He ara aupiki, he ara auheke
Aotearoa New Zealand patient experience survey

From PES to PDSA

Workbook: Using adult primary care patient experience survey data for quality improvement

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Te Kāwanatanga o Aotearoa
New Zealand Government

Me mahi tahi tātou mō te oranga ō te katoa.

We should work together for the wellbeing of everyone.

October 2022, Health Quality & Safety Commission,
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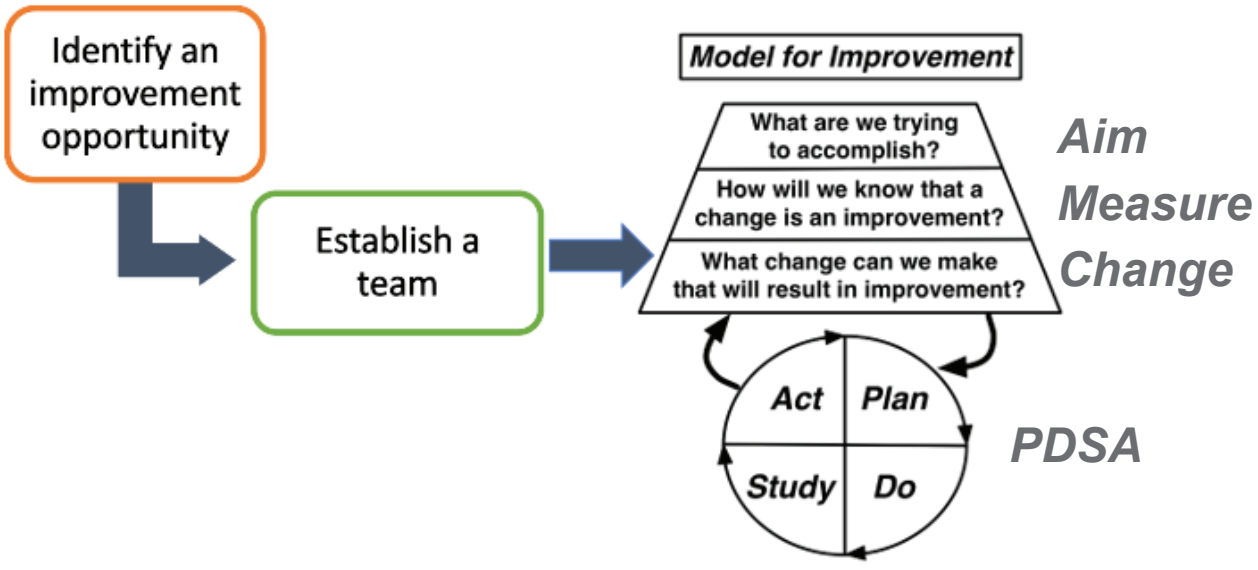
Purpose

This workbook is designed to help you use data from the Aotearoa New Zealand adult primary care patient experience survey to conduct quality improvement initiatives and track the progress of these initiatives. This will help you implement the code of expectations for health entities' engagement with consumers and whānau (consumer code of expectations)[1] and meet indicator 8.2 of the Royal New Zealand College of General Practitioner's Foundation Standard.

We show you how to engage with your data in the patient experience survey reporting portal and use this to undertake a plan–do–study–act (PDSA) cycle. We break down the PDSA cycle into well-defined steps so you can streamline quality improvement activities within your organisation. We include a worksheet at the end, which takes you through an example of how to find your improvement opportunity from your survey data in the reporting portal.

Figure 1: The Model for Improvement[2]



1 For more information see: www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau.

2 Figure source: Langley GJ, Moen RD, Nolan KM, et al. 1996. *The Improvement Guide*. San Francisco, CA: Jossey-Bass.

Introduction

About the adult primary care patient experience survey

Patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient- and whānau-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

The Health Quality & Safety Commission conducts the adult primary care patient experience survey with its survey provider, Ipsos. The survey gathers information about patients' experience of the care they receive in primary care and how their overall care was managed between their general practice and other parts of the health system.

