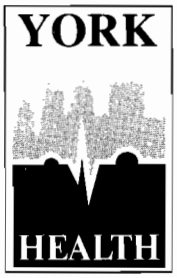

SURVEY OF THE VIEWS OF GENERAL PRACTITIONERS IN YORK HEALTH DISTRICT ABOUT THE QUALITY OF HEALTH CARE SERVICES AVAILABLE TO THEIR PATIENTS

JULY 1991

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A SURVEY OF THE VIEWS OF GENERAL PRACTITIONERS IN YORK HEALTH DISTRICT ABOUT THE QUALITY OF HEALTH CARE SERVICES AVAILABLE TO THEIR PATIENTS

BACKGROUND

1. INTRODUCTION

Health Authorities are now responsible for commissioning health care for their residents. In doing so, Health Authorities must agree with local general practitioners what referral patterns are anticipated for secondary care and what quality, style and quantity of health care is needed. Quality of health care, including the effectiveness of its outcome, is high on the agenda for commissioning Health Authorities.

Provider services also have quality of care high on the agenda in order to be sure of continuing to attract patients and to give them the best health outcomes. Providers will need to plan and deliver health care to meet identified needs. In York, the vast bulk of service will be for the surrounding local population.

This study is thus of concern to both commissioners and providers in York Health District as they consider their separate, but closely related and entwined, agendas for 1992 and beyond.

It is also important to state at the outset that no personal criticism of anyone can be inferred from any of the findings. There are many reasons for differing quality ratings and behind the same score for two services may lie quite different factors. The findings are a starting point for all concerned with health in York to begin a co-operative effort to understand and improve the service for residents and patients.

This survey was commissioned by Dr Peter Kennedy and carried out jointly between the Department of Public Health Medicine in York and the Centre for Health Economics at York University.

2. AIMS

The aims were:-

1. to test the feasibility of the survey as a method of gathering general practitioners' views on service quality;

2. to obtain, in a systematic way, the views of general practitioners about the quality of the range of health care services available to their patients;

3. to obtain general practitioners' views on the services to which they would give the highest priority for improvement;

4. to assess the criteria for judging the quality of a service to which general practitioners attach most importance.

The survey was designed and implemented with the express intention that the report should be used as a basis for a dialogue between clinicians, managers and general practitioners about how the quality of services could be improved where this was needed and in order to inform the dialogue about possible future developments.

It is one of a number of initiatives taken within the District over the last year. These have included an informal liaison group with general practitioner members nominated by the Local Medical Sub-Committee, together with consideration of how to improve communication between general practice and hospital and community services.

3. METHODS

3.1 The Questionnaire

A postal questionnaire was developed based on an adaptation of a questionnaire used in a recent study in Bristol. This postal questionnaire was sent to each general practitioner within York Health District and in Pocklington, comprising 145 general practitioners in 46 practices. Four weeks were allowed for the return of the questionnaires, after which reminders were sent to the non-responders. Two weeks later, practice managers were telephoned to ask them to encourage the remaining non-responders to complete the questionnaire.

The questionnaire was discussed with the general practitioner liaison group and with some consultants before circulation. The covering sheet with identification details about the general practitioner completing the questionnaire was detached within the Department of Public Health Medicine and has been kept confidential. It was agreed with local general practitioners that the survey would be more effective and more likely to be constructive in achieving change if general practitioners were reassured that their responses could not be identified.

The questionnaire is attached as Appendix 1. It contained eight sections.

Section A had some details about the practice in which the doctor worked.

Section B listed hospital services, diagnostic services and community services available to York residents and asked for a general quality rating of each service on a scale of one = excellent, two = good, three = adequate, four = poor, five = very poor, six = insufficient evidence to judge the quality. Quantity was regarded at this stage as an integral part of the overall quality rating.

Section C asked general practitioners to record their opinions of up to three hospital services that they most wanted to see improved. They were asked to rank them as their first, second and third choice and to rate each service chosen on 12 quality criteria using the same ranking system as in the broad assessment. Space was given for additional criteria that they wished to add and for further comments. Their view of the way patients regarded the chosen service was also requested.

There was a similar section for their first, second and third choices of community services needing improvement.

3. METHODS (Continued)

3.1 The Questionnaire (Continued)

Two further sections then asked general practitioners to review the list of quality criteria used in assessing the services needing improvement and to rank, in priority order, the top five criteria most important for them in judging the quality of a service. They were asked to do this for both a hospital service and a community service.

Finally, there was a section to record any additional services that they felt should be available and for any further comments that they wished to make.

3. METHODS (Continued)

3.2 Quality Ratings and the Quality Index

The data analysis was carried out at the Centre for Health Economics. The quality ratings scale was used to develop a standardised index of quality which gives a comparison between the different specialties and services.

The quality ratings were analysed using the scaling algorithm described in appendix two. The algorithm utilises information on the proportion of ratings in each category for individual services. Values are given as decimals but can more readily be interpreted as percentage scores with a theoretical maximum of 100% for the highest quality and 0% for the lowest quality.

One note of caution needs to be sounded in interpreting the quality index values reported here. The maximum theoretical value of 100% could be achieved only if all general practitioners gave a service a rating of one (excellent). This is unlikely to happen in practice and a figure of 90% might be selected as representing the best quality index value which might be achieved in reality. Similar arguments apply to the lower boundary of the quality index scale.

RESULTS

SECTIONS 4-10 GIVE DETAILED RESULTS.

SECTIONS 11-14 GIVE A BRIEF OUTLINE OF THE KEY RESULTS, THEIR INTERPRETATION AND THE RECOMMENDATIONS.

4. RESPONSE RATES AND GENERAL PRACTICE STRUCTURE

The response rate was 77% of general practitioners representing 112 out of the possible 145 general practitioners. There were five specific refusals or letters in response and five questionnaires returned too late for analysis, so there were only 23 general practitioners who did not respond at all. This is a magnificent response in view of the time constraints placed on general practice over the last year and the authors are most grateful.

Most of the responders (70%) had been working in the area for 10 years or less and their average age was 40.6 years. Thirty-eight (34%) worked in a training practice and 23 (20.5%) were female. There was no significant variation in response by partnership size and no other evidence that the non-responders were a selected group. Further details are in Appendix 3.

5. QUALITY RATINGS

The standardised quality ratings for each service are reported in the following section with two tables for each group of services.

The first table lists the number of general practitioners who rated each service in each of the five quality categories.

The second table in each section gives the standardised quality index value for each service and ranks the services in order of this index.

It should be remembered that quantity was regarded at this stage as an integral part of overall quality.

5. QUALITY RATINGS (Continued)

5.1 Hospital Services

Paediatrics stands out with virtually 100% of general practitioners giving it a rating of excellent or good, as shown in Table 1. Cardiology also has a high rating and there is then a group of specialties, including general medicine, general surgery, dermatology, rheumatology, diabetology with almost all good or adequate ratings.

Only a quarter of general practitioners rated ophthalmology as excellent or good and only 10% so rated orthopaedics.

Other poorly rated services included psycho-sexual counselling where, although only 78% of general practitioners felt able to rate this service, nearly 74% rated it poor or very poor. Services for the younger disabled were also rated as poor or very poor by half of the 73 general practitioners rating it.

The rating given to the pain clinic was interesting as equal proportions of general practitioners rated it excellent/good, adequate and poor or very poor.

There were some services that a majority of general practitioners felt unable to rate: services for HIV/AIDS sufferers were rated only by a third of general practitioners, of whom only 30% rated it excellent or good.

Quality Index values for hospital services are listed in Table 2. As is to be expected the values reflect the general pattern of ratings reported above, with paediatrics scoring very highly. Cardiology, including general medicine with related specialties, and general surgery, have Quality Index values of 60% or above. The poor/very poor ratings given to psychosexual counselling are reflected in the relatively low Quality Index of 32%.

The value of 42% achieved by orthopaedics is only about half that attained by paediatrics.

TABLE 1
QUALITY RATINGS GIVEN BY GENERAL PRACTITIONERS FOR HOSPITAL SPECIALTIES

Specialty/Service	Frequency of rating in each quality category					Percentage of GPs giving each rating			Number of GPs giving a rating of
	1	2	3	4	5	1 & 2	3	4 & 5	1-5
General Medicine	17	72	21	2	0	79.5	18.8	1.8	112
General Surgery	15	71	23	3	0	76.8	20.5	2.7	112
Paediatrics	74	37	1	0	0	99.1	0.9	0.0	112
Obstetrics	10	62	28	12	0	64.3	25.0	10.7	112
Gynaecology	4	32	49	26	1	32.1	43.8	24.1	112
Geriatric Services	5	35	46	22	4	35.7	41.1	23.2	112
Orthopaedics	2	10	36	51	13	10.7	32.1	57.1	112
Psychiatry	2	32	58	12	5	31.2	53.2	15.6	109
Psychogeriatrics	17	48	28	11	1	61.9	26.7	11.4	105
Accident & Emergency	11	72	24	2	0	76.1	22.0	1.8	109
Rheumatology	14	69	26	2	0	74.8	23.4	1.8	111
Dermatology	16	78	18	0	0	83.9	16.1	0.0	112
Paediatric Surgery	5	24	19	7	3	50.0	32.8	17.2	58*
Renal Medicine	9	41	20	3	1	67.6	27.0	5.4	74*
Neurology	7	47	45	8	0	50.5	42.1	7.5	107
Genito-Urinary Med	7	55	33	9	1	59.0	31.4	9.5	105
Oncology	13	46	24	7	2	64.1	26.1	9.8	92*
Chest Medicine	19	71	16	3	1	81.8	14.5	3.6	110
Ophthalmology	4	24	43	36	4	25.2	38.7	36.0	111
HIV/AIDS Services	1	10	16	8	2	29.7	43.2	27.0	37*
Younger Disabled	3	10	24	27	9	17.8	32.9	49.3	73*
Gastroenterology	2	39	57	12	2	36.6	50.9	12.5	112
Ear, Nose & Throat	8	65	32	6	0	65.8	28.8	5.4	111
Urology	13	59	27	11	0	65.5	24.5	10.0	110
Plastic Surgery	7	32	31	18	2	43.3	34.4	22.2	90*
Cardiology	35	57	18	2	0	82.1	16.1	1.8	112
Cardiac Surgery	11	28	33	17	1	43.3	36.7	20.0	90*
Diabetes	25	55	28	4	0	71.4	25.0	3.6	112
Child & Adolescent Psychiatry	6	52	29	4	0	63.7	31.9	4.4	91*
Psychosexual Counselling	0	3	20	28	36	3.4	23.0	73.6	87*
Pain Clinic	4	35	35	34	3	35.1	31.5	33.3	111

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor,
6 = insufficient evidence to rate

Note on reading the following tables

Information for each group of services is presented in two tables. The first of these lists the number of GPs who rated each specialty, in each of the five quality categories. These frequencies are also shown as percentages, with categories 1&2 (excellent/good) and 4&5 (poor/very poor) being collapsed. The total number of GPs who rated the service is given in the final column of this table. Where more than 10% of GPs indicated that they had insufficient evidence to give a rating of quality, then this total is marked by the symbol *. The second table in each section lists the standardised Quality Index value for each service, together with the rank order of each service within its group.

TABLE 2
QUALITY INDEX VALUES FOR HOSPITAL SPECIALTIES

Rank	Hospital Specialty/Service	Standardised Quality Index
1	Paediatrics	0.797
2	Cardiology	0.656
3	General Medicine	0.631
4	Dermatology	0.626
5	Rheumatology	0.620
6	Diabetes	0.619
7	General Surgery	0.617
8	Accident & Emergency	0.616
9	Chest Medicine	0.609
10	Renal Medicine	0.579*
11.5	Ear, Nose & Throat Surgery	0.577
11.5	Child & Adolescent Psychiatry	0.577*
13	Urology	0.575
14	Psychogeriatrics	0.571
15	Obstetrics	0.566
16	Oncology	0.564*
17	Genito-Urinary Medicine	0.557
18	Neurology	0.553
19	Cardiac Surgery	0.540*
20	Paediatric Surgery	0.522*
21	Plastic Surgery	0.521*
22.5	Gastroenterology	0.510
22.5	Gynaecology	0.510
24	Medicine for the Elderly	0.500
25	Pain Clinic	0.491
26	Psychiatry	0.489
27	HIV/AIDS Services	0.479*
28	Ophthalmology	0.477
29	Younger Disabled	0.442*
30	Orthopaedics	0.416
31	Psychosexual Counselling	0.318*

Derivation of the Standardised Quality Index from the Quality Ratings is given in Appendix 2.

5. QUALITY RATINGS (Continued)

5.2 Community Services

Table 3 shows ratings for 19 community services.

Terminal care provided by the Hospice received over 90% excellent or good ratings, terminal care in the community had 75% excellent or good ratings; in contrast terminal care in hospital had only 22% excellent or good ratings.

District nursing services and community midwifery were rated excellent or good by over 65% of general practitioners. Community child health, mental health services and family planning were seen as adequate by the majority of general practitioners.

Poorly rated were disability and rehabilitation services with 35 of the 78 general practitioners able to assess these services rating them poor or very poor. Chiropody and services for alcohol and drug misusers were also rated poorly, with just under 50% of general practitioners rating them poor or very poor.

The Quality Index values for community services are given in Table 4. Half have values of around 50% or lower. Hospice-based terminal care scores highly by comparison with most other services in this group.

Scoring below 50% of the theoretical maximum are physiotherapy, hospital terminal care, occupational therapy, chiropody, alcohol and drug misuse services, and disability and rehabilitation services.

