Primary care patient experience survey 2019: A review of responses in the general practice module and suggestions for the future

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Executive summary

This report seeks to give readers a focused review of responses to the general practice section of the 2019 New Zealand primary care patient experience survey. The report is intended to supplement the health service access Atlas of Healthcare Variation domain, which contains detail on seven key survey questions.

The survey questions are grouped into the following four topics:

- Appointments, wait times and reception
- Access barriers
- Continuity
- Engagement.

Key findings are presented below.

Appointments, wait times and reception

- Most respondents (91 percent) agreed that reception and admin staff always treated them with respect. This varied by district health board (DHB) from 82 to 94 percent.
- Two-thirds of respondents reported getting an answer on the same day when they contacted their practice about something important. However, one-third did not.
- The ability of patients to see their usual general practitioner (GP) within a week of making an appointment varied two-fold by DHB (from 47 to 97 percent).
- Most people (70 percent) reported waiting in reception less than 15 minutes for their appointment to start.

Access barriers

- Younger people said they did not visit their GP or nurse due to cost to a far greater extent than older people (34 percent of those aged 15–44 years compared with 8 percent of people aged 65 years and over).
- Given that Māori and Pacific peoples experience a higher burden of disease at a younger age and have a younger population, they are disproportionately affected by barriers to care.

Continuity

- On average, 86 percent of respondents said they usually see the same GP or nurse. This varied widely by DHB (from 39 to 89 percent).
- Three quarters of patients said they were confident their GP or nurse was aware of their medical history. This varied by DHB (from 51 to 82 percent).

Engagement

- Four of the questions about engagement consistently score high. Most patients agreed that they were always treated with respect (95 percent) and with kindness and understanding (93 percent), and that things were explained in a way that was easy to understand (88 percent) and they were always listened to (88 percent).
- Younger people were more likely than other age groups to report that not enough time was spent with them and that they were not as involved in decisions as much as they wanted to be. This raises questions that practices can explore to better understand how to improve responses, especially from younger people.

Introduction

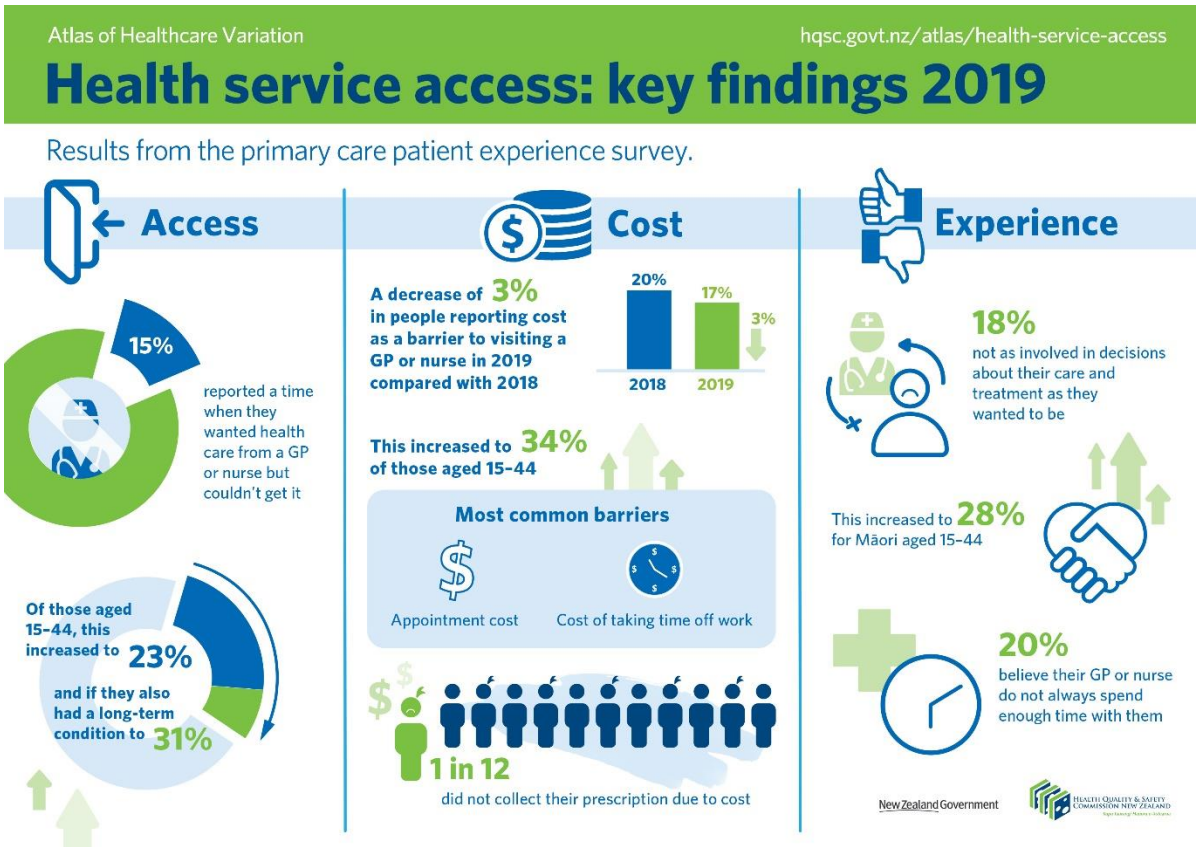
This report seeks to give readers a focused review of responses to the general practice section of the 2019 primary care patient experience survey. The report is intended to supplement other publications, specifically:

- health service access Atlas of Healthcare Variation domain (June 2020)
- https://www.hqsc.govt.nz/atlas/health-service-access/
- *Primary care patient experience survey: Results from the first year of pilots*
- https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3161/

The health service access Atlas domain selected seven key questions from the 2018 and 2019 primary care surveys to investigate whether there are differences by geographic region and/or patient demographic. These questions were selected by an expert advisory group as being key for understanding patients' experience of accessing and using health services.

The key findings from this Atlas domain are summarised in Figure 1. The data provided in the Atlas allows users to view results by age, ethnicity, gender and district health board (DHB). This report therefore does not seek to replicate this. Rather, it aims to provide some additional thought and commentary on why these questions are important, what they might mean and what improvement actions might be useful.

Figure 1: Key findings from the health service access Atlas domain



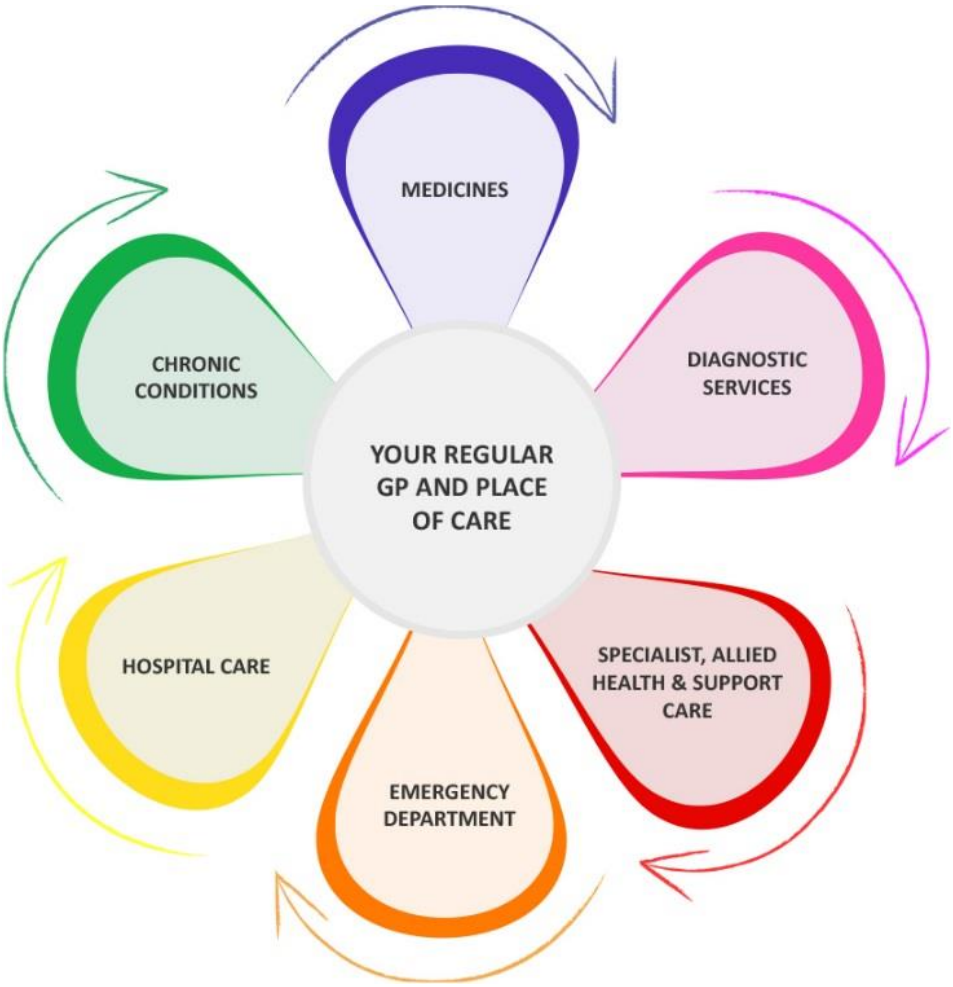
Questionnaire

The primary care patient experience survey is modular, with questions that cover experience of care outside of hospital inpatient services. Although the survey mainly focuses on general practitioner (GP) services, medicines, allied health professionals and diagnostic services, it also covers emergency departments (EDs) and outpatient services. Outside of GP services, the survey concentrates primarily on how well integrated the services are. This breadth of focus means there are specific results that are just as important for DHB hospital services to act on as GP practices and primary health organisations (PHOs).

The regular GP and place of care is the first module that respondents complete. They are then asked directional questions so that only those who received medicines or accessed hospital care and so on complete the additional modules as shown in figure 2.

Ipsos and the Commission reviewed the questionnaire at the end of the 2019 and made minor changes to the questions in order to reduce respondent burden and/or simplify or clarify time periods, and we added new questions to measure recent changes in how primary health care is delivered. Appendix 2 maps the questions in this report with the updated questionnaire.