Every three months, a sample of adult patients (15 years and over) enrolled with and seen by participating general practices are invited to take part.

See: **www.hqsc.govt.nz/our-data/patient-experience/adult-primary-care-patient-experience/**

The value of reviewing patient experience feedback

Reasons for reviewing patient experience feedback include:

- it helps practices to understand what they are doing that benefits their patients the most and identify where opportunities exist for improvement
- it helps practices to maintain a strong patient–practice relationship by listening and responding to their patients' feedback. This encourages patients to seek care when they need it and to remain with the practice. It can also help maintain the reputation of the practice in the community
- it respects and honours the time patients have taken to give feedback
- it can help strengthen the consumer and whānau voice in your improvement project and support the voice of consumers you engage with to co-design improvements.

Links with the consumer code of expectations

The consumer code of expectations sets out how health entities must work with consumers, whānau and communities in the planning, design, delivery and evaluation of health services.

For practices, actively participating in the survey programme and using lived experience, including consumer experience data, to inform improvements in health services is part of implementing the consumer code of expectations. See: **www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau/**.

Links with Foundation Standard and Cornerstone accreditation

The survey forms part of the evidence to meet indicator 8.2 of the Royal New Zealand College of General Practitioner's Foundation Standard. This requires practices to survey their population and use the results for improvement. See: **www.hqsc.govt.nz/resources/resource-library/primary-care-patient-experience-survey-foundation-standard-cornerstone-accreditation/**.

Links with Health System Indicators

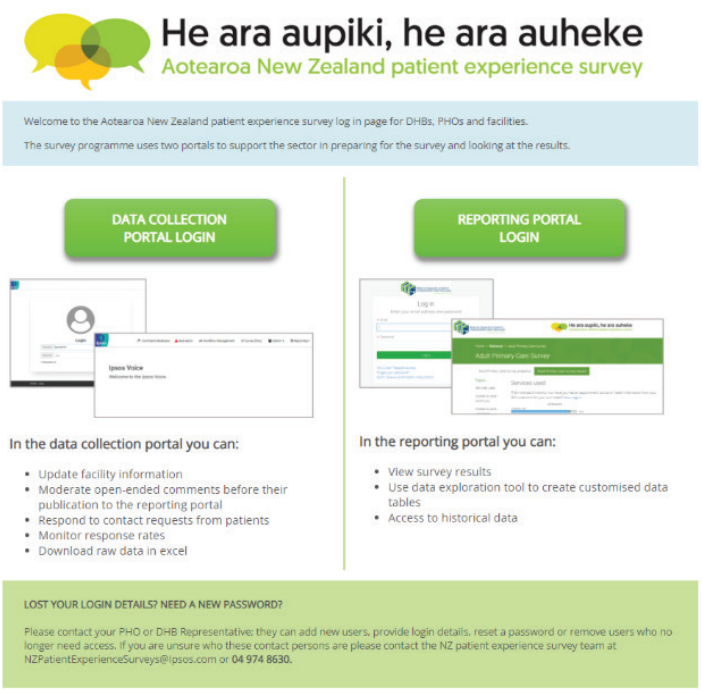
The example question used in the worksheet forms part of the Health System Indicators framework. See: **www.health.govt.nz/new-zealand-health-system/health-system-indicators-framework**.

Finding your survey data

Survey reporting portal

Ipsos has built two portals to support the sector in preparing for the survey and looking at the results.

Figure 2: Patient experience survey portals



The **data collection portal** is where you can update facility information, moderate open-ended comments before their publication to the reporting portal, respond to contact requests from patients, monitor response rates (by primary health organisation and practice) and download raw data in Excel.

The **reporting portal** is where you can see an overview of survey results compared with the national average, view each question by demographic details and use the data exploration tool to create customised tables. Free-text responses can be downloaded from this portal.

This URL: **myexperience.health.nz/sector** takes you to a page with links to both portals. For this workbook, you will use the reporting portal. If you have lost your login details or forgotten your password, please contact your primary health organisation representative. If you are unsure who this is, please contact the patient experience survey team at **NZPatientExperienceSurveys@Ipsos.com** or 04 974 8630.

