### ACCESSING YOUR GP SERVICES

**Q1** When did you last see or speak to a GP from your GP surgery?
- [ ] In the past 3 months
- [ ] Between 3 and 6 months ago
- [ ] Between 6 and 12 months ago
- [ ] More than 12 months ago
- [ ] I have never seen a GP from my GP surgery

**Q2** When did you last see or speak to a nurse from your GP surgery?
- [ ] In the past 3 months
- [ ] Between 3 and 6 months ago
- [ ] Between 6 and 12 months ago
- [ ] More than 12 months ago
- [ ] I have never seen a nurse from my GP surgery

**Q3** Generally, how easy is it to get through to someone at your GP surgery on the phone?
- [ ] Very easy
- [ ] Fairly easy
- [ ] Not very easy
- [ ] Not at all easy
- [ ] Haven't tried

### HOW DO YOU normally book your appointments to see a GP or nurse at your GP surgery?
- Please *X* all the boxes that apply to you

**Q6** How do you normally book your appointments to see a GP or nurse at your GP surgery?
- [ ] In person
- [ ] By phone
- [ ] By fax machine
- [ ] Online
- [ ] Doesn't apply

**Q7** Which of the following methods would you prefer to use to book appointments at your GP surgery?
- Please *X* all the boxes that apply to you

**Q8** Is there a particular GP you usually prefer to see or speak to?
- [ ] Yes
- [ ] No
- [ ] There is usually only one GP in my GP surgery

**Q9** How often do you see or speak to the receptionists?
- [ ] Always or almost always
- [ ] A lot of the time
- [ ] Some of the time
- [ ] Never or almost never
- [ ] Not tried at this GP surgery

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7 July 2016

GP Patient Survey – Technical Annex

2015-2016 annual report
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Introduction
1 Introduction

This technical annex provides details of the 2015-2016 GP Patient Survey (GPPS) conducted by Ipsos MORI. The survey was conducted on behalf of NHS England.

This is the tenth year that the GPPS has been conducted in England. Since 2011 the survey has taken place twice a year, having previously been conducted on a quarterly basis (April 2009 - March 2011) and annually (January 2007 - March 2009).

The survey uses a quantitative postal methodology with questionnaires sent to around 2.15 million patients across two waves, from July to September and January to March. In July 2015, around 1.07 million adult patients registered with a GP in England were sent a questionnaire, followed by a postcard reminder one week after the initial mailing and full reminder mailings to non-responders sent in August and September. In January 2016, a further 1.08 million adult patients were sent the questionnaire and postcard reminder, with full reminders again sent in the two months following the initial mailing.

A purple-coloured questionnaire was sent out in the July-September 2015 wave and a blue questionnaire was sent in the January-March 2016 wave in order to easily distinguish between the two unique sets of patients invited to take part.

Published results for GPPS are based on aggregated data collected across two separate waves of fieldwork. Table 1.1 outlines the timings for the mailings in 2015-2016, along with the dates when results were first published using responses from these specific fieldwork periods.

Table 1.1 – Survey mailout and publication dates

<table>
<thead>
<tr>
<th>Initial survey sent</th>
<th>Wave 1</th>
<th>Wave 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postcard reminder sent</td>
<td>1 July 2015</td>
<td>4 January 2016</td>
</tr>
<tr>
<td>First reminder sent</td>
<td>8 July 2015</td>
<td>11 January 2016</td>
</tr>
<tr>
<td>Second reminder sent</td>
<td>3 August 2015</td>
<td>1 February 2016</td>
</tr>
<tr>
<td>Colour</td>
<td>1 September 2015</td>
<td>1 March 2016</td>
</tr>
<tr>
<td>Purple</td>
<td>Purple</td>
<td>Blue</td>
</tr>
<tr>
<td>First results published</td>
<td>7 January 2016 (based on Jan-Mar 2015 and Jul-Sep 2015 fieldwork combined)</td>
<td>7 July 2015 (based on Jul-Sep 2015 and Jan-Mar 2016 fieldwork combined)</td>
</tr>
</tbody>
</table>
The questions were the same in both waves and asked patients about when they last saw a GP or nurse at their practice, how easy or difficult it is to make an appointment at their surgery, waiting times, satisfaction with opening hours, the quality of care received from their GP and practice nurses, out-of-hours care, and NHS dentistry; as well as their current health circumstances. This year the questionnaire also included questions about patients’ awareness and use of online services at their GP surgery such as booking appointments and ordering repeat prescriptions online.

The GPPS questionnaire was redeveloped ahead of the July-September 2016 fieldwork, largely to reflect recent changes to pathways for accessing primary care services (see Chapter 2 for more detail). Copies of the questionnaires sent in 2015-2016 can be found in the Appendix.

Note that from July 2016 there will be changes to the GP Patient Survey, including the frequency of data collection and the content of the questionnaire. More information is available on the survey website.

1.1 Survey Governance

Since February 2014, the governance of the survey has involved input from a steering group, which meets regularly to provide a forum in which stakeholders of the GPPS can be kept informed of the progress of the survey. The group provide advice to the research team and debate key issues such as questionnaire content, inclusion of practices, analysis and reporting; review the findings of the survey as they emerge; consider the need for any further research and analysis to be undertaken; and raise any questions about the GPPS project with Ipsos MORI and NHS England.

The group consists of representatives from a range of stakeholders, including the following:

- NHS England
- Ipsos MORI
- Care Quality Commission
- Healthwatch England
- National Association for Patient Participation
- General Practitioners Committee
- Academics
- CCG lay membership
- British Medical Association
- Community, Primary & Integrated Care, Nursing Directorate
- Royal College of General Practitioner's Patient Partnership Group
• Department of Health

The technical details of the survey are presented in this volume, with all survey documentation provided in the Appendix.
Questionnaire design
2 Questionnaire design

2.1 Questionnaire development for the 2015-2016 survey

The questionnaire was redeveloped for 2015-2016. The majority of these changes were made in order to more accurately capture patients’ experiences of access given recent changes to pathways for accessing primary care services.

Two existing questions were amended within the Making an Appointment section of the questionnaire to include a wider range of services:

- What type of appointment patients got the last time they tried to make an appointment, and
- If they couldn’t get an appointment or the appointment they were offered was not convenient, what they did on that occasion.

The scope of questions on out-of-hours care was expanded to both consider the entire pathway of care, and to encompass a wider range of health services. Questions from the 2014-2015 survey were replaced with the following new questions:

- Whether patients had contacted an NHS service when their GP surgery was closed in the last 6 months
- What happened on that occasion
- Timeliness of care received
- Confidence and trust in all those seen or spoken to
- Overall rating of out-of-hours care received

An additional question on learning disabilities was added to the ‘Some questions about you’ section, and the code ‘Learning difficulty’ was removed from Q31.

Finally, for the January-March fieldwork the question on sexual orientation was slightly amended to bring it in line with the work that NHS England is doing on standardising all questions on protected characteristics.

The new questions on making an appointment and out-of-hours care were developed purposively for inclusion in the GPPS through a four-stage research process:
• An initial rapid evidence review explored existing research in these areas.