Figure 2: Modules of the primary care survey with general practice at the centre.



Relevant reports for further insights into patient experience of care

- *From PES to PDSA: A guide to using the patient experience survey portal for quality improvement*
  www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3216/
- *Evaluation of the primary care patient experience survey tool*
  www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3283/
- *Open Book: Dispensing errors: Learning from the national primary care patient experience survey*
  www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3602/

Reporting portal

DHBs, PHOs and practices are usually able to review their survey responses via a reporting portal. This is currently unavailable as the survey reporting is currently being transitioned to the new provider. The new reporting portal will be available following the August 2020 survey wave.

Background

Patient experience is a vital but complex area. Growing evidence tells us patient experience is a good indicator of the quality of health services. Better experience, developing partnerships with consumers, and patient and family/whānau-centred care are linked to improved health, clinical, financial, service and satisfaction outcomes.[1,2,3]

The Health Quality & Safety Commission (the Commission) undertakes two national adult patient experience surveys: the adult hospital patient experience survey (AHPES) and the primary care patient experience survey (PCPES). These surveys aim to improve the quality of health services in New Zealand by enabling patients to provide feedback that can be used to monitor and improve the quality and safety of health services. The surveys provide consistent tools that can be used for national measurements as well as local assessment and improvement. The data is used by general practices, PHOs, DHBs, researchers and relevant government agencies.

The AHPES began in August 2014 and the PCPES in February 2016; both run quarterly nationwide. The surveys collect quantitative and qualitative data covering four key domains of patient experience: communication, partnership, coordination, and physical and emotional health. Patient feedback is anonymous and voluntary, and patients can choose to opt out of participating in the survey.

Patient experience of care has been one of the Ministry of Health's six System Level Measures since July 2016. Measures from both the AHPES and PCPES contribute to this System Level Measure.

The PCPES has been adopted by practices as part of the PHO Services Agreement.

Purpose of the PCPES

The Commission developed the PCPES to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists, and/or hospital staff.

The survey looks at a patient's experience of the whole health care system using primary care as a window. It focuses on the coordination and integration of care rather than just the last visit to their usual general practice.

Being able to capture, understand and act on patient experiences in a timely manner is a vital contributor to improving health service delivery and in prioritising attention and

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[1] Doyle C, Lennox L, Bell DA systematic review of evidence on the links between patient experience and clinical safety and effectivenessBMJ Open 2013;3:e001570. doi: 10.1136/bmjopen-2012-001570

[2] Balik B, Conway J, Zipperer L, et al. 2011. *Achieving an exceptional patient and family experience of inpatient hospital care.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/IHIWhitePapers/AchievingExceptionalPatientFamilyExperienceInpatientHospitalCareWhitePaper.aspx

[3] Agency for Healthcare Research and Quality. 2017. *The CAHPS ambulatory care improvement guide practical strategies for improving patient experience. Section 2: Why improve patient experience?* https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/2-why-improve/cahps-section-2-why-improve-patient-experience.pdf

resources. The online survey and real-time reporting enables patients to have a voice, and health teams that care for them can hear it through a direct and timely mechanism.

The PCPES is a useful tool for practices, PHOs and DHBs to identify what is being done well, as well as areas for improvement. The survey results contain both quantitative and qualitative information.

Project governance

Initially, each survey had its own governance group, reflecting their different starting points in time and different requirements. These two groups were later combined into a Patient Experience of Care Governance Group to provide a whole-of-system focus on patient experience care. This group is sector-led and has been established to provide independent advice to the Ministry of Health and the Commission on the ongoing management of the patient experience surveys. Representatives bring the following perspectives:

- Māori equity
- equity for Pacific and other high priority populations
- PHO and general practice
- DHB and hospital
- community and allied health
- consumer
- Ministry of Health and the Commission.

The group's oversight includes making sure the results of the surveys are best used to improve the patient experience at local and national levels. The group also provides governance on the collection, storage, access and use of the survey data.

General practice

The following sections of this report focus on the general practice module of the survey. This consists of 19 questions that ask about patients' experience of accessing care, appointment and wait times, continuity, and their engagement in the clinic (Table 1).

While a different number of people responded to each survey question, on average in 2019 over 79,000 people answered each of the questions reported here. Of these respondents, around 6,500 were Māori, 1,900 were Pacific peoples, 3,900 were Asian and 67,000 were from other ethnic groups. This is calculated using prioritised ethnicity.

In this report, questions from the general practice module of the PCPES are divided into four topics and reported their own sections, concluding with suggestions of where providers might address local improvement activity. Appendix 3 contains further detail on each question, including the answer options, scoring and the topic that it corresponds to.

Table 1: Questions from the general practice module in the PCPES (underlined questions are reported in the health service access Atlas domain with a breakdown by DHB, age, ethnicity, gender and year)

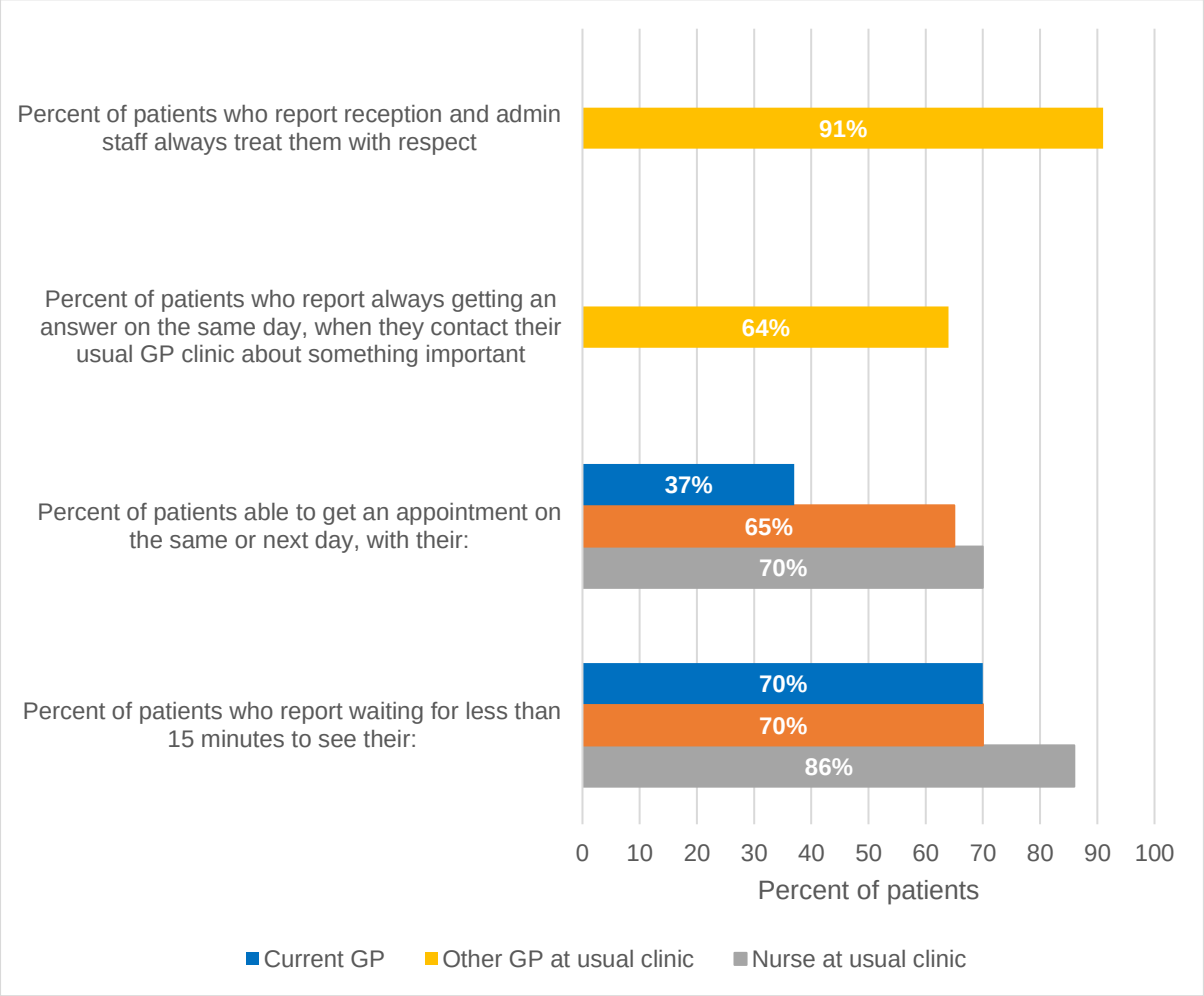
Appointments, wait times and reception
Did the reception and admin staff treat you with respect?
When you contact your usual GP clinic about something important, do you get an answer the same day?
When you ring to make an appointment, how quickly do you usually get to see… • your current GP? • any other GP at the clinic you usually go to? • a nurse at the clinic you usually go to?
How long do you usually have to wait for your consultation to begin with… • your current GP? • any other GP at the clinic you usually go to? • a nurse at the clinic you usually go to?
Access barriers
In the last 12 months, was there a time when you did not visit a GP or nurse because of cost?
Was there ever a time when you wanted health care from a GP or nurse but you couldn't get it?
Has cost stopped you from picking up a prescription?
Continuity
Is there one GP or nurse you usually see?
Are you confident that your GP or nurse is aware of your medical history?
Engagement
Does your GP or nurse explain things in a way that is easy to understand?
Have you been involved in decisions about your care and treatment as much as you wanted to be?
Does your GP or nurse… • treat you with respect? • treat you with kindness and understanding? • listen to what you have to say? • spend enough time with you?

General practice: Appointments, wait times and reception

Figure 3 summarises responses to the questions in this section.

Most patients (91 percent) agreed that reception and admin staff always treat them with respect. Two thirds of patients said they usually get an answer on the same day when they contact their usual GP clinic about something important. However, only 37 percent report being able to get a same- or next-day appointment with their usual GP, whilst two thirds could see another GP or nurse at their practice on the same or next day. Seventy percent of patients reported waiting less than 15 minutes to see a GP, and 86 percent reported waiting less than 15 minutes to see a nurse.

Figure 3: Responses to questions about appointments, wait times and reception



Did the reception and admin staff treat you with respect?