TABLE 3
QUALITY RATINGS GIVEN BY GENERAL PRACTITIONERS FOR COMMUNITY SERVICES

Community Service	Frequency of rating in each quality category					Percentage of GPs giving each rating			Number of GPs giving a rating of 1-5
	1	2	3	4	5	1 & 2	3	4 & 5	
Mental Handicap Services	0	18	44	13	3	23.1	56.4	20.5	78*
Terminal Care - Hospice	55	39	4	5	0	91.3	3.9	4.9	103
Terminal Care - Hospital	3	19	49	22	5	22.4	50.0	27.6	98*
Terminal Care - Community	30	51	21	4	1	75.7	19.6	4.7	107
Health Visiting	10	32	46	20	3	37.8	41.4	20.7	111
District Nursing	27	44	31	9	0	64.0	27.9	8.1	111
Community Midwifery	31	44	24	8	4	67.6	21.6	10.8	111
Community Child Health	1	23	49	1	11	28.2	57.6	14.1	85*
Family Planning	7	30	49	5	2	39.8	52.7	7.5	93*
Disability & Rehabilitation	1	8	26	35	8	11.5	33.3	55.1	78*
Physiotherapy	7	22	38	37	5	26.6	34.9	38.5	109
Occupational Therapy	2	22	35	22	5	27.9	40.7	31.4	86*
Dietetics	3	39	48	13	2	40.0	45.7	14.3	105
Chiropody	2	17	35	40	11	18.1	33.3	48.6	105
Speech Therapy	5	31	38	18	6	36.7	38.8	24.5	98*
Alcohol & Drug Abuse	1	18	30	25	13	21.8	34.5	43.7	87*
Audiology	15	46	42	2	1	57.5	39.6	2.8	106*
Appliances - Hospital	4	29	34	16	2	38.8	40.0	21.2	85*
Appliances - Joint Equipment	3	21	27	14	0	36.9	41.5	21.5	65*

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Note on reading the following tables

Information for each group of services is presented in two tables. The first of these lists the number of GPs who rated each specialty, in each of the five quality categories. These frequencies are also shown as percentages, with categories 1&2 (excellent/good) and 4&5 (poor/very poor) being collapsed. The total number of GPs who rated the service is given in the final column of this table. Where more than 10% of GPs indicated that they had insufficient evidence to give a rating of quality, then this total is marked by the symbol *. The second table in each section lists the standardised Quality Index value for each service, together with the rank order of each service within its group.

TABLE 4
QUALITY INDEX VALUES FOR COMMUNITY SERVICES

Rank	Community Service	Standardised Quality Index
1	Terminal Care - Hospice	0.687
2	Terminal Care - Community	0.620
3	District Nursing	0.602
4	Audiology	0.596*
5	Community Midwifery	0.582
6	Family Planning	0.546*
7	Health Visiting	0.525
8	Dietetics	0.522
9	Appliances - Hospital	0.517*
10.5	Appliances - Joint Equipment	0.507*
10.5	Community Child Health	0.507*
12	Speech Therapy	0.499*
13	Mental Handicap Services	0.495*
14	Physiotherapy	0.486
15	Terminal Care - Hospital	0.479*
16	Occupational Therapy	0.475*
17	Chiropody	0.438
18	Alcohol & Drug Abuse	0.433*
19	Disability & Rehabilitation	0.420*

Derivation of the Standardised Quality Index from the Quality Ratings is given in Appendix 2.

5. QUALITY RATINGS (Continued)

5.3 Diagnostic Services

The laboratory services all have similarly high ratings with over 90% of the responses giving a rating of excellent or good (Table 5).

The ratings for radiology and ultrasound are spread and reflect a wider variation in opinion. Less than 50% of general practitioners gave ultrasound a rating of excellent or good.

As expected, the diagnostic services yielded similar quality indices around 70% of the theoretical maximum (Table 6).

Radiology and ultrasound score some 20% below this level.

TABLE 5
QUALITY RATINGS GIVEN BY GENERAL PRACTITIONERS FOR DIAGNOSTIC SERVICES

Diagnostic Service	Frequency of rating in each quality category					Percentage of GPs giving each rating			Number of GPs giving a rating of 1-5
	1	2	3	4	5	1 & 2	3	4 & 5	
Microbiology	43	65	4	0	0	96.4	3.6	0.0	112
Histopathology	36	71	4	0	0	96.4	3.6	0.0	111
Biochemistry	40	66	6	0	0	94.6	5.4	0.0	112
Haematology	43	61	8	0	0	92.9	7.1	0.0	112
Radiology	14	47	38	10	3	54.5	18.5	11.6	112
Ultrasound	11	35	30	25	11	41.1	26.8	32.1	112
Nuclear Medicine	24	59	14	0	0	85.6	14.4	0.0	97*

TABLE 6
QUALITY INDEX VALUES FOR DIAGNOSTIC SERVICES

Rank	Diagnostic Service	Standardised Quality Index
1	Microbiology	0.697
2	Histopathology	0.687
3	Biochemistry	0.681
4	Haematology	0.676
5	Nuclear Medicine	0.627*
6	Radiology	0.535
7	Ultrasound	0.478

Derivation of the Standardised Quality Index from the Quality Ratings is given in Appendix 2.

5. QUALITY RATINGS (Continued)

5.4 Ranked Quality Index Values

Table 7 shows all services ranked by their quality index divided into four quartile bands.

The singular pattern of ratings for paediatrics resulted in a high Quality Index value which appears significantly greater than that of all other services.

The quality index for psychosexual counselling is the lowest, although this rating may be biased by general practitioners who felt unable to assess the service quality owing to insufficient evidence. This argument may or may not bear close scrutiny, since other service areas, eg nuclear medicine, which some general practitioners also felt unable to assess attracted higher ratings and Quality Index scores.

TABLE 7
ALL SERVICES RANKED BY QUALITY INDEX SCORE DIVIDED INTO FOUR QUARTILES

Rank	Service	Standardised Quality Index
1	Paediatrics	0.797
2	Microbiology	0.697
3.5	Terminal Care - Hospice	0.687
3.5	Histopathology	0.687
5	Biochemistry	0.681
6	Haematology	0.676
7	Cardiology	0.656
8	General Medicine	0.631
9	Nuclear Medicine	0.627*
10	Dermatology	0.626
11.5	Terminal Care - Community	0.620
11.5	Rheumatology	0.620
13	Diabetes	0.619
14	General Surgery	0.617
15	Accident & Emergency	0.616
16	Chest Medicine	0.609
17	District Nursing	0.602
18	Audiology	0.596*
19	Community Midwifery	0.582
20	Renal Medicine	0.579*
21.5	Ear, Nose & Throat Surgery	0.577
21.5	Child & Adolescent Psychiatry	0.577*
23	Urology	0.575
24	Psychogeriatrics	0.571
25	Obstetrics	0.566
26	Oncology	0.564*
27	Genito-Urinary Medicine	0.557
28	Neurology	0.553

TABLE 7 (CONTINUED)
ALL SERVICES RANKED BY QUALITY INDEX SCORE DIVIDED INTO FOUR QUARTILES

29	Family Planning	0.546*
30	Cardiac Surgery	0.540*
31	Radiology	0.535
32	Health Visiting	0.525
33.5	Dietetics	0.522
33.5	Paediatric Surgery	0.522*
35	Plastic Surgery	0.521*
36	Appliances - Hospital	0.517*
37.5	Gastroenterology	0.510
37.5	Gynaecology	0.510
39.5	Appliances - Joint Equipment	0.507*
39.5	Community Child Health	0.507*
41	Medicine for the Elderly	0.500
42	Speech Therapy	0.499*
43	Mental Handicap Services	0.495*
44	Pain Clinic	0.491
45	Psychiatry	0.489
46	Physiotherapy	0.486
47.5	Terminal Care - Hospital	0.479*
47.5	HIV/AIDS Services	0.479*
49	Ultrasound	0.478
50	Ophthalmology	0.477
51	Occupational Therapy	0.475*
52	Younger Disabled	0.442*
53	Chiropody	0.438
54	Alcohol and Drug Abuse	0.433*
55	Disability and Rehabilitation	0.420*
56	Orthopaedics	0.416
57	Psychosexual Counselling	0.318*

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT

Table 8 shows these choices, which were all of services provided in York. Specialties most frequently chosen correlate well with those services which received the poorest quality rating, with one or two exceptions.

Orthopaedics was the leading choice for improvement. Seventy-five (67%) general practitioners chose this service, with 50 general practitioners making it their first choice.

Ophthalmology was chosen by 52 (46%) general practitioners, with 18 making it their first choice.

Others chosen by at least 10 general practitioners were:-

Gynaecology, chosen by 27 (24%) with two first choices;

Gastro-enterology/endoscopy, chosen by 17 (15%) with two first choices;

Medicine for the elderly, chosen by 15 (13%) with five first choices;

Radiology/ultrasound, chosen by 12 (11%) with three first choices;

Psychiatry, chosen by 10 (9%) with five first choices;

Physiotherapy, chosen by 10 (9%) with one first choice.

Detailed quality criteria ratings for those hospital services chosen as priorities for improvement are shown in tables 9-16 and reported below. General practitioners in the main rated the 12 quality criteria suggested and added only a few additional criteria. The rating scale was the same as in the first part of the questionnaire.

TABLE 8
GENERAL PRACTITIONERS' CHOICE OF HOSPITAL SERVICES MOST IN NEED OF IMPROVEMENT

Specialty/Service	1st Choice	2nd Choice	3rd Choice	Total+	Percentage of GPs Choosing each Service* (n=112)
Orthopaedics	50	20	5	75	67
Ophthalmology	18	23	11	52	46
Gynaecology	2	18	7	27	24
Gastroenterology/Endoscopy	2	8	7	17	15
Medicine for the Elderly	5	4	6	15	14
Radiology/Ultrasound	3	3	6	12	11
Psychiatry	5	1	4	10	9
Physiotherapy	1	4	5	10	9
Obstetrics	2	2	2	6	5
Pain Relief Clinic	2	0	3	5	4
Urology	1	1	2	4	4
Psychosexual Counselling	1	1	1	3	3
ECG Service	1	0	1	2	2
Waiting List	1	1	0	2	2
Wait for Elective Admission	1	1	0	2	2
Clinical Psychology	0	1	1	2	2
Alcohol/Drug Abuse	0	0	2	2	2
Diabetes Care	1	0	0	1	1
Psychogeriatrics	1	0	0	1	1
Terminal Care	1	0	0	1	1
Chiropody	1	0	0	1	1
Hospital Nursing Care	1	0	0	1	1
Wait for Out-Patient Appointment	1	0	0	1	1
Appointment Department Admin	1	0	0	1	1
Speech Therapy	0	1	0	1	1
Psychosexual Medicine	0	1	0	1	1
Ear, Nose & Throat Surgery	0	1	0	1	1
General Surgery	0	1	0	1	1
Rheumatology	0	1	0	1	1
Appointment Selectivity	0	1	0	1	1
Younger Disabled	0	0	1	1	1
Orthodontics	0	0	1	1	1
Obstetrics & Gynaecology	0	0	1	1	1
Chest Medicine	0	0	1	1	1
Radiotherapy	0	0	1	1	1
General Surgery Out-Patients	0	0	1	1	1
General Practitioner Feedback	0	0	1	1	1
Discharge Letters	0	0	1	1	1
Consultant Involvement in Out-Patient Care	0	0	1	1	1
Surgical & Medical Out-Patient Appointments	0	0	1	1	1

+ Total number of first, second and third choices
* Percentage is of total 112 GPs who responded to survey

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.1 Orthopaedics

Orthopaedics was chosen by 75 (67%) general practitioners; 50 made it their first choice (Table 9).

Good or adequate ratings were given for quality of consultant care, quality of nursing, standard of accommodation and travel time for the patient.

A more mixed response was given to ease of arranging emergency admissions, ease of arranging out-patient appointments, communication with general practitioner, organisation of discharges and consultant involvement in out-patient care where a substantial minority felt that these factors were poor or very poor.

The ratings which stand out as scoring poorly are waiting time for first appointment where 73 out of 75 general practitioners scored this criterion as poor or very poor, and the waiting time for in-patient elective care where 75 (100%) general practitioners scored this as poor or very poor.

Twenty-seven out of 75 general practitioners felt they had insufficient evidence to judge the standards of accommodation and only 53% of general practitioners scored this criterion. Eighteen out of 75 felt they had insufficient evidence to score the quality of nursing and only 65% of general practitioners scored this item.

Sixty-one percent (46 of 75) of general practitioners thought that their patients would rate the service poor or very poor.

Specific comments were made by 45 of the 75. Thirty-four (75%) of the 45 general practitioners were concerned about long waiting times for out-patients and for elective surgery, particularly arthroscopy and hip replacements.

Just over one-third of general practitioners (17 out of 45)commented on poor communications both between hospital staff and general practitioners and between hospital staff and patients. Comment was also made that general practitioners wanted help in the management of orthopaedic problems and not only a decision on whether surgery was needed. Three general practitioners (6%) suggested that the service was understaffed and overstretched.

Waiting time for appointments and for in-patient elective care was the major problem highlighted but ease of arranging admissions or appointments, organisation of discharges and communication with general practitioners also need to be considered by this service.

TABLE 9
QUALITY CRITERIA RATINGS FOR ORTHOPAEDICS

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	1	1	36	37	0	100
2. Waiting time for in-patient elective	0	0	0	17	58	0	100
3. Travel time for patient	2	27	27	1	0	8	76
4. Ease of arranging emergency admission	6	25	20	14	6	0	95
5. Ease of arranging out-patient appointments	4	10	27	17	11	2	92
6. Standard of accommodation	1	20	17	2	0	27	53
7. Quality of nursing	1	24	21	3	0	18	65
8. Quality of consultant care	4	29	27	5	4	1	92
9. Communication with general practitioner	1	12	35	15	9	0	96
10. Organisation of in-patient discharges	0	8	33	13	5	10	79
11. Organisation of out-patient discharges	0	9	35	14	1	9	79
12. Consultant involvement in out-patient care	2	16	37	9	2	5	88
Total number of ratings in each category (all criteria)	21	181	280	146	133	80	
Quality rating that GPs expected patients to give to a service	0	1	16	32	14	0	84

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 75

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.2 Ophthalmology

Ophthalmology was chosen by 52 (46%) general practitioners; eighteen made it their first choice. Table 10 shows the detailed quality criteria ratings for ophthalmology.

The service was rated good or adequate on the quality of nursing and consultant care, on the standard of accommodation, ease of arranging admissions and out-patient appointments and the travel time for patients.