• This was followed by a workshop with NHS England and key stakeholders with the aim of better understanding what future provision would look like for in-hours and out-of-hours care.

• In order to interpret these different pathways and how patients understand them, and to then design the questions, qualitative research was undertaken. A total of 25 depth interviews were conducted in March 2015, covering a range of models for access provision. From these interviews a summary report of findings, along with implications for the questionnaire and a first draft of questions were shared with NHS England.

• In the final stage, once refined, these questions underwent four rounds of cognitive testing, with interim feedback provided by Ipsos MORI to NHS England together with suggested revisions to the questions after each round. A total of 20 cognitive interviews were conducted in April 2015. Quotas were set to ensure that interviews were carried out with a range of patients with respect to gender, age, ethnicity, social grade, long-term health condition, parental status and adequate representation of people who had not been able to get a GP appointment, as well as those who had tried to contact an NHS service when they needed to see a GP but the GP surgery was closed. Where possible, the whole questionnaire was tested, however the primary focus was on the new questions.

2.2 The final questionnaire

Below is a complete list of all the topics covered in the 2015-2016 questionnaire.

Accessing your GP Services

• When patients last saw a GP

• When patients last saw a nurse

• How easy patients find it to get through to someone at their surgery on the phone

• Helpfulness of receptionists

• How patients normally book an appointment

• Awareness of online services offered by GP surgery

• Use of online services at GP surgery in past 6 months

• Having and seeing a preferred GP
Making an appointment

- Last time patients wanted to see or speak to a GP or nurse from their GP surgery what did they want to do
- When they wanted to see or speak to the GP/ nurse
- Whether they were able to get an appointment to see or speak to someone
- What type of appointment they got
- Time between initially contacting the surgery and seeing and speaking to someone
- Convenience of the appointment they were able to get
- Reasons for not being able to get an appointment or the appointment offered wasn’t convenient
- What they did if they were unable to get an appointment/appointment not convenient
- Overall experience of making an appointment

Waiting times

- How long after their appointment time patients normally wait to be seen
- How patients feel about how long they normally have to wait to be seen

Last GP appointment

- How good was the GP at giving patients enough time, listening, explaining tests and treatments, involving the patient in decisions about their care, treating patients with care and concern
- Confidence and trust in GP

Last nurse appointment

- How good was the nurse at giving patients enough time, listening, explaining tests and treatments, involving the patient in decisions about their care, treating patients with care and concern
- Confidence and trust in nurse
Opening hours

- Satisfaction with opening hours
- Is the GP surgery open at times that are convenient to patients
- Opening at additional times

Overall experience

- How patients describe their overall experience of their GP surgery
- Recommending the GP surgery to someone who has just moved into the area

Managing your health

- Long-standing health condition
- Medical condition (if any)
- Enough support from local services or organisations to help manage long-term health condition(s)
- Confidence in managing own health

State of health today

- State of health today: mobility; self-care; usual activities; pain/discomfort; anxiety/depression
- Activities limited today because of recent illness (unwell) or injury

Planning your care

- Whether patients have a written care plan
- Whether they helped to put their written care plan together
- Using their written care plan to manage their health day-to-day
- Reviewing their written care plan with their GP or health professional

Out-of-hours

- Whether contacted NHS services when GP surgery was closed in the last 6 months
- What happened on that occasion
- Timeliness of care received
• Confidence and trust in all those seen or spoken to
• Overall rating of care received

NHS Dentistry
• When last tried to make an NHS dental appointment
• Whether or not the patient had visited the dental practice before
• Whether or not the patient was successful in getting an appointment
• Overall experience of NHS Dental services
• Reason for not making an appointment in last two years, if applicable

Demographics
• Gender, age, ethnicity
• Work status, journey time to work, seeing a GP during working hours
• Parent or legal guardian
• Deaf and sign language user
• Learning disability
• Smoking habits
• Carer responsibilities
• Sexual orientation
• Religion
Sampling
3 Sampling

3.1 Sample overview

For GPPS 2015-2016, an issued sample size was set to try and ensure that questionnaires were sent out to around 1.07 million patients every six months. The sample is designed to ensure that, as far as possible, these cases are distributed across practices such that the confidence intervals are of the same magnitude for each practice for any one question – calculations are based on the assumption that the estimate will be the same across all practices and based on a 50/50 question (a ‘worst case’ scenario in terms of the magnitude of the confidence interval, for example where 50% of respondents at Q28 answer “good”). This method ensures that confidence intervals are as consistent as possible between practices and that none have particularly wide intervals.

Patient samples are obtained for each practice using registration records held on the HSCIC (Health and Social Care Information Centre, formerly NHAIS) database. The data provided from HSCIC databases consists of patient name, address, NHS ID number, month/year of birth and gender.

The sampling procedure is split into two distinct stages. Initially, HSCIC provides an anonymous list of patients for final sample size determination and individual patient selection. After the selected anonymous records are returned to HSCIC, a second file containing the contact details of the selected patients is provided.

Patients are eligible for inclusion in the survey if they have a valid NHS number, have been registered with a GP practice continuously for at least six months before being selected, and are 18 years of age or over.

An additional eligibility criterion was added in 2009-2010 and continues to be in place for the 2015-2016 survey; patients cannot receive more than one GPPS questionnaire in any 12 month period. This selection rule was put in place in order to minimise survey fatigue.

HSCIC population extraction procedure

As in previous years, HSCIC provides a file of anonymous patient data for all eligible patients who reside in England or Wales and are registered with a practice in England. The file contains a unique reference number, practice code, patient gender, patient age band, and patient postcode.

This data is then analysed at practice level and a sample is drawn, as detailed below.
Practices included in the survey

The list of practices to be included is provided from the HSCIC system, and comprises all practices that have eligible patients as defined above. The list of potential practices is reviewed each wave with the following number taking part over the course of the year:

<table>
<thead>
<tr>
<th>Number of practices with eligible patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
</tr>
<tr>
<td>Wave 2</td>
</tr>
</tbody>
</table>

In total, patients in 7,787 different practices were sent questionnaires over the course of the year. At least one completed questionnaire was received from patients in 7,780 practices. A total of 7,676 practices were included in both waves of the survey.

3.2 Sample size calculation

The sample size is determined for each practice to deliver a likely confidence interval of ±9.0 percentage points (two-tailed, at the 95% level) in the majority of practices on a question where it is assumed that 50% of the respondents will respond one way and 50% will respond another. This confidence interval was determined iteratively to ensure a total annual issued sample size of c.2.15 million (1.07 million in wave 1, 1.08 million in wave 2). While this confidence interval can never be achieved in all practices, every effort is made to ensure that it is achieved in the majority of practices.

The sample design is relatively simple: a proportionately stratified, unclustered sample is drawn for each practice. There are, however, some complications around the calculation of the practice sample sizes required to deliver set confidence intervals. These complications arise because account has to be taken of:

- Practice population sizes as these are relatively small (accounted for through the finite population correction);
- Newly eligible patients and those who were eligible for the last wave of the survey; and
- The effect of the eligibility criterion introduced in 2009-2010 (patients cannot have received a GPPS questionnaire in the past 12 months).
These three factors affect sample size and therefore confidence intervals, and inform the calculations used.