Reception and admin staff are typically the first point of health care contact for most patients. This interaction from making the appointment, juggling appointment availability, greeting patients on arrival and managing payment is a key aspect of making sure patients feel at ease. Research has highlighted that the role of reception staff is particularly important for patients with high health and social needs.[4]

It is for this reason that this question is grouped with other questions on appointment and wait times.

Overall, this question was answered positively, with 91 percent of patients reporting that reception and admin staff treated them with respect. This ranged from 82 to 94 percent of respondents by DHB. Younger people (aged 15–24 years) were less likely to report they were treated with respect, with agreement increasing linearly with age.

When you contact your usual GP clinic about something important, do you get an answer the same day?

There was some variation between DHBs in patients reporting they always get an answer on the same day from their usual GP clinic. In the lowest-scoring DHB, just under half of respondents reported always being able to get a same-day answer, compared with 69 percent of those in the highest-scoring DHB (Table 2).

Table 2: Responses to the question 'When you contact your usual GP clinic about something important, do you get an answer the same day?' by DHB

Responses	Mean	Lowest DHB	Highest DHB
Yes, always	64%	48%	69%
Yes, sometimes	32%	41%	27%
No	5%	11%	4%

Analysing the most positive response (yes, always) by age and ethnicity shows that Māori and Pacific peoples are less likely to report always being able to get an answer than those of Asian and other ethnic groups (Table 3). There is also an age effect, with younger people (aged 15–24) less likely to respond positively (48 percent) compared with those aged 75 and over (73 percent).

Even though those of 'other' ethnicity were less likely to respond positively at most ages, the 'other' ethnicity group had the highest percentage of positive responses overall because the group's population is generally older.

[4] Neuwelt PM, Kearns RA, IR Cairns. 2016. The care work of general practice receptionists. *Journal of Primary Health Care* 8(2): 122–9.

Table 3: Percentage of respondents who answered 'yes, always' to the question 'When you contact your usual GP clinic about something important, do you get an answer the same day?' by age and ethnicity

	Age group					
Ethnicity	**15–24 years**	**25–44 years**	**45–64 years**	**65–74 years**	**75+ years**	**Total**
Māori	49%	52%	62%	72%	77%	61%
Pacific peoples	58%	56%	61%	68%	73%	60%
Asian	53%	61%	65%	72%	73%	64%
Other	47%	52%	61%	70%	73%	64%
Total	48%	54%	61%	70%	73%	64%

We can't infer from these responses how serious the respondent's question was or what time of day they made contact; however, these findings do raise the question as to what patients do when they are unable to get an answer on the same day to something important. What proportion of patients go on to contact Healthline, after-hours services and EDs, and what proportion wait for a response or go without care?

Making an appointment: When you ring to make an appointment, how quickly do you usually get to see…

Of those who reported same- or next-day appointment availability:

- 37 percent saw their usual GP
- 65 percent saw another GP at their usual practice
- 70 percent saw a nurse at their usual practice.

Of those who reported within-a-week appointment availability:

- 86 percent saw their usual GP
- 95 percent saw another GP at their usual practice
- 98 percent saw a nurse at their usual practice.

When we look at these results by DHB, there is wide variation in the availability of appointments. In one DHB, 14 percent of respondents could get an appointment with their usual GP on the same or next working day, compared with 57 percent in another DHB. In one DHB, **over half of their patients report waiting for over a week for an appointment with their usual GP, compared with only 4 percent in the best performing DHB**.

Patients generally don't have to wait as long to see another GP at their usual clinic, but we still see up to 40 percent of patients waiting for over a week compared with 2 percent in the best performing DHB. Access to nurses is considerably higher, with 98 percent of respondents able to see a nurse within a week (Table 4).

Table 4: Appointment availability, by DHB

Survey question: When you ring to make an appointment, how quickly do you usually get to see…	Timeframe	DHB Mean	Lowest DHB	Highest DHB
your usual GP?	**Same or next working day**	37%	14%	57%
	Within a week	86%	47%	97%
	Over a week	14%	53%	4%
another GP at your clinic?	**Same or next working day**	65%	21%	79%
	Within a week	95%	60%	98%
	Over a week	5%	40%	2%
a nurse at your clinic?	**Same or next working day**	70%	44%	80%
	Within a week	98%	88%	100%
	Over a week	2%	12%	< 1%

What do patients say?

The questionnaire allows for patients to explain why the wait for an appointment was not acceptable to them. The following themes emerged.

- The patient had a condition that needed urgent attention – for example, it was getting worse (physical and mental), it was very painful, the patient was vulnerable, or they needed a prescription.
- It was difficult for the patient to get an appointment with their regular GP. This led to the patient feeling less confident/comfortable at consultation, loss of continuity of care, and it took more time for the GP to understand the patient's history. This was particularly the case in people with long-term conditions.

> 'I value patient/GP relationship. Hard to develop/maintain when dealing with multiple GPs. Regular GP not always available.'

- Appointments were not available at times that worked for the patient, meaning they had to take time off work, which used up sick leave or was taken without pay.
- Some patients described long waits of several weeks.
- Some patients sought care elsewhere – for example, after-hours services and EDs.

> 'Twice in the last 6 weeks I have been sent to after-hours because the time to see a Dr at the Dr practice has been too long. This is both costly and time consuming and as I have a breastfeeding newborn it has meant that I haven't had ailments seen to, to avoid waiting and because of the measles outbreak.'

Wait times in the clinic

On average, 70 percent of patients waited less than 15 minutes for their appointment to begin to see their usual or another GP, and 86 percent waited less than 15 minutes to see a nurse at their clinic (Table 5). This varied by DHB.

Table 5: Percentage of respondents who waited less than 15 minutes for their appointment to begin, by DHB

Survey question: How long do you usually have to wait for your consultation to begin with…	Mean	Lowest DHB	Highest DHB
your usual GP?	70%	54%	77%
another GP at your clinic?	69%	48%	76%
a nurse at your clinic?	86%	67%	91%

Long wait times in the clinic can create a barrier to access and poorer patient satisfaction.

What do patients say?

The questionnaire allows for patients to explain why the wait time in the clinic was not acceptable to them. The following themes emerged.

- The principle of having a booked appointment – if a time is booked, that's when the patient should be seen.
- It's uncomfortable when patients feel unwell or are in pain.
- It's not reciprocal. Patients reported having their appointments cancelled or being charged extra if they were late, whereas they are expected to wait with no explanation or apology.
- Patients feel the value of their time is not acknowledged, and it can make them feel disrespected.

> 'It makes you feel your time isn't valued. They could easily text and let you know they are running late.'

- For some patients there is a cost impact – for example, not being paid for time off work, having to pay for parking or keeping a taxi waiting.
- A long time in the clinic can impact on the rest of the day.
- Patients would like to be warned in advance so they can manage their time.

> 'A text or phone call if they are running behind time would be appreciated.'

- Patients also noted issues with being in the waiting room – for example, it can be difficult with children, it's uncomfortable, and there is a risk of infection.

Appointments, wait times and reception: Key questions to answer as a provider

We invite providers to answer the following questions:

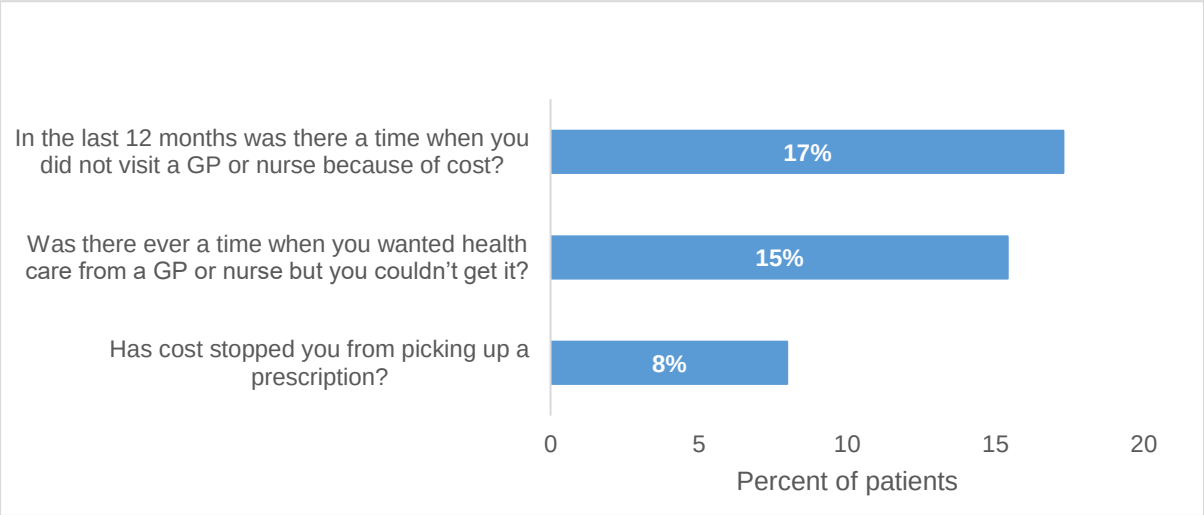
- What are the implications of patients waiting more than a week for an appointment?
- Are appointments triaged so that those who need an earlier appointment are prioritised?
- Are patients able to see their usual GP within a timeframe that is acceptable to them?
- What are patients saying about appointment availability in the free-text comments?
- Long wait times in the clinic can be frustrating for patients. Are patients informed of the wait time and given the option to be called back when their appointment is close?
- What are patients saying about the acceptability of wait times in the free-text comments?
- Which of your patients are less likely to report being treated with respect by reception and admin staff? What impact might this have on future health care interactions?

General practice: Access barriers

In 2019, on average:

- 17 percent of respondents reported not visiting their GP or nurse due to cost in the last year
- 15 percent reported that there was a time they wanted health care but couldn't get it
- 8 percent reported that cost stopped them from picking up a prescription (Figure 4).