There was a more mixed response on the communication with general practitioners and the organisation of in-patient and out-patient discharges, with 40% of the 52 general practitioners giving a poor or very poor rating. There was also a mixed response on the consultant involvement in out-patient care where a substantial minority of general practitioners rated the service as poor or very poor.

The worst ratings were on waiting time for first appointments, where 46 out of 52 general practitioners (88%) rated this as poor or very poor and waiting time for in-patient elective care, which 100% of general practitioners rated as poor or very poor.

Seventy percent (31 out of 44) of general practitioners thought that patients would rate the service poor or very poor.

Thirty-one general practitioners made specific comments. The majority were concerned with long waiting times for out-patient visits and elective surgery.

Just over one-third of general practitioners commented about communications, including feedback after out-patient visits.

A similar proportion considered that the ophthalmology service was underprovided and had a workload too great for present staffing levels.

The major problems are long waiting times for out-patient and in-patient care, together with concern about communications with general practitioners and the organisation of discharges, both in-patient and out-patient.

TABLE 10
QUALITY CRITERIA RATINGS FOR OPHTHALMOLOGY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	1	5	25	21	0	100
2. Waiting time for in-patient elective	0	0	0	17	34	1	98
3. Travel time for patient	3	12	16	3	0	5	65
4. Ease of arranging emergency admission	12	26	9	3	0	0	96
5. Ease of arranging out-patient appointments	9	26	13	2	1	0	98
6. Standard of accommodation	1	17	12	0	13	0	83
7. Quality of nursing	1	22	6	0	0	15	56
8. Quality of consultant care	6	27	13	3	0	0	94
9. Communication with general practitioner	1	14	15	12	8	0	96
10. Organisation of in-patient discharges	0	9	23	9	2	4	83
11. Organisation of out-patient discharges	1	8	16	14	6	1	87
12. Consultant involvement in out-patient care	0	7	19	16	4	2	88
Total number of ratings in each category (all criteria)	34	169	147	104	89	28	
Quality rating that GPs expected patients to give to a service	0	1	12	28	3	0	85

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 52

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.3 Gynaecology

Gynaecology was chosen by 27 (24%) general practitioners as a service in need of improvement, with two making it their first choice (Table 11).

There were excellent, good or adequate ratings for the quality of consultant care, the quality of nursing, ease of arranging admission and appointment, the standard of accommodation.

There was a more diverse rating for communication with general practitioners, organisation of in-patient discharges, organisation of out-patient discharges and consultant involvement in out-patient care, though in none of those categories was the specialty rated very poor.

Adverse ratings came in the waiting time for first appointments and the waiting time for in-patient elective care, where very few general practitioners scored the service as adequate and the majority - 22 out of 27 (81%) and 25 out of 27 (92%) - scored these criteria as poor or very poor.

Thirteen of 27 general practitioners (48%) thought that their patients would rate the service as adequate or good, with eight expecting their patients to give it a poor rating.

Between 50 and 70% of the 27 general practitioners felt that they had insufficient evidence to rate the standard of accommodation, the quality of nursing, and travel time for patients.

Fourteen of 27 general practitioners (52%) made specific comments. Most (11 out of 14) commented on long waiting times, with those for sterilisation and colposcopy specifically mentioned. Three commented on the availability of services for termination of pregnancy and three about the lack of access to ultrasound.

This service was chosen by fewer general practitioners than the preceding two, and long waiting times are the major issue, with most other factors being rated relatively highly.

TABLE 11
QUALITY CRITERIA RATINGS FOR GYNAECOLOGY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	0	5	14	8	0	100
2. Waiting time for in-patient elective	0	0	1	15	10	0	96
3. Travel time for patient	0	9	7	0	0	8	59
4. Ease of arranging emergency admission	10	14	3	0	0	0	100
5. Ease of arranging out-patient appointments	5	6	11	4	0	0	96
6. Standard of accommodation	2	7	5	0	0	10	52
7. Quality of nursing	2	8	8	1	0	7	70
8. Quality of consultant care	5	12	6	3	0	0	96
9. Communication with general practitioner	0	6	11	10	0	0	100
10. Organisation of in-patient discharges	0	4	12	5	0	4	78
11. Organisation of out-patient discharges	0	5	10	5	0	4	74
12. Consultant involvement in out-patient care	2	8	8	6	0	1	81
Total number of ratings in each category (all criteria)	26	79	87	63	18	34	
Quality rating that GPs expected patients to give to a service	0	2	11	8	1	0	81

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 27

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.4 Gastroenterology/Endoscopy

Seventeen (15%) general practitioners chose either gastroenterology or endoscopy as a service needing improvement; two made it their first choice (Table 12).

In this section, some percentages of general practitioners are based on quite small numbers, since not all the 17 general practitioners choosing this service rated every criterion. This is also true of services discussed in sections 6.5-6.8.

The service scored well on the quality of consultant/nursing care, ease of arranging admission, in emergency, and on the standard of accommodation.

There was a more diverse rating of communication with general practitioners and the organisation of discharges.

The poorest ratings were for waiting time for first appointment and for in-patient elective, care and the ease of arranging out-patient appointments. There were no excellent ratings in these categories and between six and 10 out of these 17 general practitioners rated them poor or very poor.

Five of the 13 general practitioners rating the quality of nursing care and of accommodation felt they had insufficient evidence to make a judgement.

Of the nine general practitioners rating the patients' view of the service, four thought it would be rated adequate and four poor or very poor.

Thirteen general practitioners wrote comments on this service. All the comments centred on improving access to endoscopy and it would appear that the rating given to the gastroenterology service reflects a desire to see endoscopy services improved for general practitioners.

TABLE 12
QUALITY CRITERIA RATINGS FOR GASTROENTEROLOGY/ENDOSCOPY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	3	1	7	3	0	82
2. Waiting time for in-patient elective	0	2	4	6	1	0	77
3. Travel time for patient	1	1	5	2	0	1	53
4. Ease of arranging emergency admission	0	8	4	0	0	0	71
5. Ease of arranging out-patient appointments	1	3	5	2	2	1	77
6. Standard of accommodation	0	3	4	0	1	5	47
7. Quality of nursing	1	6	1	0	0	5	47
8. Quality of consultant care	2	7	1	3	0	0	77
9. Communication with general practitioner	1	3	4	3	1	0	71
10. Organisation of in-patient discharges	1	6	3	1	0	1	65
11. Organisation of out-patient discharges	0	5	5	2	0	1	71
12. Consultant involvement in out-patient care	0	7	3	1	1	1	71
Total number of ratings in each category (all criteria)	7	54	40	27	9	15	
Quality rating that GPs expected patients to give to a service	0	1	4	3	1	1	53

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 17

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.5 Medicine for the Elderly

Fifteen (14%) general practitioners gave medicine for the elderly as a service needing improvement (Table 13). The comments covered the service provided both at York District Hospital and at the City Hospital in York. For five general practitioners, it was their first choice for improvement.

This service received diverse ratings on most factors, with good, adequate and poor ratings predominating. The waiting time for appointments in out-patients and for in-patient elective care was seen as reasonable, as was the standard of accommodation and the quality of nursing care.

The majority rated consultant care as adequate and consultant involvement in out-patient care was rated good or adequate.

Communication with general practitioners and the organisation of in-patient and out-patient discharges scored as adequate or poor.

The ease of arranging emergency admissions scored eight out of 14 (57%) very poor ratings.

Patients were seen as likely to rate the service as poor by 11 of 13 general practitioners.

Five general practitioners made specific comments which covered a range of concerns, including dislike of sectorisation, lack of long-stay beds and the inability to gain access to physiotherapy without a consultant referral.

It is difficult to draw conclusions about the specific aspects of the service needing improvement; discussions between consultants and general practitioners perhaps should centre round the organisation of emergency care and of discharges.

TABLE 13
QUALITY CRITERIA RATINGS FOR MEDICINE FOR THE ELDERLY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	2	8	2	2	1	93
2. Waiting time for in-patient elective	0	3	6	1	2	1	80
3. Travel time for patient	0	4	3	4	0	2	73
4. Ease of arranging emergency admission	1	1	3	1	8	0	93
5. Ease of arranging out-patient appointments	1	2	4	3	2	2	80
6. Standard of accommodation	0	2	5	5	0	1	80
7. Quality of nursing	1	5	5	1	0	2	80
8. Quality of consultant care	1	0	6	4	2	0	87
9. Communication with general practitioner	0	1	5	7	1	0	93
10. Organisation of in-patient discharges	0	2	4	6	2	0	93
11. Organisation of out-patient discharges	0	1	9	1	0	3	73
12. Consultant involvement in out-patient care	0	2	7	3	1	1	87
Total number of ratings in each category (all criteria)	4	25	65	38	20	13	
Quality rating that GPs expected patients to give to a service	0	1	1	11	0	0	92

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 15

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.6 Radiology/Ultrasound

Twelve (11%) general practitioners gave radiology or ultrasound as a choice for improvement. Two general practitioners made this their first choice (Table 14).

The quality of consultant care scored well.

Of the other criteria rated by most or all of the general practitioners, waiting time for the first appointment, ease of arranging out-patient appointments, and communication with general practice all scored poorly, with approximately 75% or more of the 12 general practitioners rating these factors poor or very poor.

Patients were expected to rate the service adequate or poor.

Specific comments were made by eight general practitioners. They centred on the long waiting times for routine X-rays; five general practitioners commented on the need for access to pelvic ultrasound and three about the communication of results from the radiology department.

The main issues centre around long waiting times, organisational matters and open access services.

TABLE 14
QUALITY CRITERIA RATINGS FOR RADIOLOGY/ULTRASOUND

	Frequency of rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	0	3	4	5	0	100
2. Waiting time for in-patient elective	0	0	1	0	2	2	25
3. Travel time for patient	0	3	3	0	0	3	50
4. Ease of arranging emergency admission	0	1	2	1	2	1	50
5. Ease of arranging out-patient appointments	0	2	3	5	2	0	100
6. Standard of accommodation	1	1	3	0	0	4	42
7. Quality of nursing	1	1	2	0	0	4	33
8. Quality of consultant care	1	3	2	1	0	3	58
9. Communication with general practitioner	0	1	0	6	4	0	92
10. Organisation of in-patient discharges	0	0	0	1	0	3	8
11. Organisation of out-patient discharges	0	1	0	2	0	1	25
12. Consultant involvement in out-patient care	0	1	1	2	0	0	33
Total number of ratings in each category (all criteria)	3	14	20	22	15	21	
Quality rating that GPs expected patients to give to a service	0	1	4	5	1	0	92

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 12

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.7 Psychiatry

Psychiatry was mentioned by 10 general practitioners (9%) as a choice of service in need of improvement (Table 15). Five general practitioners made it their first choice.

Ratings on the quality criteria were spread across the range.

Seven out of 10 (70%) rated waiting time for first appointments as excellent, good or adequate and five out of the six rating waiting time for in-patient elective care also rated it excellent, good or adequate.

The quality of consultant care, the organisation of in- and out-patient discharges and consultant involvement in out-patient care scored adequate or poor and were the least well-rated of the criteria.

Five of the eight general practitioners giving an expected rating by patients chose 'poor'.

Eight of the 10 general practitioners made comments about the present service which covered a range of issues; three were about sectorisation affecting quality and efficiency of service.

The nature of general practitioners' concerns about this service do not emerge clearly and there is a need for further discussion to try to elucidate what changes might be needed.

TABLE 15
QUALITY CRITERIA RATINGS FOR PSYCHIATRY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	1	3	3	2	1	0	100
2. Waiting time for in-patient elective	1	2	2	1	0	0	60
3. Travel time for patient	1	3	3	0	0	1	70
4. Ease of arranging emergency admission	1	2	3	3	1	0	100
5. Ease of arranging out-patient appointments	1	2	3	3	1	0	100
6. Standard of accommodation	1	2	4	1	0	1	90
7. Quality of nursing	0	3	3	0	0	3	60
8. Quality of consultant care	0	2	2	5	1	0	100
9. Communication with general practitioner	1	2	3	3	1	0	100
10. Organisation of in-patient discharges	0	4	3	3	0	0	100
11. Organisation of out-patient discharges	1	0	5	3	1	0	100
12. Consultant involvement in out-patient care	0	0	6	3	1	0	100
Total number of ratings in each category (all criteria)	8	25	40	27	7	5	
Quality rating that GPs expected patients to give to a service	0	1	2	5	0	0	80

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 10

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.8 Physiotherapy

Ten general practitioners (9%) gave physiotherapy as a choice of a service needing improvement, with one first choice (Table 16).

These comments relate to hospital-based physiotherapy but should be read in conjunction with comments on community-based services where physiotherapy was a choice for improvement for 20 general practitioners. Three general practitioners chose physiotherapy in both settings.

Some of the quality criteria are not relevant to physiotherapy.

Communication with general practitioners, rated by seven out of the 10 general practitioners, was mainly rated as good.

Most of the criteria were given adequate ratings, apart from the waiting time for the first appointment where seven out of the nine rating this criteria scored it as very poor.

Patients were seen as likely to rate the service good or adequate.

Seven general practitioners made specific comments which were almost all concerned with the waiting times and with the limited types of patient that could be referred to the service.

TABLE 16
QUALITY CRITERIA RATINGS FOR HOSPITAL PHYSIOTHERAPY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	0	1	1	7	0	90
2. Waiting time for in-patient elective	0	0	0	0	0	1	0
3. Travel time for patient	0	3	3	0	0	2	60
4. Ease of arranging emergency admission	0	0	2	0	0	0	20
5. Ease of arranging out-patient appointments	0	0	5	0	0	0	50
6. Standard of accommodation	0	1	3	0	0	1	40
7. Quality of nursing	0	1	0	0	0	0	10
8. Quality of consultant care	1	2	0	0	0	0	30
9. Communication with general practitioner	0	6	1	0	0	0	70
10. Organisation of in-patient discharges	0	0	0	0	0	1	0
11. Organisation of out-patient discharges	0	1	0	0	0	0	10
12. Consultant involvement in out-patient care	0	0	0	0	0	1	0
Total number of ratings in each category (all criteria)	1	14	15	1	7	6	
Quality rating that GPs expected patients to give to a service	0	3	3	1	0	0	70

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 10

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.9 Other Hospital Services Chosen

Table 8 also shows the other hospital services chosen by general practitioners with the numbers making them their first, second or third choice. Clearly, 10 general practitioners selecting a service is an arbitrary criterion and the other services which have caused some concern need consideration.