The number of patients initially selected for inclusion (the ‘issued sample’) in the sample for each practice is, therefore, determined by the following components:

- The number of cases required in order to deliver 95% confidence intervals of ±9.0 on a 50/50 question; and
- The proportion of patients included in the issued sample who respond to the survey—taking into account both the number of sampled patients found to be ineligible for the survey (i.e. those who were sampled in the previous wave of the survey or are newly registered with the practice) and the number who are eligible but do not respond.

These components are combined to determine the issued sample size in each practice as follows:

\[
\text{Issued sample} = \frac{\text{number required to deliver required confidence interval}}{\text{proportion of issued sample predicted to respond}}
\]

Both of the components involved in the above calculation need to be estimated for each practice. It is assumed that simple random sampling will be applied in each practice. On this basis, an estimate is arrived at for the number of responses required to deliver set confidence intervals around the estimate of a proportion.

It should be noted that the required issued sample size depends upon:

- The number of eligible patients in the population—practice size counts are used to give an estimate of the practice population and an estimate of the newly eligible / eligible patient split;
- The proportion being estimated—assuming a “worst case scenario” of 50% for the proportion to be estimated, that is, 50% of respondents answering a given question “yes”; and
- The magnitude of the required confidence interval—which is known to be ±9.0%.
The sample size required to deliver the target confidence interval is estimated using the actual response rate for those practices who took part in the 2014-2015 GPPS, and is set at 30% for practices new to the survey or for which fewer than 100 surveys were issued in the 2014-2015 GPPS. This is to prevent unrealistically high or low response rates being used for new and very small practices.

Adjustments to response rate estimates

To prevent issuing very large numbers of questionnaires in practices which had very low response rates in 2014-2015, a minimum response rate of 25.4% was assumed. This means that no practice had more than 240 questionnaires issued in any given wave. The mean mailout size per practice was 138 in wave 1 and 140 in wave 2. In order to ensure that a reasonable number of questionnaires were sent to practices with very high response rates, on the other hand, a maximum assumed response rate of 52% was set.

3.3 Patient sample selection

Splitting the selection between newly eligible and eligible patients

The new eligibility criterion introduced in 2009-2010 means patients are excluded if they have been selected in the previous 12 months. This is to reduce respondent fatigue and to prevent patients in small practices receiving a survey every wave. However, this suppression affects the probability of selection of new patients. For sampling purposes, eligible patients are then defined as those who were eligible for the survey in the previous wave and that are still eligible now. Newly eligible patients are those that are new to the practice; they have become eligible for the survey since the previous wave so are ‘new’ to the anonymous population.

Because the final issued sample must be drawn from patients who are not excluded, this gives a greater chance of selection to newly eligible patients. As an example:

Practice X has a population of 897 patients:

- 256 of them were registered last wave and of these 73 have already received a survey in the last 12 months so are not eligible for this wave. This leaves 183 eligible patients.
- 641 of them are newly eligible (i.e. registered at the practice after the last survey sample was drawn).
- This means that of the 897 registered patients at the practice, there are 824 patients to draw our sample from.
If randomly selecting patients from the total, they would be drawn in proportion to the total of 824. So, if we were to select 100 patients from this surgery to receive surveys:

- 22 of them would come from the list of eligible patients (because 183 eligible patients make up 22% of the total); and
- 78 of them would be newly eligible (because 641 makes up 78% of the total)

When selecting patients this way the resulting sample is representative of the population that is eligible for the survey, but not representative of the population of the practice when it comes to length of registration.

The actual method used takes this into account, and instead draws the sample from each group in proportion to their true presence in the practice. So, to draw 100 patients from this surgery to receive surveys:

- 29 of them would be eligible (256 is 29% of the total number of patients in the surgery – 897); and
- 71 of them would be newly eligible (641 (i.e. the number of ‘new’ patients at the practice) is 71% of the total number of patients in the surgery – 897).

This means that in almost all cases the number of newly eligible patients selected is proportionate to the actual population. The exceptions are very small practices (pop <10) where the eligible patients have already all (or nearly all) received a survey in the last 12 months and are, therefore, suppressed.

Within each practice, patients are sorted by gender then age band. The required number of patients is then selected on a ‘1 in n’ basis and the unique reference numbers returned to HSCIC.

**Personal Data Extraction**

On receipt of the selected records, HSCIC then extract the contact details for each of the sampled patients. The extracted file contains each patient’s name, address, month and year of birth, gender, and NHS ID number.

**Sample Cleaning and Exclusions**

A number of checks are made on the supplied names and addresses to remove inappropriate records. These checks include:

- Duplicates between practices (identified by NHS ID number). Where duplicates exist, both are removed as we are not able to confirm which practice they belong to.
- Duplicates within practice
- Non-address details or other inappropriate information contained in address. These can include:
  - Key safe numbers, telephone numbers and other numeric codes
  - Unexpected words or phrases in the name or address (including “unknown”, “homeless”, “deceased”, “test”, etc.)
  - Incomplete addresses

All sampled patients from all practices are then randomly sorted before being allocated sequential reference numbers (to ensure there is no link between reference numbers and practices). A “mod-10” check digit is added to the end of the reference numbers to ensure processing integrity during data capture.

**Total number of questionnaires sent per wave**

Table 3.2 shows the final number of patients to whom questionnaires were sent after all sample cleaning had been finished.

**Table 3.2 – Number of questionnaires sent per wave**

<table>
<thead>
<tr>
<th>Wave</th>
<th>Number sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>1,068,800</td>
</tr>
<tr>
<td>Wave 2</td>
<td>1,079,991</td>
</tr>
<tr>
<td>Total</td>
<td>2,148,791</td>
</tr>
</tbody>
</table>
Communications with patients and practices
4 Communications with patients and practices

In order to raise the profile of GPPS and provide patients and practices with information about the survey, a series of communication activities are undertaken, such as hosting a survey website, and providing a survey helpline to respond to frequently asked questions. These are described in more detail below.

4.1 Information for display in GP practices

A poster is made available for GP practices to display in their surgeries in English and 13 other languages. Copies of the poster are available on the GPPS website for download and printing. A version for electronic notice boards is also available for download.

4.2 2015-2016 survey website

A dedicated survey website is maintained and hosted by Ipsos MORI. The advertised web address is www.gp-patient.co.uk although the site can also be accessed at www.gp-patient.com. The 2015-2016 site is designed to reflect the branding of the questionnaire and all other related material (see Figure 4.1 for the website home page).

Figure 4.1 – The www.gp-patient.co.uk homepage
The 2015-2016 website was updated on the first day of each wave of fieldwork, as the first questionnaires are delivered to patients, and is arranged around the following headings.

- **About**, covering the aims of the survey, ways to take part and information about accessibility. Also included within this link are videos that welcome British Sign Language (BSL) users to the website, explain the survey, and provide responses to a selection of FAQs. The page also links to an online BSL version of the questionnaire.