Figure 4: Percentage of patients who answered 'yes' to questions about access barriers



Figures 5–*7* highlight the impact of age on the experience of barriers to access, with younger people of all ethnic groups more likely to report cost barriers than older people. At all ages, Māori and Pacific peoples are more likely to report both cost and other barriers to care than those of Asian and other ethnic groups. **Given that Māori and Pacific peoples experience a higher burden of disease at a younger age and have a younger population, they will be disproportionately affected.**

Figure 5: Percentage of patients who answered ‘yes’ to the question ‘In the last 12 months was there a time when you did not visit a GP or nurse because of cost?’ by age and ethnicity

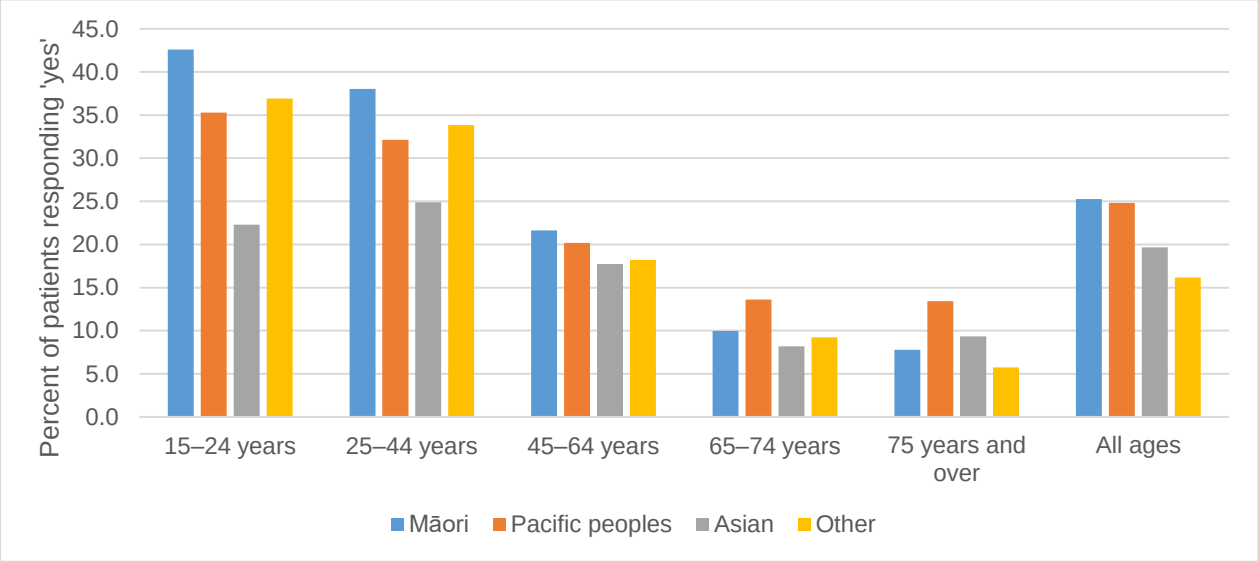


Figure 6: Percentage of patients who answered ‘yes’ to the question ‘Was there ever a time when you wanted health care from a GP or nurse but you couldn’t get it?’ by age and ethnicity

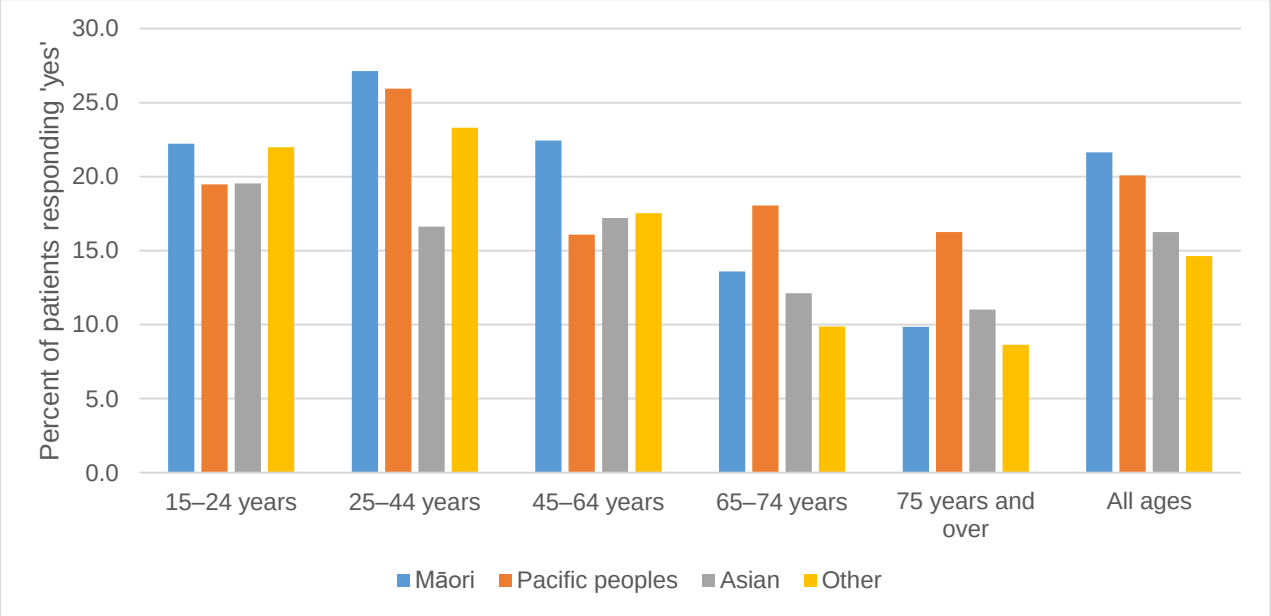
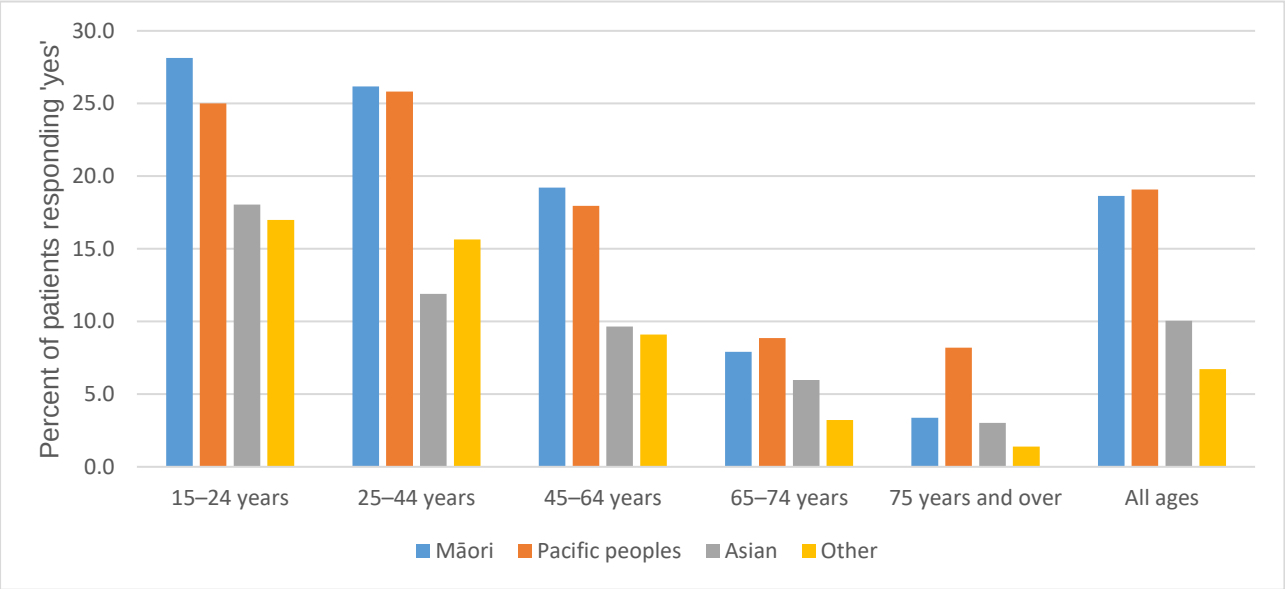


Figure 7: Percentage of patients who answered 'yes' to the question 'Has cost stopped you from picking up a prescription?' by age and ethnicity



What do patients say?

The questionnaire allows for patients to explain why they were not able to access health care from a GP or nurse when they wanted it. The following themes emerged.

- Patients did not have enough money; the appointment was too expensive.

  'We have had to pick and choose what health issues we address as this clinic charges high fees – even for ACC injuries.'

- Patients had no access to mental health and addiction (MHA) services, or their GP provided insufficient MHA support.
- People were unable to get appointments when needed. Reasons included the practice being too busy, not being able to get an appointment with their usual GP, needing after-hours care and needing care during holiday periods.

Access barriers: Key questions to answer as a provider

We invite providers to answer the following questions:

- Which population groups in your area are delaying important care?
- Does your population know how to access relevant subsidies and low-cost access practices? Is community services card information visible at practices?
- What is the impact of rurality?
- What impact does this have on ED presentations and acute demand?
- What are the common reasons your patients cite for not being able to get health care?
- Which of these can you modify? Can you work with consumers to co-design a better system?

- How are DHBs and PHOs working to deliver a model of care that can help people better afford primary care and prescriptions (eg, DHBs funding the cost of asthma preventers to reduce ED admissions)?
- What is the impact of delaying care for Māori health outcomes?

General practice: Continuity

Continuity of care is defined as seeing the same GP or nurse over a period of time. This is one of the hallmarks of general practice. Patients value establishing a relationship with a practitioner where the context of their lives and priorities are understood and health advice is tailored accordingly.[5]

Continuity of care in general practice is associated with greater patient satisfaction, improved health promotion, increased adherence to medication and reduced hospital use.[6]

There are three questions that are relevant:

- Is there one GP or nurse patients usually see?
- Are they confident their GP or nurse is aware of their medical history?
- How long have they been enrolled at their current practice?

The last question is not included in this report because responses reflect practice characteristics; however, it is useful to guide interpretation of the other two questions.

- Is there one GP or nurse you usually see?

  On average, 86 percent of patients saw the same GP or nurse. This varied by DHB from 39 to 89 percent.

- Are you confident that your GP or nurse is aware of your medical history?

  Three quarters of patients were confident their GP or nurse was aware of their medical history. This varied by DHB from 51 to 82 percent.