6. HOSPITAL SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

6.10 Summary

The choice of orthopaedics and ophthalmology by 67% and 46% of general practitioners respectively was the overwhelming response of this section. These services should have a high priority for discussion between the commissioning authority, general practitioners, consultants and managers in the provider to work out ways of bringing about improvement.

The quantity of service available as measured by waiting times is clearly an important factor in their poor rating in terms of quality. There are also issues about the organisation of services and communication patterns with general practitioners and with patients which need to be addressed.

7. COMMUNITY SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT

Twenty-eight community services or aspects of such services were mentioned at least once, as seen in Table 17.

Seventy-four out of the 112 general practitioners chose to comment on a community service but 34% did not so choose. This may be because there were fewer community services causing major concerns or may possibly be related to the fact that community services were in the second half of the questionnaire following the section on hospital services.

Four services were chosen by more than 10 general practitioners and detailed comments follow.

Health visiting was chosen by 25 general practitioners, 22% of the total sample and 35% of those choosing a community service.

District nursing was chosen by 24 general practitioners, 21% of the total sample and 33% of those choosing a community service.

Two more general practitioners chose community nursing as their first choice without giving an indication as to whether it was health visiting or district nursing that was being considered. These two responses have not been added into the analysis of general practitioners rating those services individually but do add extra weight.

Physiotherapy was chosen by 20 general practitioners, 18% of the total sample and 27% of those choosing a community service.

Chiropody was chosen by 18 general practitioners, 16% of the total sample and 24% of those choosing a community service.

TABLE 17
GENERAL PRACTITIONERS' CHOICE OF COMMUNITY SERVICES MOST IN NEED OF IMPROVEMENT

Specialty/Service	1st Choice	2nd Choice	3rd Choice	Total	Percentage of GPs Choosing each Service* (n = 112)
Health Visiting	10	14	1	25	22
District Nursing	11	6	7	24	21
Physiotherapy	7	7	6	20	18
Chiropody	12	3	3	18	16
Midwifery	7	1	1	9	8
Terminal Care	4	1	2	7	6
Speech Therapy	4	1	0	5	5
Occupational Therapy	3	1	1	5	5
Social Services	0	2	3	5	5
Disability and Rehabilitation	1	3	0	4	4
Community Psychiatric Nursing	1	2	1	4	4
Home Helps	2	1	0	3	3
Mental Handicap	2	0	1	3	3
Community Nursing	2	0	0	2	2
Diabetes Care	1	0	0	1	1
Psychogeriatrics	1	0	0	1	1
ECG Service	1	0	0	1	1
Outreach Teams	1	0	0	1	1
Psychiatric/Mental Health	1	0	0	1	1
Management	1	0	0	1	1
Wait for Initial Contact	1	0	0	1	1
Appointment Selectivity	1	0	0	1	1
Alcohol/Drug Abuse	0	1	0	1	1
General practitioner Feedback	0	1	0	1	1
Advisory Nurse	0	1	0	1	1
Domiciliary Care Assistants	0	1	0	1	1
Community Child Health	0	1	0	1	1
Family Planning Clinics	0	0	1	1	1

* Percentage is of total 112 GPs who responded to survey

Only 74 general practitioners made a choice of a community service for improvement.

7. COMMUNITY SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

7.1 Health Visiting

Health visiting was the choice of 25 (22%) general practitioners (Table 18). For 10 it was their first choice. These health visiting services were located at several health centres in all sectors.

Most of the quality criteria were rated comparatively highly by general practitioners, with ease of communication with general practitioner and quality of staff care being particularly well-rated. Integration with the primary care team was rated poor by eight of the 19 general practitioners who scored this criterion.

Eleven general practitioners thought that patients would view the service as excellent, good or adequate, whilst four thought it might be seen as poor or very poor.

Eighteen of the 25 general practitioners gave specific comments.

Eleven commented on the service being overworked and understaffed. This is the largest group of comments.

Five general practitioners commented on the need for health visitors to be more involved with the elderly, but that this was not possible owing to present workloads.

The major concern with this service would appear to be the availability of resource in the service as on most of the quality ratings it does well with very few poor ratings.

TABLE 18
QUALITY CRITERIA RATINGS FOR HEALTH VISITING

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	2	8	5	0	1	2	64
2. Ease of communication with general practitioner	4	5	5	2	1	0	68
3. Ease of access for patients	3	3	8	2	1	1	68
4. Ease of urgent care	1	4	7	3	1	1	64
5. Standard of accommodation	0	2	5	0	0	7	28
6. Quality of staff care	6	4	6	4	0	0	80
7. Integration with team	3	4	4	8	0	0	76
8. Feedback to general practitioner	2	5	8	3	1	0	76
9. Co-ordination with Social Services	1	4	7	2	0	4	56
10. Supply of appliances	1	2	3	1	0	7	28
11. Time spent with patient	2	2	6	3	0	3	52
Total number of ratings in each category (all criteria)	25	43	64	28	5	25	
Quality rating that GPs expected patients to give to a service	1	2	8	3	1	0	60

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 25

7. COMMUNITY SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

7.2 District Nursing

Twenty-four general practitioners (21%) chose district nursing, with 11 first choices (Table 19). The services were located at several health centres in all sectors.

The service was rated as excellent, good or adequate on most criteria. The quality of staff care scored outstandingly highly with 22 out of 23 general practitioners rating it excellent or good. There were also high ratings for integration with the primary care team and the feedback to general practitioners.

A small number of poor ratings related to four in 24 (17%) poor ratings for ease of access for patients and seven out of 22 (29%) general practitioners rating supply of appliances as poor or very poor. The time spent with the patient was also rated poor by six out of the 17 (25%) general practitioners scoring this.

Thirteen of the 18 general practitioners who gave a patient rating estimated that patients would rate the service as excellent or good. Only one thought patients would rate the service as poor.

Eighteen general practitioners gave comments about the existing service, the majority of which were about the district nursing service being overstretched.

Comments about the quality of the care received from this service were favourable.

There were specific comments from four general practitioners about the lack of an out-of-hours or weekend service.

The service was rated highly overall, but it is perceived to need improvement in terms of resources devoted to it.

TABLE 19
QUALITY CRITERIA RATINGS FOR DISTRICT NURSING

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	3	13	5	0	0	0	88
2. Ease of communication with general practitioner	7	9	6	1	0	0	96
3. Ease of access for patients	2	6	10	4	0	1	92
4. Ease of urgent care	4	9	7	2	0	0	92
5. Standard of accommodation	0	0	3	0	0	9	13
6. Quality of staff care	12	10	0	1	0	0	96
7. Integration with team	3	10	8	2	0	0	96
8. Feedback to general practitioner	5	10	7	1	0	0	96
9. Co-ordination with Social Services	0	5	6	2	0	6	54
10. Supply of appliances	3	4	8	6	1	0	92
11. Time spent with patient	0	3	8	6	0	4	71
Total number of ratings in each category (all criteria)	39	79	68	25	1	20	
Quality rating that GPs expected patients to give to a service	1	10	4	1	0	0	75

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 24

7. COMMUNITY SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

7.3 Physiotherapy

Twenty general practitioners (18%) gave physiotherapy as their choice (Table 20), with seven first choices. Although the section was about community services, six general practitioners specifically mentioned the location of services they were commenting on as being in York District Hospital and this section should be seen in conjunction with the hospital physiotherapy service, which was also a choice for improvement by 10 general practitioners. Twenty-seven individuals chose physiotherapy 30 times. The ratings pattern for hospital physiotherapy services is similar to that for the community service.

The quality of staff care was rated highly, with 12 excellent or good ratings out of 14 general practitioners commenting.

Feedback to general practitioners scored well, with 12 out of 15 seeing this as excellent, good or adequate.

For most other criteria there was a range of ratings but the waiting time for first appointment, rated by 12 general practitioners, was scored very poor by nine and poor by three.

Of the seven who commented, three general practitioners thought that their patients would see the services as adequate, one as good and three as poor.

Ten general practitioners made specific comments; the majority were about the need for a greater level of service, saying that the service is "all but non-existent" and that "it would be a major addition if it was available".

Twenty-four percent of all general practitioners responding chose physiotherapy in one or other setting as a service having high priority for improvement.

The major disquiet is about lack of access to the service, as the quality of care and communication with general practitioners were rated well. This is a service that should receive early and detailed discussion between physiotherapists, consultants, general practitioners and managers to reach an understanding of the reasons for the prominence of these services as needing improvement.

TABLE 20
QUALITY CRITERIA RATINGS FOR PHYSIOTHERAPY (COMMUNITY SERVICE)

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	0	0	0	3	9	2	60
2. Ease of communication with general practitioner	0	6	3	2	2	1	65
3. Ease of access for patients	0	6	3	1	4	1	70
4. Ease of urgent care	0	2	3	3	5	1	65
5. Standard of accommodation	1	3	4	0	0	4	40
6. Quality of staff care	3	7	1	0	1	2	60
7. Integration with team	1	4	2	3	2	2	60
8. Feedback to general practitioner	2	5	4	1	2	1	65
9. Co-ordination with Social Services	0	1	1	0	2	6	20
10. Supply of appliances	1	5	3	1	1	3	55
11. Time spent with patient	1	4	5	0	2	2	60
Total number of ratings in each category (all criteria)	9	43	29	14	30	25	
Quality rating that GPs expected patients to give to a service	0	1	3	3	0	0	35

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 20

7. COMMUNITY SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

7.4 Chiropody

Eighteen general practitioners (16%) gave chiropody as a choice for a service needing improvement, 12 making it a first choice (Table 21). Services were situated in a number of health centres in all sectors.

The service was rated well on the quality of staff care, with excellent, good or adequate ratings from 15 of the 18 general practitioners who commented.

The waiting time for the first appointment was the major item poorly rated, receiving 16 out of 18 poor or very poor ratings.

Poor or very poor ratings were also given by just over half the general practitioners for the ease of access for patients, the ease of communication with general practitioners, integration with the primary care team and feedback to general practitioners.

Ten out of the 11 general practitioners who made specific comments thought that their patients would rate the service as poor or very poor.

There are problem areas for chiropody in the amount of service available, in access to the service and with the way in which it relates to general practitioners.

TABLE 21
QUALITY CRITERIA RATINGS FOR CHIROPODY

Quality Criteria	Frequency of Rating in Each Quality Category						Percentage of GPs giving a rating between 1 and 5
	1	2	3	4	5	6	
1. Waiting time for first appointment	1	0	1	8	8	0	100
2. Ease of communication with general practitioner	0	2	4	6	5	0	94
3. Ease of access for patients	0	0	7	8	2	0	94
4. Ease of urgent care	0	0	2	7	7	0	89
5. Standard of accommodation	0	6	0	0	0	6	33
6. Quality of staff care	1	6	8	0	0	1	83
7. Integration with team	1	0	2	8	5	0	89
8. Feedback to general practitioner	0	2	2	7	6	0	94
9. Co-ordination with Social Services	0	1	2	1	3	9	39
10. Supply of appliances	0	2	5	0	1	6	44
11. Time spent with patient	0	3	2	3	0	7	44
Total number of ratings in each category (all criteria)	3	22	35	48	37	29	
Quality rating that GPs expected patients to give to a service	0	0	1	8	2	0	61

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor, 6 = insufficient evidence to rate

Number of general practitioners rating service = 18

7. COMMUNITY SERVICES CHOSEN AS MOST IN NEED OF IMPROVEMENT (Continued)

7.5 General Comments

The message from the detailed ratings of community services seen as a priority for improvement are that the services are in the main perceived as giving good quality of care but as being hopelessly inadequately resourced and staffed. These services are highly valued by general practitioners and should be discussed in detail to clarify what should be the future pattern of service.

8. QUALITY CRITERIA ADDITIONAL TO THOSE SET OUT IN THE QUESTIONNAIRE

Few general practitioners gave additional quality criteria, although the opportunity was given to do so. These are detailed in Appendix 4.

Most frequently chosen (seven general practitioners) was cover for sickness or absence in the community-based services.

The next section gives an analysis of the importance which general practitioners gave to individual quality criteria in judging services.

9. WHICH QUALITY CRITERIA ARE MOST IMPORTANT TO GENERAL PRACTITIONERS?

General practitioners were asked to identify which of the five quality criteria used in the questionnaire to rate services were most important to them and to rank their top five in order of importance. This was done separately for hospital and community services with the chance to add additional criteria if wished.

9.1 Quality Criteria in Hospital Services

The response rate to this section of the questionnaire was lower than that for other sections, where concrete examples were being assessed. Half of respondents, 66 general practitioners, completed some or all of this section; Table 22 gives the details.

Seventy-one percent of those general practitioners attached some degree of importance to the waiting time taken for an initial out-patient appointment.

Delay in organising in-patient admission was included by 56 out of 66 (85%) of respondents, as was the quality of care provided by individual consultants - 51 out of 66 general practitioners (77%).

Less than half the respondents (28 out of 66 general practitioners) put communication with general practitioners in their top five criteria. Travel time for patients was selected by only one general practitioner as being in the top criteria.

The standard of physical accommodation and discharge arrangements for both in-patients and out-patients were also given lower importance by those completing this section of the questionnaire.

The weighted scores given in Table 23 reflect the relative importance attached to waiting time, and to the quality of care provided by individual consultants. For technical reasons no weight could be calculated for the travel time for patients, and this is assigned a zero score.

The weighted scores were derived using the scaling algorithm described in Appendix 2 as previously applied to produce the quality index values.