- **Received a survey in the post?** providing information about the online version and links to complete it in either English, BSL or another language. Also provided is a link to previous survey results.

- **Frequently Asked Questions (FAQs)**, including information about how patients are selected, help with completing the survey, data protection and accessing the results.

- **Languages**, providing information in the 13 languages, including Arabic, Bengali, Czech, French, Gujarati, Mandarin, Polish, Portuguese, Punjabi, Slovak, Somali, Turkish and Urdu. The FAQs, questionnaire, and covering letter are all translated into these languages in order to make the survey as widely accessible as possible.

- **Promote the survey**, a page that contains the poster in English and 13 other languages.

- **Website feedback**, a link to a form allowing users to rate the site, provide comments and leave contact details.

- **Search for or compare a practice**, takes users to the practice report tool, which allows users to view practice results and compare them to results of other practices.

- **Analysis tool**, a link which sends the user through to the analysis tool website which allows them to interrogate the GPPS data further.

- **Latest results**, an archive of all previous datasets, reports, questionnaires and letters which were sent out.

- **For GP staff**, a page that contains information for GPs about the benefits of the survey.
• Why use the survey data? providing information about the GP Patient Survey, what information can be found in the survey results, and how the website can help the user. It also includes a GP Handbook developed by academic partners giving practices advice on how to use their survey results to improve patient care.

• How do I...? providing guidance on how to complete the survey, how to find practice and CCG data, and how to use the website and analysis tool to conduct further analysis on the data.

• Contact Us, telephone and email details for the GPPS team at Ipsos MORI.

4.3 Helplines

Ipsos MORI set up freephone helplines for patients who would like more information about the survey, with separate numbers set up for the English and foreign language lines. In total, almost 15,000 calls were handled by the helplines over the course of the year.

English language telephone helpline

The English helpline was staffed by a fully trained Ipsos MORI team between 9am and 9pm on weekdays and 10am to 5pm on Saturdays from 1 July to 28 September 2015 and 5 January to 28 March 2016. A voicemail system is used during quieter periods (see details below). In order for call handlers to answer patients’ queries, they are provided with a manual containing a complete list of over 200 FAQs. These are updated regularly to ensure that an answer could be provided for any questions which were not originally included. Where the call handlers cannot answer a caller’s query, the details are passed on to the GPPS research team, a member of which then responds to the query.

During quieter periods (generally 10 days after each mailing), a voicemail message briefly explains the purpose of the survey and asks the caller to leave a message and telephone number if they wish to be called back. Interviewers then try to return the calls within two working days. Up to eight attempts are made to return the call.

As well as being a source of information for patients, the helpline also enables patients with valid reference numbers to complete the survey on the telephone.

Patients can also opt out of the survey by providing their reference number to helpline staff or in a voicemail message.
Foreign language telephone helpline

In order to make the survey as accessible as possible, there are separate helplines for each of the 13 foreign languages. Each language has its own freephone number which is connected to a voicemail message in the different languages. As with the English language voicemail, a message briefly explains the purpose of the survey and asks the caller to leave a message and telephone number if they wish to be called back. Interviewers in Ipsos MORI’s International CATI Centre then return the calls within two working days. Up to eight attempts are made to return the call. As with the English language helpline, patients are able to complete the survey over the phone or opt out of taking part.

Email helpline

As well as using the telephone helpline, patients are also able to email the GPPS team at Ipsos MORI with any queries about completing the survey or accessing the survey online. In total, approximately 700 email queries were received across both waves of the 2015-2016 survey.
Data collection
5 Data collection

The GP Patient Survey is predominantly a postal survey. However, patients also have the opportunity to complete the survey online or by telephone. These options are discussed in greater detail below.

5.1 Postal survey

Processing the sample

Each wave, the sample is delivered in person, encrypted, on DVD to the printing house where it is cleaned using the Postcode Address File (PAF). This process ensures that the questionnaires are sent to the correct postal address and that the mailing is eligible for postage discounts. A downstream access provider is used for processing the questionnaire packs, with items then handed over to Royal Mail for ‘final mile’ delivery.

Printing

All questionnaires, letterhead, C5 Business Return envelopes, and C5 outer envelopes are printed in advance of the survey. Once the sample is made available, the questionnaires are then personalised with a unique reference number and online password. The letters are also personalised with name, address, and the same unique reference number as appears on the questionnaire.

A single questionnaire, letter, and Business Return envelope are then packed into an outer envelope by machine, and sorted into Walksort batches, ready for collection by the downstream access provider.

Posting the questionnaires

Initial letters and questionnaires were sent to patients on the dates in Table 5.1, followed by a postcard reminder. Two additional full reminder mailings (letters and questionnaires) were then sent to patients for whom no recorded response was received by the printing deadline. Copies of all letters can be found in the Appendix.

Patients who were not sent a full reminder included:

- those who returned their questionnaire to Ipsos MORI and it was processed before the deadline;
- those who completed the questionnaire online;
- those who completed the survey via the helpline;
• those who telephoned or emailed the helpline and opted out of the survey;

• those who replied via letter indicating they wished to opt out of the survey;

• those who opted out via NHS England;

• those whose questionnaires were returned to sender; and

• those recorded as deceased on the HSCIC database.

Table 5.1 – Survey mailout dates by wave

<table>
<thead>
<tr>
<th></th>
<th>Wave 1</th>
<th>Wave 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial mailing sent</td>
<td>1 July 2015</td>
<td>4 January 2016</td>
</tr>
<tr>
<td>Postcard reminder</td>
<td>8 July 2015</td>
<td>11 January 2016</td>
</tr>
<tr>
<td>1st reminder mailing</td>
<td>3 August 2015</td>
<td>1 February 2016</td>
</tr>
<tr>
<td>2nd reminder mailing</td>
<td>1 September 2015</td>
<td>1 March 2016</td>
</tr>
</tbody>
</table>

5.2 Alternative methods of completion

Although patients are offered several methods of completion, only one response per patient is included in the final data.

Online completion

Patients are offered the option to complete the survey online via the GPPS website in English, one of the 13 other languages offered, or in BSL. These different versions of the survey are accessible from different pages on the website. The online survey page of the website gives those invited to take part the opportunity to choose the language in which they wish to complete the survey (English, Arabic, Bengali, French, Czech, Gujarati, Mandarin, Polish, Portuguese, Punjabi, Slovak, Somali, Turkish or Urdu). Patients are also offered the option of completing the survey in large print, which they can request via the helpline by email or telephone.

Likewise, there is also the option for patients to access a BSL version via the pages dedicated to supporting BSL users. This involves showing video clips of a BSL user signing the instructions, questions, and options available (see Figure 5.1).
Figure 5.1 – Viewing the questionnaire in BSL

Regardless of the language chosen, each patient in the sample is assigned a unique reference number and password (printed on the front page of the paper questionnaire) that allows them to access the online versions of the questionnaire. In order to complete the survey online, patients are required to enter these details on a first login screen (see Figure 5.2 below).