A webinar of how to use the reporting portal and a Q&A document are available in the How-to Library (**https://cx.myexperience.health.nz/library**). Also provided is a Reporting Portal How-to Guide.

Finding your quality improvement opportunity

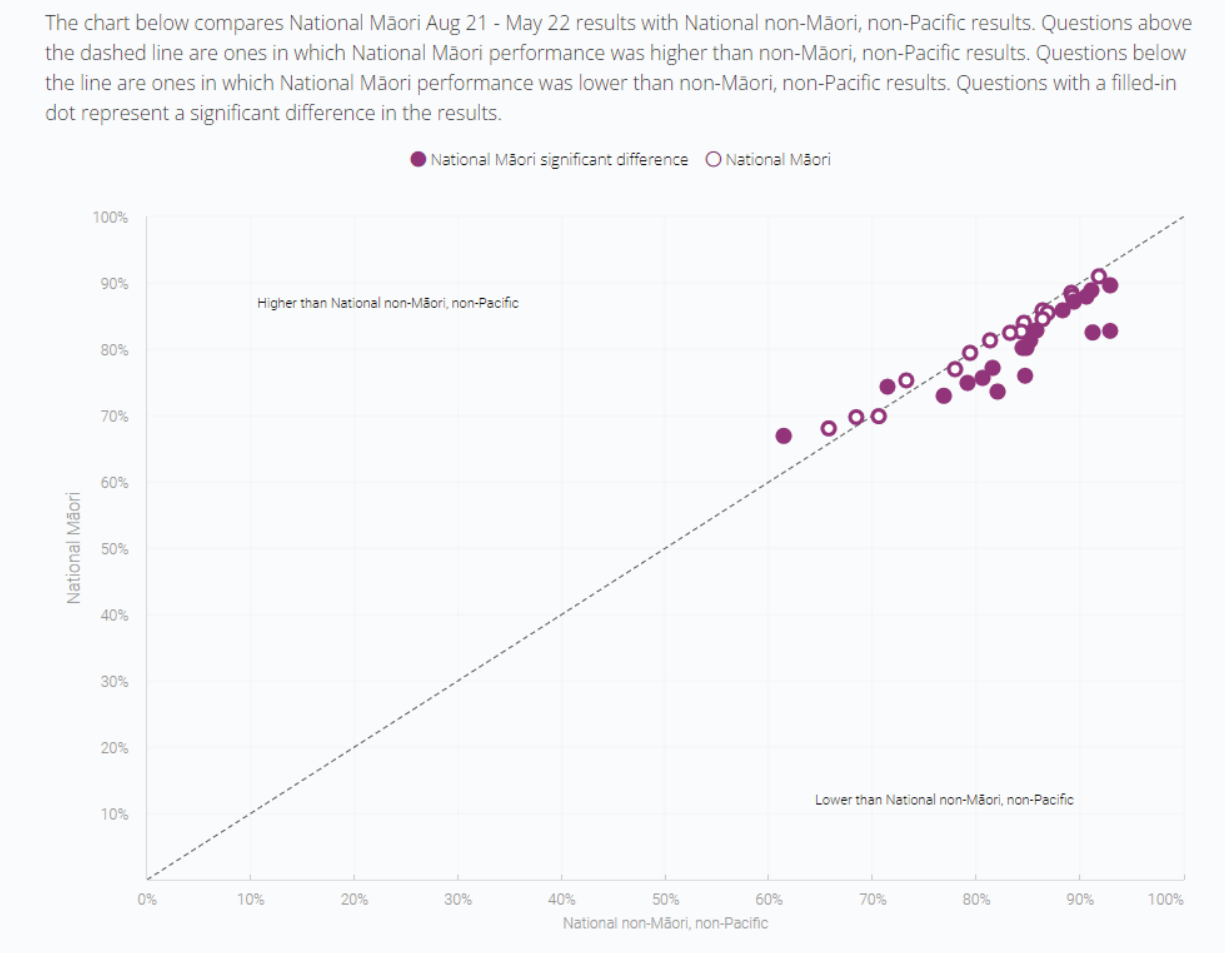
Working with consumers, whānau and the community from the start can help you identify topics for improvement that are important to them. This also helps with meaningful interpretation of the data from different perspectives, particularly for Māori. You may already know the area you wish to focus on and who is best placed to work with you. You likely know that, unless you take the time to stop and look at the problem, nothing will change. However, you don't have to do this work alone. Luckily, the reporting portal is designed to lessen the burden of time. So let's log in.