TABLE 22

RATINGS BY GENERAL PRACTITIONERS OF CRITERIA ASSESSED AS MOST IMPORTANT TO THEM IN JUDGING QUALITY OF HOSPITAL SERVICES

Quality Criteria	Frequency of rating in each category of importance					Percentage of GPs giving each degree of importance			Number of GPs giving a rating of 1-5
	1	2	3	4	5	1 & 2	3	4 & 5	
Waiting time for first appointment	25	22	10	6	3	71.2	15.2	13.6	66
Waiting time for in-patient elective	8	20	10	10	8	50.0	17.9	32.1	56
Travel time for patient	0	0	0	0	1				
Ease of arranging emergency admission	6	4	17	5	5	27.0	45.9	27.0	37
Ease of arranging out-patient appointments	3	10	8	18	9	27.1	16.7	56.3	48
Standard of accommodation	1	1	0	0	3	40.0	0.0	60.0	5
Quality of nursing	2	2	2	8	2	25.0	12.5	62.5	16
Quality of consultant care	20	6	8	4	13	51.0	15.7	33.3	51
Communication with general practitioner	2	0	9	4	13	7.1	32.1	60.7	28
Organisation of in-patient discharges	0	0	1	1	2	0.0	25.0	75.0	4
Organisation of out-patient discharges	0	0	1	0	3	0.0	25.0	75.0	4
Consultant involvement in out-patient care	1	4	2	10	5	22.7	9.1	68.2	22

Key: General practitioners were asked to score five of the quality criteria as follows:

1 = most important to them in assessing quality of health care
2 = next most important to them in assessing quality of health care
3 = third most important to them in assessing quality of health care
4 = fourth most important to them in assessing quality of health care
5 = fifth most important to them in assessing quality of health care

TABLE 23

WEIGHTED SCORES FOR QUALITY CRITERIA ASSESSED BY GENERAL PRACTITIONERS AS MOST IMPORTANT TO THEM IN ASSESSING QUALITY OF HOSPITAL SERVICES

Rank	Quality Criteria	Weighted Score
1	Wait for 1st OP appointment	0.609
2	Quality of consultant care	0.524
3	Wait for elective IP admission	0.509
4	Ease of emergency admission	0.496
5	Quality of nursing care	0.453
6	Ease of arranging urgent OP appointment	0.437
7	Physical accommodation	0.430
8	Consultant involvement	0.408
9	Communication with GP	0.372
10	Organisation of IP discharge	0.348
11	Organisation of OP discharge	0.296

Key: A. Rank 1 = most important criterion in judging quality
Rank 11 = least important criterion in judging quality

B. Weighted score reflects the degree of importance (between first and fifth choice) given to each criterion by general practitioners.

9. WHICH QUALITY CRITERIA ARE MOST IMPORTANT TO GENERAL PRACTITIONERS? (Continued)

9.2 Quality Criteria in Hospital Services - Real and Abstract Compared

The task of giving an ordered choice of their five most important criteria in judging quality was completed by only half of the general practitioners and may have been seen as too difficult or restrictive. However, there was still an opportunity to compare the use of the quality criteria in judging real services seen as most needing improvement with the abstract ranking of the criteria by their importance in the previous section.

The ratings given by general practitioners to their first choice of hospital service requiring improvement were pooled. The pattern of ratings can be seen in Table 24.

Sixty percent of ratings for the quality of nursing care were excellent/good - even amongst those services which general practitioners identified as requiring improvement. Over half the general practitioners considered the standard of physical accommodation in the same way. Less than 5% of general practitioners gave the patients' travel time a poor/very poor quality rating.

The aspects of these services which most frequently attracted poor ratings were the waiting times for out-patient appointments and elective in-patient admissions, with 90% of general practitioner ratings in the lowest categories.

Weighted scores were again derived using the same scaling algorithm. These scores are given in Table 25.

The scores indicate relatively little difference in weighting between the first four or five criteria which were, in rank order: quality of nursing care, standard of physical accommodation, travel time for patients, quality of consultant care and ease of emergency admission. In the services given top priority for improvement these factors scored between 0.566 and 0.527 on the standardised weighted score.

Waiting times for appointment or elective admission receive much lower scores.

It is interesting to compare the rankings obtained through the two approaches to scaling the quality criteria, ie when considering criteria in the abstract and when considering a service needing improvement.

9. WHICH QUALITY CRITERIA ARE MOST IMPORTANT TO GENERAL PRACTITIONERS? (Continued)

9.2 Quality Criteria in Hospital Services - Real and Abstract Compared (Continued)

Arrangements for out-patient discharge are rated poorly in the hospital services identified as in need of improvement (10th out of 12); however as a single quality criterion only four general practitioners put it in the top five criteria and it ranked last overall. It has low salience as a factor in judging quality.

By contrast, waiting for initial out-patient appointments has a relatively high score and ranks first as a quality criterion. Services identified as needing improvement produce a low score on this factor.

The standard of physical accommodation is seen as less important in these services, which nevertheless score fairly highly on this factor. Travel time for patients is regarded as virtually no problem - it appears also that it is not one of the most important criteria so far as the general practitioners themselves are concerned.

TABLE 24
DETAILED QUALITY RATINGS FOR ALL FIRST CHOICES OF A HOSPITAL SERVICE IN NEED OF IMPROVEMENT (COMBINED FIRST CHOICES)

n = 112

Quality Criteria	Frequency of rating in each quality category					Percentage of GPs giving each rating			Number of GPs giving a rating of 1-5
	1	2	3	4	5	1 & 2	3	4 & 5	
Waiting time for first appointment	1	4	5	43	44	5.2	5.2	89.7	97
Waiting time for in-patient elective	1	1	6	22	55	2.4	7.1	90.6	85
Travel time for patient	3	28	34	3	0	45.6	50.0	4.4	68
Ease of arranging emergency admission	13	31	21	16	9	48.9	23.3	27.8	90
Ease of arranging out-patient appointments	7	20	30	17	15	30.3	33.7	36.0	89
Standard of accommodation	4	24	20	5	0	52.8	37.7	9.4	53
Quality of nursing	3	30	18	4	0	60.0	32.7	7.3	55
Quality of consultant care	10	34	29	10	6	49.4	32.6	18.0	89
Communication with general practitioner	3	23	29	23	13	28.6	31.9	39.6	91
Organisation of in-patient discharges	0	18	27	21	5	25.4	38.0	36.6	71
Organisation of out-patient discharges	1	18	33	18	7	24.7	42.9	32.5	77
Consultant involvement in out-patient care	1	17	40	18	6	22.0	48.8	29.3	82

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor,
6 = insufficient evidence to rate

TABLE 25

WEIGHTED SCORES OF DETAILED QUALITY RATINGS FOR ALL FIRST CHOICES OF A HOSPITAL SERVICE IN NEED OF IMPROVEMENT (COMBINED FIRST CHOICES)

Rank	Quality Criteria	Weighted Score
1	Quality of nursing care	0.566
2	Standard of physical accommodation	0.559
3	Travel time for patients	0.556
4	Quality of consultant care	0.541
5	Ease of emergency admission	0.527
6	Organisation of IP discharge	0.492
7	Ease of arranging urgent OP appointment	0.479
8	Consultant involvement with OP care	0.465
9	Communication with GP	0.464
10	Organisation of OP discharge	0.462
11	Wait for 1st OP appointment	0.326
12	Wait for elective IP admission	0.297

Key: Rank 1 - Highest rated criterion, ie the best aspect of the services
Rank 12 - Lowest rated criterion, ie the worst aspect of the services

9. WHICH QUALITY CRITERIA ARE MOST IMPORTANT TO GENERAL PRACTITIONERS? (Continued)

9.3 Quality Criteria in Community Services

A low response rate for this section of the questionnaire suggests that general practitioners had some difficulty in relating to the abstract quality criteria that they were asked to assess. Despite the minority response, the data were subject to the same analysis as has been reported in the previous section. The ratings for quality criteria in judging community services are listed in Table 26.

Sixty-eight percent of respondents placed the greatest importance on the time taken for initial patient contact with the service, a somewhat higher proportion than the 55% who gave importance to the quality of care provided by individual staff. Only six general practitioners (14%) rated co-ordination with Social Services Departments in their top five criteria. Less than a quarter of respondents chose the supply of appliances for the top five criteria - a similar number to those who chose the time spent with each patient as an important criteria. No general practitioners chose the standard of physical accommodation of community services in their top five criteria.

The weighted scores given in Table 27 correspond with the pattern of rankings, waiting time for initial patient contact being the most strongly rated of the quality criteria. Appropriate feedback to general practitioners scored low in terms of importance, just ahead of supply of appliances.

TABLE 26

RATINGS BY GENERAL PRACTITIONERS OF CRITERIA ASSESSED AS MOST IMPORTANT TO THEM IN JUDGING QUALITY OF COMMUNITY SERVICES

Quality Criteria	Frequency of rating in each category of importance					Percentage of GPs giving each degree of importance			Number of GPs giving a rating of 1-5
	1	2	3	4	5	1 & 2	3	4 & 5	
Waiting time for first appointment	19	11	11	1	2	68.2	25.0	6.8	44
Ease of communication with general practitioner	3	7	9	7	7	30.3	27.3	42.4	33
Ease of access for patients	6	8	9	7	5	40.0	25.7	34.3	35
Ease of urgent care	4	13	6	9	4	47.2	16.7	36.1	36
Quality of staff care	14	3	8	2	4	54.8	25.8	19.4	31
Integration with team	3	5	4	5	9	30.8	15.4	53.8	26
Feedback to general practitioners	1	2	4	10	7	12.5	16.7	70.8	24
Co-ordination with Social Services	0	0	0	4	2	0.0	0.0	100.0	6
Supply of appliances	0	1	1	4	4	10.0	10.0	80.0	10
Time spent with patient	2	2	1	3	6	28.6	7.1	64.3	14

Key: General practitioners were asked to score five of the quality criteria as follows:

1 = most important to them in assessing quality of health care
2 = next most important to them in assessing quality of health care
3 = third most important to them in assessing quality of health care
4 = fourth most important to them in assessing quality of health care
5 = fifth most important to them in assessing quality of health care

TABLE 27

WEIGHTED SCORES FOR QUALITY CRITERIA ASSESSED BY GENERAL PRACTITIONERS AS MOST IMPORTANT TO THEM IN ASSESSING QUALITY OF COMMUNITY-BASED SERVICES

Rank	Quality Criteria	Weighted Score
1	Waiting time for initial patient contact	0.625
2	Quality of care given by staff	0.568
3	Ease of arranging urgent care	0.504
4	Ease of access for patients	0.503
5	Ease of communication with service	0.460
6	Integration of others in PHCT	0.440
7	Time spent with each patient	0.424
8	Co-ordination with Social Services	0.418
9	Appropriate feedback to GPs	0.384
10	Supply of appliances where needed	0.347

Key: A. Rank 1 = most important criterion in judging quality
Rank 11 = least important criterion in judging quality

B. Weighted score reflects the degree of importance (between first and fifth choice) given to each criterion by general practitioners.

9. WHICH QUALITY CRITERIA ARE MOST IMPORTANT TO GENERAL PRACTITIONERS? (Continued)

9.4 Quality Criteria in Community Services - Real and Abstract Compared

Table 28 gives the pooled ratings of the detailed criteria for general practitioners' first choice of community services requiring improvement.

The quality of care is highly regarded even amongst these services identified as in need of improvement.

Both the time taken for initial patient contact with the service, and the ease of arranging patient access receive poor/very poor ratings. Integration with other members of the primary health care team is also poorly rated amongst this group of services.

Of particular note is the very small number of respondents who gave a rating to the standard of physical accommodation, although such ratings were generally favourable.

Table 29 lists the weighted scores for each of the quality criteria for all services which were a first choice for improvement. The quality of care given by staff was regarded as a highly important factor in judging community services (Table 27). General practitioner judged this aspect of services which they had chosen as needing improvement to be mainly excellent or good.

General practitioners clearly regard the ease of arranging urgent care for patients as important, and it is here that present community services score less well with those needing improvement being given the lowest ratings on this criterion.

A similar picture emerges for the waiting time for initial patient contact, given a high rating in the abstract and judged to be poor for services needing improvement.

9. WHICH QUALITY CRITERIA ARE MOST IMPORTANT TO GENERAL PRACTITIONERS? (Continued)

9.5 General Comments

Quality criteria judged most important by general practitioners in assessing services in hospital and the community centre on the waiting time for care to commence, the quality of professional care, the ease of arranging urgent care and, in the community, ease of access for patients and of communication between the service and general practitioners.

TABLE 28
DETAILED QUALITY RATINGS FOR ALL FIRST CHOICES OF A COMMUNITY SERVICE IN NEED OF IMPROVEMENT (COMBINED FIRST CHOICES)

Quality Criteria	Frequency of rating in each quality category					Percentage of GPs giving each rating			Number of GPs giving a rating of 1-5
	1	2	3	4	5	1 & 2	3	4 & 5	
Waiting time for first appointment	5	15	6	16	12	37.0	11.1	51.9	54
Ease of communication with general practitioner	6	13	17	12	8	33.9	30.4	35.7	56
Ease of access for patients	2	11	22	18	4	22.8	38.6	38.6	57
Ease of urgent care	2	10	12	19	6	24.5	24.5	51.0	49
Standard of accommodation	1	10	7	0	0	61.1	38.9	0.0	18
Quality of staff care	12	27	12	4	1	69.6	21.4	8.9	56
Integration with team	6	8	16	19	8	24.6	28.1	47.4	57
Feedback to general practitioners	7	10	17	17	7	29.3	29.3	41.4	58
Co-ordination with Social Services	2	6	15	7	3	24.2	45.5	30.3	33
Supply of appliances	3	6	19	7	2	24.3	51.4	24.3	37
Time spent with patient	2	11	16	12	0	31.7	39.0	29.3	14

Ratings: 1 = excellent, 2 = good, 3 = adequate, 4 = poor, 5 = very poor,
6 = insufficient evidence to rate

TABLE 29

WEIGHTED SCORES OF DETAILED QUALITY RATINGS FOR ALL FIRST CHOICES OF A COMMUNITY SERVICE IN NEED OF IMPROVEMENT (COMBINED FIRST CHOICES)

Rank	Quality Criteria	Weighted Score
1	Quality of care given by staff	0.600
2	Standard of physical accommodation	0.523
3	Supply of appliances where needed	0.501
4	Ease of communication with service	0.486
5	Time spent with each patient	0.484
6	Appropriate feedback to GPs	0.483
7	Co-ordination with Social Services	0.480
8	Ease of access for patients	0.467
9	Integration with others in PHCT	0.467
10	Waiting time for initial patient contact	0.462
11	Ease of arranging urgent care	0.450

Key: Rank 1 - Highest rated criterion, ie the best aspect of the services
Rank 11 - Lowest rated criterion, ie the worst aspect of the services

10. ADDITIONAL SERVICES MENTIONED AND GENERAL COMMENTS

General practitioners were asked to indicate whether there were any services not specifically mentioned in the questionnaire which they considered should be available to their patients.