Figure 5.2 – Login screen for online survey

For all versions of the online survey, the questions are identical to those on the paper questionnaire in terms of wording and design.
Figure 5.3 – Question from the online survey

Only one online response per patient is accepted. If patients try to complete it more than once online, a message appears letting them know they have already completed the survey. If they fail to complete the survey in one sitting, their reference number and password will return them to where they had left off.

Telephone completion

Patients are also able to complete the GPPS questionnaire on the telephone (including in the 13 foreign English languages) by calling the freephone helplines. Patients are asked for their reference number before they can complete the survey and there is an automatic check on the reference number to ensure that it is valid for the live survey. Helpline staff enter callers’ answers to the survey questions directly into the online version of the survey.

Braille and Large Print versions

Braille users are offered the opportunity to receive the questionnaire and letter in Braille, and large print is again made available for those who request a copy of the letter and questionnaire in this format.

Total number of online returns

Table 5.2 shows that 40,776 patients completed the survey online.
Table 5.2 — Number of online completes per wave

<table>
<thead>
<tr>
<th>Wave</th>
<th>Number completed online</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>19,192</td>
</tr>
<tr>
<td>Wave 2</td>
<td>21,584</td>
</tr>
<tr>
<td>Total</td>
<td>40,776</td>
</tr>
</tbody>
</table>

Of these 40,776 online completes, Table 5.3 details how many patients completed the survey in each available foreign language and British Sign Language.

Table 5.3 — Completes per language

<table>
<thead>
<tr>
<th>Language</th>
<th>Wave 1</th>
<th>Wave 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>16</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Bengali</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Czech</td>
<td>9</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>French</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Gujarati</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Mandarin</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
<tr>
<td>Polish</td>
<td>278</td>
<td>326</td>
<td>604</td>
</tr>
<tr>
<td>Portuguese</td>
<td>14</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Punjabi</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Slovak</td>
<td>19</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Somali</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Turkish</td>
<td>9</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Urdu</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>384</td>
<td>435</td>
<td>819</td>
</tr>
<tr>
<td>BSL</td>
<td>3</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>
Data analysis
6 Data analysis

6.1 Questionnaire processing

As in previous years, questionnaires are returned in supplied freepost Business Reply Envelopes (2nd class) to the scanning house.

Envelopes are guillotined and questionnaires collated and prepared for scanning. Any other items of correspondence are set aside for review and response by Ipsos MORI or NHS England, as appropriate.

Questionnaires are scanned and processed using barcode recognition and Optical Mark Recognition technology, with operator verification of uncertain entries. All marks on the forms are recognised at this stage, regardless of whether they are in accordance with the questionnaire instructions.

Questionnaire data collected online is logically prevented from containing data contrary to the questionnaire instructions (such as multiple responses to a question requiring a single answer).

Questionnaires were accepted and included each wave if they were received by the following dates:

Table 6.1 — Cut off dates for returns

<table>
<thead>
<tr>
<th>Wave</th>
<th>Cut off for returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>2 October 2015</td>
</tr>
<tr>
<td>Wave 2</td>
<td>1 April 2016</td>
</tr>
</tbody>
</table>

6.2 Inclusions and exclusions

The rules and protocols used for delivering the data for the 2015-2016 reports are as follows:

- All questionnaires received with identifiable reference numbers allowing linkage to GP practice, along with all completed online responses, are eligible for inclusion.

- Returned questionnaire figures are based only on those qualifying for inclusion in the dataset as described in this document.

- The calculated response rates are based on all completed questionnaires returned and all questionnaires sent. They have not been adjusted to exclude questionnaires which did not reach the patient, e.g. where envelopes have been returned undelivered etc.
The following are excluded from the reports:

- All questionnaires marked as completed by under-18s;
- All questionnaires where there is only data for a limited number of questions (e.g. only the first page was completed).
- All questionnaires where the barcode number was not in the valid range for the live wave of the survey.
- All questionnaires without a valid practice code.
- All blank questionnaires.

Questionnaire data are combined from scanned and online data sources. Where duplicates between mode of completion exist, the data used are selected according to the case that is the most complete (i.e. with the fewest unanswered questions). If there is no difference in completeness, the data used are then selected according to a priority order with online data having precedence. Where duplicates exist within a completion mode, the earliest return is included.

### 6.3 Editing the data

As the majority of the completed questionnaires are on paper, there is a degree of completion error that occurs (e.g. ticking more than one box when only one response is required, answering a question not relevant to them, or missing questions out altogether). Therefore, it is necessary to undertake a certain amount of editing of the data to ensure the data is logical. For example:

- If a patient ticks more than one box where only one answer is required, then their reply for that question is excluded.

- Where patients are allowed to select more than one box for a particular question, the reply for that question is excluded if they select two conflicting answers – for example, at Q5 (‘How do you normally book appointments to see a GP or nurse at your GP surgery?’), if a patient ticks any of the first four options as well as ‘Doesn’t apply’, then their response for that question is excluded. The following list shows the questions this applied to, as well as the response options that are treated as single code only:
  - Q5 – ‘Doesn’t apply’
  - Q6 – ‘None of these’ and ‘Don’t know’
  - Q7 – ‘None of these’
- Q27 – ‘None of these’
- Q31 – ‘None of these conditions’ and ‘I would prefer not to say’
- Q41 – ‘Can’t remember’

- There are also some questions for which patients are allowed to select more than one response option, although this is not specified on the questionnaire itself:
  - Q10
  - Q13
  - Q17 (except for ‘Didn’t see or speak to anyone’ which is treated as a single code only)
  - Q41 (except for ‘No’, which is treated as a single code only)

- If all boxes are left blank the reply for that question is excluded.

- If a patient fails to tick the relevant answer for a filter question then any responses are excluded from the subsequent questions relating to the filter question. For example, if a patient responds to Q9 without having first responded ‘Yes’ at Q8, their response to Q9 is removed.

- For the question on whether they were able to get an appointment to see or speak to someone (Q12), any patients who select ‘Yes’ and ‘Yes, but I had to call back closer to or on the day I wanted the appointment’ have their answer edited to just ‘Yes, but I had to call back closer to or on the day I wanted the appointment’.

- For the question on whether they have a long-standing health condition (Q30), patients who initially answer other than ‘Yes’ have their answer recoded to ‘Yes’ if they went on to select any medical conditions at Q31.

- Where the ethnicity question (Q53) is multi-coded, patients are included in the ‘White English / Welsh / Scottish / Northern Irish / British’ group if this was selected alongside any other response. If someone selects more than one response under any of the ethnic groups (‘Mixed / multiple ethnic groups’, ‘Asian / Asian British’, ‘Black / African / Caribbean / Black British’, and ‘Other ethnic group’) then they are recoded into the ‘other’ response within that grouping; for example, a patient selecting Indian and Pakistani is coded into ‘Any other Asian background’. The same rule applies to multiple responses in the ‘White’ section in cases where ‘White English / Welsh / Scottish / Northern Irish / British’ is not selected. If someone selected two or more responses which are not in the same section,
they would be coded into the ‘Any other ethnic group’ category
(again with the exception of cases where ‘White English / Welsh /
Scottish / Northern Irish / British’ was selected).

