دەتوانیت لەگەڵ موتەرجیمێکی زمانی کوردی سۆرانی قسە بکەیت ☎ 0800 085 8535

如果你对此调查有何疑问，或需要协助来完成所附上的问卷，请拨打此免费电话，你将会获得普通话口译员的协助。☎ 0800 085 8535

ਜੇਕਰ ਤੁਸੀਂ ਸਰਵੇਖਣ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਪੁੱਛਣੇ ਹਨ, ਜਾਂ ਨਾਲ ਭੇਜੇ ਗਏ ਸਵਾਲਨਾਮੇ ਨੂੰ ਭਰਨ ਵਿਚ ਤੁਸੀਂ ਮਦਦ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਫ਼ਰੀਫ਼ੋਨ ਹੈਲਪਲਾਈਨ ☎ 0800 085 8535 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ ਜਿਥੇ ਤੁਸੀਂ ਇਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਪੰਜਾਬੀ ਵਿਚ ਗੱਲਬਾਤ ਕਰ ਸਕਦੇ ਹ।

இந்த ஆய்வு சம்பந்தமாக உங்களுக்கு ஏதாவது கேள்விகள் இருப்பின் அல்லது இணைக்கப்பட்டுள்ள கேள்விப்படிவத்தை நிரப்புவதற்கு உதவி தேவைப்படின் தயவுசெய்து இலவச தொலைபேசியில் அழைக்கவும். இத்தொலைபேசியில் நீங்கள் ஒரு தமிழ் உரைபெயர்ப்பாளருடன் பேச முடியும். ☎ 0800 085 8535

หากท่านมีปัญหาอะไรที่เกี่ยวข้องกับการสำรวจนี้ หรือต้องความช่วยเหลือในการกรอกแบบคำถามที่แนบมานี้ กรุณาโทรหาหน่วยช่วยเหลือที่หมายเลขฟรี ☎ 0800 085 8535 ที่ท่านสามารถคุยกับล่ามภาษาไทย

Bu anketle ilgili sorularınız varsa veya ekteki anket formunu doldurmak için yardım almak istiyorsanız, aşağıdaki ücretsiz yardım hattımızı arayarak Türkçe konuşan bir tercümanla görüşebilirsiniz. ☎ 0800 085 8535

اگر آپ کے ذہن میں اس سروے کے بارے میں کوئی سوال ہو یا آپ کو بھیجے جانے والے سوالنامے کو پُر کرنے کے لیے مدد کی ضرورت ہو تو براہ مہربانی مفت ہیلپ لائن کے ٹیلیفون نمبر ☎ 0800 085 8535 پر فون کریں جہاں آپ کسی ترجمان سے اردو میں بات کر سکتے ہیں۔

Si vous avez des questions au sujet de cette enquête ou que vous aimeriez recevoir de l'aide afin de remplir le questionnaire ci-joint, veuillez appeler le service d'assistance téléphonique gratuit au ☎ 0800 085 8535 afin de pouvoir parler à un interprète en français

Qualora Lei abbia delle domande da fare su questa indagine, o abbia bisogno di un aiuto per compilare l'accluso questionario, La preghiamo di telefonare al Numero Verde servizio assistenza dove potrà parlare con un interprete in italiano. ☎ 0800 085 8535

Jeżeli masz jakiekolwiek pytania w odniesieniu do sondażu, lub chcesz uzyskać pomoc w wypełnieniu załączonego formularza, prosimy zadzwoń pod bezpłatną linię pomocy gdzie będziesz mógł rozmawiać z tłumaczem w języku polskim ☎ 0800 085 8535

Se tiver alguma pergunta sobre a sondagem, ou se precisar de ajuda para preencher o questionário anexo por favor telefone para a linha telefónica gratuita de ajuda onde poderá falar em Português com um intérprete. ☎ 0800 085 8535

Если у вас возникнут каки-либо вопросы или требуется помощь в заполнении приложенной анкеты, пожалуста звоните по бесплатному телефону службы помощи где вы сможете задать вопросы по-русски. ☎ 0800 085 8535

Haddii aad su'aal ka qabtid daraasadda, ama doonaysid in lagaa caawiyo buuxinta su'aalaha, fadlan soo wac telefoonkan bilsaashka ah oo kuu suuurtogelinaya inaad la hadashid turjumaan Soomaali ah. ☎ 0800 085 8535

Si Usted tiene alguna pregunta acerca de este estudio o quiere que le ayuden a rellenar el cuestionario que se adjunta, por favor llame al numero de teléfono gratuito ☎ 0800 085 8535 donde Usted puede hablar con un interprete español.

ANNEX E Survey Materials – Introductory Letter

Better Together

GP Patient Survey

<<first name and surname>>
<<Patient address 1>>
<<Patient address 2>>
<<Patient address 3>>
<<Patient address 4>>
<<POSTCODE>>

Crystal Mark 18827
Clarity approved by Plain English Campaign

«UID Number»

<<Date>>

Dear <<first name and surname>>

Can you spare a few minutes to tell us about the services provided by your GP surgery?

I am writing to ask you to take part in the Scottish GP patient survey. 'GP' is short for 'general practitioner', which is what we call family doctors in Scotland.

I understand that your GP surgery is **«GP surgery name and location»**.

I would like you to answer the questions about **your experiences** at this GP surgery.

Your answers are completely **confidential** and nobody at your GP surgery or NHS board will see them.

There is more information about the survey on the other side of this page, and on the survey website at **www.bettertogetherscotland.com**.

If you have any questions, need help filling in the survey or would prefer not to receive any more letters about the survey, please phone the Better Together helpline on **0800 783 2896**.

Thank you very much for your time.

Yours sincerely

Carol Sinclair

Carol Sinclair
Programme Director, Better Together

Helpline: 0800 783 2896

Please turn over

NHS SCOTLAND

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SCOTTISH GOVERNMENT

Some questions and answers

Why are you carrying out this survey?
We would like to find out about your experience of using your GP surgery. For example, how easy it is for you to speak to someone at your GP surgery, and how you are treated by the staff.

Why do you need to know?
Finding out about your experience can help us to make things better for other people, so please be honest in your replies. What you say will not affect your ability to get treatment or care at your GP surgery.

Do I have to take part?
No, you don't have to take part if you don't want to, but taking part should help your GP surgery to improve the service and care it provides for everyone. If you would prefer not to receive any more letters about the survey, please phone the **Better Together helpline** on **0800 783 2896**.

Can someone help me with the survey?
A relative, friend or carer may help you to fill in the survey, but please remember that you should give all of the answers from your own point of view. If you would prefer, you can give your answers over the phone instead, by phoning the helpline on **0800 783 2896**. The person on the phone will need you to tell them the number that is on the front of this letter.

How did you get my name and address?
We picked names **at random** from the NHS database of patients registered with a GP. The NHS stores your contact details securely and confidentially. We have given you a unique ID number which lets us know if you have returned your form. The person reading your reply will only be able to see this number, not your name or address.

Do I have to answer every question?
No, you don't have to answer every question if you don't want to. But we hope you will, as your answers will help us to have the best possible picture of people's experiences. Sometimes we will ask you to skip a question if it doesn't apply to you.

Will my GP surgery see my answers?
No, staff at your GP surgery will not know if you have taken part in the survey or not. We will group together replies from all the patients at your surgery and your GP surgery will only see the overall results.

What happens to the results?
We will give your GP surgery a summary report on their results so they can see how they are doing compared with other GPs. You will be able to find the survey results in summer 2010 on www.bettertogetherscotland.com.

What is Better Together?
Better Together is a new programme which aims to improve the experience patients have when they use the health service in Scotland.

- You can fill in the survey online at **www.gpsurvey.org.uk**.
- If you have any other comments about the NHS in Scotland, please share your story online at **www.bettertogetherscotland.com**.

ANNEX F Survey Materials – Reminder Letter

Better Together

GP Patient Survey

<<first name and surname>>
<<Patient address 1>>
<<Patient address 2>>
<<Patient address 3>>
<<Patient address 4>>
<<POSTCODE>>

Crystal Mark 18828
Clarity approved by Plain English Campaign

«UID Number»

January 2010

Dear <<first name and surname>>

This is a reminder letter to ask you to take part in the Scottish GP patient survey. If you have already returned your survey, thank you very much. If not, there is still time to send it back.

It has been a few weeks since I wrote to you. You may have contacted your GP surgery since then, and now have experiences you would like to tell us about.

I understand that your GP surgery is **«GP surgery name and location»**.

I would like you to answer the questions about **your experiences** at this GP surgery.

Your answers are completely **confidential** and nobody at your GP surgery or NHS board will see them.

There is more information about the survey on the other side of this page, and on the survey website at **www.bettertogetherscotland.com**.

If you have any questions or need help filling in the survey, please contact the **Better Together helpline** on **0800 783 2896**.

Thank you very much for your time.

Yours sincerely

Carol A Sinclair

Carol Sinclair
Programme Director, Better Together

Helpline: 0800 783 2896

Please turn over

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SCOTTISH GOVERNMENT

Some questions and answers

Why are you carrying out this survey?
We would like to find out about your experience of using your GP surgery. For example, how easy it is for you to speak to someone at your GP surgery, and how you are treated by the staff.

Why do you need to know?
Finding out about your experience can help us to make things better for other people, so please be honest in your replies. What you say will not affect your ability to get treatment or care at your GP surgery.

Do I have to take part?
No, you don't have to take part if you don't want to, but taking part should help your GP surgery to improve the service and care it provides for everyone. If you would prefer not to receive any more letters about the survey, please phone the Better Together helpline on **0800 783 2896**.

Can someone help me with the survey?
A relative, friend or carer may help you to fill in the survey, but please remember that you should give all of the answers from your own point of view. If you would prefer, you can give your answers over the phone instead, by phoning the helpline on **0800 783 2896**. The person on the phone will need you to tell them the number that is on the front of this letter.

How did you get my name and address?
We picked names at random from the NHS database of patients registered with a GP. The NHS stores your contact details securely and confidentially. We have given you a unique ID number which lets us know if you have returned your form. The person reading your reply will only be able to see this number, not your name or address.

Do I have to answer every question?
No, you don't have to answer every question if you don't want to. But we hope you will, as your answers will help us to have the best possible picture of people's experiences. Sometimes we will ask you to skip a question if it doesn't apply to you.

Will my GP surgery see my answers?
No, staff at your GP surgery will not know if you have taken part in the survey or not. We will group together replies from all the patients at your surgery and your GP surgery will only see the overall results.

What happens to the results?
We will give your GP surgery a summary report on their results so they can see how they are doing compared with other GPs. You will be able to find the survey results in summer 2010 on www.bettertogetherscotland.com.

What is Better Together?
Better Together is a new programme which aims to improve the experience patients have when they use the health service in Scotland.

- You can fill in the survey online at **www.gpsurvey.org.uk**.
- If you have any other comments about the NHS in Scotland, please share your story online at **www.bettertogetherscotland.com**.

ANNEX G Survey Materials – Second reminder Letter

Better Together

GP Patient Survey

<<first name and surname>>
<<Patient address 1>>
<<Patient address 2>>
<<Patient address 3>>
<<Patient address 4>>
<<POSTCODE>>

Crystal Mark 19084
Clarity approved by Plain English Campaign

«UID Number»

March 2010

Dear «First name and Surname»

I wrote to you a few weeks ago to ask you to take part in our survey about your GP surgery.

If you have already returned your survey, thank you very much. If not, this is your last chance to give us your views. I will not contact you again about this survey.

Please fill in the survey, and post it in the enclosed envelope as soon as possible. (You do not need a stamp.) The survey will close on 31 March 2010.

I understand that your GP surgery is **«GP surgery name»**, **«GP surgery location»**.

I would like you to answer the questions about **your experiences** at this GP surgery.