Fifty-one general practitioners made 102 suggestions, the three most often mentioned being physiotherapy which 19 out of 51 general practitioners (37%) suggested, ultrasound suggested by 10 out of 51 general practitioners (20%) and gastroscopy/endoscopy suggested by eight out of 51 general practitioners (16%). There were particular comments in these three areas about needing more open access and community services.

The other additional services suggested by general practitioners are listed in Appendix 5.

There was also a space for general comments about hospital and community services. Forty-one general practitioners made use of this opportunity. The largest numbers of responses centred around three topics.

Twelve (29%) of the 41 general practitioners commented that the quality of care was almost always good once care was started, specifically mentioning services including cytology, community psychiatric nursing, district nursing and health visiting.

Eleven (27%) mentioned management and communications. These comments included concerns about poor liaison between the Family Health Services Authority and the District Health Authority, the lack of awareness by the Health Authority of the general practitioners' role, the need for 'more caring' bureaucrats, that too many hospital staff had no concept of the realities of general practice and that the motivation of staff was low.

Ten general practitioners (24%) commented that waiting times were unacceptable in some areas for both in-patients and out-patients.

The remaining comments covered a variety of topics, each with a few responses only, and are listed in Appendix 6.

11. SUMMARY OF RESULTS

11.1 Response Rate

The response rate at 77% was excellent and representative. One hundred and twelve of 145 possible general practitioners responded with completed questionnaires before analysis was undertaken. Only 23 made no response at all.

11.2 Quality Ratings of Services

Quality ratings with quantity as an integral part of the ratings were given on a one - five scale.

Paediatrics had the highest standardised quality rating.

Other services rated of good quality were:

- pathology
- terminal care in the hospice
- general medicine, with related specialties
- general surgery
- accident and emergency services.

Orthopaedics and ophthalmology were major hospital specialties rated as less good.

Other services rated of less good quality were:

- HIV/AIDS services
- terminal care in hospital
- ultrasound investigations
- chiropody
- physiotherapy
- younger disabled services
- occupational therapy
- disability and rehabilitation services
- services for drug and alcohol misuse.
- psychosexual counselling

11. SUMMARY OF RESULTS (Continued)

11.3 Hospital Services Chosen as a Priority for Improvement

Service	No of General Practitioners naming service as one of their three priority choices for improvement
Orthopaedics	75 (67%) - 50 first choices
Ophthalmology	52 (46%) - 18 first choices
Gynaecology	27 (24%) - 2 first choices
Gastroenterology/Endoscopy	17 (15%) - 2 first choices

The clinical care given by professional staff was mainly rated as good or adequate in all services.

Orthopaedics was rated poorly on waiting times for out-patient attendance and for in-patient admission, on communication with general practitioners, on organisation of discharges and on ease of arranging appointments or admissions.

Ophthalmology was similarly rated poorly on waiting time for out-patient appointments, and for in-patient admission, on communication with general practitioners and organisation of discharges.

Gynaecology was poorly rated on waiting times for both out-patient appointments, and in-patient admissions.

Gastroenterology was poorly rated on waiting times for both out-patient appointments and in-patient admissions, but overall, nearly 90% of general practitioners rated gastroenterology as adequate, good or excellent.

Thirteen of the 17 general practitioners giving gastroenterology as a choice for improvement cited the need to improve access to endoscopy as the reason for their choice.

11. SUMMARY OF RESULTS (Continued)

11.3 Hospital Services Chosen as a Priority for Improvement (Continued)

Medicine for the elderly received variable ratings, the poorest being on communication with general practitioners, organisation of emergency admission and organisation of discharge. More local discussion is needed to understand the improvements needed. Comments centred on a dislike of sectorisation, lack of long-stay beds and restricted access to physiotherapy.

Radiology/ultrasound was rated poorly on waiting time, ease of arranging out-patient appointments and communication with general practitioners.

Psychiatry received variable ratings with the organisation of discharges being less well rated. The nature of the areas of dissatisfaction does not emerge clearly.

Physiotherapy was rated adequate or good except for the waiting time for first appointment, which was rated very poor.

11. SUMMARY OF RESULTS (Continued)

11.4 Community Services Chosen as a Priority for Improvement

Service	No of General Practitioners choosing as 1st, 2nd or 3rd choice for improvement*
Health Visiting	25 (22%) - 10 first choices
District Nursing	24 (21%) - 11 first choices
Physiotherapy	20 (18%) - 7 first choices
Chiropody	18 (16%) - 12 first choices

* 38 General practitioners (34%) did not choose to comment on a community-based service.

Health visiting scored well on all the quality criteria, although integration with the primary care team scored less well in some instances. The comments related to the service being overworked and understaffed, the improvement needed being seen as more of the same.

Similarly for district nursing, scoring was high on all criteria, but comments related to the service being overstretched and under-resourced, and needing more staff to improve this service.

Physiotherapy scored poorly on waiting time, access for patients and access to urgent care. Physiotherapy was also chosen by 10 general practitioners in the hospital section. Twenty-seven doctors gave physiotherapy 30 choices.

Chiropody scored poorly on waiting time, communications with general practitioners and integration with the primary care team.

Comments for these services centred around the need for more staff in the community, or for the introduction of a community service in the case of physiotherapy.

11. SUMMARY OF RESULTS (Continued)

11.5 Important Quality Criteria for General Practitioners

The quality criteria most important to general practitioners when they were asked to choose the most important five criteria in rank order were as follows:-

For Hospital Services

1. Waiting time for first out-patient appointment
2. Quality of consultant care
3. Waiting time for first elective admission
4. Ease of emergency admission
5. Quality of nursing care

For Community Services

1. Waiting time for initial patient contact
2. Quality of care given by staff
3. Ease of arranging urgent care
4. Ease of access for patients
5. Ease of communication with service

This can be summarised by saying that the quality of professional care and ease of access to the services are the most important criteria by which general practitioners judge health care services.

Only about half of the general practitioners completed this section.

11. SUMMARY OF RESULTS (Continued)

11.6 Quality in Hospital Service most Needing Improvement

In hospital services chosen as first choice for improvement, waiting times for appointment or elective admission were rated as poor by 90% of the general practitioners in line with the importance given to these factors in judging services. Quality of nursing and consultant care was relatively well-rated.

There were concerns about the ease of communication with general practitioners and the organisation of appointments, admissions and discharges, particularly in orthopaedics and ophthalmology.

The picture is of services in which general practitioners would like to see shorter waiting times, but also improved organisation, communication and responsiveness.

11. SUMMARY OF RESULTS (Continued)

11.7 Quality in Community Services most Needing Improvement

In community services chosen as first choice for improvement, waiting times for initial patient contact and the ease of access for patients were rated poorly as expected from the importance attached to these factors in the abstract. Quality of care by staff was rated highly, and was also a top priority in judging services.

The picture is of services which general practitioners would like better resourced to give more care of similar quality.

11. SUMMARY OF RESULTS (Continued)

11.8 Additional Services

Additional services mentioned by general practitioners in the 'free' comment section were:-

- physiotherapy
- ultrasound
- gastroscopy/endoscopy

These comments mainly related to the need for open access to these services or for provision in a community setting.

11. SUMMARY OF RESULTS (Continued)

11.9 General Comments

General comments were of three main types:

- quality of care in community services is almost always good once care is started;
- poor liaison between some health care services and general practitioners, with a lack of appreciation of the realities of general practice;
- unacceptable waiting times in some services.

12. DISCUSSION

12.1 The Feasibility of the Survey

The study has shown that it is feasible to carry out this kind of postal questionnaire. The questionnaire received a very high response rate and it was a pleasant surprise that so few general practitioners commented adversely on the length of time that it took to fill in. It is a measure of the willingness of general practitioners to contribute to detailed consideration of the services available to their patients that so many replied in detail to a relatively complex questionnaire in a short timescale. The survey team is extremely grateful for the time and effort of all general practitioners who contributed, which is the vast majority of general practitioners in the District.

12. DISCUSSION (Continued)

12.2 The Quality Ratings

There was a remarkable unanimity about which services were rated highly, such as paediatrics, and which received poor ratings. The fact that so many general practitioners replied gives weight to the findings as being representative across the district.

The composite rating scale used, in which quantity was seen as an integral part of quality, has left some unanswered questions about services which received a poor or mixed quality rating but which did not receive priority for improvement. The survey cannot further explain the poor rating of these services.

Small services, such as the pain relief service, are examples. Anecdotal evidence suggests that this is seen to offer a high standard of care but has a lengthening waiting list. The evidence of dissatisfaction with such services needs to be explored in local discussion; they must not be ignored because of their relatively small scale. Local discussion might enable the identification of changes which could improve some of these services not seen as a priority for initial efforts, and could find ways to ease the pressure on such services.

12. DISCUSSION (Continued)

12.3 The 'Insufficient Evidence' Rating

There were some services that many general practitioners felt they had insufficient evidence to rate overall. These included services for HIV/AIDS which only 37 out of 112 general practitioners felt able to rate, services for the younger disabled which 73 out of 112 felt able to rate, and paediatric surgery which 58 out of 112 felt able to rate.

This suggests that it would be useful to ensure that all general practitioners have some knowledge of how to access such services which are used relatively infrequently, particularly by smaller practices, so that patients receive the full range of services that the commissioning district can offer to its residents.

There is evidence that some of the quality criteria ratings used when considering services in detail were criteria for which many general practitioners felt that they had insufficient evidence to produce a rating. These were particularly the standard of accommodation and the quality of nursing care. Travel time for patients was also often not rated and in the community section co-ordination with social services or the time spent with patients was very often felt not to be ratable by general practitioners.

The lack of knowledge about standard of accommodation is interesting in view of the emphasis nationally on the standard of accommodation and facilities available to patients. It suggests that this may not be a factor that general practitioners will use in deciding where to refer patients. It would be interesting to explore whether patients who experience facilities and accommodation more directly give these factors a higher priority.

Underlying the National Health Service reforms is the assumption that general practitioners will, in choosing secondary health care services, reflect their patients' wishes. This implies that general practitioners and patients will share similar views on what constitutes a good quality service.

Many general practitioners in this study felt unable to say how they would expect their patients to rate a service. This finding is a reminder of the need to test how far the above assumption holds good. Follow-up study is needed to see how patients and their general practitioners rate health care services used and whether they share the same views about the relative importance of different factors in judging quality.

12. DISCUSSION (Continued)

12.4 The Role of a Standardised Quality Index

The role of a standardised quality index as a tool to give a broad measure of quality should be tested further. The index gives only a broad indication of perceived quality and cannot give an indication of the reasons behind particular ratings.

The quality index could be very useful as a signal of changing views over time or a measure of whether changes have had the desired impact. General practitioners are, in the main, geographically stable and if the simplified rating scale to give an index is acceptable, it might be possible to chart the progress of change in views of a service systematically.

The index could also be used to compare services from different providers, where general practitioners have a realistic choice.

This index should be further developed as a tool for monitoring general practitioners' views of service quality.

12. DISCUSSION (Continued)

12.5 Services most in need of Improvement

In the hospital service, two services stand out as priorities: orthopaedics and ophthalmology.

It is interesting that these are specialties with recently developed elective surgical procedures for common conditions which can have great direct benefit to the quality of patients' lives. These procedures consume a considerable amount of resource in terms of medical staff commitment, operating theatre time and in costs of consumables. Long waiting times are inevitable without planning for the implementation of such new procedures to treat previously untreatable conditions.

Operations for joint replacement and cataract removal are most often needed in the elderly, whose numbers are rising.

Another factor may be involved in the priority given to orthopaedics. Training for the specialty necessarily emphasises the acquisition of a high level of technical expertise in performing skilled surgical operations. Consultants rightly see it as important to utilise these scarce skills to the full.

General practitioners see a large number of patients with acute and chronic musculoskeletal and arthritic problems which loosely come under an 'orthopaedic' heading, but for which an operation is not appropriate. This may be part of the explanation for the priority given to improving physiotherapy services and in particular to improving direct referral to these services and providing a community service.

The challenge for a commissioning health authority is to assess the need for health care based on the prevalence of particular conditions or groups of conditions in the community and to plan a service profile which is likely to be most effective in meeting these needs.

12. DISCUSSION (Continued)

12.5 Services most in need of Improvement (Continued)

An assessment, for example, of the elements of service needed for people with back pain or for those with head injury might propose a very different pattern and balance of service provision from an assessment which starts from fixed assumptions about which professionals should do what and where they should do it.

The services chosen in the hospital section received a poor rating because of waiting times for assessment and treatment, but significant concerns about how care was organised and how the hospital service related to general practice were elicited. There was less emphasis on the need for more resource in the service as the sole answer to the difficulties.

In community services, the perception was of services such as health visiting and district nursing being under severe pressure but of fewer difficulties in general in the organisation of care and communication with general practitioners.

Paramedical services received more emphasis from the general practitioners than might have been anticipated. These services are seen as vital to the network of supporting primary care services and this issue needs to be explored further to make best use of the resource and to strengthen community care services.

Constraining general practitioners to choose three services in each setting for improvement brings out which services are of major concern to most general practitioners. Many services not rated as a priority for improvement should nevertheless be the subject of discussion so as to understand both the good points and the not-so-good and to implement appropriate changes where agreed.

