Patient Participation in 2012/13

Practice Report

Red & Green Practice (J82056)

An open report to our patients and Hampshire PCT giving details of how Red & Green Practice and Hythe and Blackfield Patient Groups have worked together to improve services for patients in 2012/13.

This report is also available online at the practice website (www.redandgreenpractice.co.uk) and at NHS Choices

5th March 2013
**Patient Participation DES 2012/13 – Practice Report**

This report follows a template for reporting on practice achievement of the Patient Participation Scheme DES 2011/13. In doing so, it provides evidence of key stages for the DES in 2012/13, but this only tells half a story and does little to highlight the fantastic engagement of the group with the practice.

The Patient Group established itself in 2008 to work with GPs to improve services to patients and we are pleased the group has engaged so readily with the practice – it has made a real difference to our decision making. Registered as a charity, it is not a fund-raising group but has raised sufficient funds to maintain its independence, activities and profile. The group has the confidence to challenge the practice at its regular monthly meetings (where managers, Practice Manager and GPs routinely attend) as well as providing positive support for improvement and change.

The Patient Group has helped the practice become far more patient-focused and we genuinely look forward to continue working with the group as national policy changes begin to impact on locality health provision in the years ahead.

---

**Gary Young**

Practice Manager
Index

Step 1: Develop a PRG (criteria a and b) 4
Step 2: Agree areas of priority with the PRG (criteria c) 5
Step 3: Collate patient views through use of a survey (criteria d) 5
Step 4: Provide PRG with opportunity to discuss survey findings and reach agreement on changes to services (criteria e) 5
Step 5: Agree action plan with the PRG and seek PRG agreement to implementing changes (criteria f, g and h) 6
Step 6: Publicise actions taken – and subsequent achievement 6
Step 6a: Opening Hours and Access (criteria i and j) 7

Appendix 1: Red & Green practice population variation (2007-2012) 9
Appendix 2: Patient Group Waiting Room Screen 10
Appendix 3: Patient Group Recruitment Flyer 11
Appendix 4: Waterside Patient Group Notice Board 12
Appendix 5: Patient Group Local Survey – May/June 2012: Report 13
Appendix 6: Practice Continuity Plan (September 2012) 31
Step 1: Develop a PRG (criteria a and b)

a) Provide a description of the profile of the members of the PRG

<table>
<thead>
<tr>
<th>Practice population profile</th>
<th>PRG profile</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Under 16</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>% 17 - 24</td>
<td>8%</td>
<td>% 17 - 24</td>
</tr>
<tr>
<td>% 25 - 34</td>
<td>12%</td>
<td>% 25 - 34</td>
</tr>
<tr>
<td>% 35 - 44</td>
<td>12%</td>
<td>% 35 - 44</td>
</tr>
<tr>
<td>% 45 - 54</td>
<td>15%</td>
<td>% 45 - 54</td>
</tr>
<tr>
<td>% 55 - 64</td>
<td>14%</td>
<td>% 55 - 64</td>
</tr>
<tr>
<td>% 65 - 74</td>
<td>12%</td>
<td>% 65 - 74</td>
</tr>
<tr>
<td>% 75 - 85</td>
<td>7%</td>
<td>% 75 - 85</td>
</tr>
<tr>
<td>% Over 85</td>
<td>3%</td>
<td>% Over 85</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>96%</td>
<td>White</td>
</tr>
<tr>
<td>% British Group</td>
<td>0%</td>
<td>% British Group</td>
</tr>
<tr>
<td>% Irish</td>
<td>0%</td>
<td>% Irish</td>
</tr>
<tr>
<td>Mixed</td>
<td>0%</td>
<td>Mixed</td>
</tr>
<tr>
<td>% White &amp; Black Caribbean</td>
<td>0%</td>
<td>% White &amp; Black Caribbean</td>
</tr>
<tr>
<td>% White &amp; White African</td>
<td>0%</td>
<td>% White &amp; White African</td>
</tr>
<tr>
<td>% White &amp; Asian</td>
<td>0%</td>
<td>% White &amp; Asian</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0%</td>
<td>Asian or Asian British</td>
</tr>
<tr>
<td>% Indian</td>
<td>0%</td>
<td>% Indian</td>
</tr>
<tr>
<td>% Pakistani</td>
<td>0%</td>
<td>% Pakistani</td>
</tr>
<tr>
<td>% Nepalese</td>
<td>0%</td>
<td>% Nepalese</td>
</tr>
<tr>
<td>% Bangladeshi</td>
<td>0%</td>
<td>% Bangladeshi</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0%</td>
<td>Black or Black British</td>
</tr>
<tr>
<td>% Caribbean</td>
<td>0%</td>
<td>% Caribbean</td>
</tr>
<tr>
<td>% African</td>
<td>0%</td>
<td>% African</td>
</tr>
<tr>
<td>Chinese or other ethnic group</td>
<td>0%</td>
<td>Chinese or other ethnic group</td>
</tr>
<tr>
<td>% Chinese</td>
<td>0%</td>
<td>% Chinese</td>
</tr>
<tr>
<td>% Any Other</td>
<td>3%</td>
<td>% Any Other</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Male</td>
<td>50%</td>
<td>% Male</td>
</tr>
<tr>
<td>% Female</td>
<td>50%</td>
<td>% Female</td>
</tr>
</tbody>
</table>

b) Where a particular group has been identified as being under represented, the efforts made by the practice to engage / recruit these patients.