Your answers are completely **confidential** and nobody at your GP surgery or NHS Board will see them.

There is more information about the survey on the other side of this page, and on the survey website at **www.bettertogetherscotland.com**.

If you have any questions or need help filling in the survey, please contact the **Better Together helpline** on **0800 783 2896**.

Thank you very much for your time.

Yours sincerely,

Carol A Sinclair

Carol Sinclair
Programme Director Better Together

Helpline: 0800 783 2896

Please turn over

NHS SCOTLAND

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SCOTTISH GOVERNMENT

Some questions and answers

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We would like to find out about your experience of using your GP surgery. For example, how easy it is for you to speak to someone at your GP surgery, and how you are treated by the staff.

Why do you need to know?
Finding out about your experience can help us to make things better for other people, so please be honest in your replies. What you say will not affect your ability to get treatment or care at your GP surgery.

Do I have to take part?
No, you don't have to take part if you don't want to, but taking part should help your GP surgery to improve the service and care it provides for everyone. If you would prefer not to receive any more letters about the survey, please phone the Better Together helpline on **0800 783 2896**.

Can someone help me with the survey?
A relative, friend or carer may help you to fill in the survey, but please remember that you should give all of the answers from your own point of view. If you would prefer, you can give your answers over the phone instead, by phoning the helpline on **0800 783 2896**. The person on the phone will need you to tell them the number that is on the front of this letter.

How did you get my name and address?
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Will my GP surgery see my answers?
No, staff at your GP surgery will not know if you have taken part in the survey or not. We will group together replies from all the patients at your surgery and your GP surgery will only see the overall results.

What happens to the results?
We will give your GP surgery a summary report on their results so they can see how they are doing compared with other GPs. You will be able to find the survey results in summer 2010 on www.bettertogetherscotland.com.

What is Better Together?
Better Together is a new programme which aims to improve the experience patients have when they use the health service in Scotland.

- You can fill in the survey online at **www.gpsurvey.org.uk**.
- If you have any other comments about the NHS in Scotland, please share your story online at **www.bettertogetherscotland.com**.

ANNEX H PwC Summary of Literature Review Findings

In this annex the numbers in superscript refer to items in the bibliography. Annex I shows the literature review bibliography.

Consultation time

The length of time that a patient spends with their GP during a consultation is prominent in the literature related to patient experience of general practice. A number of studies[22,43,55,74] have found the length of the consultation to be an important aspect of primary care to patients – for example, Wensing et al[81] found **'time for care'** to be rated highly as a patient priority in primary care.

Consultation time also appears to influence **patient outcomes and enablement** following the consultation - Howie et al [47] found that patient enablement correlated best with longer consultations. Edwards et al[30] found that improvements in patients' confidence in decisions and expectation to adhere to their chosen treatments were evident with the provision of more time and a 'protected' environment.

In a further study, patients did not feel that they had enough **'quality' time** during their consultation and this was linked to underestimating the length of their consultation with the GP[68]. Ogden[68] suggested that the desire for more time reflects a sense of dissatisfaction with how the time was spent rather than how much time they received, and that if patients have their emotional needs met, feel listened to and understood, regardless of the actual time spent with the doctor, then they are satisfied not only with the process of the consultation but also with consultation length.

Cape[14] found that a **lack of consultation time** was not correlated with a negative patient experience, suggesting that patients' perceptions of consultation time are influenced not just by actual consultation length, but by other aspects of their experience of the consultations. Braddock et al[9] note that many physicians and health care leaders express **concern about the amount of time** that they have for clinical practice and that the perception that the time they have with patients is inadequate is commonly held. They note that this perception has ethical significance as it may cause clinicians to forego activities and behaviours that promote important aspects of the patient-physician relationship, discourage shared decision making and deter physician obligations to act as patient advocates.

Longer consultations are essential in the treatment of **chronic diseases** – Campbell et al[13] found longer consultations to be essential in the provision of high quality clinical care, particularly in relation to chronic diseases.

Organisation of care (booking system) may have an impact on patient experience relating to consultation time. An international comparative study of consultation length in general practice[27] found intercountry variation in consultation length possibly due to the organisation of the healthcare system (structure of healthcare organisations).

Access / waiting times / availability

The literature suggests that the length of time patients have to wait before they can get an appointment with their GP and also the length of time they wait (in the waiting room) for their consultation to begin impacts on patient experience.

Patient satisfaction with **'getting an appointment'** was lowest in the UK in an international comparison of patient satisfaction with the availability of general practice[80].

Next day appointments and a 6-10 minute wait for consultations to begin were found to be satisfactory standards of access[7]. Coulter[23,74] argues that patients view the **availability of appointments at short notice** with much higher priority than doctors. Doctors tended to place greater emphasis on co-ordination of care, home visits and continuity[1].

Research suggests that patients are critical about the **availability of and access to the GP on the telephone**[55, 80]. Jung et al[55] also found that GPs themselves rated and ranked this poorly, although the introduction of nurse telephone consultation has in some areas reduced GP workload while allowing for faster access to information and advice[74].

The **quick response of GPs to urgent problems** was rated as highly important to patients in a number of studies[55, 81,74] including patients in an international study across 8 countries[43].

One study[6] highlighted the important role played by GPs in relation to **end-of-life care**, particularly the availability of GPs for home visits and after office hours and continuity of care. It concluded that future developments in the organisation of primary care such as the restriction of time for home visits, more part-time jobs and GP cooperatives responsible for care after office hours reduce patient experience of end of life care.

One study[18] suggested that access to primary care may be improved by **diversifying** modes of provision, by **enhancing** the roles of staff and by **implementing** services more flexibly. It reviewed a range of different provision initiatives including personal medical services, GP-led and nurse-led telephone consultation, nurse practitioner-led care in general practice, walk-in centres and pharmacist-led interventions. However the study did not find sufficient evidence to make clear recommendations regarding ways to improve access to primary care.

Some studies suggest that there are particular groups who experience problems relating to access:

- Physical access is an important consideration particularly for the physically disabled – barriers such as steps and double doors can dissuade a physically disabled person from accessing their GP[74].
- Waiting rooms and waiting times can represent a challenge to some people with disabilities, and visiting a GP can be a very stressful experience for them, with noisy environments leading to an increase in these stress levels[64].
- Those without a permanent address or those who are not registered with a GP experience difficulties accessing GP services[74].
- Other groups that have difficulty in accessing GP services are those with learning disabilities[25] and a recent DH consultation[26] identifies the need for GPs (and health professionals in general) to have an understanding of how to make their services accessible to people with learning disabilities.

Improving access via alternative communication

A number of studies have reviewed the importance to patients and the effectiveness of alternative means of communication between GPs and their patients. These have included telephone consultations and email communications.

Car et al1[6] found that patients increasingly wish to have the option of telephone consultations with their GP and that satisfaction with this type of consultation is high. However the ability to get through to the practice on the telephone has been rated very poorly by patients[55] and in some cases can actually be a barrier to services for those with language difficulties such as ethnic minorities or those with hearing problems[74]. GPs in villages received more positive evaluations in relation to getting through to the practice on the telephone.[81]

Patients value email communication with their GP [72, 73]. Mechanic[63] argued that email communication with patients, properly structured and with adequate safeguards, helps maintain continuity of care, provides opportunities to deal expeditiously with routine matters, and allows more time for meaningful communication.

Practice Size

A number of studies have assessed the **impact of practice size** on patient experience and enablement in general practice – the findings varied across the studies:

- Campbell et al[13] found some associations between size of practice and quality of care. For example smaller practices scored better than larger practices for access to care, but for diabetes care, larger practices had higher scores than smaller ones. They concluded that **no single type of practice has a monopoly on high quality care** – different sizes of practice may have different strengths.
- In contrast, Wensing et al[80] found that **patients favour small practices** (ie. fewer number of GPs) and full-time GPs and these factors were most strongly associated with positive ratings in a study into the availability of general practice.
- Howie et al[47] found that **more enabling doctors work in smaller practices** than less enabling doctors.

Unscheduled Care / Out of Hours Primary Care

McKinley and Roberts[61] found that the characteristics of the out of hours primary care service influenced patient experience of these services. In particular, they found that:

- there is a **mismatch** between patients' expectations, their medically defined need, and the resources of the health service which is providing care;
- patients were **less satisfied with deputising doctors;**
- the **longer the delay between the request and the home visit**, the lower the level of overall satisfaction with out of hours primary care; and
- patients' desire to have **out of hours care at home from a doctor they know** is likely to be eroded by the continuing establishment of general practitioner out of hours cooperatives with which patients are no more satisfied than deputising services.

Continuity of Care

Studies have shown that **patients want continuity of care** in general practice and that this leads to more positive patient outcomes and experience.

Continuity of care is especially important to those with particular communication difficulties such as the deaf, ethnic minorities and those with long term medical problems[74].

Bower et al[7] found that patients viewed a satisfactory level of continuity of care as seeing the same GP 'a lot of the time'.

A systematic review of the literature on patient priorities for general practice care showed that 'continuity of care' was seen as important in half of the studies that included this aspect of general practice[81]. Another study[70] found that of the generic attributes of primary care consultation, patients placed higher priority on continuity of care (physician's knowledge of the patient) when compared to person-centred care (involvement of patient in their care and greater priority placed on personal relationship between patient and doctor).

One study[52] suggested that GPs do not view continuity of care as highly in importance as patients in ratings of what makes a 'good GP'. Paradoxically, Mechanic[63] noted that **personal continuity of care leads to a more productive use of the consultation time**,

because personal continuity of care between doctor and patient builds trust and doctors who know their patients use the time differently.

Continuity of care (shared experiences between patient and physician and length of patient-physician relationship) is associated with **positive outcomes** for the patient. Higher continuity is associated with a higher level of trust between patient and GP, and this may improve quality and outcomes of care[58]. There is also evidence to suggest that patients who have experienced continuity of care appear able to accept and tolerate less than optimum care if the usual care is good and satisfactory[57].

Pereira-Gray et al[69] found that **primary care would be much impoverished** by a move away from continuity (duration of registration with doctor and total time in direct communication with doctor) and identified many positive associations with continuity of care:

- continuity improves the uptake of preventive care;
- continuity improves quality of chronic disease care; and
- continuity enhances adherence to treatment.

Lack of continuity of care (defined as four consecutive face to face consultations which did not take place with the doctor with whom the patient was registered**) can have negative consequences**[76]:

- additional morbidity;
- an increased number of relationship problems;
- 'difficult' consultations and non-attendances; and
- an increase in the use of open access clinics.

Carmody et al[17] found that private patients value a **personal relationship** with their GP and choose to have a personal and longitudinal continuity of care with their GP.

Continuity of care (both relationship duration and visit-based continuity) was also strongly correlated to voluntary disenrollment. **The issue of who they were given access to and the quality of their connection with that clinician mattered more**[71].

GP working practices

There are differences in the literature on the relationship between physician working practices and the primary care experience of patients:

One study[80] found that **patients favour full-time GPs.** Another study[66] found no significant differences in the experiences of patients of part-time, full-time and overtime physicians, except in the area of visit-based continuity of care – in this area, GPs who worked overtime (in excess of 65 hours per week) provided more continuity of care than full or part-time physicians.

Confidentiality

Confidentiality of patient data was ranked as an important aspect of care in a number of studies. Jung et al[55] found that both patients and GPs agreed that **'keeping data confidential'** was one of the five most positively evaluated aspects of primary care. While this was found to be a universally important aspect of care, independent of country, healthcare system and culture[43], it has been found to be of particular importance to young people, gay men and lesbians[74]. Overall, patients did not seem to be opposed to the presence of medical students in general practice consultations, with **only a small proportion of patients objecting to the presence of a medical student in consultations**. In addition, it was found that a significant minority said that the presence of a student improves the consultation[21].