It is important that the results of this survey are used constructively and that the poor rating of a service is seen as an opportunity for productive dialogue in which all parties contribute ideas and a willingness to change their own practices if that is needed to bring about change. Improvements will be for the benefit of patients and may come from a variety of actions. This survey will be successful only if it is used in a way that facilitates change to improve the care given to patients.

12. DISCUSSION (Continued)

12.6 Comparison with Other Surveys

This survey is one of a number of attempts in other parts of the country to elicit general practitioners' perceptions of the quality of service and their priorities for improvement. The results of similar studies in eight other districts spread throughout the UK show a remarkable consistency. General practitioners in all nine districts, including York, gave top priority to improving orthopaedics. Ophthalmology was the second or third priority in seven of the nine.

12. DISCUSSION (Continued)

12.7 Quality Criteria used by General Practitioners to Judge a Service

The factors that general practitioners rated most highly in judging a service were the quality of professional care, the waiting times for assessment and treatment and the communication between hospital and general practitioners in community services.

Whilst the findings are interesting, only half of the general practitioners felt able to complete this section and there is a need to explore further how real these criteria feel to general practitioners. It may be that the 'forced' choice of five criteria ranked in order is not the best way to elicit the factors used by general practitioners in judging quality. Further development work is needed.

It is, however, interesting that the quality of professional care and the rapidity of access to services have come out as key factors for general practitioners. That is very much as would be expected from general practitioners considering the best chance of gaining relief for their patient and advice on further management. They are not always the factors on which quality management programmes concentrate.

12. DISCUSSION (Continued)

12.8 Outcome Measurement

There is one overriding aspect of quality which this survey was not designed to consider but which subsequent work must address. This survey has relied on 'process' criteria, making the implicit assumption that a highly rated service will have a good outcome for patients.

This is a reasonable assumption but it is important for commissioning and providing authorities alike to progress to consider the outcomes of care for the patient and his or her ability to live an unrestricted life. This is the ultimate test of good quality health care, and systematic knowledge about health outcomes is severely limited.

CONCLUSIONS

1. The survey has succeeded in systematically gathering the views of general practitioners on the quality of health care services available to residents of York Health District.

2. The quality ratings show a wide variation between services and will have differing explanations for each service. Individual services need discussion between clinicians, general practitioners and managers to understand the perceptions, to see where changes are needed and how they can be implemented.

3. Many general practitioners felt that they had insufficient knowledge of some services or aspects of others to give a quality rating. More information may be needed to enable general practitioners to utilise the full range of services available.

4. The assumption underlying the NHS reforms that patients will judge services on the same criteria as general practitioners should be tested in further work.

5. The standardised quality index should be developed to test its potential as a 'performance indicator' of general practitioners' views on quality.

6. Orthopaedics and ophthalmology have the highest priority as services chosen as needing improvement. Physiotherapy, gynaecology, health visiting and district nursing have the next highest priority as choices for improvement. Other services also need review and change, and should not be neglected.

7. It is important to view the results constructively as a starting point to achieve change by general practitioners, clinicians, other professional staff and managers working together for the benefit of patients.

8. More work is needed on the quality criteria used by general practitioners to judge a service but a start has been made.

9. The measurement of the outcome for the health of patients is the next important task for quality measurement studies.

RECOMMENDATIONS

1. This report should be widely circulated to general practitioners, consultants, other professional staff, managers and the health authority as the authority commissioning health care.

2. Early discussion should be held with general practitioners and consultants to explore the meaning of the results and agree on their interpretation.

3. The mechanisms and arrangements to foster continuing dialogue with general practitioners need to be monitored for effectiveness and developed. This will need action at several different levels, including those of the health authority, general managers, consultant staff and of other professional staff.

4. An action plan should be agreed by all parties concerned to respond to the priority concerns of general practitioners within a defined time period.

   This process will need to involve the health authority, managers, general practitioners, consultants and other professional staff, and will require commitment by all to generate change for improved quality.

5. Other services should be the subject of discussion and action as appropriate in the medium-term.

6. Further research should be carried out:

   (a) to find out whether patients use the same criteria to judge quality of services as do general practitioners;

   (b) to further elucidate the criteria most important to general practitioners in judging service quality;

   (c) to develop the standardised quality index as a monitoring tool;

   (d) to develop the measurement of the outcome of health care in terms of the improved health of patients.

Department of Public Health Medicine
York Health Authority
Dr J M Carpenter
(Director of Public Health)
Dr I H Cameron
(Senior Registrar in Public Health Medicine)

Centre for Health Economics
University of York
Mr P Kind
(Research Fellow)
Dr B Leese
(Research Fellow)

Correspondence to Dr Carpenter, please, from whom more detailed information about the findings can be obtained.

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North Yorkshire Health Care Commissioning Project
Sovereign House
Kettlestring Lane
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YORK YO3 4XF

July 1991

HEALTH SERVICES FOR RESIDENTS OF YORK HEALTH DISTRICT

A survey of all general practitioners in York Health Authority undertaken jointly by the Department of Public Health Medicine and the Centre for Health Economics.

Study Number [ ]

1. Name _____

2. Main Practice Address _____

_____

_____

Postcode _____

Please return completed questionnaire by 31st December 1990 in s.a.e. provided to:

Dr. J.M. Carpenter
Director of Public Health
District Headquarters
Bootham Park
York Y03 7BY.

This sheet will remain confidential to the Department of Public Health Medicine, and will be removed prior to data analysis

HEALTH SERVICES FOR RESIDENTS OF YORK HEALTH DISTRICT

SECTION A

We need a few general details about you and your practice

Please answer all questions in the space provided

1. Please state the number of years worked in general practice locally

2. Are you full-time ? Yes / No (please ring)

   If not in full-time practice, are you 1/2 time, 3/4 time or less than 1/2 time?

   1/2 time ☐ 3/4 time ☐ less than 1/2 time ☐

3. How many partners are there in your practice ?

   Number of full-time ☐

   Number of part-time (any no. of sessions) ☐

4. Which category is your practice list size in ?

   below 2700 ☐ 2700 to 5100 ☐

   5100 to 7300 ☐ over 7300 ☐

5. Is yours a training practice ? Yes / No (please ring)

6. Please state your age and sex

   Age ☐ Sex (M / F) ☐

SECTION B

This section is about your perception of the overall quality of all hospital and community services available to your patients.

Some of these services are provided in York - others are provided outside the District.

Quality of service can be judged in different ways but it is your overall impression that we would like to have.

Space is provided towards the end of this questionnaire for any explanatory comments that you would like to make.

When recording your initial response please use the following notation

Quality
1 = excellent
2 = good
3 = adequate
4 = poor
5 = very poor
6 = insufficient evidence

This rating system is repeated on each page.

GENERAL SERVICES

Quality
1 = excellent
2 = good
3 = adequate
4 = poor
5 = very poor
6 = insufficient evidence

Please rate each of the following services by writing the number which best reflects your opinion in the box adjacent to the relevant service.

	Quality rating
General Medicine	
General Surgery	
Paediatrics	
Obstetrics	
Gynaecology	
Geriatric Services	
Orthopaedics	
Psychiatry	
Psychogeriatrics	
Accident and Emergency	

SUB SPECIALTIES

Quality
1 = excellent 2 = good 3 = adequate 4 = poor 5 = very poor 6 = insufficient evidence

	Quality rating
Rheumatology	
Dermatology	
Paediatric Surgery	
Renal Medicine	
Neurology	
Genito-urinary Medicine	
Oncology	
Chest Medicine	
Opthalmology	
Services for HIV / AIDS patients	
Services for the younger disabled	

SUB SPECIALTIES

Quality
1 = excellent 2 = good 3 = adequate 4 = poor 5 = very poor 6 = insufficient evidence

	Quality rating
Gastroenterology	
Ear Nose and Throat	
Urology	
Plastic Surgery	
Cardiology	
Cardiac Surgery	
Diabetes	
Child Psychiatry	
Psychosexual counselling	
Pain Clinic Services	

COMMUNITY SERVICES

Quality
1 = excellent 2 = good 3 = adequate 4 = poor 5 = very poor 6 = insufficient evidence

	Quality rating
Mental Handicap Service	
Terminal Care - Hospice	
Terminal Care - Hospital	
Terminal Care - Community service	
Health Visiting	
District Nursing	
Community Midwifery	
Community Child Health Services	
Family Planning	
Disability and Rehabilitation Services	

ANCILLARY SERVICES
(including direct access and hospital access services)

Quality
1 = excellent 2 = good 3 = adequate 4 = poor 5 = very poor 6 = insufficient evidence

	Quality rating
Physiotherapy	
Occupational Therapy	
Dietetics	
Chiropody	
Speech Therapy	
Alcohol and Drug Abuse Services	
Audiology	
Appliances - hospital	
- joint equipment store	

DIAGNOSTIC SERVICES

Quality
1 = excellent 2 = good 3 = adequate 4 = poor 5 = very poor 6 = insufficient evidence

	Quality rating
Microbiology	☐
Histopathology including Cytology	☐
Biochemistry	☐
Haematology	☐
Radiology	☐
Ultrasound	☐
Nuclear Medicine	☐

OTHER SERVICES
(please specify)

..... ☐

SECTION C : HOSPITAL-BASED SERVICES NEEDING IMPROVEMENT

You may feel that some hospital-based services need improvement.

Please use the following pages to record your opinions about up to 3 hospital-based services that you most want to see improved.

We would like to know more about how you see these services - both their strengths and weaknesses.

Please rate each of the services using the same convention as before.

Quality
1 = excellent
2 = good
3 = adequate
4 = poor
5 = very poor
6 = insufficient evidence

Feel free to add further comments as you see fit.

Improving hospital-based services 1st. choice for improvement

Hospital service needing improvement _____

Location of service : _____

QUALITY CRITERIA

	Rating		Rating
Waiting time for 1st out-patient appointment	☐	Quality of nursing care	☐
Waiting time for in-patient elective admission	☐	Quality of care provided by individual consultants	☐
Travel time for patient	☐	Communication with GP on discharge	☐
Ease of arranging emergency admissions	☐	Organisation of in-patient discharge arrangements	☐
Ease of arranging urgent out-patient appointments	☐	Organisation of out-patient discharge arrangements	☐
Standard of physical acommodation	☐	Consultant involvement in out-patient care	☐

Additional criteria (please specify)

..... ☐ ..... ☐

Overall how do you think your patients rate this service ☐

Please make any further comments that you feel appropriate

Improving hospital-based services 2nd. choice for improvement

Hospital service needing improvement _____

Location of service : _____

QUALITY CRITERIA

	Rating		Rating
Waiting time for 1st out-patient appointment	☐	Quality of nursing care	☐
Waiting time for in-patient elective admission	☐	Quality of care provided by individual consultants	☐
Travel time for patient	☐	Communication with GP on discharge	☐
Ease of arranging emergency admissions	☐	Organisation of in-patient discharge arrangements	☐
Ease of arranging urgent out-patient appointments	☐	Organisation of out-patient discharge arrangements	☐
Standard of physical acommodation	☐	Consultant involvement in out-patient care	☐

Additional criteria (please specify)

..... ☐ ..... ☐

Overall how do you think your patients rate this service ☐

Please make any further comments that you feel appropriate

Improving hospital-based services 3rd. choice for improvement

Hospital service needing improvement _____

Location of service : _____

QUALITY CRITERIA

	Rating		Rating
Waiting time for 1st out-patient appointment	☐	Quality of nursing care	☐
Waiting time for in-patient elective admission	☐	Quality of care provided by individual consultants	☐
Travel time for patient	☐	Communication with GP on discharge	☐
Ease of arranging emergency admissions	☐	Organisation of in-patient discharge arrangements	☐
Ease of arranging urgent out-patient appointments	☐	Organisation of out-patient discharge arrangements	☐
Standard of physical acommodation	☐	Consultant involvement in out-patient care	☐
Additional criteria (please specify)			
.....	☐	.....	☐

Overall how do you think your patients rate this service ☐

Please make any further comments that you feel appropriate

SECTION D : YOUR QUALITY CRITERIA FOR A HOSPITAL-BASED SERVICE

The preceding pages recorded your opinions about hospital-based services which you feel need improvement. Listed below are the quality criteria we have used on those pages. This list may not be complete.

Please

(a) make any additions that you feel are appropriate in the spaces provided

(b) review this list, including any additional quality criteria, and rank the 5 you consider to be the most important (1 = most important).

Waiting time for 1st out-patient appointment	☐	Quality of nursing care	☐
Waiting time for in-patient elective admission	☐	Quality of care provided by individual consultants	☐
Travel time for patient	☐	Communication with GP on discharge	☐
Ease of arranging emergency admissions	☐	Organisation of in-patient discharge arrangements	☐
Ease of arranging urgent out-patient appointments	☐	Organisation of out-patient discharge arrangements	☐
Standard of physical acommodation	☐	Consultant involvement in out-patient care	☐

Additional criteria (please specify)

.....	☐	.....	☐
.....	☐	.....	☐

SECTION E : COMMUNITY-BASED SERVICES NEEDING IMPROVEMENT

You may feel that some community-based services need improvement. Please use the following pages to record your opinions about up to 3 community-based services that you most want to see improved.

We would like to know more about how you see these services - both their strengths and weaknesses.

Please rate each of the services using the same convention as before.

Quality
1 = excellent
2 = good
3 = adequate
4 = poor
5 = very poor
6 = insufficient evidence

Feel free to add further comments as you see fit.