Based on returns made by committee and virtual group members, <16’s are not represented, 17-44 year olds are under represented, 45-64 year olds are fully represented and those >65 years are over represented. This is not surprising given the aging population of our patient list (see appendix 1). Females are marginally over represented. Appendices 2, 3 and 4 illustrate the PRG being promoted on reception screens, flyers, and waiting room notice boards. In addition, the PRG is promoted on the practice website and the PRG also has its own website. Positive promotion of the group has helped improve representation with an increase in percentage of members below retirement age compared to 2011/12.

Clinical system information shows 0.70% of the total registered patient population have learning difficulties, are in residential care or wheelchair users. Although a small proportion (176 patients) of an approximate 25,000 list, the Practice and the Patient Group remain very mindful of their greatly increased needs.
Step 2: Agree areas of priority with the PRG (criteria c)

In order to encourage as much feedback and engagement as possible, the PRG publish an annual newsletter (following AGM) which, along with minutes of regular meetings, is published on the PRG website, circulated to committee PRG members (those who choose to attend meetings) and virtual group members (those who agree to receive minutes and respond to surveys and other PRG committee requests) by email and traditional post (if member does not have email). There are 18 PRG members (committee) and 114 virtual group members, 132 in total.

As a result of PRG work carried out in 2011/12, PRG identified “improving continuity of care” as a high priority for 2012/13. (Ref: PRG meeting minutes 19th March 2012). In April, the PRG discussed other areas arising from a variety of sources including complaints, surveys and feedback to identify problems such as delays returning to locality phlebotomy access, car parking, especially Blackfield surgery during school drop-off and pick-up times, and possible use of Waterside waiting room space for volunteer groups (Ref: PRG meeting minutes 14th May 2012). To establish if patients “want” improved continuity, additional questions were discussed and agreed to be added to the local survey planned for May/June 2012. The practice agreed.

Step 3: Collate patient views through use of a survey (criteria d)

A ten question survey was agreed between the PRG and the practice in May 2012, see Appendix 1 within the attached report “Patient Group Local Survey – May/June 2012: Report (29th June 2012)” (Appendix 5). Available online through the practice and PRG websites between 14th May and 29th June 2012, it was also available as a paper survey in the surgery waiting rooms.

Step 4: Provide PRG with opportunity to discuss survey findings and reach agreement on changes to services (criteria e)

The report of 29th June was presented and discussed with the PRG at a meeting on 2nd July 2012. The PRG and practice discussed the results, impact of consultation rates rising with population age and reviewed our patient satisfaction with continuity in context of Hampshire PCT, South Central SHA and national survey results. The group concluded the survey was representative and valid, that it proved the practice needed to improve continuity of care and that the practice needed to develop a plan to improve continuity of care. Finally, the group concluded that of the issues identified in previous meetings, continuity of care is the correct priority for 2012/13.

With the next PRG meeting scheduled for September 2012, the report was sent by email or post to all committee and virtual PRG members for consideration ahead of the next meeting. The practice agreed to consider how it could effect a whole system change and, if agreed by the partners, would prepare a plan for presentation at the next PRG meeting in September 2012 (Ref: PRG meeting minutes 2nd July 2012).
Step 5: Agree action plan with the PRG and seek PRG agreement to implementing changes (criteria f, g and h)

At the PRG meeting on 3rd September, the practice presented a plan to improve continuity of care, acknowledging the PRG survey indicated (and practice agreed) that GP continuity of patient care could be improved. The plan outlined the approach and detail of the key steps taken to identify how, and in what ways, the practice can make the deep rooted systemic changes needed to make a genuine improvement.

The aim was to create a form of “personalised list” system whilst retaining patient choice and the benefits of a large multi-disciplinary team. The practice outlined how it had identified historic continuity by analysing GP/patient consultation patterns and stratified risk within the whole patient list to identify individual patient need for continuity. In turn, this helped identify and resolve possible workload inequities that may have otherwise arisen. Obviously complex to implement due to the impact on all systems, especially medication reviews and repeat prescribing, the practice felt a soft launch would allow maximum opportunity to respond to any problems during the change. The objective was to start making clinical system changes in December 2012 and introduce changes to the appointment booking system early in 2013. The practice also agreed to run a large survey throughout November and December 2012 to establish baseline patient satisfaction across all key indicators so changes in satisfaction after changing the system could be measured and compared.

Those present at the PRG meeting agreed the plan as proposed (Appendix 6) which was then attached to the minutes, published on the website and circulated to all committee and virtual group members for feedback and review in the usual way so any queries or issues could be aired before confirming implementing the changes at the next meeting in November (Ref: PRG meeting minutes 3rd September 2012).