The portal's dashboard (Figure 3) gives you an immediate snapshot of where to focus. You can quickly see where you are doing well and areas to work on. Topics for improvement can come in many forms. We have provided some examples on the following pages, based on looking at:

1. variation between groups of people (eg, Māori reporting worse access to care compared with non-Māori, non-Pacific)
2. a low-scoring question
3. variation between practices.

Example 1: Identify your improvement opportunity by comparing Māori results with non-Māori, non-Pacific

Figure 3: Overview page identifying your improvement opportunity by comparing Māori results with non-Māori, non-Pacific (these results are also presented in a table format)



In the example in Figure 3, the questions with a filled-in dot represent a significant difference in results. Filled dots above the line show where Māori results were significantly more positive than non-Māori, non-Pacific, and filled dots below the line show where Māori experience was poorer. Hover over the dot to see which question it represents. Note, these results are not standardised for age. We recommend further analysis to look at results by age and ethnicity.

Example 2: Identify your improvement opportunity by reviewing the lowest-scoring questions

Figure 4: Overview page identifying your improvement opportunity by reviewing results where the practice is significantly lower than national results

Questions in which results for Medical Practice were significantly lower than the National results.

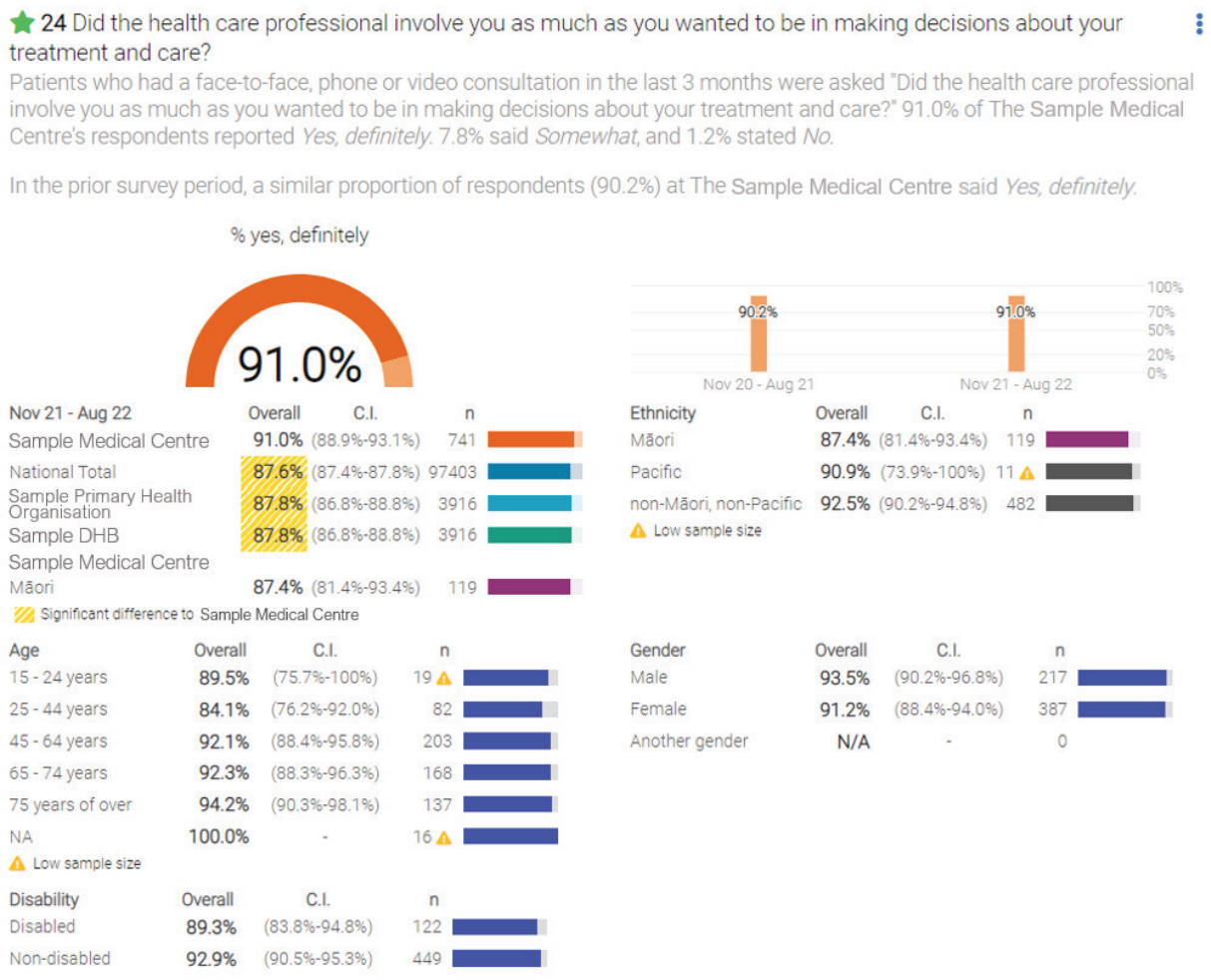
⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
The health care professional definitely treated the patient with kindness and understanding.	Aug 2022	89.0%	(82.2%-95.8%)	82
	New Zealand	94.5%	(94.2%-94.8%)	27746