Continuity: Key questions to answer as a provider

We invite providers to answer the following questions:

- What proportion of your patients report having a usual GP or nurse? Does this proportion match your understanding?
- Are patients able to get an appointment to see their usual GP within a timeframe that is acceptable to them? If not, how might this be improved?
- Are your patients confident that their GP or nurse is aware of their medical history?
- How does awareness of medical history compare to the numbers of patients who report having a usual GP or nurse?
- How does awareness of medical history compare to the length of time patients have been enrolled at your practice?

[5] Sheridan NF, Kenealy TW, Fitzgerald AC, et al. 2019. How does it feel to be a problem? Patients' experiences of self-management support in New Zealand and Canada. *Health Expectations* 22(1): 34–5.
[6] Pereira Gray DJ, Sidaway-Lee K, White E, et al. 2018. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open* 8(6): e021161.

General practice: Engagement

This set of questions captures the heart of what a quality practitioner–patient relationship consists of: meeting patients physical and emotional needs, good communication and a partnership.

Physical and emotional needs

Table 6 shows that the percentage of patients who reported always being treated with respect and always being treated with kindness and understanding was high (95 and 93 percent respectively).

One in every five patients did not feel that their GP or nurse spent enough time with them. Spending enough time with patients acknowledges their effort of attending the appointment and ensures they have enough time to explain their symptoms and for their diagnoses and treatments to be properly explained.

Communication

Eighty-eight percent of patients agreed that their GP or nurse always explains things in a way they understand and always listens to what they say. Research shows that health care practitioners often interrupt patients when they are telling their story.[7] If health care practitioners just listen, most people don't talk for long, and they will report feeling that they have been listened to. As Sheridan et al (2019) note, 'The onus to facilitate communication and relationships with patients lies with health providers.'8

Partnership

On average, 82 percent of patients agreed that they were always as involved in decisions about their care and treatment as they wanted to be. In the lowest scoring DHB, only 65 percent of patients agreed.

[7] Phillips KA, Ospina NS. 2017. Physicians interrupting patients. *JAMA* 318(1): 93–4. https://doi.org/10.1001/jama.2017.6493

[8] Sheridan NF, Kenealy TW, Fitzgerald AC, et al. 2019. How does it feel to be a problem? Patients' experiences of self-management support in New Zealand and Canada. *Health Expectations* 22(1): 34–45.

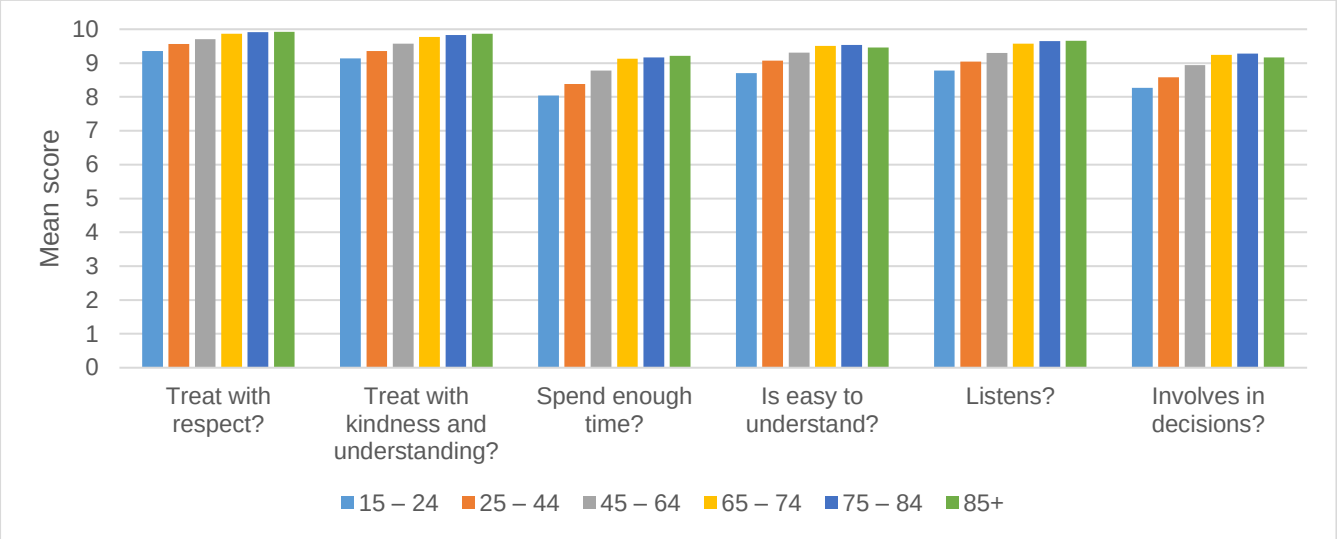
Table 6: Percentage of respondents who answered 'yes, always' to questions about engagement, by DHB

Domain	Question	Mean	Lowest DHB	Highest DHB
Physical and emotional needs	Does your GP or nurse treat you with respect?	95%	89%	98%
	Does your GP or nurse treat you with kindness and understanding?	93%	82%	97%
	Does your GP or nurse spend enough time with you?	80%	68%	89%
Communication	Does your GP or nurse explain things in a way that is easy to understand?	88%	78%	91%
	Does your GP or nurse listen to what you have to say?	88%	78%	91%
Partnership	Have you been involved in decisions about your care and treatment as much as you wanted to be?	82%	65%	87%

Figure 8 and Figure 9 show mean weighted scores for the six questions listed in Table 6. The scoring method is shown in Appendix 1, and the weighting method is provided in Appendix 4.

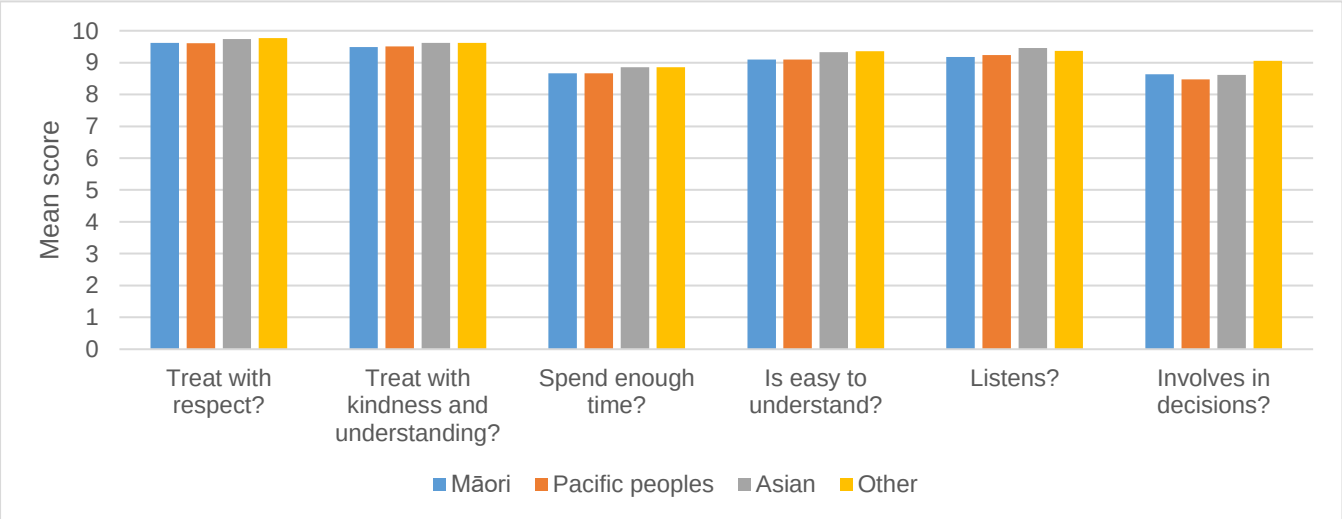
The mean scores below underscore the impact of age on experience: without exception, those aged 65 and over report a more positive experience than those aged less than 65 years.

Figure 8: Mean scores for the engagement questions, by age



The mean scores in Figure 9 show responses by ethnic group. Across the engagement questions, those of 'other' ethnicity reported a better experience than Māori and Pacific peoples. 15 – 24

Figure 9: Mean scores for the engagement questions, by ethnicity



These scores are not standardised to account for the different age structure between ethnic populations. Age-standardised analyses are available on the health service access Atlas domain. This shows that age-standardisation has a minimal impact on the overall score, and the relative trend between the groups remains consistent. That is, scores for Asian and other ethnic groups remain higher following age-standardisation.

The two lowest-scoring questions in this section were 'Did your GP or nurse spend enough time with you?' and 'Were you as involved in decisions about your care and treatment as much as you wanted to be?' For both questions, around a third of those aged 15–24 reported not enough time was spent with them and they were not as involved in decisions as they would have liked, compared with around 15 percent of those aged 65 and over reporting the same. Spending enough time with patients and making sure they are involved

in decisions about their care and treatment are critical components for ensuring patients feel empowered and able to take actions to improve their health.

Engagement: Key questions to answer as a provider

We invite providers to answer the following questions:

- If young people feel less involved in their care and treatment, might their understanding of their treatment plan also be impacted?
- Are there focus groups of young patients to understand why they have a less positive experience? Do you need to co-design a better way to engage young people?
- Do younger patients have a greater need for longer consultation times?
- What is the role of patient health status and multi-morbidity on patients reporting that their GP or nurse spends enough time with them?
- Is there a correlation with length of time with the same GP or nurse and other aspects of patient experience?
- Does the doctor's appointment schedule allow enough time for a visit? What processes are in place to understand how long different appointment types take? How are appointments that require extra time accounted for?
- Do patients know how long appointments are when they book?
- Do patients feel rushed and pressured for time when the clinic is behind schedule?
- At the time of the visit, is the doctor able to spend the amount of time needed to provide care to the patient, or are there competing priorities?
- Is the room prepared with the equipment needed for each visit? Is there enough time left at the end of each visit for the doctor to complete documentation?

Survey participation

Sapere conducted a formative evaluation of the PCPES programme in 2017 to assess how well the survey was working and what improvements could be made. The evaluation concluded that the participation rate was comparable with similar surveys nationally and internationally and identified some options to improve participation.

Since then, this issue has been considered further by the Patient Experience of Care Governance Group, and we have developed a series of national and local initiatives.