Improving community-based services 1st. choice for improvement

Community service needing improvement _____

Location of service : _____

QUALITY CRITERIA

	Rating		Rating
Waiting time for initial patient contact with service	☐	Integration with others in primary health care team	☐
Ease of communication with services by GPs	☐	Appropriate feedback from service to GP	☐
Ease of access to services for patients	☐	Coordination with Social Services Department	☐
Ease of arranging urgent care	☐	Supply of appliances where needed	☐
Standard of physical accommodation	☐	Time spent with each patient	☐
Quality of care provided by individual staff	☐		

Additional criteria (please specify)

..... ☐ ..... ☐

Overall how do you think your patients rate this service ☐

Please make any further comments that you feel appropriate

Improving community-based services 2nd. choice for improvement

Community service needing improvement _____

Location of service : _____

QUALITY CRITERIA

	Rating		Rating
Waiting time for initial patient contact with service	☐	Integration with others in primary health care team	☐
Ease of communication with services by GPs	☐	Appropriate feedback from service to GP	☐
Ease of access to services for patients	☐	Coordination with Social Services Department	☐
Ease of arranging urgent care	☐	Supply of appliances where needed	☐
Standard of physical accommodation	☐	Time spent with each patient	☐
Quality of care provided by individual staff	☐		
Additional criteria (please specify)			
.....	☐	.....	☐

Overall how do you think your patients rate this service ☐

Please make any further comments that you feel appropriate

Improving community-based services 3rd. choice for improvement

Community service needing improvement _____

Location of service : _____

QUALITY CRITERIA

	Ranking		Ranking
Waiting time for initial patient contact with service	☐	Integration with others in primary health care team	☐
Ease of communication with services by GPs	☐	Appropriate feedback from service to GP	☐
Ease of access to services for patients	☐	Coordination with Social Services Department	☐
Ease of arranging urgent care	☐	Supply of appliances where needed	☐
Standard of physical accommodation	☐	Time spent with each patient	☐
Quality of care provided by individual staff	☐		

Additional criteria (please specify)

..... ☐ ..... ☐

Overall how do you think your patients rate this service ☐

Please make any further comments that you feel appropriate

SECTION F : YOUR QUALITY CRITERIA FOR A COMMUNITY-BASED SERVICE

The preceding pages recorded your opinions about community-based services which you feel need improvement. Listed below are the quality criteria we have used on those pages. This list may not be complete.

Please

(a) make any additions that you feel are appropriate in the spaces provided

(b) review this list, including any additional quality criteria, and rank the 5 you consider to the most important (1 = most important).

Waiting time for initial patient contact with service	☐	Integration with others in primary health care team	☐
Ease of communication with services by GPs	☐	Appropriate feedback from service to GP	☐
Ease of access to services for patients	☐	Coordination with Social Services Department	☐
Ease of arranging urgent care	☐	Supply of appliances where needed	☐
Standard of physical accommodation	☐	Time spent with each patient	☐
Quality of care provided by individual staff	☐		

Additional criteria (please specify)

.....	☐	.....	☐
.....	☐	.....	☐

SECTION G : Additional services

We would like to know if you feel that there any other services, not specifically mentioned in this questionnaire which you consider should be available to your patients.

If there are, then please specify :

_____

_____

_____

_____

_____

_____

SECTION H : Further comments

Please use the space below for any futher comments

_____

_____

_____

_____

_____

_____

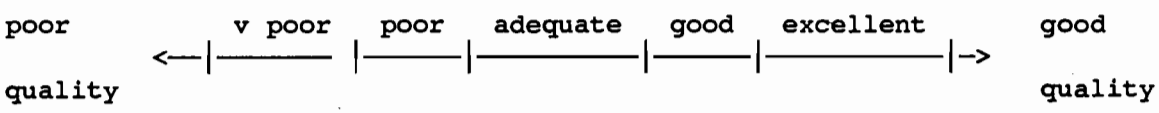
Thank you for your help in completing this questionnaire.

If you have any questions regarding this survey then please contact

Dr. J. Carpenter, Director of Public Health Medicine, York Health Authority (tel : York 610700)

APPENDIX 2
TORGERSON'S CATEGORICAL JUDGEMENT MODEL

This appendix describes the stages involved in computing values for the quality index according to a categorical scaling model described by Torgerson (1958). Assume for a moment that subjective judgements about quality of service can be represented along a line. Good quality, as a characteristic of health authority services, is located towards one end of the line. Poor quality is located towards the opposite end. At intervals along the line are a number of boundaries. These define intervals or categories.



Torgerson defines a procedure for deriving arithmetic values for the category boundaries in such a model, thereby allowing estimates to be made of the scale values of items located along the judgement domain. By utilising information about the frequency with which raters place services in each of the categories it is possible to estimate scale values for both the category boundaries, but more importantly to estimate values for the services themselves.

In summary, his model postulates that:

(a) an individual's psychological continuum (in this case perceived quality of service) can be divided into a finite series of ordered categories;

(b) because of many factors, including experimental error and subject performance, the boundary between adjacent categories varies and gives rise to a normal distribution around a mean location;

(c) different category boundaries may have different means and distributions;

(d) a subject will place an item (hospital service) below a given category boundary when the value of that item on the quality continuum is lower than the value of that category boundary.

The computational steps are simple and are demonstrated here using the ratings for diagnostic services produced by 112 general practitioners. The basic frequency matrix, F, shows the number of times that each marker state was rated one, two .. five (excellent - very poor).

Frequency Matrix F - Diagnostic Services

(rank)	1	2	3	4	5	weighted row sum
Microbiology (2)	43	65	4	0	0	185
Histopathology (4.5)	36	71	4	0	0	190
Biochemistry (4.5)	40	66	6	0	0	190
Haematology (3)	43	61	8	0	0	189
Radiology (6)	14	47	38	10	3	277
Ultrasound (7)	11	35	30	25	11	326
Nuclear Medicine (1)	24	59	14	0	0	184

In this relatively simple matrix it is possible to see:

(a) **the form of the distribution of categories** assigned to each state. Microbiology has a very compact distribution - with 43/112 respondents rating in category two (very good). By comparison, ultrasound ratings appear throughout the full range from excellent to very poor.

(b) **The overall rank of the states.** The weighted row sum is given in the final column. This is computed by multiplying each F_{ij} element by its corresponding category (one = excellent ... five = very poor), across each row (eg for microbiology = 43x1 + 65x2 + 4x3 = 185). From these totals it is clear that on the basis of these data, microbiology and ultrasound are placed at the top and bottom of the quality rankings.

The information in the F matrix can be interpreted as probabilities rather than frequencies. Hence in this sample of general practitioners the probability of microbiology receiving an excellent rating was 43/111. The basic frequency matrix is next converted into a cumulative probability matrix, which is shown below. Since all general practitioners had rated microbiology in the first three categories all the 'votes' had been exhausted. The probability of placing microbiology in third place or better is 1.0 and remains so across all remaining elements in that row. The last column (five in this example) will always have a probability of 1.0. This column is discarded for the remaining stages of the computation.

P-Matrix
(Cumulative Probabilities)

	Quality Rating Category				
	1	2	3	4	5
Microbiology	0.38	0.96	1.00	1.00	1.00
Histopathology	0.32	0.96	1.00	1.00	1.00
Biochemistry	0.36	0.95	1.00	1.00	1.00
Haematology	0.38	0.93	1.00	1.00	1.00
Radiology	0.13	0.54	0.88	0.97	1.00
Ultrasound	0.10	0.41	0.68	0.90	1.00
Nuclear Medicine	0.25	0.86	1.00	1.00	1.00

The probabilities in the P-matrix are converted to corresponding z-scores based on the unit normal distribution. Where there are probabilities of 0 or 1, indicating perfect certainty in predicting categories, these elements are flagged as missing data since they strictly yield z-scores of infinity. In the transformed matrix these are shown as **.

Z-Matrix
(z-scores based on the P-Matrix)

Microbiology	-0.29	1.80	**	**
Histopathology	-0.46	1.80	**	**
Biochemistry	-0.37	1.61	**	**
Haematology	-0.29	1.47	**	**
Radiology	-1.15	0.11	1.19	1.93
Ultrasound	-1.29	-0.23	0.46	1.29
Nuclear Medicine	-0.68	1.06	**	**

Such incomplete matrices are commonplace in practical settings and a variety of algorithms have been proposed in order to overcome the problem of estimating category boundaries and scale values. Torgerson describes one such procedure based on the average difference between categories. Hence for microbiology the absolute difference between the first and second columns (in matrix notation $| Z(1,1) - Z(1,2) |$) is -0.29 - 1.80 = 2.09.

Absolute Differences

	i,1 i,2	i,2 i,3	i,3 i,4	i,4 i,5	
Microbiology	2.10	**	**	**	
Histopathology	2.25	**	**	**	
Biochemistry	1.98	**	**	**	
Haematology	1.76	**	**	**	
Radiology	1.26	1.08	0.74	0.93	
Ultrasound	1.07	0.69	0.83	0.29	
Nuclear Medicine	1.74	**	**	**	
mean column totals	1.74	0.89	0.79	0.61	
category boundary	0.000	1.74	2.63	3.41	4.02

(Rounding in the print routines used to display these figures means that some elements may have slight arithmetic differences)

The lowest category boundary is set to zero, and successive boundaries are generated by accumulating the average differences. The scale values are given by computing the mean difference between category boundary scores and the corresponding elements in the Z-matrix.

The calculation for microbiology is (0.0 + 0.29) + (1.74 - 1.80) = 0.23 / 2 since all other elements are missing values, and this yields a mean of 0.115 (the raw score for microbiology).

Service	Unadjusted Score	Transformed Score
Microbiology	0.115	0.697
Histopathology	0.197	0.687
Biochemistry	0.246	0.681
Haematology	0.283	0.676
Nuclear Medicine	0.679	0.627
Radiology	1.420	0.535
Ultrasound	1.882	0.478

There exist two theoretical limits to the pattern on quality ratings. All ratings could be in category one (excellent) or in category five (very poor). By superimposing these two additional sets of quality rating it is possible to establish the proportion of the theoretical maximum quality score for each of the services. The final stage in calculating quality scores using the Torgerson algorithm is shown in the last column. In this case the raw score for microbiology of 0.115 becomes 0.697, or 69.7% of the theoretical maximum.

APPENDIX 3
PRACTICES RESPONDING

Table 3A
Time General Practitioners had worked locally

Time in practice (years)	Number of GPs	Percentage of GPs
1 - 5	37	33
6 - 10	33	30
11 - 15	15	13
16 - 20	9	8
21 - 25	10	9
26+	8	7
Total	112	100

Table 3B
Age of responding General Practitioners n = 111

Age (years)	Number of GPs	Percentage of GPs
< 30	2	2
30 - 39	59	53
40 - 49	32	29
50 - 59	16	14
60+	2	2
Missing	1	-
Total	112	

Table 3C
List size of General Practitioners taking part in the survey

List size	Number of GPs	Percentage of GPs
< 2700	7	6
2701 - 5100	25	22
5101 - 7300	22	20
> 7301	58	52
Total	112	100

APPENDIX 3 (CONTINUED)

Table 3D
Response rates by partnership size

Partnership Size	Number of Practices	Eligible GPs	Number of Eligible GPs who Responded	Percentage of Eligible GPs who Responded
1-3	31	66	51	77
4-6	11	52	38	73
7-10	3	27	23	85
Total	45	145	112	77

APPENDIX 4
ADDITIONAL QUALITY CRITERIA SUGGESTED BY GENERAL PRACTITIONERS

Additional quality criteria given by general practitioners on which to rate their chosen hospital-based services in need of improvement

	Additional quality criteria	Number of mentions
1.	Time taken to report	4
2.	Politeness to patients	4
3.	Communication re on-going management of patients	2
4.	Open access scans	1
5.	Use of day hospital care by GPs	1
6.	Appointed sector consultant	1
7.	Consultant commitment/initiative	1
8.	Wait at clinic	1

Additional quality criteria given by general practitioners on which to rate their chosen community-based services in need of improvement

	Additional Criteria	Number of mentions
1.	Cover for sickness/absence	7
2.	Health promotion	3
3.	Is the department big enough	2
4.	Communications with those in authority	1
5.	Can service complete its whole function	1
6.	Premature discharge	1
7.	Extent of service offered	1

APPENDIX 5
ADDITIONAL SERVICES SUGGESTED BY GENERAL PRACTITIONERS

There were 102 suggestions from 51 general practitioners. These have been listed with the number of general practitioners making the suggestion in brackets.

NHS

- physiotherapy (19)
- ultrasound (10)
- gastroscopy/endoscopy (8)

- night-time nursing service (1)
- emergency beds for severely mentally impaired, especially children (1)
- out-of-hours service - pharmacy (travel long distance, Sundays), dental (2)
- cottage hospital/short-term NHS local nursing home (1)
- more: DN (1), HV (1), CPN (1), OT (3), chiropody (3) speech therapy (1), midwifery (1), community dietitian (1), counselling services (2), clinical psychology (3), orthodontist (1)
- community orthoptic screening for children (1)
- infertility clinic (1)
- facilities for chronic young sick (1)
- day care psychiatry in Selby (1)
- more domiciliary services in rural areas with poor public transport (1)
- improved funding for family centre therapy (1)
- local services: dermatology (1), rheumatology, ophthalmology (1),
- X-ray screening osteoporosis (1)
- help to integrate chronic psychiatric patients discharged into the community (1)

Non- NHS

- improved bus service
- better public sector residential care for the elderly (1)
- more social workers

APPENDIX 6
ADDITIONAL COMMENTS BY GENERAL PRACTITIONERS ABOUT HOSPITAL AND COMMUNITY SERVICES

Forty-one general practitioners made 67 suggestions or comments. These have been listed with the number of general practitioners making the suggestion in brackets.

Good quality of care (12)
Management/communication (11)
Waiting times (10)

Increased general practitioner/primary care workload - work shifting from hospital to general practitioner, eg earlier discharge, diabetic care, practice nurses being expected to perform work previously done by hospital nurse (4)

Discharge notes take too long to reach general practitioner (2)

Patients should not be discharged without medication (2)

Make sure general practitioners know what tests should be done before referring (1)

Feedback to general practitioners to tests received (1)

Unnecessary follow-up appointments, eg varicose veins, hernias (1)

Patients should always be seen by consultant or senior registrar on first appointment (2)

Can't order fracture splints without going through hospital (1)

Sectorisation of psychiatric services means the practice relates to every psychiatrist so none is known well (1)

Under-funding (3)

Switchboard to York District Hospital polite but takes too long (1)

Investment in health promotion needed to decrease demand on secondary care services (1)

General practitioners to be more involved in planning, their views listened to (2)

Questionnaire took far too long/too simplistic

Whole surgery under pressure, stress levels risen in the last 18 months