## 6.4 Weighting strategy

The weighting scheme for 2015-2016 follows the same weighting strategy
as used previously, incorporating the following three elements:

1. A design weight to account for the unequal probability of selection;

2. A non-response weight to account for differences in the
characteristics of responders and non-responders; and

3. A calibration weight to ensure that:
   - The distribution of the weighted responding sample across
     practices resembles that of the population of eligible patients; and
   - The age and gender distribution within each Clinical
     Commissioning Group (CCG) resembles the population of eligible
     patients within the CCG.

Design weights are computed to account for the design of the survey (e.g.
disproportionate stratified random sample by practice and length of time
the patient has been registered with the practice). Design weights are
calculated for each patient as the inverse of the probability of selection. The
probability of selection is calculated separately for newly registered /
previously registered patients. For each group this is generated by dividing
the number of selected patients over the total number of eligible patients in
the practice at the time of sampling for wave two. This weight gives you the
number of patients from the practice represented by each individual who is
sampled for GPPS from said practice.

Non-response weights are constructed using a model based approach to
estimate the probability of responding. This model estimates the probability
of responding based on socio-economic and demographic characteristics
of the patient and the neighbourhood in which the patient lives. This
strategy aims to reduce demographic and socio-economic differences
between respondents and non-respondents. The modelling is run
separately by wave of data collection, to allow any small differences, such
as seasonal differences, in response behaviour to be accounted for.

Data from the GPPS sampling frame (patients’ age, gender and
Government Office Region) is linked to external data using the home
postcode of the patient. External data is obtained from the Office of National
Statistics aggregated at the Output Area (OA), and A Classification Of
Residential Neighbourhoods (ACORN) system. OA variables included:
deprivation indicators, crime scores, ethnicity, marital status, overcrowding,
household tenure and employment status. The OA variables are based on the 2011 Census data, except for the Index of Multiple Deprivation (IMD) and the Crime Deprivation Index, which are from the 2015 deprivation indicators. The ACORN system categorises all postcodes in UK into various types based on Census data and lifestyle surveys.

Where selected patients do not have a valid postcode or their postcode is missing they are assigned the practice modal OA (the OA that most of the patients had within the practice). If there is more than one modal OA, the OA is selected randomly among the modal OAs. Complete information was available for most of the patients except in IMD score/crime; the IMD score/crime for these patients is imputed using the average score for the practice that they attended.

The probability of response is estimated using a logistic regression model. Standardised design weights are applied when running the model to obtain unbiased estimates for the coefficients. Similar patterns are seen in both waves: non-response was higher among younger patients and males, with an interaction between age and gender which shows that females are generally more likely to respond than males, with the exception of older age groups where the pattern is reversed. There are also some differences by Region, with response tending to be lower in the North East and North West in both waves. Response in both waves is also lower in ACORN groups P (‘Struggling Estates’), K (‘Student Life’) and R (‘Other’). Response also decreases in the following:

- OAs with higher deprivation and crime scores;
- OAs with an increasing proportion of non-white people;
- OAs with an increasing proportion of single, separated or divorced people;
- OAs with an increasing proportion of households with three or more people;
- OAs with an increasing proportion of privately rented households.

In contrast, response increases with an increasing proportion of employees.

The non-response pre-weights are calculated as the reciprocal of the predicted probability of response. The pre-weights are capped after using standardised weighting to determine this level. Capping can introduce some bias into the survey estimates; however, in this case it is minimal given that the number of respondents with capped weights represents less than 0.3% of the total respondent sample. The pre-weights are multiplied by the design weight to obtain the non-response weight.
The non-response weight is calibrated to produce a final weight that makes
the weighted sample of respondents resemble the eligible population by
practice, and by age/gender within CCG. The non-response weights, which
are generated separately within each wave, are standardised by practice.
The standardised non-response weights are then combined in a single
dataset and the calibration step is run. The practice population totals used
for the calibration are based on the average practice population from both
waves.

Calibration can lead to very variable weights if applied to small cells. In
GPPS, small cells can typically arise in any CCG which has only a small
number of responders in a particular age-sex band, or in practices with a
low response rate. To overcome these issues, the age-sex bands are
combined into six categories, and a small amount of additional capping is
performed. In particular, practices with fewer than ten respondents have
their weights capped. Finally, the weights are standardised to sum to the
sample size.

6.5 Weighting strategy for wave 2 dentistry data

Separate weights are calculated for reporting NHS dentistry results (which
are based on one wave of data only), while all other questions are reported
based on combined wave 1 and wave 2 data. The calculation of weights for
wave 2 dentistry data follows the same procedure as outlined above in the
weighting strategy for the two waves combined.

6.6 Confidence Intervals

Participants in GPPS represent a sample of the total population of interest—
this means we cannot be certain that the results of a question are exactly
the same as if everybody within that population had taken part (“true
values”). However, we can predict the variation between the results of a
question and the true value by using the size of the sample on which results
are based and the number of times a particular answer is given.

The confidence with which we make this prediction is 95% – that is, the
chances are 95 in 100 that the true value will fall within a specified range
(the “95% confidence interval”).

The table below gives examples of what the confidence intervals look like
for an ‘average’ practice and CCG, as well as the confidence intervals at
the national level based on weighted data.
Table 6.2 – Confidence intervals for practices, CCGs and national data

<table>
<thead>
<tr>
<th></th>
<th>Average sample size on which results are based</th>
<th>Approximate confidence intervals for percentages at or near these levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 1: 10% or 90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+/- (%)</td>
</tr>
<tr>
<td>National</td>
<td>836,900</td>
<td>0.09</td>
</tr>
<tr>
<td>CCG</td>
<td>4,000</td>
<td>1.18</td>
</tr>
<tr>
<td>Practice</td>
<td>100</td>
<td>5.05</td>
</tr>
</tbody>
</table>

For example, taking a CCG where 4,000 people responded and where 30% give a particular answer, there is a 95% likelihood that the true value (which would have been obtained if the whole population had been interviewed) will fall within the range of +/-1.86 percentage points from that question’s result (i.e. between 28.14% and 31.86%).

In instances where the base size is small (e.g. practices where 100 patients or fewer responded to a question) confidence intervals will be wider. Findings for these questions should be regarded as indicative rather than robust.

Lower and upper limits for confidence intervals for a selection of questions are presented in the practice and CCG Excel reports (https://gp-patient.co.uk/surveys-and-reports).

Often statistical tests are based on simplified assumptions about how the underlying population is distributed. These assumptions hold for many real life situations but can fail for extreme situations; such is the case with confidence intervals. Within the context of GPPS many satisfaction scores are around 99%, there is more scope for such an estimate to fall than there is for it to increase (this makes sense intuitively as well as probabilistically), hence we would expect the lower limit to be larger than the upper limit. As a result, we use Wilson’s method to calculate confidence intervals which accounts for this, and permits intervals to be asymmetric – the lower and upper limits can be unequal in size (unlike other confidence interval tests)\(^1\).