National initiatives to improve participation

National initiatives that have been implemented since 2017 include:

- creating survey flyers for sharing at practices to explain the survey (these have been translated into te reo Māori, Samoan and Tongan and are available on the Commission's website to download and print)
- creating a video explaining the survey that can be played at practices during survey week (these videos are available in English, te reo Māori, Samoan and Tongan to inform patients about the survey during survey week)
- increasing the profile of the survey.

A new contract has been let with a new survey provider with an explicit focus on improving participation. This has been combined with a review of the questionnaire in a series of workshops with the sector to refine and improve the questions.

An important change from 2020 onwards will be the availability of a helpline for all respondents to contact if they need support completing the questionnaire.

Initiatives that we will trial once surveying starts in 2020 include:

- re-designing the survey invitation to make sure it is culturally appropriate and conveys trustworthiness and the importance of responding
- monitoring the timing of sending survey invitations by different groups to find the optimal time of day
- pairing the sending of an invitation with an SMS message, which has been shown in other jurisdictions to be an effective way to improve participation (due to cost limitations in the number of SMS each quarter, this method may be focused on boosting participation in Māori and potentially Pacific peoples)
- trialling the use of zero-cost data for completing the survey
- monitoring email delivery statistics, including email bounce back rates, email opening rates and click through rates
- ensuring respondents have an appropriate user experience when completing the survey
- making improvements to support the sector, including changes to the reporting portal, the ability to customise and print local reports, combining the reporting portal for the two surveys and quarterly highlight reports.

Local initiatives to improve participation

PHOs and practices can increase engagement of their Māori and Pacific populations by:

- playing the patient experience survey videos available in te reo Māori, Samoan and Tongan to inform patients about the survey during survey week
- using kaiāwhina and health navigators to distribute flyers about the survey
- demonstrating the value of the survey to front desk staff (eg, by sharing survey feedback with the team)
- supporting front desk staff during survey week to engage with Māori and Pacific patients to collect email addresses and encourage survey completion
- demonstrating the value of the survey to the patients (eg, using posters to share improvements that have been made because of survey feedback).

Data for quality improvement at the practice level

This section of the report looks at what needs to happen to ensure practices are getting a sufficient number of responses each quarter, what contributes to this, and what actions may lead to an improvement. As a general rule, the Commission recommends that for quantitative feedback, a minimum of 30 responses is required in order to draw conclusions from the data. There is no minimum number of responses required for qualitative feedback; each comment is valued, and individual comments can provide considerable insight.

Each practice needs to send around 140 email invitations every quarter in order to reach 30 responses.

This analysis focuses on email invitations, as 96 percent of invitations are sent via email. SMS invitations are costly to send in New Zealand and in the past have had a much lower response rate than email. Invitation by SMS is capped to 5,500 per quarter. In order to improve participation among Māori and Pacific patients, the SMS allocation is used only for Māori and Pacific patients who do not have an email address but who do have a mobile phone number.

All eligible patients with an email address receive a survey invitation.

Based on the current response rate of around 22 percent, around 140 invitations need to be sent in order to achieve a minimum of 30 responses each quarter.

Data from the National Enrolment Service (NES) allows us to analyse qualifying encounter dates to identify potential survey candidates during the survey sample week. A qualifying encounter date is the date a patient was provided with clinical health services by a member of the general practice team – that is, the date of a consultation.

The survey inclusion criteria are applied to the qualifying encounter dates with a consultation date in the relevant survey period.

People were excluded from the survey for the following reasons.

- About 20 percent were under 15 years of age.
- On average, 1.5 percent opt out (see below for more detail on opting out).
- About 4 percent were invited in the previous survey round (in this case in August 2019 survey).
- Less than one percent had a date of death recorded.

This leaves the eligible candidate pool. Only 4 percent of potential candidates were excluded due to being invited in the previous survey quarter. This is partly a reflection of the survey periods not being perfectly aligned to a quarterly schedule, with the gap ranging between 9 and 13 weeks.

Opting out

On average, 1.5 percent of patients opt out at the practice. A small number of practices had much higher opt out rates.

It is important to make sure people have the chance to say 'no' to participating in the survey and that there are multiple ways for people to opt out. It is possible that people may wish to provide feedback on their experience at another time, so we encourage people not to opt out permanently from the survey. It is better they ignore the invitation at the time if they don't have any feedback but keep the option open to provide feedback in the future.

Unsubscribe

Patients may also use the unsubscribe button at the end of the email invitation to opt out of the survey. Since the survey began in February 2016, 11,304 unique email addresses have used this function. This represents under 2 percent of those who were sent a survey invitation.

Forty-six percent of eligible candidates did not have an email address recorded in November 2019

Table 7 shows the number and percentage of eligible candidates who had contact details and were sent an invitation for the November 2019 survey round. Overall, 54 percent of the pool of eligible candidates had an email address, and 2 percent were invited via SMS. Forty-six percent of the pool did not have a valid email address recorded.

Table 7: Number and percentage of eligible candidates who were sent a survey invitation

	Number of people	Percent
Eligible candidate pool November 2019	236,186	
No contact details	103,075	44%
Email address	127,611	54%
SMS candidate	5,500	2%
Total invited (email plus SMS)	133,111	56%

Instructions for recording email addresses in the practice management system are available on the Commission's website (www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/primary-care-patient-experience/resources/). Instructions are available for best practice, Medtech, and MyPractice.

Email collection rates are proportionally lower for Māori and Pacific peoples

Table 8 shows that there are ethnic differences in email address collection, with much lower rates of collection for Māori and Pacific peoples. It is critical to improve email collection rates for these groups.

Table 8: Email address collection rates, by ethnicity

Prioritised ethnicity	Email collected (%)
Māori	39.9%
Pacific peoples	36.3%
Asian	60.4%
Other	56.6%
Total	54.0%

A note on email and phone address collection

While it is best practice to collect individual email addresses for the survey, the Office of the Privacy Commissioner has confirmed that shared email addresses (eg, familyinbox@gmail.co.nz) are acceptable. This is because the email invitation is personally addressed, so it is clear who is being invited to complete the survey. The wording of the email does not disclose recent attendance.

Shared mobile phone numbers (eg, with a spouse) are not used for survey invites. This is because the text invite is short and does not include a salutation, so it would not be clear who the invitation is for.

Shared mobile phone numbers are identified in the NES by removing duplicate mobile contacts from the invitation list. Additionally, mobile phone numbers with a text suffix are also excluded (eg, 021 123 456 wk) to avoid sending invitations to work phones that may be shared.

Given the number of invitations sent, not all practices will achieve a sufficient number of responses each quarter.

Summary: Survey participation

Our goal is to ensure that all eligible candidates are given the opportunity to participate. The national digital inclusion framework (see 'Digital inclusion' in Appendix 1) will improve the ability of some groups to participate, and there are actions at the national and local levels that may improve participation.

In November 2019, 46 percent of eligible candidates did not have an email address recorded in the NES. Email collection rates were proportionally lower for Māori and Pacific peoples. Instructions for recording email addresses in the practice management system are available on the Commission's website.[1]

Recommendations

Email address collection is a key driver to obtain responses at the practice level. If your practice is not reaching 30 responses a quarter, firstly confirm your data is being sent to the NES. NES champions can provide advice in PHOs.

Small practices that typically see less than 140 eligible candidates over the sample week can combine data over survey quarters to ensure that improvement activities are based on robust data.

Questions to consider:

- What is your email collection rate?
- Are you taking steps to ensure the accuracy of email addresses (eg, confirm details are correct at least once a year)?
- Are you asking all patients aged 15 and over for their email address? Are you collecting email addresses at a similar rate for Māori and Pacific peoples as for Asian and other ethnicities?
- How many invitations are you sending each quarter?
- Are your response rates markedly lower than the national average?
- Are you monitoring the number of patients opting out of the survey?

1. www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/primary-care-patient-experience/resources/#[4]

Appendix 1: Survey process

There are four steps in the survey process.

1. **Capturing patient contact details**
   Patient contact information to be used in the survey is captured within the practice management systems. This information is uploaded regularly to the Ministry of Health's NES database. Practices can update the NES database in near real time through their practice management system.
2. **Identifying eligible patients**
   Patients who attend their general practice during the survey sample week are identified by their encounter date in the NES. The survey inclusion and exclusion criteria are applied to this sample to create a list of eligible patients.
3. **Sending invitations**
   Invitations to participate in the survey are sent to patients via email. A sample (5,500 per quarter) of Māori and Pacific patients who do not have an email address are invited by text message. Patients complete the survey online via any web-based browser, mobile phone or tablet computer.
4. **Reporting results**
   Data users at individual practices, PHOs, DHBs, the Commission and the Ministry of Health have varied levels of access to a reporting portal to view survey results.

Survey inclusion and invitation

Inclusion and exclusion criteria

Patients aged 15 years and over who have received a consultation (defined per the PHO services agreement) from the primary care service provider they are enrolled with during the survey sample week receive a survey invitation.

Exclusions: children under 15 years; people who were invited to participate in the previous quarter; people with a date of death.

The survey runs every three months (four times a year). The survey timetable is on the Commission's website.[9]

Collection method

The PCPES is a self-complete electronic online survey. This is an efficient way to collect a large number of responses. Most patients selected for surveying are contacted by email (as a preference due to low cost and higher response rate), and 5,500 Māori and Pacific peoples with no email address are contacted via SMS. Each survey invitation comes with a unique online survey link to click on or type into an internet browser to submit responses. All online links expire three weeks from the time the initial survey invitation is sent.

[9] www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/primary-care-patient-experience/resources/#[3]

Digital inclusion

The Government has a vision for digital inclusion[10] for New Zealanders that goes beyond access to the internet alone. There are four elements that are considered necessary for a person to be considered digitally included: motivation, access (connectivity, affordability, accessibility), skills, and trust.

Previous initiatives mean there are now very few parts of New Zealand where internet is not physically available. For example, the completed rural broadband initiative gives 90 percent of rural households and businesses broadband. Ninety-nine percent of all internet connections use broadband, and over 70 percent of all broadband internet connections have no data cap.

As part of the COVID-19 response, the Ministry of Education undertook an initiative to address the affordability issue by providing an estimated 80,000 school students with digital devices and internet connections.

These initiatives will mean that, increasingly, those who were unable to participate historically will now have access. However, absence of internet access is concentrated among poorer populations, rural communities and people aged 75 and older, some of whom may be high users of health services.