Outcome of Consultation

There are conflicting findings in the literature relating to the impact on patient experience of whether or not patients receive a prescription from the GP. There are some suggestions that not receiving a prescription impacts negatively on patient satisfaction and also impacts upon their enablement and compliance with their treatment plan.

In one study[47] patients who wanted, but did not get, a prescription reported **lower enablement** following their consultation. In contrast, McKinley & Roberts[61] found that **receipt of a prescription only increased patient satisfaction** with 'communication and management' and 'access' and suggest that this may reflect an insufficient explanation of why a prescription was not necessary by the doctor. They found that overall, the issue of a prescription did not affect satisfaction with out of hours primary care.

Skills and expertise

Branthwaite[10] notes that the power relationship between patient and doctor has changed over time, through a new status of patients as consumers. As consumers, patients no longer take what is said on trust and scrutinize the doctors' behaviour for signs and meanings. On the other hand, some of the literature suggests that GPs underestimate the importance that patients place on the medical technical aspects of their care [52, 78], or that patients do not readily distinguish good technical care from good interpersonal care[19]. However, most studies have identified that patients place high value on the skills and expertise of their GPs, and this impacts on their experience of primary care [1, 43]. Historically there has been a lack of expertise among GPs in the area of learning disabilities[64] although recent policy developments suggest that specialist expertise in specific areas improves the quality of services to patients – for example, Department of Health (DH) are taking action to develop GPs with a special interest in learning disabilities to help surgeries to improve services for this group[26]. A recent inquiry into access to healthcare for people with learning disabilities also suggested that lack of GP training in learning disabilities results in a reduction in the likelihood of a GP delivering a good standard of health care to patients with a learning disability, and that there is a possibility of diagnostic overshadowing where assumptions about the behaviour of patients with learning disabilities obscures ill health[64].

'Competence/accuracy' was rated highly as a patient priority in general practice care[81] and Roland et al[70] found that of the generic attributes of primary care consultation, patients placed higher priority on the technical quality of care (thoroughness of physical examination).

Primary care team / multi-disciplinary working

There is evidence to suggest that patient experience of primary care is influenced by all those individuals with whom they come into contact – this includes GPs, locums, nurses, other healthcare professionals and practice staff such as receptionists[8]. For example, deaf people described confusion as to when to see the doctor in a practice as the relevant systems were not in place or a receptionist forgot to tell them[74].

Campbell et al[13] found that good team climate reported by staff was associated with a range of aspects of high quality care reported by patients, including access to care, continuity of care and overall satisfaction.

Interpersonal aspects of GP consultations

A prevalent theme in the literature relating to patient experience of primary care is the quality of the relationship between the GP and the patient, and studies suggest that this exerts a considerable influence on the patient experience[44]:

Safran et al[71] identified that the quality of the physician-patient relationship significantly predicted patient loyalty – specifically, this related to the patients' trust in their physician, their assessments of how well the physician knows them and the quality of communication and interpersonal treatment.

A number of other studies noted the 'trust' aspect of primary care as being central to a positive patient experience[20, 22, 23]. Baker[1] identified the depth of the patient's relationship with the doctor as a predictor of positive patient experience and satisfaction.

One study suggests that the personal relationship between a patient and GP may be enhanced by the availability of a doctor's personal list of patients[80].

In studies exploring the impact of interpersonal skills training on GP performance in this area, patient-based assessments were found to be a useful tool in the development of GP training [40, 41]. The patient ratings of interpersonal skills were significantly higher for those GP registrars who participated in the interpersonal skills training. Most GPs found the experience of patient feedback useful for gaining a better understanding of their interpersonal skills and for identifying areas in which they needed to improve.

One study[15] noted that more effective interpersonal care may help GPs to target their time more successfully - an increased knowledge of patients' reasons for presenting or not disclosing psychological problems may assist in identifying groups of patients with different management needs, and facilitate the targeting of GPs' time and therapeutic efforts to patients who would most benefit.

Jung et al[55] found that 'helpfulness of staff' was one of the five most positive aspects of primary care, as evaluated by both patients and GPs.

Communication

Studies have identified that the communication and listening skills of their GP are important to patients in the care they receive [38, 43, 55, 77].

One study[11] attributed patient misunderstandings related to GP prescribing decisions to lack of quality communication between doctors and patients, and that misunderstandings are based on "inaccurate guesses and assumptions". It concluded that doctors need to listen more and "ask the right question". The extent to which the GP has listened has been shown to impact upon the patient following advice or returning for further care[74].

Another study[12] found that for patients with psychological problems, a continuing doctor-patient relationship characterised with genuine interest and empathy is central for a positive patient experience.

Communication skills are particularly important for people with disabilities and research has found that up to one fifth of deaf patients leave a GP practice unclear of their diagnosis[74].

Work by Greco[42] suggests that there will be a greater emphasis in the future on measuring patient experience of general practice, and argues that the focus should be on the experience as an 'interaction' rather than a 'transaction'. He found that small-medium sized practices which discussed their patient experience survey results with a patient group improved their scores significantly when repeating a questionnaire later. Larger practices did improve, but not significantly. Those who did not share with patients did not improve.

Due to coding issues, many GPs are only recording those patients with extreme disabilities meaning that those with more mild yet significant disabilities are not captured[64].

Patient involvement in decision making

Some studies suggest that the involvement of patients in making decisions about their own care is highly rated as a priority in primary care[81]. A number of studies have emphasised the **importance and effectiveness of a partnership** or shared model of care[5], particularly in relation to the management of chronic and partner in care having the potential to create a new generation of patients who are empowered to take action to improve their health and potentially reduce dependence on primary care and the health system in general. Kaplan et al[56] suggest that at least 20 minutes in consultation are needed for participatory decision making i.e involving the patient in decisions about treatment, giving them a sense of control, and asking them to take responsibility for care. Blakeman et al[5] noted some barriers to partnership in care identified by GPs as conflicting with professional responsibility and accountability as well as contextual factors that drive GP behaviour, such as consultation length.

One study[32] noted that while GPs have traditionally ignored the second half of the consultation i.e. the stage of the consultation where decisions are made and future management agreed with the patient, this is changing due to the **development of a mood of questioning consumerism** and the unprecedented electronic access to information which is re-defining the role of the generalist. They argue that the **clinician should be prepared to adapt to the patient's preferred role, to hand over, share, or take overall responsibility for decision-making.**

Geest et al[37] found that an effective way of increasing patient involvement (particularly older patients) was through the use of appropriately structured and targeted information leaflets – they could support patients' memories, educate them and support self-responsibility, promote involvement and compliance, increase patient satisfaction and perception of communication. One of the most important characteristics that leaflets should have in order to increase patient involvement is that they are written in large type, easy to understand yet not too simple and that they are accompanied by careful oral instruction.

Alternative means of communication with patients

The internet may also provide an opportunity for GPs to provide information through a practice website, to link patients with useful, valid and relevant sources of information. The PRIDE project[67] explored the things that really matter in communication between GP practices and patients, and found that use of the internet was a useful communication tool for both the GP practice and the patient:

- allows practices to be in control of updating information as and when necessary and to showcase individual practice qualities and achievements;

- members of the public regard current sources of information about general practice as inadequate and want to be better informed;

- the public is more interested in information about the context and availability of services than about the performance of individual practices;

- the public do not like performance league tables and most do not want to use comparative information to choose between practices, preferring to work in partnership with their existing practice to improve services; and

- the public want to be clear about the source if information so that they can make personal judgements about its trustworthiness [59, 60].

Information provision

Patients expect to receive information in a number of areas including on the illness and on the diagnostic and treatment procedures necessary, and the treatment options available [23, 43]. Studies have shown that patients value and want information for a variety of reasons including as preparation for what to expect from specialist or hospital care[55].

Hopkins[53] identified the benefits of using electronic medication records for patients:

- avoiding medication errors;
- when getting help from others;
- bringing other doctors up to speed; and
- helping in managing their own health.

Also the barriers to using electronic medication records for patients:

- not knowing the records are available;
- incomplete records;
- use of computer during consultation;
- some consumers not wanting additional paper;
- perceived overlap with pharmacy services; and
- privacy concerns.

Applicable accessible information provision was also deemed to be important to some vulnerable groups such as ethnic minority groups as well as the deaf or visually impaired. There has also been criticism of GPs in terms of knowledge of services that would support learning disability patients for example[74].

GP understanding of patient needs/expectations/priorities

A few studies [52, 78] found great similarity between the priorities of patients and GPs, although the prevalent message from the literature is that doctors could be better predictors of predicting patient satisfaction in the consultation [45, 52, 62, 75, 83].

GPs and patients may have different perceptions of what makes a good GP. Patients emphasise the availability of, access to, and communication skills of the GP, whereas GPs have their own interests with respect to workload, time management and practice management [78].

Lings et al[57] argue that the 'lived experience' of being a patient and being a GP means that while the importance they place on different aspects of primary care differs, they do not necessarily contradict each other.

Patient Characteristics

Patient priorities can be expected to vary between individual patients and between patients from different cultures and healthcare systems [2, 81].

Patient's health

The literature suggests that the **status of the patient's health** when they attend a GP consultation has an influence on how they perceive the care they receive. Patients who have had recent experience of medical care tend to give higher, less critical ratings than patients whose experience is less current[23]. Patients with more complex problems required longer consultations to achieve equal enablement as those with non-complex problems[47]. The stage in the course of the disease episode and the severity of their condition was found to have influenced patient preferences for involvement in their care[23].

Patient's expectations

A number of studies found that patient expectations have an influence on patient enablement and their view of their consultation experience [7, 48].

Patients who wanted, but did not get, a prescription reported lower enablement for equal duration of consultation[47].

McKinley & Roberts[61] found that patient satisfaction with out of hours primary care is related to the expectations of the patient.

One study[3] notes that unmet expectations adversely affect both patients and physicians as satisfying patients needs is a fundamental goal in medicine. The study warns that physicians can damage the clinical relationship if they ignore patients' expectations for care.

Patient's gender, age and ethnicity

Patient experience of primary care is influenced by their personal circumstances, including their gender, age and ethnicity[61]. For example:

- Older patients were found to have longer consultations and higher enablement in primary care[47] and were more satisfied with the care they received in out of hours primary care[61].
- Women had longer consultations than men[47].
- Bower et al[7] found that acceptable waiting time for consultations to begin was the issue most sensitive to socio-demographic factors. Age and ethnicity were the most consistent moderating factors, with patients from ethnic minorities generally having higher standards and patients in the older age groups (46-59 and ≥ 60 years) having lower standards.
- McKinley & Roberts[61] found that non-white patients expressed lower average satisfaction with 'communication and management', the 'doctor's attitude' and the 'initial contact person' but did not find any evidence of lower overall satisfaction with out of hours primary care. Other language speaking patients knew their doctors better than did English speaking patients – they also reported significantly higher enablement and shorter consultations than did English speaking patients.

Socio-economic status

A number of studies have found a relationship between the socio-economic status of the patient and their experience of care from a GP.

McKinley & Roberts[61] found that patients from a lower socio-economic group reported lower overall satisfaction with out of hours primary care and lower satisfaction with the 'doctor's attitude' and the 'initial contact person'.

Campbell et al[13] found that deprivation predicted a poorer uptake of *preventive* care, highlighting that quality of care in general practice is influenced by environmental factors. This relationship was specific to preventive care, where patient actions influence the quality of care than can be provided. In other areas of care where practices had the main control, no significant associations between deprivation and quality of care were found.

Vulnerable groups

The literature suggests[74] that the GP experience of people with disabilities both intellectual and physical, ethnic minorities, the homeless and those with mental health problems' is influenced by their particular condition or situation:

- Language problems for individuals such as asylum seekers and refugees mean that they may not even be aware of services available or have difficulty accessing them; and
- In addition, people from ethnic communities who have a learning disability suffer particular discrimination in accessing health care[33].