The patient did NOT identify perceived unfair treatment	Aug 2022	85.1%	(77.0%-93.2%)	74
	New Zealand	96.0%	(95.8%-96.2%)	23750
The health care professional definitely spent enough time with the patient.	Aug 2022	79.7%	(70.8%-88.6%)	79
	New Zealand	88.4%	(88.0%-88.8%)	27685
In the last 12 months, the patient was always involved as much as they wanted to be in decisions about the best medicine(s) for them.	Aug 2022	74.6%	(64.5%-84.7%)	71
	New Zealand	85.1%	(84.7%-85.5%)	26341
The patient was told how they could find out the results of the x-ray, scan, blood test, or other medical test.	Aug 2022	67.1%	(56.1%-78.1%)	70
	New Zealand	79.9%	(79.4%-80.4%)	23322
The health care professional always asked if uncertain how to say patient's name	Aug 2022	63.5%	(53.3%-73.7%)	85
	New Zealand	76.6%	(76.1%-77.1%)	28508
The patient did not mind the wait (availability of appointment).	Aug 2022	55.6%	(44.1%-67.1%)	72
	New Zealand	76.9%	(76.4%-77.4%)	22955
The patient did not have to go back to hospital or get emergency care because of complications or their condition's worsening within a month after being discharged from hospital.	Aug 2022 ⚠	53.3%	(28.1%-78.5%)	15
	New Zealand	79.4%	(78.2%-80.6%)	4424
The patient was always told, in a way they could understand, by someone at their GP / nurse clinic or pharmacy what to do if they experienced side effects.	Aug 2022	44.4%	(32.1%-56.7%)	63
	New Zealand	61.0%	(60.4%-61.6%)	22749
The patient's GP / nurse clinic is definitely informed and up to date about the plan for follow-up (post hospital stay).	Aug 2022 ⚠	40.0%	(15.2%-64.8%)	15
	New Zealand	69.9%	(68.6%-71.2%)	4659
The patient was able to get an appointment on the same day or the next working day.	Aug 2022	15.5%	(7.8%-23.2%)	84
	New Zealand	35.1%	(34.5%-35.7%)	28142

The example in Figure 4 shows results where the practice was significantly lower than national results for August 2022.