At 5th November meeting, no issues had been raised by virtual group members, or through the website. The practice confirmed we would progress the plan, invest in software upgrades to the appointment system and start implementing changes in December 2012 (Ref: PRG meeting minutes 5th November 2012).

Step 6: Publicise actions taken – and subsequent achievement

At PRG meeting on 7th January 2013, the practice indicated results from the large autumn survey were being processed and ready for presentation in February, along with this report in outline. The PRG agreed to an Extraordinary Meeting in February to review the results (Ref: PRG meeting minutes 7th January 2013).

At the meeting on 5th February 2013, the practice outlined the highlights of this report, including the local survey finding continuity is important to 90% of Red and Green patients, yet only 54% of our patients felt it is achieved. The presentation looked at how the plan proposed in September 2012 had been implemented, and the problems we had overcome to achieve prescriptions, letters and results being directed to each patient’s “usual GP”. The appointment booking software had been purchased and, bar a few teething problems, was now up and running. In short, the
practice fulfilled the plan and achieved systemic change required to enable improved continuity of care for some 25,000 patients registered in Hythe and Blackfield.

The PRG and practice then reviewed headline results from the autumn survey (539 patients) over a 7-week period during October-December 2013. With a high (98%) confidence interval, many results were consistent with previous practice surveys (increasingly high satisfaction with same and next day booking (now average 86%) and almost 100% satisfaction with opening hours, clinical care and administration). However, we noticed an apparent correlation between dips in satisfaction with routine appointment booking and satisfaction with continuity of care. We discussed the phenomenon, and speculated on reasons why there is an observable correlation. The practice intends to continue running patient surveys to see how satisfaction with continuity of care and other key indicators change as the new system settles in.

The PRG agreed to attach the presentation to the minutes, publish on the website, and circulate to all group members for feedback and review in the usual way so queries could be resolved before reviewing and agreeing the final written report at the next meeting in March 2013 (Ref: PRG meeting minutes 5th February 2013).

At the PRG meeting on 4th March 2013, this report was formally agreed by the PRG for submission by the practice to the PCT on or before 31st March 2013.

**Step 6a: Opening Hours and Access (criteria i and j)**

**Opening Hours:** As supporters of extended opening, we provide a full reception service 114 hours/week between the two surgeries on an “open doors” basis with full telephone access: two receptionists at each surgery allow patients to drop/collect prescriptions, obtain normal test results, make general enquiries and book or rearrange GP or nurse appointments, etc.

In 2011, we assured our patients we would continue to provide extended opening and even increase clinical provision by a further 6 hours per week, to provide 19.5 hours of late evening GP and nurse time every week between 6:30pm and 8:00 pm.

We have consistently carried out surveys and proactively engaged with patients to shape and deliver services best suited to meet differing needs of the populations served by each of our two Health Centres. This is an ongoing process resulting in year on year improvements in patient satisfaction, as described throughout this report. Patients indicate they are happier with all aspects of service now than in 2007/08. This is especially true of opening hours, with the practice achieving 98.2% Good or Excellent responses in the latest patient survey carried out in autumn 2013.
Hythe and Blackfield: There are differences between our two local communities. Our 2011 demographic study showed Hythe residents have an older average age than in Blackfield, while an earlier practice survey (measuring reaction to real-time Saturday opening), concluded Hythe residents tend to commute more with a greater need for access to the surgery outside of core hours. The same study also found late night opening meets patient needs better at both surgeries than fewer hours on a Saturday morning. This is why, in order to meet patient needs, our late night opening provides more hours than the Extended Hours LES specification requires.

<table>
<thead>
<tr>
<th>Waterside Health Centre</th>
<th>Blackfield Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>08:00 – 20:00</td>
</tr>
<tr>
<td>Tuesday</td>
<td>08:00 – 20:00</td>
</tr>
<tr>
<td>Wednesday</td>
<td>08:00 – 20:00</td>
</tr>
<tr>
<td>Thursday</td>
<td>08:00 – 20:00</td>
</tr>
<tr>
<td>Friday</td>
<td>08:00 – 18:30</td>
</tr>
<tr>
<td>Saturday</td>
<td>Closed</td>
</tr>
<tr>
<td>Sunday</td>
<td>Closed</td>
</tr>
</tbody>
</table>
Appendix 1: Red & Green practice population variation (2007-2012)

Source: Non-Elective admissions, case mix and demography for the Red and Green Practice (J82056), Waterside; part of West Hampshire CCG (10.02.12)
Appendix 2: Patient Group Waiting Room Screen

The Hythe and Blackfield Patient Groups support the work of the Red and Green Practice to improve service and provide patients with a way of communicating with GP's, Practice Manager and staff.

All patients are automatically members of the groups and are welcome to attend our monthly meetings, the Annual General Meeting, become committee members or volunteer to help.