A targeted approach to survey-specific cohorts, such as in situ, focus groups or face-to-face, may be a good way to supplement the findings from the online survey.

Survey sample

The PCPES is the largest health survey in New Zealand and is second in size only to the census. The Commission's approach for the PCPES is essentially a census seeking to get as many responses as possible among all eligible contactable patients. In designing the survey, three potential risks were identified:

1. too small a sample of respondents, leading to excessively wide confidence intervals and unstable results, which make changes hard to interpret
2. a sample unrepresentative of those who attend primary care
3. response bias (ie, respondents with unrepresentative opinions – more or less content with their experiences than the average – being more likely to respond).

These risks have been mitigated or assessed not to have an impact, as follows.

1. A large sample is drawn. The Commission aims deliberately to over-sample high users of health services, which is why this survey is given to all eligible adults receiving services, rather than simply the PHO-enrolled population.
2. National reports apply weighting statistics based on who attends primary care. If a group is under- or over-represented in responses, their response is either up- or down-weighted to correct for this.

[10] www.digital.govt.nz/dmsdocument/167~digital-inclusion-outcomes-framework/html#vision-for-digital-inclusion-in-new-zealand

3. Response bias is not significant. Results published in the *New Zealand Medical Journal* showed that there were no statistically significant differences in how people who didn't respond to the survey would have answered questions.[11]

Limitations

The survey sample does not include:

- those not enrolled with a PHO – this may include students who access student-health centres and homeless people
- those with no internet access or mobile phone.

There are also a small number of practices that are unable to participate in the survey because their practice management systems do not allow capture of patient preferences. The Ministry of Health has been working with the vendor to try and get this to happen.

Email and mobile phone collection

As most survey invitations are sent to patients via email, invitation relies on practices collecting and accurately recording patient email addresses.

Email notification and online collection

All eligible patients with an email address receive a survey invitation. If the patient has not completed the survey within seven days, they will receive a reminder. After 21 days from the original send date, the survey link will expire.

SMS notification and online collection

Up to 5,500 patients who identify as Māori or Pacific without an email address but with a mobile phone number will be sent an SMS invitation to complete the survey each quarter. If the patient has a smartphone, they can click on the link to complete the survey on their phone. If they have a standard mobile phone, they can go to the web page (www.myexperience.health.nz) in any device's internet browser, enter a short code (that is in the SMS message) and complete the survey online. After 21 days, the survey link will expire.

Invitations and reminders

Invitations are then sent promptly on receipt by the survey provider. This aims to minimise the risk of the patient's circumstances having changed, and this may include their death. Patients with a recorded date of death are excluded from the NES file; however, it can take up to three months for systems to be updated following a patient's death. While there is no way to entirely remove the risk of sending a survey or reminder to the family of someone who has died, it can be mitigated by minimising the timeframes.

Evidence shows that a reminder will generate further responses of around one third to a half that the original survey contact achieves. For this reason, the Commission includes a reminder seven days after the initial contact of the patient.

[11] Thomson M, Pledger M, Hamblin R, et al. 2018. Comparing initial and follow-up responders to a New Zealand patient experience survey. *New Zealand Medical Journal* 131(1482): 46–58.

During the pilot phase, the Commission tested sending a second reminder, but this generated negative feedback from patients who were 'sick of receiving texts'.

Opting out

Patients can opt out of the survey permanently in two ways:

1. by asking reception staff to opt them out in the patient preferences field on the practice management system
2. by clicking the 'unsubscribe' button at the bottom of the survey email invitation. This will stop their email address ever being included in future survey invitations.

Instructions for opting patients out via the practice management system are available here: www.hqsc.govt.nz/ourprogrammes/health-quality-evaluation/projects/patient-experience/primary-care-patientexperience/resources.

Frequency of surveying

The survey runs every three months (four times a year). The survey timetable is on the Commission's website.

For national reporting purposes and consistency, the survey will be sent to patients seen within the same one-week period in each quarter in each participating practice. The one-week period chosen avoids public holidays and provides a series of snapshots over the course of a year. The number of weeks between each survey period varies, in part due to the avoidance of public holidays. This reduces the likelihood of sampling (and excluding from every second survey) patients who are on regular three-monthly appointments.

Scoring

The questions used in this analysis are directional; that is, we know what answer represents the most positive experience. This means we can use all the data in the survey to create scores out of 10 for each question.

All answers are assigned a value based on the Picker scoring methodology[12] (eg, 10 = Excellent, 0 = Poor; 10 = Yes/Completely, 5 = Yes/To some extent, 0 = No).

The question scores are calculated by adding the 'score calculation' of all responses and dividing by the total 'number of responses'.

Table 9 shows an example of how the performance ratings are calculated for each question.

[12] www.cqc.org.uk/sites/default/files/20151125_nhspatientsurveys_scoring_methodology.pdf

Table 9: Calculating question score example

Survey question: Have you been involved in decisions about your care and treatment as much as you wanted to be?

Response option	Number of responses	Percentage of respondents	Score assigned	Score calculation
Yes	328	82.0%	10	3,280
Yes, sometimes	64	16.0%	5	320
No	8	2.0%	0	0
Total	**400**			**8.9 (3,600/400)**

Appendix 2: Survey questionnaire 2019 mapped to 2020 questionnaire

All of the questions reported here are retained in the updated questionnaire, and the majority have been slightly adjusted to make them easier for the respondent to answer or to clarify aspects such as time period. The 2020 questionnaire asks patients at the start of the survey which health care practitioner they saw most recently and then pipes this response to subsequent questions. Response options are a GP/doctor, a nurse or nurse practitioner, a mental health professional, or another health care professional. The piping is shown in [brackets] below.

2019 questions	2020 questions
Appointments, wait times and reception	
Did the reception and admin staff treat you with respect?	And on this occasion, did the reception and/or admin staff treat you with respect?
When you contact your usual GP clinic about something important, do you get an answer the same day?	In the last 3 months when you contacted your GP/nurse clinic about something important (other than booking an appointment), did you get an answer the same day?
When you ring to make an appointment, how quickly do you usually get to see… • your current GP? • any other GP at the clinic you usually go to? • a nurse at the clinic you usually go to?	When you made the appointment, how quickly were you able to be seen by [a GP/doctor, a nurse or nurse practitioner, a mental health professional, another health care professional, please specify]?
How long do you usually have to wait for your consultation to begin with… • your current GP? • any other GP at the clinic you usually go to? • a nurse at the clinic you usually go to?	When you arrived at your GP/nurse clinic, how long after your booked time did you have to wait for your appointment to begin with [a GP/doctor, a nurse or nurse practitioner, a mental health professional, another health care professional, please specify]?
Access barriers	
In the last 12 months was there a time when you did not visit a GP or nurse because of cost?	In the last 12 months, which of the following has happened to you? I did not visit a GP or nurse because the appointment was too expensive.
Was there ever a time when you wanted health care from a GP or nurse but you couldn't get it?	In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it?
Has cost stopped you from picking up a prescription?	In the last 12 months, which of the following has happened to you? I did not pick up medicine because of the cost.
Continuity	
Is there one GP or nurse you usually see?	Is there one [healthcare professional] you usually see?

Are you confident that your GP or nurse is aware of your medical history?	Were you confident that the [healthcare professional] knew enough about your medical history?
Engagement	Did the [GP, nurse, mental health professional or health care professional]:
Does your GP or nurse treat you with respect?	treat you with respect?
Does your GP or nurse treat you with kindness and understanding?	treat you with kindness and understanding?
Does your GP or nurse spend enough time with you?	spend enough time with you?
Does your GP or nurse explain things in a way that is easy to understand?	explain things in a way you could understand?
Does your GP or nurse listen to what you have to say?	listen to you?
Have you been involved in decisions about your care and treatment as much as you wanted to be?	involve you as much as you wanted to be in making decisions about your treatment and care?

Appendix 3: Interpreting each question

	Question	Description	What questions might you ask?
Access barriers	**In the last 12 months, was there a time when you did not visit a GP or nurse because of cost?**	The question seeks to quantify unmet need for primary care due to cost in a cohort of patients who are able to access primary care to some extent. Affordability is a combination of service cost and related expenses such as cost to get there, childcare, and opportunity cost, such as time off work. Poor access to primary care is associated with inadequate prevention and management of chronic diseases, delayed diagnoses, incomplete adherence to treatments, overuse of drugs and technologies, and coordination and safety problems.[13] Delaying primary care can lead to more serious illnesses and hospital admissions.[14] The results from this survey aligns with data from 2018/19 New Zealand Health Survey, which reports 15 percent of people not accessing their GP due to cost in the year, and the Commonwealth Fund International Health Policy Surveys (2016), where New Zealand ranks third-worst of the 11 countries surveyed with 18 percent of New Zealanders reporting a cost-barrier to care.	• Which population groups in your area are delaying important care? • Does your population know how to access relevant subsidies and low-cost access practices? Is community services card information visible at practices? • What is the impact of rurality? • What impact does this have on ED presentations and acute demand?
	Was there ever a time when you wanted health care from a GP or nurse but you couldn't get it?	This question looks at the ability of people to receive health care from their GP or nurse when they want it. An answer of yes to this question highlights unmet need for GP or nurse care; however, there are many reasons for this response.	• What are the common reasons your patients cite for not being able to get health care? • Which of these can you modify? Can you work with consumers to co-design a better system?