When results are compared between separate groups within a sample, the difference may be “real” or it may occur by chance (because not everyone in the population has been interviewed). A difference must be of at least a certain size to be statistically significant. The following table shows the size of the difference needed between two estimates, in order for this difference to be statistically significant at the 95% confidence level and assuming 80%\(^1\)

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\(^1\) Standard confidence interval testing uses the Wald method.
power for an ‘average’ practice and CCG, as well as the size of the difference needed at the national level.

Table 6.3—Subgroup sampling tolerances

<table>
<thead>
<tr>
<th></th>
<th>Average sample size on which results are based</th>
<th>Amount of change needed between two estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 1: 10% or 90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 2: 30% or 70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 3: 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+/- (%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+/- (%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+/- (%)</td>
</tr>
<tr>
<td>National</td>
<td>836,900</td>
<td>0.18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.27</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.29</td>
</tr>
<tr>
<td>CCG</td>
<td>4,000</td>
<td>1.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.91</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.15</td>
</tr>
<tr>
<td>Practice</td>
<td>100</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18.6</td>
</tr>
</tbody>
</table>

For example, taking a practice where 100 people responded and where 30% give a particular answer, the estimate from a second practice of a similar size would need to be +/-18.4 percentage points in order to be statistically significant (and not due to random chance).

At national level, it is recommended that comparisons are made between data from non-overlapping fieldwork periods, i.e. July 2016 should be compared with July 2015 etc. Taking a national level data set of 836,900 patients where 30% gave a particular answer, the estimate in July 2016 would need to be +/-0.27 percentage points compared to July 2015 in order for the difference to be statistically significant (and not due to random chance).
Response rates
7 Response rates

The overall response rate for England over both waves was 38.9%, based on 2,148,791 questionnaires sent out and 836,312 returned. This is based on the following figures for each individual wave:

Table 7.1 – Surveys sent, returned and response rates

<table>
<thead>
<tr>
<th></th>
<th>Number sent</th>
<th>Number returned</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>1,068,800</td>
<td>420,610</td>
<td>39.4%</td>
</tr>
<tr>
<td>Wave 2</td>
<td>1,079,991</td>
<td>415,702</td>
<td>38.5%</td>
</tr>
<tr>
<td>Total</td>
<td>2,148,791</td>
<td>836,312</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

Table 7.2 – Response rates by gender

<table>
<thead>
<tr>
<th></th>
<th>Wave 1</th>
<th>Wave 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>44.5%</td>
<td>43.4%</td>
</tr>
<tr>
<td>Men</td>
<td>34.2%</td>
<td>33.7%</td>
</tr>
</tbody>
</table>

Table 7.3 – Response rates by age

<table>
<thead>
<tr>
<th></th>
<th>Wave 1</th>
<th>Wave 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–24</td>
<td>16.7%</td>
<td>15.9%</td>
</tr>
<tr>
<td>25–34</td>
<td>20.5%</td>
<td>19.5%</td>
</tr>
<tr>
<td>35–44</td>
<td>28.9%</td>
<td>27.6%</td>
</tr>
<tr>
<td>45–54</td>
<td>38.6%</td>
<td>37.7%</td>
</tr>
<tr>
<td>55–64</td>
<td>55.9%</td>
<td>54.9%</td>
</tr>
<tr>
<td>65–74</td>
<td>70.6%</td>
<td>70.1%</td>
</tr>
<tr>
<td>75–84</td>
<td>64.8%</td>
<td>69.6%</td>
</tr>
<tr>
<td>85+</td>
<td>56.5%</td>
<td>54.8%</td>
</tr>
</tbody>
</table>
Figure 7.1 — Number of practices within each response rate band over time

Number of practices within each response rate band over time

### Table 7.4 — Number and proportion of practices within each response rate band

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>0-9%</td>
<td>56</td>
<td>1%</td>
<td>94</td>
<td>1%</td>
<td>66</td>
<td>1%</td>
<td>64</td>
<td>1%</td>
<td>56</td>
</tr>
<tr>
<td>10-19%</td>
<td>196</td>
<td>3%</td>
<td>665</td>
<td>8%</td>
<td>487</td>
<td>6%</td>
<td>406</td>
<td>5%</td>
<td>292</td>
</tr>
<tr>
<td>20-29%</td>
<td>1,146</td>
<td>15%</td>
<td>1,949</td>
<td>25%</td>
<td>1,727</td>
<td>22%</td>
<td>1,636</td>
<td>20%</td>
<td>1,331</td>
</tr>
<tr>
<td>30-39%</td>
<td>2,037</td>
<td>26%</td>
<td>2,563</td>
<td>32%</td>
<td>2,492</td>
<td>31%</td>
<td>2,374</td>
<td>29%</td>
<td>2,265</td>
</tr>
<tr>
<td>40-49%</td>
<td>2,431</td>
<td>31%</td>
<td>2,144</td>
<td>27%</td>
<td>2,556</td>
<td>32%</td>
<td>2,641</td>
<td>32%</td>
<td>2,809</td>
</tr>
<tr>
<td>50-59%</td>
<td>1,662</td>
<td>21%</td>
<td>501</td>
<td>6%</td>
<td>667</td>
<td>8%</td>
<td>982</td>
<td>12%</td>
<td>1,424</td>
</tr>
<tr>
<td>60-69%</td>
<td>258</td>
<td>3%</td>
<td>12</td>
<td>*</td>
<td>10</td>
<td>*</td>
<td>25</td>
<td>*</td>
<td>81</td>
</tr>
<tr>
<td>70-79%</td>
<td>1</td>
<td>*</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>80-100%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>*</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7,787</td>
<td>100%</td>
<td>7,928</td>
<td>100%</td>
<td>8,005</td>
<td>100%</td>
<td>8,129</td>
<td>100%</td>
<td>8,258</td>
</tr>
</tbody>
</table>

*indicates less than 0.5%
Reporting
8 Reporting

8.1 Deliverables

The survey reporting specifications were created by Ipsos MORI in collaboration with NHS England. The specifications detail the content and layout of each of the Excel and PDF reports required, as well as the SPSS datasets.

All data and reports are encrypted and supplied to NHS England via a secure FTP (File Transfer Protocol) site.

Tables 8.1 to 8.4 describe the reports and datasets which are produced.