In the past some of these vulnerable groups have not been represented in the Quality Outcomes Framework (QOF), for example learning disability did not appear in any of the ten disease areas therefore not generating a financial incentive for GPs to target this disability[33].

ANNEX I Better Together literature review - Bibliography

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ANNEX J PwC report - Summary of findings from the cognitive testing

Summary of findings from rounds one and two of cognitive testing

Please note that the question numbers referred to in this annex are not the same as those in the final version of the questionnaire in Annex C. Question numbers also changed between the rounds of cognitive testing.

Introduction

As part of the Better Together Patient Experience Programme, PriceWaterhouseCoopers LLP (PWC) and Scottish Government have developed a questionnaire to support quantitative data gathering for Module 2, users of GP services. The development process has been assisted with input from key Scottish Government staff and workshops involving a representation of GPs, practice managers and health board staff.

In order to robustly test the GP questionnaire and accompanying cover letter, a series of cognitive test interviews were organised with health service users across three NHS Boards in Scotland. The purpose of this report is to summarise the methodology used in the cognitive testing and the recommendations arising from analysis of the cognitive test interviews.

Phased approach

A phased approach to cognitive testing was adopted, thereby facilitating revisions to the questionnaire and letter and testing of revised versions:

- Round 1, NHS Greater Glasgow & Clyde (Glasgow) and NHS Highlands (Inverness) from 17th – 19th February 2009; and
- Round 2, NHS Grampian (Aberdeen) from 5th - 6th March 2009.

Following Round 1, PwC submitted a summary paper to Scottish Government setting out proposed revisions to the questionnaire and cover letter to reflect the feedback from participants in cognitive testing. Scottish Government responded with comments and a revised version of the questionnaire and cover letter were agreed and issued for testing in Round 2.

Recruitment of participants

Selection of participants was based on those who had contact with their GP surgery in the previous 12 months and by their background characteristics. Fifteen participants were recruited from three NHS Boards in Scotland - nine participants took part in Round 1, and the remaining six participated in Round 2.

Participants were recruited through on-street interviewing within the Greater Glasgow and Clyde, Grampian or Highland Health Board areas. Recruitment consisted of field interviewers approaching members of the public and asking them a series of questions to establish their appropriateness and availability for taking part in the cognitive testing interviews.

To ensure that a wide range of views were gathered from a variety of different participants, our sample criteria consisted of recruiting across a range of equality groups[19], including age groups, gender type, socio-economic groups and urban and rural locations.

Demographic data such as ethnicity and religion was also captured within the interview process. This was used to understand the extent of the representation of equality groups in the cognitive testing interviews. In addition to a range of ages and both genders, participants varied in background by ethnicity and religion, and included people with a physical disability, mental health condition, chronic illness and other conditions. In addition, one participant with English as a second language was included.

Table 1 presents the achieved sample profile for the cognitive testing interviews.

Table 1: Achieved cognitive testing participant profile

Round	Interview	Age	Gender	Urban / Rural	Socio-economic group[20]	Board area
1	1	17-25	Male	Urban	ABC1	NHS Greater Glasgow and Clyde
	2	26-30	Female	Urban	C1C2	NHS Greater Glasgow and Clyde
	3	31-45	Male	Urban	C1C2	NHS Greater Glasgow and Clyde
	4	46-64	Female	Urban	AB	NHS Greater Glasgow and Clyde
	5	26-30	Male	Rural	DE	NHS Highland
	6	31-45	Female	Rural	AB	NHS Highland
	7	31-45	Female	Rural	C1C2	NHS Highland
	8	46-64	Male	Rural	C1C2	NHS Highland
	9	65+	Female	Rural	C2DE	NHS Highland

[19] The Scottish Government identifies six equality groups within Scotland. These are age, gender, disability, lesbian / gay / bisexual / transgender (LGBT), faith/religion and ethnicity.

[20] For the purposes of recruitment, socio-economic group was classified using 6 social grades as follows: A – professionals, senior managers, top level civil servants, B – middle management, small business owners, C1 – junior management, others in non-manual positions, C2 – all skilled manual workers, D – all semi-skilled and un-skilled apprentices and trainees, E – all those entirely dependant on the state, unemployed or through sickness.

Round	Interview	Age	Gender	Urban / Rural	Socio-economic group[20]	Board area
2	10	17-25	Female	Urban	C2DE	NHS Grampian
	11	26-30	Male	Urban	AB	NHS Grampian
	12	31-45	Male	Urban*	DE	NHS Grampian
	13	46-64	Female	Urban	DE	NHS Grampian
	14	46-64	Male	Rural	AB	NHS Grampian
	15	65+	Male	Urban	ABC1	NHS Grampian

* The profile of participant number 12 differs slightly from what was agreed in the Cognitive Testing Approach document with regard to the urban/rural classification. However, given the challenges associated with recruiting a participant with English as an additional language, it was felt that this was a justified variance to ensure inclusion.

Conduct of interviews

The aims of the cognitive testing were to:

- explore the thought processes of participants as they responded to the questions, to understand if their interpretation of the statements and/or questions was in line with the designated purpose/objective;
- explore the usability of the questionnaire, exploring whether participants found it easy to read and navigate and their visual impression of the questionnaire;
- discuss the relevance of the topics contained in the questionnaire to the experience of the participant; and
- seek to identify any potential problems in how the statements and/or questions were framed.

Interviews were by means of semi-structured face to face interviews with participants. A combination of think aloud and verbal probing techniques were used to achieve these aims, promoting a focused approach to the discussion. This also had the advantage of allowing the interviewer to concentrate on particular areas within the questionnaire which were considered to be potentially problematic for participants.

The techniques used and the associated rationale for their use in cognitive testing is outlined in Table 2.

Table 2: Techniques used in Cognitive Testing

Technique	Rationale
Think aloud	The interviewer asked the participant to think aloud when considering certain questions, and then recorded the participant's verbal think-aloud stream. This helped to capture the thought processes of the participant immediately, recording their initial reactions in relation to the questions, statements and response categories. It also helped to identify problems relating to the usability and relevance of the questions, statements and/or response categories.
Probe	Probes used during cognitive testing were both *proactive* (i.e. those that we could anticipate beforehand and plan to use) and reactive (i.e. those that emerged during the course of the testing). A mixture of concurrent and retrospective probing was incorporated: • Concurrent verbal probing i.e. the interviewer probed the participant as they reached each question. The information was fresh in the minds of participants, thereby avoiding a situation where they could not remember what they were thinking when they answered a question. • Retrospective verbal probing i.e. the interviewer avoided interrupting the interview with questions and left it until the end of a question/section/the questionnaire to do any probing. This may have helped to avoid reactivity effects due to the cumulative effects of probing. It was also a helpful method to use when testing a self-administered questionnaire like the GP Survey, when the purpose of testing included determining the participant's ability to manage a self-completion instrument unaided. Exemplar cognitive probes included: ▪ comprehension / interpretation - what does the term 'X' mean to you? ▪ paraphrasing - can you repeat the question I just asked in your own words? ▪ confidence judgement - how sure are you that .....? ▪ recall probe - how do you remember that ....? ▪ specific probe - why do you think that...? ▪ general probes - how did you arrive at that answer?

In total, a team of two interviewers conducted the cognitive testing within the three health Board areas. Interviews were conducted by experienced research consultants from PricewaterhouseCoopers LLP who are experienced in the development and testing of research tools. Interviews were recorded to aid recall of discussions and subsequent analysis.

Analysis and reporting

Following Round 1 of cognitive testing, the interviews were transcribed and analysed. Scottish Government and the Co-ordination Centre held discussions about the results. Based on the findings from Round 1, a Summary Report was submitted to Scottish Government outlining proposed revisions to the cover letter and questionnaire. Scottish Government provided feedback and made suggestions for areas to be tested in Round 2. A revised version of the letter and questionnaire for Round 2 testing were agreed. On completion of Round 2 testing, the interviews were transcribed and analysed.

This report sets out the summary findings of Rounds 1 and 2, including an outline of the revisions made following Round 1 and the recommended revisions following on from Round 2. Summary of key findings and revisions from Round 1

This section sets out the summary results from Round 1 of cognitive testing. These are presented for the cover letter and then the questionnaire by section theme.

Cover letter

Round 1 participants were positive about the content and visual appeal of the cover letter. They commented that first impressions were important to them and that the questionnaire did not look or feel like a lengthy or onerous document to complete. Participants suggested that the response rate to a GP Patient Experience Survey would be high as people would be keen to provide their views. Participants stated that while the public receive many surveys requesting completion, the opportunity to have their say and contribute to making experience better would be an incentive to complete the questionnaire.

Feedback from participants suggested that they would 'trust' the questionnaire as it was from an NHS source. There was positive feedback to the confidentiality references and to the statement that the GP surgery would not know if the recipient had taken part in the survey. Participants stated that the 12 month timeframe was clearly highlighted as was the reference to completion by a friend/carer/relative if needed.

In general participants commented that it was unlikely that many people would read the letter, although it was useful to have it so that recipients would be able to refer back to it if needed.

There was only one suggested amendment to the letter to be tested in Round 2. This was based on feedback from participants who found that there were no instructions on how to request not to receive further requests to participate. Suggested additional wording was incorporated into the version to be tested on Round 2 as follows: *If you would prefer not to receive any further mailings about the survey, please contact the* ***Better Together helpline*** *on <<FREEPHONE number>> here.*

Questionnaire instructions

Feedback from participants in Round 1 suggested that it is unlikely questionnaire recipients will read the instructions. When prompted, they were reassured by the confidentiality statement although were broadly indifferent to the statement that signposted to the comments box at the end of the questionnaire.

When participants were asked to explain the instructions in their own words, all referred to 'ticking' the appropriate box(es), and all participants in Round 1 selected their answers using a ✓ rather than a ×. As a result, it was agreed that we introduce a worked example at the start of the questionnaire to illustrate how the questionnaire should be completed.

Participants tended to navigate towards the boxes where they had to take action e.g. cross a box rather than reading the instructions. This suggested that the reference to the 12 month timeframe in the instructions may be overlooked by some questionnaire recipients. As a result, the formatting was amended so that the instructions relating to the 12 month timeframe became the first question to which recipients respond as Round 1 findings suggested that it is likely recipients would take more notice of this. This suggestion was agreed and a new Q1 was added to the version to be tested in Round 2.

Additional changes to questionnaire instructions were the inclusion of instructions on accessing an online version of the questionnaire. This suggestion was actioned and included as a footer at the start and end of the questionnaire that was tested in Round 2.

Section 1: Access

There were no suggested changes to the 'Access' questions following Round 1. While a few participants commented that the first page was quite 'wordy', the majority of feedback suggested that

the Access questions were set out clearly and participants were able to select an appropriate answer from the options. Most people commented on the high number of questions with routing, but overall participants were satisfied that they could follow the instructions relatively easily.

Section 2: Making an appointment

Overall, participants commented that language used in Section 2 was clear and that they did not have any difficulty in understanding instructions and statements or recalling their experience. Feedback on the scales used in this section was positive with participants indicating that they were able to pick an answer from the options that they felt accurately reflected their experience. Participants were positive that Section 2 covered all the issues that they had faced when trying to make an appointment.