To find out more about your Patient Group look us up on the internet:

www.hythepatientgroup.co.uk
www.blackfieldpatientgroup.co.uk
WE NEED YOUR COMMENTS, OPINIONS AND SUGGESTIONS

One of our main aims is to improve Patient/Health Centre communication and in order to do this we wish to set up a list of Patients who would be willing to answer a few questions from time to time. These may be about specific proposed changes in the way the Health Centres function or deal with matters which patients raise as a matter of concern.

The most cost effective and prompt way of collecting information is by e-mail contact although we would still welcome responses from patients without a computer.

If you would be willing to go on the list please fill in one of the forms and place it in the box.

hythepatientgroup.co.uk

blackfieldpatientgroup.co.uk
Appendix 4: Waterside Patient Group Notice Board
Carried out by Red and Green Practice for the Hythe and Blackfield Patient Group (PPG), the survey was available online using Survey Monkey through the practice and PPG websites, and as a paper-based survey in Waterside and Blackfield Health Centre reception areas from 14th May 2012 to 29th June 2012.

Limited to 100 responses, this local survey was commissioned by the PPG as an action arising from the Patient Participation Practice Report 2011/12, to establish patients view towards ‘continuity of care’: (WATERSIDE AND BLACKFIELD HEALTH CENTRES, JOINT PATIENT REFERENCE GROUP MEETING, MONDAY 19TH MARCH 2012: Action 5. Propose initial local survey to establish if patients “want” improved continuity, i.e. ability to see the same doctor each time they visit. Two example questions were discussed reflecting previous national survey questions, so we can measure changes to historic patient satisfaction with continuity.)

Contact:
Gary Young
Practice/Business Manager
Red and Green Practice
Waterside Health Centre
Beaulieu Road
Hythe, Hampshire
SO45 5WX

023 8084 5955 ext 3346
garyyoung@nhs.net
www.redandgreenpractice.co.uk

29th June 2012
Executive Summary

Arising from survey work with the practice in 2011/12, the Patient Group identified the priority for 2012/13 as “continuity of care”, i.e. the ability of a patient to see the same doctor each time the patient visits the surgery. Using a local survey, the group set out to establish if ‘continuity’ was the right priority, i.e. something ‘wanted’ by patients, and to establish if the practice needed to improve continuity to meet patients’ needs. Finally, the local survey had to be valid with results representative of patients’ views.

Results here, and in recent and historic national surveys, strongly indicate that patients value continuity: less than 10% of respondents to this survey identified continuity as “Not Important”. Having identified continuity as a priority in 2011/12, the results from this survey confirm the Patient Group priority for 2012/13 is valid.

When determining “does the practice need to improve continuity”, 54.3% satisfaction with continuity correlates with national survey results of 49% in March 2012. Moreover, tracking satisfaction with continuity indicates Red and Green patients are reporting a decline in satisfaction falling from 61% in March 2010, to the current level of 54% recorded here. When taken together, and in context of PCT (county), SHA (regional) and national satisfaction with continuity, these results strongly indicate the practice does need to improve continuity of care to meet patients’ needs.

When considering validity, there is some bias toward female and elderly respondents due to self selection which has also been experienced in National surveys from 2007 to 2011. The effect is most observable in respondent rate of consultation, calculated as 5.7 GP consultations per patient per annum, compared to current estimated practice demand of 3.9 GP consultations/patient/annum. The percentage of respondents with a long standing illness, disability or infirmity is 10% higher than might be expected; reflecting surveys were completed by Patient Group and virtual group volunteers as well as patients attending surgery. These groups value continuity more than younger, healthier patients not engaging in practice decision-making or attending surgery.

Nonetheless, concurrence of results to five questions asked in previous practice and National GP Patient Surveys (Ipsos Mori, 2007-2012), establishes that results from this survey are valid, and therefore justly representative of patients’ views.

The results here will be shared with the Patient Group at a meeting on Monday 2nd July 2012, and with the practice shortly after. The Patient Group will meet with the practice again on Monday 3rd September to discuss if both parties agree a need to change, allowing the practice time to consider the implications of any such change before setting out any proposals for change that meets identified Patient Group priorities.
Results

The survey asked seven questions together with demographic data (gender, age group and ethnic background) and was open to all patients: Patient Group members were invited first and then paper based survey forms (see Appendix 1) were made available in the two surgery reception areas and open to patients via practice and PPG websites.

Question 1 (Consultation Rate)

Most patients asked (34%) had visited the surgery 3-4 times in the past six months, and 32% had visited once or twice (64% in total). 15% of respondents had not visited the surgery in the past 6 months, while 19% had visited 5 times or more.

This result indicates an average 5.7 GP consultations per patient per annum (estimated for the practice 142,500 GP appointments/year). Based on QResearch data (Health and Social Information Centre, 2009), the national average rate of consultation is forecast to be 3.7 GP consultations per patient per annum (estimated for the practice of 92,500 GP appointments/year).