[13] Schneider EC, Sarnak DO, Squires D, et al. 2017. *Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care*. Commonwealth Fund. https://interactives.commonwealthfund.org/2017/july/mirror-mirror/

[14] Milne BJ, Parker K, J McLay et al. 2015. Primary health care access and ambulatory sensitive hospitalizations in New Zealand. *Journal of Ambulatory Care Management* 38(2): 178–87. https://doi.org/10.1097/JAC.0000000000000057

	Question	Description	What questions might you ask?
		A low score in this question may highlight unmet need. It is recommended that you review patient comments as to why they weren't able to get health care when they wanted it.	
	Has cost stopped you from picking up a prescription?	This highlights patients who have paid the appointment cost but have not been able to afford the medicine cost. This is a missed opportunity to receive a medicine deemed by a prescriber as likely to have clinical benefit. Further research to determine which medicines people are not getting dispensed is required, although it is likely that some of these reflect barriers to long-term condition management and have been highlighted in other Atlas domains, such as gout, asthma and diabetes.	• How are DHBs and PHOs working to deliver a model of care that can help people better afford primary care and prescriptions (eg, DHBs funding the cost of asthma preventers to reduce ED admissions)? • Do you know which pharmacies in your area are offering zero prescription fees?
Appointments, wait times and reception	**When you contact your usual GP clinic about something important, do you get an answer the same day?**	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0).	• If patients are not able to get a same-day answer to an important question, what do they do? How many seek alternatives, such as calling Healthline or visiting after-hours services or EDs? • How many patients delay care? Does this impact on outcomes?
	When you ring to make an appointment, how quickly do you usually get to see… • **your current GP?** • **any other GP at the clinic you usually go to?** • **a nurse at the clinic you usually go to?**	The answer options are: • same day • next working day • within a week • over a week. These are scored as: • same or next working day (10)	• What are the implications of patients waiting more than a week for an appointment? • Are appointments triaged so that those who need an earlier appointment are prioritised?

	Question	Description	What questions might you ask?
		• within a week (5) • over a week (0). This set of questions looks at how long patients report waiting to get an appointment at their usual clinic. A follow-on question asks patients whether the wait time is acceptable to them (yes or no), with free-text for those who answer no.	• Are patients able to see their usual GP within a timeframe that is acceptable to them? • What are patients saying about appointment availability in the free-text comments?
	How long do you usually have to wait for your consultation to begin with… • **your current GP?** • **any other GP at the clinic you usually go to?** • **a nurse at the clinic you usually go to?**	The answer options are: • 5 minutes or less • 6–15 minutes • 16–30 minutes • more than 30 minutes. These are scored as: • 0–15 minutes (10) • 16–30 minutes (5) • more than 30 minutes (0). A follow-on question asks patients whether the wait time is acceptable to them (yes or no), with free-text for those who answer no.	• Long wait times in the clinic can be a source of frustration for patients. Are patients informed of the wait time and given the option to be called back when their appointment is close? • What are patients saying about the acceptability of wait times in the free-text comments?
	Did the reception and admin staff treat you with respect?	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0). Reception and admin staff are typically the first point of health care contact for most patients. This interaction from making the appointment, juggling appointment availability, greeting patients on arrival and managing payment is a key aspect of ensuring patients	• Which of your patients are less likely to report being treated with respect? What impact might this have on future health care interactions?

	Question	Description	What questions might you ask?
		feel at ease. This is particularly important for patients with high health and social needs.[15]	
Continuity	**Is there one GP or nurse you usually see?**	The answer options are yes (10) or no (0). Continuity of care is defined as seeing the same GP or nurse over a period of time. This is one of the hallmarks of general practice. There is strong evidence that patients 'value relationships with providers that were characterized by listening, caring and shared decision making; were supported by continuity of care; and where providers knew the context of their lives and acted upon this knowledge'.[16] Repeated contact gives patients and doctors the opportunity for improved understanding of each other's views and priorities. Continuity of care can be considered to be a proxy measure for the strength of patient–doctor relationships. Continuity of care in general practice is associated with greater patient satisfaction, improved health promotion, increased adherence to medication and reduced hospital use.[17]	• What proportion of your patients reporting having a usual GP or nurse? Does the proportion seem about right? • Are patients able to get an appointment to see their usual GP within a timeframe that is acceptable to them? • Are your patients confident that their GP or nurse is aware of their medical history? • How does awareness of medical history compare to the numbers of patients who report having a usual GP or nurse? • How does awareness of medical history compare to the length of time patients have been enrolled at your practice?
	How long have you been going to your current GP or nurse clinic?	The answer options are: • less than one year • one to five years • more than five years. Answers are not scored.	

[15] Neuwelt PM, Kearns RA, IR Cairns. 2016. The care work of general practice receptionists. *Journal of Primary Health Care* 8(2): 122–9.
[16] Sheridan NF, Kenealy TW, Fitzgerald AC, et al. 2019. How does it feel to be a problem? Patients' experiences of self-management support in New Zealand and Canada. *Health Expectations* 22(1): 34–5.
[17] Pereira Gray DJ, Sidaway-Lee K, White E, et al. 2018. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open* 8(6): e021161.

	Question	Description	What questions might you ask?
	Are you confident that your GP or nurse is aware of your medical history?	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0) • don't know.	
Engagement	**Does your GP or nurse treat you with respect?**	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0).	• How can this be changed? Research shows that health care practitioners often interrupt patients when they are telling their story.[18] If health care practitioners just listen, most people don't talk for long, and they will report feeling that they have been listened to. • What is the role of patient health status and multi-morbidity on patients reporting that their GP or nurse spends enough time with them? • Are there focus groups of young patients to understand why they have a less positive experience? Do you need to co-design a better way to engage young people? Do younger patients have a greater need for longer consultation times
	Does your GP or nurse treat you with kindness and understanding?	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0).	
	Does your GP or nurse spend enough time with you?	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0). **Physical and emotional needs** Analysis of survey responses find scores for this question correlate strongly with scores for questions on kindness and understanding, and being treated with respect. This suggests this question is a good marker for the quality of the interaction. That is, patients who report their GP or nurse spends enough time with them also report they are treated kindly and with respect. Spending enough time with patients acknowledges their effort of	

[18] Phillips KA, Ospina NS. 2017. Physicians interrupting patients. *JAMA* 318(1): 93–4. https://doi.org/10.1001/jama.2017.6493

	Question	Description	What questions might you ask?
		attending the appointment and ensures they have enough time to explain their symptoms and for their diagnoses and treatments to be properly explained.	or do they access different types of medical centre? • Is there a correlation with length of time with the same GP or nurse? • Have local young people been asked how they would like to be involved in decisions about their care and treatment? Are there groups you could engage with? • If young people feel less involved in their care and treatment, might their understanding of their treatment plan also be impacted?
	Have you been involved in decisions about your care and treatment as much as you wanted to be?	The answer options are: • yes (10) • yes, to some extent (5) • no (0). Being involved in decisions about care and treatment as much as is wanted is a critical component of ensuring patients accept practitioner's advice.	
	Does your GP or nurse explain things in a way that is easy to understand?	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0) • N/A.	
	Does your GP or nurse listen to what you have to say?	The answer options are: • yes, always (10) • yes, sometimes (5) • no (0).	

Appendix 4: Weighting

Weighting of scores for this report uses the population structure of those who attended primary care in each DHB and compares this with the sample structure (ie, those who responded to the survey). This creates a co-efficient that is applied to the results of the survey. This then increases or decreases a particular score and provides a weighted result. This approach is distinct from standardisation. We are not seeking to compare DHBs with each other using this method. Rather, we are seeking to weight the scores so that the results accurately reflect the views of a representative local population who attend primary care inside a DHB.

Weighted scores for individual questions at each DHB give different values to responses, effectively reflecting how many patients of a different age, gender and ethnicity each respondent is representing. The more over-represented a particular group among the responders, the fewer total patients each responder represents, and thus the response is down-weighted and vice versa.

Appendix 5: Practice low and high responses

Table 10 shows the percentage of patients who answered most positively to the questions. Responses in the low or high category are one standard deviation above or below the mean, that is, are significantly higher or lower.

Table 10: Percentage of patients who gave the most positive answers to the survey questions

Question	Practice average	Low alert level (potential to improve)	High alert level (potential leader)
Did the reception and admin staff treat you with respect?	91%	83%	98%
When you contact your usual GP clinic about something important, do you get an answer the same day?	64%	50%	78%
When you ring to make an appointment, how quickly do you usually get to see your usual GP? (responded within a week)	37%	11%	63%
When you ring to make an appointment, how quickly do you usually get to see another GP? (responded within a week)	65%	43%	87%
When you ring to make an appointment, how quickly do you usually get to see a nurse? (responded within a week)	70%	52%	87%
How long do you usually have to wait for your consultation to begin with your usual GP? (responded 15 minutes or less)	70%	51%	90%
How long do you usually have to wait for your consultation to begin with another GP? (responded 15 minutes or less)	70%	50%	89%
How long do you usually have to wait for your consultation to begin with a nurse? (responded 15 minutes or less)	86%	72%	99%
In the last 12 months was there a time when you did not visit a GP or nurse because of cost?	83%	74%	92%

Was there ever a time when you wanted health care from a GP or nurse but you couldn't get it?	85%	75%	94%
Has cost stopped you from picking up a prescription?	92%	84%	100%
Is there one GP or nurse you usually see?	86%	71%	100%
Are you confident that your GP or nurse is aware of your medical history?	77%	63%	90%
Does your GP or nurse treat you with respect?	95%	90%	100%
Does your GP or nurse treat you with kindness and understanding?	93%	86%	100%
Does your GP or nurse spend enough time with you?	80%	69%	91%
Does your GP or nurse explain things in a way that is easy to understand?	88%	80%	97%
Does your GP or nurse listen to what you have to say?	88%	80%	97%
Have you been involved in decisions about your care and treatment as much as you wanted to be?	82%	72%	92%

Table 11 shows the percent of respondents by DHB who reported waiting over a week for an appointment.

Table 11: Percentage of respondents who waited for over a week for an appointment, by DHB

DHB	Usual GP	Any GP	Nurse
South Canterbury	4%	2%	0.3%
Auckland	5%	2%	1.1%
Waitematā	8%	2%	1.1%
Bay of Plenty	8%	2%	1.2%
Southern	8%	2%	0.9%
Counties Manukau	11%	3%	1.5%
Canterbury	11%	2%	1.3%
Capital & Coast	13%	5%	3.7%
Whanganui	14%	10%	2.7%
Waikato	15%	6%	1.8%
Nelson Marlborough	17%	7%	1.8%

Hawke’s Bay	17%	10%	3.8%
Hutt Valley	19%	5%	2.7%
Tairāwhiti	22%	12%	1.4%
Taranaki	22%	10%	3.9%
Northland	25%	10%	2.7%
Lakes	25%	6%	1.8%
Wairarapa	34%	8%	2.2%
West Coast	42%	40%	11.0%
MidCentral	53%	28%	11.7%