There were two suggested changes in Section 2. Q8 was removed due to confusion regarding the interpretation of 'open access session' e.g. turn up and wait your turn, group meeting/discussion, drop-in clinic. For example:-

> *'I was thinking that was like a group meeting, a group discussion. It doesn't mean anything to me, maybe go to any doctor?' (Male, Glasgow, C2, Urban, 44)*

> *'Open Access? I've never heard of it, don't know that term...It's just a term that's not used here, it's maybe used in other areas but I've certainly never heard of it' (Female, Glasgow, B, Urban, 64)*

The removal of Q8 necessitated the rewording of Q9 as these two questions were originally linked. In addition, the majority of patients chose their answer based on their *summative* experience, even though the original Q8 wording clearly stipulated them to consider 'the last time' they made an appointment. For example:

> *'There is a note on the wall in the practice saying they will see you within 10 minutes of your appointment and I think maybe only once I had to wait longer than this, so they tend to keep their appointments' (Female, Glasgow, B, Urban, 64).*

Section 3: At the GP surgery

Round 1 feedback was positive for Section 3 and there was broad consensus across the participants that this section addressed many important issues related to patient experience at their GP surgery. Participants commented that language used in the questions in Section 3 was clear. They had no difficulties with the question phrasing (including 'how often have you experienced each of the following?') and they did not have any problems in understanding what they were being asked to do.

Interpretation of the statements in Q13 and Q14 was broadly similar across doctors and nurses and when participants were prompted on the order of statements, they either commented that they had not noticed the order or that it appeared logical. The exceptions were Q13.2 (the doctor has all the information they need to treat me) and Q13.3 (the doctor shows consideration for my personal circumstances) where there were a variety of interpretations. As the findings from Round 1 for these statements were inconclusive, they were retained for further exploration in Round 2.

Feedback from participants in Round 1 suggested that it may be unlikely that many questionnaire recipients would know the difference between the different types of nurses at their GP surgery, and participants expressed preference to leave the reference to 'nurses' in the general sense to avoid confusion.

Participants were able to answer the questions relating to medicines without difficulty and could select an option from the scale that they felt accurately reflected their experience. There was

variation in the rationale for choosing particular answers i.e. participants 'knew enough' about their medicines for different reasons.

Feedback on the frequency and agreement scales used in this section was positive with participants indicating that they were able to pick an answer from the options that they felt accurately reflected their experience.

There were two suggested changes in Section 3. The first change was based on feedback from a participant who stated that 'I feel bothered' was much more about perception than what actually happens to the patient in the waiting room, and that 'I am bothered' would capture much more meaningful information. For example:-

> *'Maybe ask have you ever been bothered or threatened instead of do you feel bothered or threatened as that is something you can stop, you can't really stop people's individual feelings towards other people as they are kind of prejudiced and stuff' (Male, Glasgow, C1, Urban, 20).*

Q16 was reformatted following feedback from participants who commented that they had difficulty picking the answer that applied to them because the statements were quite similar, they were spread out across the page and reading across the page was found to be difficult.

> *'I was darting about there trying to get the right answers. It's quite hard to be honest a lot of it seems the same, I'm involved more than I want to be, I'm involved as much as I want to be. Maybe you could have highlighted the much and more. Trying to get an answer there is a wee bit hard' (Male, Glasgow, C2, Urban, 44).*

As a result, it was agreed to align the 'I am involved' statements to the left, making bold the differentiators, and moving the other answer options to the right hand side.

In post-Round 1 discussion with Scottish Government, additional changes to this section were discussed. This included the removal of the 'Don't know' option from the scales to explore if its absence impacted on the ability of participants to select an option that they felt accurately reflected their experience. This was tested in Round 2.

Section 4: Overall Experience / Other comments box

There were no suggested changes to Section 4. Participants indicated that there was sufficient difference between the 'dignity and respect' and 'values and beliefs' statement to justify inclusion of both statements, and welcomed the opportunity to provide comments on their experience. A few participants felt that it might be useful to have smaller comments boxes spread throughout the questionnaire, although when prompted they felt that they would not want the questionnaire to be any longer in length as this might be a deterrent to some people in completing the questionnaire.

Section 5: About You

There were mixed comments during Round 1 relating to the 'About You' questions. A few participants wondered why the questionnaire needed to collect this information. However, most were of the opinion that there was merit in collecting this information for equality purposes and that people would be familiar with being asked for this information as it appears in other official documentation e.g. job applications.

Participants commented that Section 5 would not deter them from returning the questionnaire and they took comfort from the statement that indicated they could skip any questions that they preferred not to answer.

There was one suggested change to Section 5. Q20 was rephrased to reflect the respondent providing a rating of their own health rather than '*How is your health in general?'*.

Additional changes to this section included separation of the Section 5 instructions from the 'Section 5: About You' title for testing in Round 2.

General comments

Participants indicated that the length of time to complete the questionnaire was reasonable (less than ten minutes). They also commented that the questionnaire was well structured and the language used throughout was clear.

Summary of key revisions made following Round 1

The key revisions made to the cover letter and questionnaire following Round 1 of cognitive testing were:

- Cover letter, 'Do I have to take part?'. Additional line to inform recipients how they can request not to receive any reminders about the questionnaire;
- Questionnaire instructions – reformatted, introduction of worked example showing recipient how to complete questionnaire by placing a X in the appropriate response box;
- Timeframe instruction reformatted into a question;
- Q8, type of appointment – removed;
- Q9, waiting time – removed reference to 'the last time';
- Q12, reworded from 'I feel bothered...' to 'I am bothered or threatened by other patients';
- Q16, reformatted to make answer options bold and logically ordered; and
- Q20, reworded from 'How is your health in general?' to 'How would you rate your health in general?'.

Additional changes for testing in Round 2 included:

- inclusion of instructions for online completion;
- scales – removal of 'don't know' option from tables; and
- Section 5, 'About You' instructions removed from the title box.

Summary of key findings and revisions from Round 2

This section sets out the summary results from Round 2 of cognitive testing. These are presented for the cover letter and then the questionnaire by section theme.

Cover letter

Round 2 participants were broadly positive about the content and visual appeal of the cover letter. First impressions were that they knew it was a survey and it was obvious it was from an NHS source. Participants indicated that they would complete the questionnaire if they received it in the post as their GP experience is of high importance and they would be pleased to have the opportunity to give their views.

It was clear that the cover letter conveyed the intended information as evidenced by responses to think alouds and verbal probes which showed that:

- participants were able to explain that the questionnaire related to experience of their GP surgery in the previous 12 months;
- they also reasoned that the survey was for improvement purposes;
- participants understood that a friend/carer/relative could complete the questionnaire on their behalf if they were unable to do so themselves; and
- none of the participants expressed any concerns about how to request not to receive any further reminder letters and were able to explain that they could skip a question if they preferred not to answer it.

The participant with English as an additional language commented that they felt the letter contained too much information and that the information could be better formatted for ease of reading (suggested bullet points). However, the rest of the participants indicated that the information in the letter was presented clearly and concisely and answered all of the queries they may have had.

Participants did not comment on the Unique Identification (UID) number detailed in the letter and when prompted, they did not have any concerns about this or how their personal details were sourced.

There were mixed thoughts from participants on the inclusion of translated statements for recipients with English as an additional language – the participant with English as an additional language commented that the questionnaire should just be in English. When explored with participants, the majority commented that although they felt the wording used throughout the questionnaire was simple, they wondered if recipients with English as an additional language may find it challenging to complete an English language version.

Based on this feedback, it is recommended that Scottish Government add translated statements to the cover letter to inform recipients how they can request another language version.

Questionnaire instructions

The worked example included after Round 1 appeared to be much more effective than the instruction box used in Round 1. Participants were able to explain the instructions in their own words and all selected their answers with a ×.

Some participants did not notice the reference to online completion at the bottom of the first and last pages that was introduced following Round 1, although were able to recall that the letter contained a

reference to a website. While a few indicated that they would still complete the postal survey, most participants commented that they would consider availing of the option for online completion. It is recommended that the reference to the availability of online completion is made more prominent through reformatting in order to increase the likelihood that recipients will notice it.

Section 1: Access

The new Q1 introduced following Round 1 to increase the likelihood that recipients would notice the 12 month timeframe was effective, with all participants completing this question and able to explain that the questionnaire was only for people who had contact with their GP surgery in the last 12 months.

In line with Round 1, feedback on the Access questions was broadly positive, with participants indicating that the routing used was clear and that they were able to select an answer from the options provided that accurately reflected their experience.

There are no suggested changes to the 'Access' questions following Round 2 testing.

Section 2: Making an appointment

Similar to Round 1, participants commented that the language used in Section 2 was clear and concise and that they did not have any difficulty in understanding what they were being asked to do or in recalling their experience.

The revised Q9 (length of time waiting to be seen once arrived) was tested to explore whether participants interpreted the question to mean the time they waited *after* their allotted appointment time or their wait from time of arrival at the surgery. When prompted about their rationale for choosing their answer, participants explained that they were thinking about the time they had to wait to be seen after their appointment time, and that they were thinking about their experience in the summative sense (rather than one specific instance).

Overall feedback on the scales used in this section was positive with participants providing clear explanations and rationale for having chosen their answer option. Comments suggested that there were enough answer options for participants to choose something that they felt accurately reflected their experience.

When discussed, there were mixed comments from participants about retaining the 'Can't remember/don't know' option. Some commented that those people who have had less frequent contact with the GP surgery may not be able to remember their experience e.g. '*...that would be quite helpful for somebody who maybe it's been a long time since they phoned the doctor*'. This contrasted with other comments such as '*...surely if you had seen your GP in the last 12 months, you would remember...*'.

Based on these mixed findings, it is recommended that the 'Can't remember/don't know' option is retained. Retention of this option will not impact on those recipients who can recall their experience and will provide those who cannot remember (or feel that they cannot form an opinion) with an answer option that accurately reflects their opinion.

Section 3: At the GP surgery

Feedback on Section 3 suggested that this section reflects many important issues related to patient experience at their GP surgery. As in Round 1, participants had no difficulties with the language used in the questions and statements (including 'how often have you experienced each of the following?') and they did not have any problems in understanding what they were being asked to do.

Participants felt that the statements in Q12 were important and relevant. With specific reference to Q12.3 (being threatened / bothered by other patients), the majority of participants indicated that they had rarely experienced this, although felt that it was important to retain it as they knew of other people for whom this would be particularly relevant.

Interpretation of the statements in Q13 and Q14 was broadly similar across doctors and nurses. Similar to Round 1, there were a variety of interpretations for Q13.2 (the doctor has all the information), with participants interpreting 'information' to be their personal details (e.g. age, date of birth, address), the information that they tell the doctor during the consultation, medical history. When explored, participants indicated that this statement should be retained because it was important to them that they felt the doctor had all the information needed.

In both Rounds 1 and 2, there was some ambiguity around Q13.3 (the doctor shows consideration for my personal circumstances). Some participants did not provide an opinion for this statement. When explored further, they indicated that they did not understand the meaning of the statement, and even some of those who provided an opinion were not clear on what 'personal circumstances' were. For those who could provide a rationale for their answers, 'personal circumstances' included patient lifestyle, medical history and the listening skills of the doctor. These interpretations vary from the purpose of the statement which was to capture the doctor's knowledge of the wider circumstances of the patient. It developed from 'the doctor knows enough about me' which was split into two statements to capture both the information aspect and the wider knowledge aspect of care.[21] These findings suggest that participants are not interpreting this statement to mean solely 'personal circumstances' and it is therefore recommended that further discussion takes place on the inclusion of Q13.3 and Q14.3 in their current form.

As in Round 1, feedback from the second round suggested that it may be unlikely that many questionnaire recipients would know the difference between the different types of nurses at their GP surgery, and participant preference was to leave a reference to 'nurses' in the general sense to avoid confusion.

Round 2 testing explored the impact of the retained 'Not relevant' and the excluded 'Don't know' answer options[22]. These were explored most extensively in Q12, Q13 and Q14 and the findings from these discussions were as follows:

- The retention of 'Not relevant' as an answer option: - While the frequency scale used in Q12 was felt by participants to be appropriate, there were mixed views on the 'Not relevant' category. Some participants indicated that the 'Not relevant' option should be removed because they felt everyone would have contact with receptionists and other patients and therefore all the statements would be 'relevant'. Others felt that it was necessary to include 'Not relevant' as an option for recipients who may not want or feel able to provide an opinion for a particular statement because it had not featured in their experience. On balance, these findings suggest that a response category that allows recipients to note that they cannot remember / prefer not to answer / it did not feature in

[21] This was split into two statements as follows: 'I believe that the doctor has all the information they need to treat me' and 'The doctor shows consideration for my personal circumstances in treating me.'