Historically, approximately 27% of Red and Green patients responding to the national GP Survey indicate they have not attended surgery in the past 6 months, compared to 15% here. Taken together with frequency of attendance, the indication is that patients responding to this survey consult with a GP more frequently than the national average.
Question 2 (Urgent Access)

This question relates to previous national and practice surveys measuring satisfaction with “same day” access. Historically low, satisfaction with access has improved from 32% in 2007 rising to 76% (Patient Survey March 11). The “same day” Minor Illness Clinic was introduced at Waterside Health Centre in April 2011 and at Blackfield in November 2011: satisfaction with ‘urgent’ access was measured as 84% at Waterside and 73% at Blackfield by the in-practice patient group survey (Nov 2011-Mar 2012) (average 78.5%).

Of those that replied to this question, 73.2% can normally be seen on the same day, 11.3% cannot normally be seen on the same day and 15.5% “don’t know”. Applying the same weighting system as the national survey (to exclude “Don’t Know” replies), 86.7% replying “Yes-No” here could normally be seen on the same day while 13.3% could not normally be seen on the same day.

Although not a direct measure of satisfaction, when considered “urgent” by the patient, patients increasingly recognise the ability to be seen on the same day is improving.
When asked about importance of seeing the same GP each time, 52.6% responded it is “Very Important”, 37.9% “Fairly Important” and 9.5% “Not Important”. In all, 90.5% of responses indicate continuity is Very or Fairly Important.

Keywords in fifteen free type responses (Appendix 2) indicate “trust”, “relationship”, “confidence” and “time saving” are recurrent themes. Responses also indicate patients own state of health is a factor, and recognise the need for “continuity” increases for those with long term conditions or serious illnesses.
The national patient survey measures patient satisfaction with continuity by grouping “Always”, “Almost Always” and “A lot of the time” to indicate an overall achievement of continuity. The results here represent 54.3% achievement of continuity.

The national survey results for 2010/11 show two thirds of our patients (66%) want ‘continuity of care’ and only 60% of those who want continuity of care said they could see their doctor of choice “always”, “almost always” or “a lot of the time”. In the latest national survey (March 2012), this has fallen to 49%. The results of the national survey, and here, indicate ability of patients to achieve continuity has declined since 2010.

In the previous question, less than 10% indicated continuity is “Not Important”, and responses to this question validate feedback and responses to previous surveys and the conclusion drawn by the PPG (March 2012) that “there is room for improvement”.

Eight free type responses (Appendix 3) indicate a wide variance in patient attitude from “I don’t mind who I see” to “I refuse to book with anyone else!” Patients responding here indicate they will often from several days to ‘weeks’ to see their “usual” doctor implying that for some, continuity is of paramount importance.
Two of eight free type responses (Appendix 4) indicate ambiguity in the question: does the question relate to the survey or the previous question (frequency of seeing usual doctor). The question relates to the previous question, but responses should be viewed with caution given obvious misunderstanding.

Almost a third (31.9%) indicate the current system is rated “Very Good” to “Excellent”; almost half (47.9%) rate the current system “Good” to “Fair”; in all, 79.8% rate as “Fair” or better. That 20.2% rate the current system “Poor” or “Very Poor” reflects the conclusion drawn by the PPG (March 2012) that “there is room for improvement”.

Question 5 (Satisfaction with Continuity)
Question 6 (Attitude to Continuity)

The majority of those responding (64.5%) would rather wait for their usual GP than be seen quickly by any doctor (28%). A small number (7.5%) don't know. This result mirrors national survey results for 2010/11 showing two thirds of our patients (66%) want 'continuity of care'.

Eight free type responses (Appendix 5) indicate patients differentiate between ‘routine’ appointments (willing to wait to see usual GP) and ‘emergency' when being seen quickly increases in importance.
Almost two thirds (61.3%) of those responding have a long-term condition, compared to a little over a third (38.7%) who do not. Patients giving free type responses (Appendix 6) indicate their long term condition.

The percentage of patients responding “Yes” in previous national surveys has increased steadily from 47% (Mar 2009) to 53% (Mar 2011), rising at average 6% of respondents per annum. This correlates with an increasing consultation rate trend and a rapidly aging practice list where over 65’s increase as a percentage of overall list make up by 1% per annum. The question style was changed in the 2012 national survey, making comparison this year difficult, but a general estimate would be to expect 56% to answer “Yes” here in 2012, rising to 60% answering “Yes” here in 2013.

So, despite looking high, those responding to this survey with long-standing illnesses are only in the order of 10% higher than expected in the whole practice population.
### Question 8 (Gender)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>39.8%</td>
<td>37</td>
</tr>
<tr>
<td>Female</td>
<td>60.2%</td>
<td>56</td>
</tr>
</tbody>
</table>

The ratio of female to male respondents is approximately 60:40, which is commonly found in health related surveys where patients self select to respond, including previous in-practice surveys of 1,500+ responses.
Question 9 (Age)