Table 8.1 — Weighted reports (wave 1 and 2 — published via the website)

<table>
<thead>
<tr>
<th>Report Type</th>
<th>Detail/purpose</th>
<th>Date published</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Summary report</td>
<td>National headline results of the survey</td>
<td></td>
</tr>
<tr>
<td>National-level CSV file</td>
<td>One file in CSV (Comma-separated value) format that contains all the national-level data within the Excel based reports</td>
<td></td>
</tr>
<tr>
<td>CCG-level report</td>
<td>One Excel report containing survey results for every CCG and the national results</td>
<td>Wave 1: 7 January 2016</td>
</tr>
<tr>
<td>CCG-level CSV file</td>
<td>One file in CSV format that contains all the CCG-level data within the Excel based reports</td>
<td>Wave 2: 7 July 2016</td>
</tr>
<tr>
<td>Practice-level report</td>
<td>One Excel report containing survey results for every practice and the national results</td>
<td></td>
</tr>
<tr>
<td>Practice-level CSV file</td>
<td>One file in CSV format that contains all the practice-level data within the Excel based reports</td>
<td></td>
</tr>
</tbody>
</table>
Table 8.2 – Weighted datasets provided to NHS England (not published)

<table>
<thead>
<tr>
<th>Dataset Type</th>
<th>Detail/purpose</th>
<th>Date provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person dataset</td>
<td>Person level dataset (SPSS) to allow for a range of ad hoc analyses</td>
<td></td>
</tr>
<tr>
<td>Practice dataset</td>
<td>Practice level dataset (SPSS) to allow for a range of ad hoc analyses</td>
<td>Wave 1: 27 November 2015</td>
</tr>
<tr>
<td>Dentistry person dataset</td>
<td>Person level dataset (SPSS) to allow for a range of ad hoc analyses around the dentistry questions</td>
<td>Wave 2: 27 May 2016</td>
</tr>
</tbody>
</table>

Table 8.3 – Unweighted reports (wave 1 and 2 — published via the website)

<table>
<thead>
<tr>
<th>Dataset Type</th>
<th>Detail/purpose</th>
<th>Date published</th>
</tr>
</thead>
<tbody>
<tr>
<td>National-level CSV file</td>
<td>One file in CSV format that contains all the national-level data within the Excel based reports</td>
<td></td>
</tr>
<tr>
<td>CCG-level report</td>
<td>One Excel report containing survey results for every CCG and the national results</td>
<td></td>
</tr>
<tr>
<td>CCG-level CSV file</td>
<td>One file in CSV format that contains all the CCG-level data within the Excel based reports</td>
<td>Wave 1: 7 January 2016</td>
</tr>
<tr>
<td>Practice-level report</td>
<td>One Excel report containing survey results for every practice and the national results</td>
<td>Wave 2: 7 July 2016</td>
</tr>
<tr>
<td>Practice-level CSV file</td>
<td>One file in CSV format that contains all the practice-level data within the Excel based reports</td>
<td></td>
</tr>
</tbody>
</table>
Table 8.4 — Annual reports (published via the website)

<table>
<thead>
<tr>
<th>Technical annex</th>
<th>Detail/purpose</th>
<th>Date published</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Communicate operational</td>
<td>7 July 2016</td>
</tr>
<tr>
<td></td>
<td>details of survey</td>
<td></td>
</tr>
</tbody>
</table>

The GPPS ‘Surveys and reports’ link

In 2014-2015 the GPPS website went through a redesign. Part of this included incorporating the ‘Survey Results’ site into the main survey website via the Surveys and reports’ link. This link is designed to allow users to view and analyse the results of the survey in a user-friendly and accessible way. The link allows visitors to access all published current and archived reports.

Figure 8.1 — Survey and reports link on the GPPS website

Survey results and other information

What’s on this page?
- Questionnaires and letters from each period of survey fieldwork
- Recent reports including practice reports, CCG reports and national level data
- Older reports including PCT reports, NHS dentistry reports and care planning reports
- A yearly technical annex detailing how the survey was administered that year
- Individual CCG slidedpaks presenting the key results for each CCG

Find survey materials and reports by year published
- 2016
- 2015
- 2014
- 2013
- 2012
- 2011

Older surveys and reports by year published
- 2010
- 2009
- 2008
- 2007

Latest survey and reports January 2016

<table>
<thead>
<tr>
<th>Survey fieldwork dates and materials</th>
<th>January - March 2015</th>
<th>July - September 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire</td>
<td></td>
<td>Questionnaire</td>
</tr>
<tr>
<td>Letter</td>
<td></td>
<td>Letter</td>
</tr>
</tbody>
</table>

At the top of the ‘Survey and reports’ page are a number of links which provide quick access to the current and archived reports.
All current reports for practices and CCGs are accessible through this page (in weighted and unweighted data), along with the other published reports as detailed in tables 8.1 to 8.4. Note that prior to January 2016 reports are available for Regions and Area Teams; these are no longer provided following the integration of Area Teams into the four existing Regional Teams.

Also available on the ‘Survey and reports’ page is a link to the CCG slidepacks page of the website for each relevant publication. This link takes users to an A-Z tool bar which allows easy access to each of the weighted PowerPoint reports for individual CCGs (see figure 8.7). These slide packs are available for the January 2015 publications onwards.

Figure 8.2 – CCG slide packs page

CCG Slidepacks (January 2016)

If you are having trouble opening the slide packs, or if you would like them in a different format, please contact GPPatientSurvey_Enquiry@iposs-mori.com

A

NHS AIREDALE, WHARFEDALE AND CRAVEN CCG
NHS ASHFORD CCG
NHS AYLESBURY VALE CCG

B

NHS BARKING AND DAGENHAM CCG
NHS BARNET CCG
NHS BARNSLEY CCG
NHS BASILDON AND BRENTWOOD CCG
NHS BASSETLAW CCG
NHS BATH AND NORTH EAST SOMERSET CCG
The Analysis Tool website

The GPPS Analysis Tool is available for users to analyse the latest results, compare them to the results for every other practice and CCG in England and analyse any trend data which is available.

Figure 8.3 – Main page on the Analysis tool website

From the main page users can select the following to analyse their results in more detail:

- Topline practice results: after selecting a practice, this section of the website allows the user to download an Excel spreadsheet of the results for that practice or view the results of each question on a chart. CCG and the national results are also available to add to the chart for comparison. These charts are available to view weighted or unweighted.

- Topline CCG results: after selecting a CCG, this section of the website allows the user to download an Excel spreadsheet of the results for that CCG or view the results of each question on a chart. The national results are again also available to add to the chart for comparison. These charts are available to view weighted or unweighted.

- Profile analysis: the profile analysis tool allows users to interrogate the data further by examining the responses collected from different respondent groups. These profile groups can contain any required combination of CCG, GP practice or demographic information.
• Cross tabulation: the cross tabulation tool allows visitors to examine the results by looking at the responses to specific questions as answered by specific groups. This tool allows the survey data to be broken down by patient demographics, as well as by all of the survey questions in up to three different levels to produce detailed tabular results.

• Trend analysis: Where a question has been asked in more than one 12-month period, visitors can see how responses from different groups of individuals and at different levels (practice, CCG, Region or national) have changed over time. The trend data for surveys from January 2009 to March 2011 are available separately to data from June 2011 onwards.

Practice comparison tool

Since June 2015, the main GPPS website also allows users to compare results across practices, CCGs, and at the national level. This tool is available either through the ‘Compare a practice’ link on the GP Patient Survey main page or via the practice search function.

The practice comparison tool allows users to:

• view the results for a particular practice, and compare these results to CCG and national results;
• compare results to another local practice (within a 5 mile radius); and
• compare results to any other practice in the country.

Results are available for either weighted or unweighted data, with weighted data shown by default.
For more information

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www.twitter.com/IpsosMORI

About Ipsos MORI’s Social Research Institute
The Social Research Institute works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. This, combined with our methodological and communications expertise, helps ensure that our research makes a difference for decision makers and communities.