[22] Feedback from participants suggested that they viewed there was a difference between 'Neither agree nor disagree'' and 'Not relevant' e.g. *'(Neither agree nor disagree)...I wasn't bothered, didn't really have an opinion on it...(not relevant)...I've never had that experience...not relevant, you've never had any of these things happen to you. If you 'neither agree nor disagree' these things may have happened but you weren't bothered either way about what they were'.* Therefore it is recommended that both answer options are retained.

their experience is included. This minimises the risk of such recipients using the opinion scale inappropriately and/or not completing the questionnaire; and

- The inclusion of 'Don't know' as an answer option: – The rationale for recommending that 'don't know' should be added back in as an answer option is demonstrated in the findings related to Q13.2 (the doctor has all the information) and Q13.3 (the doctor shows consideration for my personal circumstances). There was ambiguity in participant understanding of these statements, evident in the rationale for some responses. For Q13.2, one person indicated 'neither agree nor disagree' because they didn't know what information the doctor held relating to them. Some participants indicated that the 'Neither agree nor disagree' option captured a 'Don't know' response. As noted above, there were issues with the interpretation of Q13.2. Some participants did not provide an opinion for this statement, and when explored further, they indicated that this was because they did not understand the meaning of the statement. Even some of those who provided an opinion were not clear on what 'personal circumstances' were. These findings suggest that, for some statements, participants felt that they could not make an informed decision about their experience. In the absence of a 'don't know' option, participants either did not provide an opinion or appeared to be compelled to select an option in the scale. However this is an inaccurate reflection of their actual experience and will have implications for the accuracy of the survey findings. It is therefore recommended that a 'don't know' answer option is added to the questionnaire so that those recipients who feel unable to form an opinion have an option that reflects this view.

As in Round 1, participants were able to answer Q15 relating to medicines without difficulty and could select an answer option from the scale that they felt accurately reflected their experience. There was variation in the rationale for choosing particular answers i.e. participants 'knew enough' about their medicines for different reasons e.g. the doctor and/or chemist told them, they read the information leaflet that comes with the medicine, they did research themselves.

Feedback on the frequency scale used in Q15 was positive, with respondents indicating that it was rational that the scale moved from negative on the left to positive on the right.

The reformatting of Q16 (about involvement in decisions around care and treatments) for testing in Round 2 was effective as participants did not report any difficulty in answering the question. One participant commented that they felt Q16 looked 'out of place' because it was formatted differently from the rest of the questionnaire, but no other participant commented on this, on a prompted or unprompted basis.

Section 4: Overall Experience / Other comments box

As in Round 1, participants were broadly satisfied with the statements, the agreement scale and the 'Excellent – Very poor' scale used in this section.

Feedback on Q19 (comments box) suggests that participants found the comments box useful and appropriately located in the questionnaire. In line with Round 1, one or two participants suggested that it might be useful to have a comments box at the end of the various sections, although the overall view was that the potential impact in length might deter people from completing the questionnaire if it looks like they have a lot of work to do.

Section 5: About You

As in Round 1, there were mixed comments on the 'About You' questions. Some participants wondered why the questionnaire needed to collect this information, particularly relating to Q21 (conditions), Q25 (sexuality) and Q26 (religion). There was recognition from other participants that there was merit in collecting this information for equality purposes and as mentioned in Round 1,

people may be familiar with providing this information as it appears in other official documentation e.g. job applications.

Participants commented that Section 5 would not deter them from returning the questionnaire. Some noticed that the instructions indicated that recipients could skip any question they did not want to answer. However, others felt that this message was 'tucked away' within other text at the top and it could perhaps be made clearer. It is recommended the 'opt out' statement in the Section 5 title is made more prominent through reformatting to increase the likelihood of it being noticed by recipients, particularly considering points raised regarding the purpose and relevance of Q21 (long term conditions), Q25 (LGBT) and Q26 (religion) in the questionnaire.

There were no significant comments on the rewording of Q20 (rating of general health) following Round 1, and while one person commented that there could be an answer option more positive than 'Good' and more negative than 'Poor', no-one else commented on this, on a prompted or unprompted basis.

General comments

Participants were broadly content with the length of the questionnaire and completion time (ten to fifteen minutes), although it took the participant with English as an additional language longer to complete (twenty minutes).

Feedback suggests that the instructions and language used in the questionnaire are clear and concise and the routing was easy to follow.

Summary of key revisions suggested following Round 2

Recommended revisions for the cover letter and questionnaire following Round 2 of cognitive testing are as follows:

- addition of translated statements to the cover letter to inform recipients how they can request another language version;
- reference to the availability of online completion to be made more prominent in the questionnaire (and perhaps mentioned in the cover letter) through reformatting so as to increase the likelihood that recipients would notice it;
- retention of the 'Cant remember/don't know' option in Section 2 to provide an accurate response option to recipients who may have difficulty recalling their experience';
- further discussion needed on the inclusion of Q13.3 and Q14.3 in their current form as findings suggest that participants are not interpreting this statement to mean solely 'personal circumstances';
- retention of reference to 'nurses' in the general sense in Q14 as the majority of participants indicated that they would not be able to distinguish between the different types of nurses;
- retention of 'Not relevant' option in the questionnaire to provide an answer option for those recipients who cannot remember / prefer not to answer / it did not feature in their experience. This minimises the risk of such recipients using the opinion scale inappropriately and/or not completing the questionnaire;
- addition of a 'Don't know' option to Sections 3 and 4 so that those recipients who feel unable to form an opinion have an option that accurately reflects this view; and

- the ‘opt out’ statement in Section 5 to be reformatted to increase the likelihood of being noticed by recipients. This is particularly important considering the queries from participants of the relevance of Q21, Q25 and Q26 in the questionnaire.

Summary report of findings from round three cognitive testing (lower literacy)

Introduction

As part of the Better Together Patient Experience Programme, Price Waterhouse Coopers LLP (PwC) and Scottish Government developed a questionnaire to support quantitative data gathering for Module 2, users of GP services. The development process has been assisted with input from key Scottish Government staff and workshops involving a representation of GPs, practice managers and health board staff.

In order to robustly test the GP questionnaire and accompanying cover letter with people with lower levels of literacy, a series of cognitive test interviews were organised in Glasgow.

The purpose of this report is to summarise the methodology used in the cognitive testing and the recommendations arising from analysis of the cognitive test interviews.

Recruitment of participants

The aim of the cognitive testing was to test the GP survey and cover letter with six individuals who had low levels of literacy. To be eligible for participation in cognitive testing, participants must have had contact with their GP surgery in the previous 12 months, be at least 17 years of age, and not have participated in research in the last 6 months.

Recruitment was a targeted approach in Glasgow, with participants being recruited from adult literacy programmes via the following organisations[23]:

- Glasgow Women's Library;
- Glasgow Simon Community;
- Culture & Sport Glasgow; and
- Gowrie Care.

Profile of participants

There was a good mix of gender and age. Demographic data such as ethnicity and religion was also captured within the interview process. This was used to understand the extent of the representation of equality groups in the cognitive testing interviews. In addition to a range of ages and both genders, participants varied in background by religion and sexual orientation, and included people with a physical disability, mental health condition, chronic illness and other conditions.

Conduct of interviews

Interviews were by means of semi-structured face to face interviews with participants. A combination of think aloud and verbal probing techniques were used to achieve these aims, promoting a focused approach to the discussion. Facilitators were also able to observe the participant as they completed the survey.

Analysis and reporting

This report sets out the summary findings of cognitive testing, including recommended revisions following on from this.

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[23] These organisations were sourced via Learndirect Scotland.

Summary of key findings

This section sets out the summary results from cognitive testing. These are presented for the cover letter and then the questionnaire by section theme.

Cover letter

Participants were positive about the content and visual appeal of the cover letter. Participants found the letter informative and noticed that they could go to the website for more information if they needed it, and/or get a friend/carer to help them complete the form. It was evident from their comments that they noticed from the letter the twelve-month timeframe for contact with the GP surgery, and participants remarked that the letter told them they had been picked randomly to receive the survey and that their responses would be confidential.

Participants were clear that the helpline and online icons meant that they could telephone for help in completing the survey and use the internet to get more information and/or complete it online. One participant struggled to recognise the word 'translation' and it was not clear to them from the icon alone that it represented a translation line. However, the majority of participants recognised the translation icon as being for people who would want to complete the survey in another language.

Questionnaire instructions

Participants were clear from the icon and information provided at the top of the survey that they could complete it online if they wished (although no-one indicated that they would complete it in this way), and that they needed their ID number in order to do this.

Feedback from participants suggests that the worked example was effective as otherwise they may have 'ticked' the box rather than placing an 'X' to indicate their answers. Comments were also positive in relation to the limited number of open questions (*"...you just 'X' things and not having to write things so it's better"*).

Question 1: Contact in the last 12 months

Comments from participants indicated that it was clear that the survey was only to be completed if you had contact with your GP surgery in the previous twelve months.

Section 1: Access

Overall, feedback on the 'Access' questions was broadly positive. Participants indicated that the routing was easy to follow and interpretation of phrases such as 'getting through on the telephone' (Q2), 'polite and helpful' (Q3) and 'preferred doctor' (Q10) was consistent and did not pose any challenges to participants. The scale and answer options available were adequate with participants indicating that they could select an option that they felt reflected their actual experience.

Specifically, interpretation of 'fairly quickly' in Q4 varied and included being contacted by telephone within a couple of hours, being seen immediately/on the same day and being seen in less than two days. In addition, 'working days' (Q5) was interpreted by all respondents to mean Monday to Friday without reference to the explanation provided in the GP Access Survey.

While participants said that they preferred a shorter Q7 to the longer version (referring to the version in the GP Access Survey that includes an explanation as a preamble to the question), participant responses suggest that the preamble may be required to enhance understanding of what the question is asking. Some participants interpreted Q7 as asking if they were able to get an appointment within three days of requesting it (*"give yourself three days after requesting it"* and *"if I phoned on the Monday it would be the Thursday"*); another commented that while you can make an advance appointment at their surgery, most of the time you can just get it that same day, suggesting that they did not understand the implication in the question that patients may want to book an appointment on a

specific date rather than wanting to be seen as soon as possible. In addition, one participant showed a lack of awareness of being able to book advance appointments, commenting that it is not possible to book advance appointments at their GP surgery (*"you have to telephone on the day"*) and requested the inclusion of a 'Not relevant' option to capture this.

There were mixed responses to Q11, with some participants assuming that Q11 referred to the length of time they had to wait to be seen *after* their allocated appointment time and answering it on this basis, and others answering it from their arrival time (*"it's the length of time from you step over the door")*. The current wording accounts for patient experience of surgeries that operate appointment systems and those that do not, and on the whole (and considering the findings from previous rounds of cognitive testing) it is not considered that this should be altered.

Suggested changes to Section 1 are as follows:

- Q7 – consider adding an explanation to the question (as in GP Access Survey) to explain why individuals may want to book in advance, to enhance patient understanding of the question; and

- Q7, Q8, Q9 – consider replacing reference to "3 or more days in advance" with "in advance" to avoid confusion relating to "3 days".

Section 2: At the GP surgery

Overall, participants commented that the language used in Section 2 was clear and that they did not have any difficulty in understanding instructions and statements, following routing or recalling their experience. The frequency and agreement scales used did not pose a problem to participants who commented that they could select an option without difficulty that they felt accurately reflected their experience.