As seen below, survey respondents (over 17yrs) under 45 years are under represented (average 33% practice population compared to 18.3% of survey respondents). Likewise, those aged 65 – 85 years are over-represented in the survey (average 20% of practice population compared to 45% of survey respondents).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Practice Population Profile</th>
<th>Survey Profile</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 - 24</td>
<td>10%</td>
<td>3.20%</td>
<td>-6.80%</td>
</tr>
<tr>
<td>25 - 34</td>
<td>11%</td>
<td>6.50%</td>
<td>-4.50%</td>
</tr>
<tr>
<td>35 - 44</td>
<td>12%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>45 - 54</td>
<td>15%</td>
<td>10.1%</td>
<td>-3.40%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>14%</td>
<td>19.4%</td>
<td>5.40%</td>
</tr>
<tr>
<td>65 - 74</td>
<td>6%</td>
<td>25.8%</td>
<td>13.80%</td>
</tr>
<tr>
<td>75 - 85</td>
<td>8%</td>
<td>10.4%</td>
<td></td>
</tr>
<tr>
<td>Over 85</td>
<td>11%</td>
<td>1.1%</td>
<td></td>
</tr>
</tbody>
</table>

Difficulty in achieving an age-matched profile in self selecting surveys is common; the national survey (2011) resulted in a very similar response profile by age as this survey, and the most recent national survey (2012) also has 45-74 age group over represented.
Question 10 (Ethnicity)

The practice population is 92% white and survey respondents who indicated ethnicity are 98.8% white, and is in line with the 2012 national survey (98%).

General Comments

In all, 32 general comments (Appendix 1-7) were added by patients prior to concluding the survey, perhaps reflecting the strength of opinion regarding provision of health care.
Discussion

In general, the results from this survey are in line with results from previous in-practice and national surveys, giving confidence results here can be relied on as representative of patient experience of the service provided by Red and Green Practice.

The distinction between “experience” and “satisfaction is an important one as the survey set out to establish the broad level of service provided in terms of “urgent” same day access and “the ability of the patient to consult with the same GP and achieve continuity of care”, with the exception of Question 5 which seeks to establish a measure of satisfaction with current continuity/system.

Results of Question 1 (consultation rate) require further analysis as GP consultation rate impacts on the ability of the practice to provide enough capacity to make any change to the system. Results indicate an average 5.70 GP consultations per annum, compared to a national average of 3.7 visits per patient per annum to see a GP.

Over representation of females (60:40) and ages 65–85 is significant when considering consultation rates, the table below (QResearch: Health and Social Information Centre, 2009) indicates consultation rates are higher for women of child bearing age and are also higher for male and female patients at the extremes of age, i.e. the very young and the elderly. As survey results are biased toward the 65-85 years age group, age is more significant than gender when considering estimated consultation rates.

The consultation rate of an average person over 65 years is twice that of an average 45 year old and the consultation rate of an average person over 75 years three times of an average 45 year old.
Current GP appointment demand on the practice is approximately 3.9 GP appointments per patient per annum (face to face and telephone consultations): a little more than the projected national average of 3.7, but significantly less than the 5.7 consultations per patient per annum indicated by respondents to Question 1.

Questions 3 & 4 attempt to determine the “need” for continuity, and if the need is being met: the national patient survey indicates that, for those patients who identify a need for continuity, the perception of achieving continuity has decreased since 2010 (from 60% at March 2011 to 49% at March 2012). This correlates with 54.3% achievement indicated in this survey. The extract below (2012 national survey) compares practice, Primary Care Trust, Strategic Health Authority and National achievements of continuity, to illustrate the results from this survey in context:

![GP Patient Survey Results July 2011-March 2012 (Ipsos MORI)](image)

Of interest to the practice will be that two thirds of patients responded they would prefer to wait and see their “usual” GP than be seen quickly (Question 6). With demand rising in the “same day” Minor Illness Clinic, improving continuity of care for routine (non-urgent) appointments may reduce pressure on other parts of the appointment system.
Conclusions

The survey set out to establish if

   a) the Patient Group was right in identifying “continuity” as a priority, and 
   b) whether the practice needs to improve continuity

In order to use this survey to answer these questions, the Patient Group also needed to know if the survey results were representative of patients’ views, and a valid survey.

Representative and Valid

Question 2 (same day access) has been asked before in National GP Patient Survey (Mori) and in-practice surveys since 2007, and results here correlate with a persistent upward trend in satisfaction with access, most notably since introduction of the “same day” Minor Illness Clinic at Waterside in April 2011 and at Blackfield in November 2011.

Question 3 (preferred GP) has been asked in National GP Patient Survey (Mori) since 2007 and has declined from 66% saying they “have a preferred GP” (March 2011) to 57% in March 2012. Using similar question and answer options as the national survey, this survey recorded 53% saying it is “Very Important” to see the same doctor each time they visit (importance of continuity), correlating with the national survey findings.

Question 4 (achieving continuity) has been asked in National GP Patient Survey (Mori) since 2007 with a downward trend evident from 61% satisfaction (March 2010) to 49% satisfaction in March 2012. Using the same question and answer options as the national survey, this survey recorded 54% satisfaction, correlating with national survey findings.

Question 7 (long-standing illness), Question 8 (gender), Question 9 (age) and Question 10 (ethnicity) are all in line with previous in-practice and national survey results.

• In conclusion: this local survey is valid, with results correlating to previous surveys, so reliably reflecting current patients’ views.