There were no issues with understanding or interpretation of the statements relating to the receptionist and the waiting area, with respondents selecting their answers without difficulty and their explanations suggested that they interpreted the statements consistently. All but one respondent indicated that they were 'never' bothered or threatened by other patients, most participants indicated that they thought there was an important difference between 'I was' and 'I felt' bothered or threatened by other patients (*"'I was' may be forcing the issue on some people – sounds too straight to the point"*). The one person who indicated that they 'rarely' were bothered or threatened by other patients said that they would change their answer to 'sometimes' if the statement was changed from 'I was' to 'I felt'.

Interpretation of the statements in Q14 (doctors) and Q15 (nurses) was broadly similar for both doctors and nurses, and was consistent across the participants themselves. In particular, there were no difficulties in understanding the phrase 'personal circumstances' and explanations from participants included *"my family history"*, *"if I'm depressed or worried about my child"*, *"what I'm going through"* and *"my alcoholism"*.

When explored, participants expressed a preference for the generic term 'nurse' rather than a particular type of nurse, as they felt that this could be confusing and suggested that it was unlikely survey recipients would know the difference between the different types of nurses at their GP surgery.

Participants did not encounter any difficulties in understanding the statements relating to medication and could select an option from the scale that they felt accurately reflected their experience. There was variation in the rationale for choosing particular answers i.e. participants 'knew enough' about their medicines for different reasons e.g. information leaflets, talking to GP, talking to pharmacist etc.

Comments on Q17 (involvement in decisions) suggested that participants understood the question and could select an answer option that they felt adequately reflected their experience. There were positive comments on the bold font as this helped participants to select their answer option.

Section 3: Overall Experience

One respondent was able to differentiate clearly between 'dignity and respect' and 'personal values and beliefs' in Q18, however most participants felt that 'dignity and respect' and 'personal values and beliefs' were very similar and found it difficult to make a distinction between the two statements (*"It's different wording but very similar terms"*).

Participants indicated that the answer options available in Q19 (overall experience) were sufficient and that they could select something that they felt adequately reflected their whole experience. When explored, 'fair' meant 'in the middle'.

Comments were positive in relation to the comments box, with participants indicating that the box is located in an appropriate position, and is of an appropriate size.

Suggested changes to Section 3 are as follows:

- Q18 - further consideration of the inclusion of the two statements in Q18 – are 'dignity and respect' and 'personal values and beliefs' too similar?

Additional question ('I got the best treatment')

An additional statement ('I got the best treatment') not featured in the current survey was tested with participants. Reaction to this varied, with some participants indicating that they felt they couldn't answer this as they would need to be aware of other treatments and other patients' experiences to be able to say if they got the best treatment. Others wondered if 'treatment' was just the medical treatment from the doctor, or did it include the wider patient experience e.g. treatment by receptionist.

Section 4: About You

Participants were content to answer the questions in Section 4 and demonstrated an understanding of why these questions featured in the survey.

There were a few comments in relation to some of the language used. Specifically, 'heterosexual' in Q26 posed a challenge to some participants who indicated that they did not know the meaning of the word. However they commented that they recognised the word 'straight' and could therefore select an option that they felt reflected their personal situation.

When prompted, participants indicated that 'chronic' was a rather negative word and some expressed a preference for 'long term' as it sounded less *"scary"*. One person interpreted chronic to mean 'life-threatening' and although he had a heart condition he chose not to select 'chronic illness' because of his interpretation of the word.

Suggested changes to Section 4 are as follows:

- Q22 - consider replacing 'chronic' with 'long term'.

General comments

The observational exercise provided an insight into participant reaction and approach to completing the survey. No-one appeared to struggle with completion of the survey and participants commented that they were broadly content with the length of the questionnaire and completion time (c.20 minutes).

Summary of initial suggestions

Overall, feedback on the cover letter and questionnaire was positive from the six participants in cognitive testing. Q7 generated comments that suggested there was an issue with participant

interpretation of the question in general, and due to the responses of one or two individuals to Q18 and Q22, they may also merit further consideration.

In summary, initial suggestions following cognitive testing are:

- Q7 – consider adding an explanation to the question (as in GP Access Survey) to explain why individuals may want to book in advance, to enhance patient understanding of the question;

- Q7, Q8, Q9 – consider replacing reference to “3 or more days in advance” with “in advance” to avoid confusion relating to “3 days”.

- Q18 - further consideration of the inclusion of two statements in Q18 – are ‘dignity and respect’ and ‘personal values and beliefs’ too similar? and

- Q22 - consider replacing ‘chronic’ with ‘long term’.

ANNEX K PwC Report - Summary of findings from pilot survey

Introduction

1 As part of the Better Together Patient Experience Programme, PriceWaterhouseCoopers LLP (PwC) Co-ordination Centre and Scottish Government have developed a questionnaire to support quantitative data gathering for Module 2, users of GP services. The development process has been assisted with input from key Scottish Government staff and workshops involving a representation of GPs, practice managers and health board staff.

2 The purpose of this report is to summarise the survey and feedback results from all returned data collection tools.

Technical overview

Approach

3 The aim of piloting the GP survey was to test the suitability of the proposed GP survey methodology and to identify any areas of the questionnaire that could be problematic for respondents to complete in order to confirm a core set of questions for the final questionnaire.

4 A random sampling approach was used. Sample was constructed from household population data and checks were made by postcode and gender to ensure that a spread of sample across Scotland was achieved.

5 Fieldwork commenced 10th July 2009 for a period of 3 ½ weeks with data collection field period finishing on 5th August 2009.

6 Survey packs were distributed to all sample. Survey packs included an introductory letter explaining the purpose of the survey, a questionnaire and a FREEPOST self-addressed envelope (see Appendices). Packs also included a feedback form so that potential respondents could provide further detail on areas that they found useful and any difficulties or areas within the questionnaire which they felt should be changed or refined.

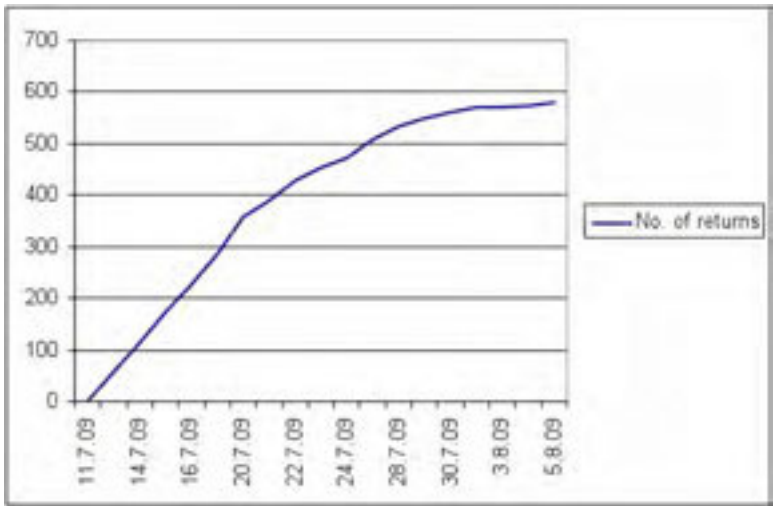
7 A helpline number was set up and details included in the introductory letter in order to allow potential respondents to ring and ask if they had any queries about any aspect of the survey. The helpline operated on a FREEPHONE 0800 number and allowed callers to leave a message. Better Together Coordination Centre team members then phoned callers back to resolve any queries that they had.

8 Survey returns were entered and quality assured by the PricewaterhouseCoopers Data Production Services team and analysis and interrogation of the data took place using industry standard SPSS software.

Profile of respondents

9 A total of 2,000 survey packs were distributed with 581 returned representing a response rate of 29%. Most questionnaire returns were received within the first week of field work with a total of 286 returns during this period. Graph 1 illustrates questionnaire returns throughout the fieldwork period.

Graph 1 Questionnaire returns throughout the fieldwork period



10 In addition to 581 completed questionnaire returns, two blank questionnaires were returned with a note from a family member notifying the Co-ordination Centre that the intended recipient had passed away.

11 A spread of respondents was achieved across 16 postcode areas, with most respondents (20.9%) residing within the Glasgow postcode area.

12 202 males (34.9%) and 377 females (65.1%) took part in the GP Survey. In addition, 2 respondents returned completed questionnaires with unique reference numbers removed which meant that gender and postcode data could not be linked to them. Table 1 provides a percentage breakdown of sample profile by gender and postcode area and compares this with the profile of respondents who completed and returned a questionnaire.

Table 1 Percentage breakdown of sample profile by gender and postcode area in comparison with the profile of respondents who completed and returned a survey

	Sample Profile	Respondent Profile
Gender		
Male	42.5%	34.9%
Female	57.5%	65.1%
Postcode Area		
AB	9.0%	9.8%
DD	4.9%	6.2%
DG	2.5	3.3%
EH	17.0%	19.9%
FK	5.4%	5.2%
G	22.5%	20.9%
HS	0.3%	0.3%
IV	4.2%	3.8%
KA	7.7%	6.4%
KW	1.3%	1.4%
KY	7.2%	6.2%
ML	8.2%	7.1%
PA	4.5%	3.6%
PH	2.6%	2.4%
TD	3.0%	3.3%
ZE	3.0%	0.2%

13 550 respondents (95.5%) had seen their GP within the previous 12 months.

14 Most respondents (60.2%) felt that their health was ‘good’, whilst nearly a third (31.2%) felt it was fair. 8.6% felt that their health was ‘poor’.

15 Respondents were asked if they had any of conditions listed within the questionnaire; 16.5% of respondents indicated that they had a chronic illness, over one tenth (11.3%) noted that they had a physical disability and 8.4% were deaf or had a severe hearing impairment. Other conditions which respondents noted that they had included a mental health condition, blindness or severe vision impairment and learning difficulties.

16 21.4% of respondents felt that they were limited a little by a health related problem or disability, whilst 15.2% felt that they were limited a lot by their problem or disability.

17 35.1% of respondents were 65 years old or over; 22.4% were between 55 and 64, 17.6% were between 45 and 54; 14.2% were between 35 and 44. 9.1% were between 18 and 34 years old.

18 Most respondents (98.9%) were white. The remaining respondents were either Asian (0.9%) or from an ‘other’ ethnic group (0.2%).

19 Of those respondents who answered, 98.6% indicated that they were heterosexual, 0.2% were gay / lesbian and 0.6% were bisexual.

20 Most respondents indicated that their religion, religious denomination or body was either Church of Scotland (49.3%), none (26.9%) or Roman Catholic (13.5%).

Operation of phoneline

21 A FREEPHONE helpline number was set up for potential respondents to ring if they had any queries. This operated 24 hours each day on an answer machine basis whereby callers left a message and a member of the Better Together Coordination Centre team would call them back at a time of their convenience to resolve their query.

22 Most calls were made in the immediate days following survey packs being distributed. The Better Together GP Survey team were able to follow up on calls within 48 hours of a message being left.

23 A total of 5 messages were left on the answer machine ranging from queries about what the respondent should do with the questionnaire if the person named on the letter had passed away, a carer of a potential respondent phoning to advise that the named person did not wish to take part and general queries such as how demographic questions should be answered.

Questionnaire routing and missing responses

24 Whilst most questions had a high instance of completion, a number of questions contained missing answers. Table 2 shows the total missing counts in order of which questions attracted the most.

Table 2 Percentage of missing responses by each question

	Missing counts
Q12b. Overall how would you rate the arrangements for getting to see a nurse in your GP surgery?	42 (7.6%)
Q27. Which of the following options best describes how you think of yourself?	34 (6.2%)
Q13b. I am worried because other people can overhear me talking to the receptionist.	26 (4.7%)
Q13c. I am bothered or threatened by other patients.	23 (4.2%)
Q24. Do you need an interpreter or other help to communicate?	19 (3.5%)
Q18b. My personal values and beliefs are respected	18 (3.3%)
Q23. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? (Include problems related to old age).	17 (3.1%)
Q14b. I feel that the doctor has all the information they need to treat me.	16 (2.9%)
Q14d. The doctor talks in a way that helps me understand my condition and treatment	15 (2.7%)
Q21. How would you rate your health in general?	15 (2.7%)
Q14e. I am confident in the doctors' ability to treat me	14 (2.5%)
Q14a. The doctor listens to me.	13 (2.4%)
Q14c. The doctor shows consideration for my personal circumstances in treating me	12 (2.2%)
Q14f. I have enough time with the doctor	12 (2.2%)
Q17. How do you feel about being involved in decisions about your care and treatment?	11 (2.0%)
Q4. In the last 12 months, have you contacted your GP surgery because you needed advice fairly quickly because you felt unwell or were worried about something? *(Please include contacting your GP surgery for someone else, for example a child or elderly person who is registered at the same surgery).*	10 (1.8%)
Q7. In the last 12 months, have you tried to book a doctor's appointment 3 or more days in advance?	10 (1.8%)
Q16a. Have you been prescribed medicines at your GP surgery in the last 12 months?	10 (1.8%)
Q28. What religion, religious denomination or body do you belong to?	10 (1.8%)

25 There were a total of 40 routing errors by respondents. Table 3 summarises the routing issues encountered when analysing survey returns.

Table 3 Routing issues encountered within GP questionnaire

Question number	Routing Instruction	Issues
Q3. When you have phoned your GP surgery, was the person who answered polite and helpful?	Q2. 'Never' or 'I haven't tried to phone' – Go to Q4	2 respondents completed question contrary to routing instruction.
Q5. The last time this happened, did you see or speak to a doctor or nurse within 2 working days?	Q4. Yes – Go to Q5 Q4. No – Go to Q7	4 respondents completed question contrary to routing instruction.
Q6. Why did you not see or speak to a doctor or nurse within 2 working days?	Q5. Yes, I saw a doctor or nurse face to face – Go to Q7 Q5. Yes, I spoke to a doctor or nurse on the telephone – Go to Q7 Q5. No – Go to Q6	11 respondents completed question contrary to routing instruction.
Q7. In the last 12 months, have you tried to book a doctor's appointment 3 or more days in advance?	Q4. Yes – Q5 Q4. No – Q7 Q5. Yes, I saw a doctor or nurse face to face – Go to Q7 Q5. Yes, I spoke to a doctor or nurse on the telephone – Go to Q7 Q5. No – Go to Q6	1 respondent completed question contrary to routing instruction.
Q8. The last time you tried to book 3 or more days in advance, were you able to get an appointment?	Q7. Yes – Go to Q8 Q7. No – Go to Q10	1 respondent did not complete this question when they should have. 7 respondents completed question contrary to routing instruction.
Q9. Why did you not get an appointment for 3 or more days ahead?	Q8. Yes – Go to Q10 Q8. No – Go to Q9 Q8. Can't remember – Go to Q10	1 respondent did not complete this question when they should have. 10 respondents completed question contrary to routing instruction.
Q10. When arranging to see a doctor at your GP surgery can you *usually* see your preferred doctor?	Q8. Yes – Go to Q10 Q8. No – Go to Q9 Q8. Can't remember – Go to Q10	2 respondents completed question contrary to routing instruction.
Q15. Have you seen a nurse at your GP surgery in the last 12 months?	No – Go to Q16 Yes – Continue	1 respondent completed question contrary to routing instruction.

Reliability Analysis

26 A series of reliability tests were used to measure internal consistency within the survey tool. These consisted of identifying statements with common constructs and using Cronbach's Alpha to measure the coefficient of reliability. A measure of over 0.7 was considered as a high indicator of reliability.

27 All areas of the questionnaire conformed to or exceeded our measure of high reliability with the exception of inter-item analysis of Q13 which provided a Cronbach Alpha of 0.526.

Overview of feedback form results

28 97% of respondents (532) returned a feedback form with their completed questionnaire. This provided valuable insight into the views of respondents on how they found completion of the questionnaire. Table 3 provides an overview of the results.

Table 3 Overview of results from feedback form

Question		% Positive Result	% respondents adding comments
F1	Questions were not difficult to understand or confusing	98%	2% (11)
F2	Able to choose a suitable answer for any of the questions	90%	9% (50)
F3	Length of the questionnaire was about right	93%	<1% (4)
F4	Instructions on how to complete the questionnaire were easy to follow	99%	<1% (2)
F5	Any other comments about the questionnaire	10%	9% (50)
F6	Preferred to complete the survey online	14%	-

29 As presented in Tables 5 and 6, Question F2 and Question F5 attracted a larger number of comments from respondents. These were coded to identify broad thematic areas to help provide further insight into what respondents thought of the questionnaire.

30 Table 5 presents a summary of the most common survey questions and broad thematic areas that respondents included in Question F2 when explaining why they felt they could not choose a suitable answer.

Table 5 QF2. Did you feel that you couldn't choose a suitable answer for any of the questions?'

Question	Broad themes – why respondent could not choose a suitable answer	Example of comment	No. respondents adding comments
Q6	Answer options did not reflect experience	*"I was not offered the chance because my GP was on holiday and I chose not to see another GP. Therefore it was not the fault of the GP practice"*	3
Q7	Incorrect patient interpretation	*"At my surgery I simply ask for an appointment (not 2 days hence) and have never had to wait more than 30 hours Question could ask the longest wait for an appointment."*	2
Q7	No requirement by patient for advance booking	*"I don't ask for an appointment 3 days in advance. I would want it as soon as possible but it is impossible at the surgery. Why "3" days?"*	2
Q11	Waiting time varies from visit to visit	*"Depends on doctor, time, day, busy or quiet, never the same"*	2
Q14	Different experience with different doctors	*"I usually see different doctors in the practice so it is impossible to answer this as they're all so different."*	6
Q16	Wanted clarity around how they 'knew enough' about medicines	*"I answered always to all because I read up on any medicines myself and do not rely on GP explaining them as often they don't. Maybe include "I know about my medicines because I find out myself."*	2
General	Response scale inappropriate e.g. preference for something 'in between' on the scale; preference for agreement scale versus frequency and vice versa, etc	*"Jumped from good to excellent I feel you should put very good in between".* *"Prefer never, rarely, sometimes etc., rather than disagree to strongly disagree".*	17

31 Table 6 presents a summary of the most common issues raised by respondents in Question F5 when providing any other comments they had on the questionnaire.

Table 6 QF5. Do you have any other comments about the questionnaire?'

Most common issues raised in 'other comments'	Example of comment	No. respondents adding comments
Positive comments – good questionnaire	*"The questionnaire I have received this week, the others being from local council and a local community service. Your one is the most sensible of the 3, which is something to be said for it."*	6
Reasons for survey?	*"Why is this questionnaire necessary as we do not have any complaint about attendance by our doctor?"*	5
Demographic questions (necessary?)	*"Don't know what my religion has to do with it except in case of my death"*	4
Additional content suggested	*"More questions should be about the people running the surgery i.e. receptionists".*	3
Comments box (location, size)	*"The paragraph about your experiences at your surgery wasn't large enough."*	3
How much is being spent on the survey?	*"How much is this exercise costing? Could the money not have been spent better on other things?"*	3
Response scale	*"Some of the answer boxes where these all say 5 options are in reverse order to orders. i.e., some start off with a positive, others with a negative. It would be better to be consistent."*	3
Different experience with different doctors	*"It would be better if you could have identified your doctor as not all in my surgery would have been given the same answers."*	2
Economic and environmental impacts of survey	*"Both sides of the paper would have saved a tree or two! Smaller A5 envelops would have saved on postage cost."*	2

Overview of survey results

Section 1 Access

32 When asked about their views on accessing services within the GP practice, most respondents provided positive feedback. Table 7 provides a summary of mean scores by each scalar variable within Section 1.

Table 7 Mean scores for statements within Section 1: Access

Question		Mean Score
Q2	In the last 12 months, when you have phoned your GP surgery, could you get through on the phone?	4.38
Q3	When you have phoned your GP surgery, was the person who answered polite and helpful?	4.64
Q12a	Overall how would you rate the arrangements for getting to see a doctor in your GP surgery?	4.05
Q12b	Overall how would you rate the arrangements for getting to see a nurse in your GP surgery?	4.17

33 359 respondents (66.5%) had contacted their GP surgery because they needed advice fairly quickly because they felt unwell or were worried. Of these people, 64.5% saw a doctor or nurse face to face and 24.3% spoke to a doctor or nurse on the telephone. 40 respondents (11.2%) did not see or speak to a doctor or nurse within 2 working days; the main reason for this was because they were not offered the chance (62.5%), or they were offered the chance, but the person they wanted was not available (15.0%).

34 68.0% or respondents have tried to book a doctor's appointment 3 or more days in advance. Of those who had, 69.9% had been able to get an appointment. Of the 29.6% who had not, the main reasons for this were that there were no advance appointments available for booking (62.3%), there were no appointments available with the doctor they wished to see (25.5%) or there were no appointments available at a time that suited them (10.4%).

35 Just over two thirds (66.5%) of respondents could usually see their preferred doctor. 13.6% noted that they could not and 18.7% indicated that they did not have a preferred doctor.

36 Most (86.0%) of respondents felt that they usually waited a reasonable amount of time after they arrived at their GP surgery.

Section 2 At the GP surgery

37 A small number of participants noted that they were worried about other people overhearing them talking to the receptionist, however overall views on the doctors and nurses that they saw at the GP surgery were positive.

Table 8 Mean scores for statements within Section 2: At the GP surgery

Question		Mean Score
Q13a	The receptionist is polite and helpful	4.59
Q13b	I am worried because other people can overhear me talking to the receptionist	3.61
Q13c	I am bothered or threatened by other patients	4.88
Q14a	The doctor listens to me	4.20
Q14b	I feel that the doctor has all the information they need to treat me	4.05
Q14c	The doctor shows consideration for my personal circumstances in treating me	4.15
Q14d	The doctor talks in a way that helps me understand my condition and treatment	4.22
Q14e	I am confident in the doctors' ability to treat me	4.20
Q15a	The nurse listens to me	4.26
Q15b	I feel that the nurse has all the information they need to treat me	4.16
Q15c	The nurse shows consideration for my personal circumstances in treating me	4.23
Q15d	The nurse talks in a way that helps me understand my condition and treatment	4.24
Q15e	I am confident in the nurses' ability to treat me	4.25
Q15f	I have enough time with the nurse	4.25
Q16a	I know enough about what my medicines are for	4.59
Q16b	I know enough about how and when to take my medicines	4.84
Q16c	I know enough about possible side effects of my medicines	4.25
Q16d	I would know what to do if I had any problems with my medicines	4.53

38 86.1% of respondents felt that they were involved as much as they wanted to be in decisions about their care and treatment, whilst 6.9% felt that they were not involved enough.

Section 3 Overall experience

39 Reflecting positive views expressed previously, most respondents (88.5%) rated the care provided by their GP surgery as either 'excellent' or 'good'.

Table 9 Mean scores for statements within Section 3: Overall Experience

Question		Mean Score
Q18a	I am treated with dignity and respect	4.23
Q18b	My personal values and beliefs are respected	4.15
Q19	Overall, how would you rate the care provided by your GP surgery?	4.31

Summary of recommendations

40 All queries to the helpline number were easily resolved and as the volume of calls was low, the helpline could in future be operated on an answer message basis.

41 To control for missing data, an option such as 'I did not see a doctor/nurse' should be considered within Question 12.

42 Further development of Question 13 should be considered to ensure that participants are clear on which answer option most clearly expresses their view.

43 Whilst there were a small number of instances of incorrect question completion due to routing error, within feedback forms 99% of respondents felt that instructions were easy to follow.

44 As 13.8% would have preferred to complete the survey online, an option to complete the survey by this method should be provided in the future.

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