Was the Patient Group was right in identifying “continuity” as a priority

Question 2 (urgent access) evidences the “same day” Minor Illness Clinic supported by the Patient Group in 2011/12 continues to be effective and the Patient Group do not need to revisit “access” in 2012/13.

Question 3 (importance of continuity) provides evidence that over 90% of respondents think continuity is at least “Fairly Important” with less than 10% (9.5%) identifying that “seeing the same Doctor each time” is “Not Important”.

Question 6 (waiting for usual GP) provides supporting evidence with almost two thirds of respondents (64.5%) indicating they would rather wait to see their “usual” GP than be seen quickly by any Doctor.

- **In conclusion: patients value continuity and the Patient Group was right to identify “continuity” as a priority.**

### Does the practice need to improve continuity?

Question 4 (achieving continuity) provides evidence that around half of all respondents (54.3%) achieve continuity “a lot of the time or more” reflecting the national survey (2012) which showed 49% of Red and Green patients achieve continuity “a lot of the time or more”. The Hampshire PCT average is 72%, the SHA average is 69% and the national average is 65% (National GP Patient Survey July 2011-March 2012).

Red and Green achieve 54% compared to Hampshire average of 72%, with 18.3% of respondents seeing their “usual” doctor “Never” or “Almost Never”, compared to the Hampshire PCT average of 6%, SHA average of 6% and the national average of 7% (National GP Patient Survey July 2011-March 2012) in response to the same question.

Red and Green patients are least likely to say they achieve continuity with a “usual” GP and more likely to say the never or almost never achieve continuity when compared to county, regional or national averages.

- **In conclusion: continuity needs to improve to meet the needs of patients.**
Appendix 1 – Survey Form

Patient Group Short Survey – May/June 2012

Dear Patient

Last year your Patient Group supported the Practice improving access to appointments and, in 2012/13, we would like to support the Practice in looking at ways to improve continuity of care, i.e. seeing the same doctor each time you visit the surgery.

Before undertaking a large survey, we would be grateful if you would complete a short survey about your experience in the past 6-months. Feedback from this survey will help us identify areas that need improvement. Your opinions are therefore very valuable.

Please answer ALL the questions that apply to you. There are no ‘right’ or ‘wrong’ answers and your doctors will NOT be able to identify your individual responses.

Thank you.

<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 In the past 6 months, how many times have you seen a Doctor from your practice?</td>
<td>None</td>
<td>Once or twice</td>
<td>3 - 4 times</td>
<td>5 - 6 times</td>
<td>7 times or more</td>
</tr>
<tr>
<td>2 If you need to see a Doctor urgently can you normally be seen on the Same Day?</td>
<td>YES</td>
<td>NO</td>
<td>Don’t Know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 How important is it that you see the same Doctor each time you visit the practice?</td>
<td>Very Important</td>
<td>Fairly Important</td>
<td>Not Important</td>
<td>Don’t Know</td>
<td></td>
</tr>
<tr>
<td>4 In general, how often do you see your usual Doctor when you visit the practice now?</td>
<td>Always</td>
<td>Almost Always</td>
<td>A Lot of the time</td>
<td>Some of the time</td>
<td>Almost Never</td>
</tr>
</tbody>
</table>

PLEASE TURN OVER for questions 5, 6 and 7 THANK YOU
5. How do you rate this?

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Question 6 assumes your reason for seeing the doctor is routine, NOT urgent to be seen on the Same Day

6. In general, would you prefer to be seen quickly by “any” Doctor, or would you prefer to wait and see your “usual” Doctor (if you have one)?

<table>
<thead>
<tr>
<th></th>
<th>Quickly by any GP</th>
<th>Wait for my usual GP</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

7. Do you have any long-standing illness, disability or infirmity?

Yes [ ] No [ ]

By long-standing we mean anything that has troubled you over a period of time, or is likely to trouble you over a period of time.

Gender

- Male [ ]
- Female [ ]

Age Group

- 17 – 24 [ ]
- 25 – 34 [ ]
- 35 – 44 [ ]
- 45 – 54 [ ]
- 55 – 64 [ ]
- 65 – 74 [ ]
- 75 – 85 [ ]
- Over 85 [ ]

Ethnic Background

- White [ ]
- Asian [ ]
- Black [ ]
- Chinese [ ]
- Other [ ]

We are interested in any other comments you may have, please write them here

Thank you for taking time to complete this questionnaire
Appendix 6: Practice Continuity Plan (September 2012)

**Patient Group: Continuity 3rd September 2012**

**Headlines:**

PPG Survey indicated Continuity could be improved  
Practice agrees with PPG  
Practice proposes a plan to improve

**Background:**

The PPG identified the practice could improve and invited R&G to (a) agree with PPG/survey results and (b) come up with a plan

At 2nd July PPG meeting, we discussed patient survey results and agreed they indicate that continuity could be improved based on what our patients told us.

We also discussed if a larger “public” venue would be needed. View from the practice is that changes will be gradual improvements rather than “step change” so prefer to avoid a “loud launch”. If feedback from PPG/virtual group so far indicates a public meeting is needed, then we could reconsider. Discuss.

**What Have R&G Done So Far?**

**STEP 1:** We started by looking at what continuity of care means to doctors and patients; usually interpreted as “personal lists”: GP as sole practitioner rather than a team sharing skills and expertise (shared care, as present). Vigorous discussion on this point resulted in a “hybrid” suggestion (nominal lists). Here, each GP would still have a defined list of patients but patients seeing only one GP will not be strictly enforced (see Step 2: balance GP workload).

The hybrid solution also reflects discussion in previous PPG meetings which expressed concern about strictly enforced personal lists.

It works by the GP having overall responsibility for individual pt’s management but the pt has freedom to see other GPs (different specialities, holiday, study or training commitments, emergency, etc). Likewise, a GP may internally refer a pt to see another GP with a specific expertise, but retain responsibility for follow up.

For all the aim is to enable pts to see the same GP, it is flexible and we expect the impact (time taken for pts to notice a difference) to take time (6m?).

After discussion R&G achieved majority agreement to change how we deliver care from a shared care system to a new nominal list system.
**STEP 2**: We then looked at how pts could be allocated to a GP (or vice-versa).

There were three aspects we looked at: historic continuity, patient need for better continuity and balancing GP workload.

**Historic Continuity**: We reviewed all GP/patient appointments since the merger in July 2009 (3-yrs) and found some patients had visited a lot, others very little. Of those who visited the surgery a lot, some had achieved a high level of continuity (seeing same doctor) and others had seen almost as many doctors as they had appointments. We cannot jump to conclusions here as there may be many reasons for this.

**Need**: Some pts have a greater need for continuity than others, for example an elderly pt with several diseases and multiple medications is likely to appreciate continuity more than a young fit person who visits the surgery very infrequently.

Based on our research and visits to other surgeries that had improved continuity already, we decided to establish 3 tiers (risk stratification), where Tier 1 are high need pts and Tier 3 are low need patients.

Tier 1 patients are over 70 and/or in a Care Home and/or have Dementia and/or have Cancer and/or have recognised Learning Disabilities and/or are using 8 or more prescribed medications (there are more similar criteria too). The essence being, pts in this group have a high need to continuity with their GP.

Tier 3 had three or fewer consultations in the past 12 months.

Tier 2 is everyone in between Tier 1 and Tier 3.

**Balance GP Workload**: When we applied ‘historic continuity’ and ‘patient need’ to each GP in turn, to see what such a change would make, we found some GPs had higher workload than others. Getting a fair and balanced workload is obviously important to making the change work, so we spent time finding ways to balance workload with minimum impact on established continuity. The aim is for each GP to have the same proportion of Tier 1, 2 and 3 pts on their lists while making sure historic continuity is maintained. Not easy but we agreed how to do it and we are almost at the point where each GP knows what their individual lists of pts is.

We had to get agreement on this before we could formally “agree” to change.

**STEP 3**: We then needed to look at the patient pathway, this is mainly the journey from calling to book an appointment, having the appointment and all the administration and management that follows, including tests/results, prescriptions and repeat prescriptions, medication reviews, recall systems, etc (see Step 4).
Change is an opportunity to make improvements in our working efficiency; it is good for us and will be noticed by patients. This is the area we are looking at now - the working party meets again tomorrow to discuss and report back to partners on 13th September. One change not “needed” but would really help receptionists to help pts is a software upgrade to make booking an appointment through the new system easier – costs £3,000+. With pressure on resources, this may be delayed until improved continuity is “working” and pts are happy with the change.

After 13th September we should be able to progress the ‘mechanics’ of changing how we work quite quickly. Optimistically, we may be able to start making changes this November, but need to think about flu vaccinations and that winter can be significantly busiest time of year.

**Summary**

The practice agree the need to improve continuity and, after intense scrutiny, believe we can overcome the problems of changing how we work and make improved continuity of care a reality.

We have defined how we identify those most in need of better access to the same GP and how we allocate lists to GPs. There may be some reaction from some pts, especially if their view of “who their doctor is” is different to what it seems, but our overarching aim is to make a major improvement and we hope patients will bear with us and be positive as we go through the changes needed.

We are currently looking at the complex systems that support the GPs and expect to be able to recommend improvements as a result of better continuity.

November is an “optimistic” start date that is dependant on other factors beyond our control; hence unwilling to make a big announcement (or public meeting).

Some pts will notice changes much quicker than others (high need verses low need) and as the only change should be easier to see the same doctor, there is no step change (as say the merger). We prefer to implement changes at a pace we can manage while continuing to measure patient feedback. This way we can make improvements and bend with pt reaction to the changes. Once changes are made, and we feel pt feedback is positive, we can announce the change.

**Next Steps**

Do the Group agree with our plan? If “Yes”, our plan needs to be shared with those not present, including virtual group, who can consider our plan and feedback their thoughts. If yes, we will assume OK to carry on unless told otherwise – keep things moving). Is this Ok?

Gary Young 3rd September 2012