Example 3: Identify your improvement opportunity by reviewing responses by demographic variables (eg, age, ethnicity, gender and disability status)

Figure 5: Survey results page reviewing responses by demographic variables



Tip: In the survey results page, click on the three blue dots on the top right of the question and select 'show demographic breakdown' to view results by age, ethnicity, gender and disability status.

The lower the percent, the more people are reporting not being involved in decisions about their treatment and care as they would like.

From looking at these results, you can see the following groups were more likely (although not statistically significantly) to report not being involved in decisions as much as they wanted:

- those aged 15–44 years (89.5 percent and 84.1 percent compared with 91 percent overall)
- disabled people (89.3 percent disabled compared with 92.9 percent non-disabled)
- Māori and Pacific people (87.4 percent and 90.9 percent respectively compared with 92.5 percent)
- females (91.2 percent compared with 93.5 percent).

The comments section in the survey can be used, together with the demographic information survey respondents provide. We discuss how to do this on page 17.

Tip: Interpreting confidence intervals

The confidence intervals are calculated at 95 percent confidence level. If the lower or upper limits do not overlap with other groups, the difference is considered statistically significant.

Figure 6: Interpreting confidence intervals

Ethnicity	Overall	C.I.	n
Māori	74.2%	(73.0%-75.4%)	4900
Pacific	74.1%	(71.7%-76.5%)	1324
non-Māori, non-Pacific	81.0%	(80.5%-81.5%)	21230

In the example in Figure 6, the upper limit for Māori (75.4 percent) does not overlap with the lower limit for non-Māori, non-Pacific (80.5 percent). This means the difference between responses for Māori and non-Māori, non-Pacific is statistically significantly different, and Māori were significantly more likely to report a time when they wanted care but could not get it. The column 'n' shows the number of people who answered the question by each ethnicity; in this example, 4,900 Māori responded.

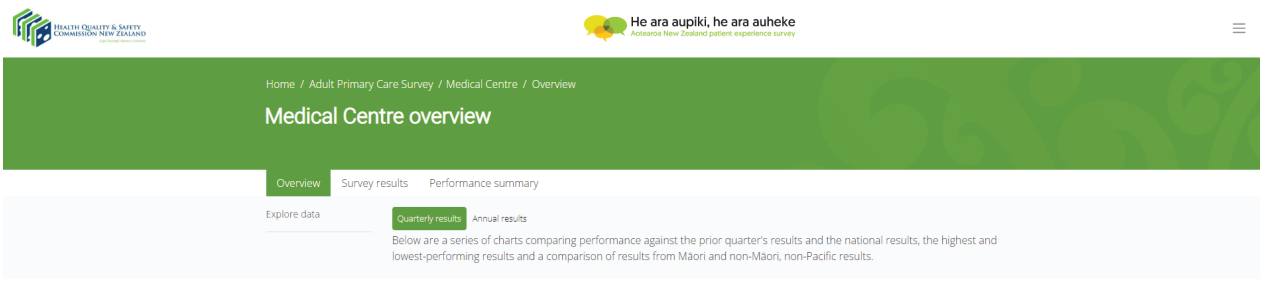
Tip: Data suppression and small numbers

For confidentiality, where the number of people responding to a question is less than five, filters such as age, gender or ethnicity will not be able to be applied. This is to prevent potential loss of anonymity. Where results are suppressed, we recommend using the national data as a guide. For example, we see from the national data that young people more commonly report barriers to access than older people. What is seen nationally is likely to be observed in your practice as well.

For statistical robustness, a warning of low numbers is given where the number of people responding to the question is lower than 30. When you want to use the data to inform a quality improvement project, it is better if you base this on at least 30 responses per question. Fewer than 30 responses can limit your ability to see trends and make predictions, but when compared against national data are still useful. For example, you will be able to see if your patients' responses are markedly different or not.

You can group your data to display annual rather than quarterly survey results, to increase the number of responses.

Figure 7: Selecting quarterly or annual results



A minimum number of responses does not apply to qualitative comments. Each comment can provide rich insight from your patients.

Before you start

Before you start, think about how you will manage any potential ethical risks for the consumers involved and how you will manage the use of new or existing data.

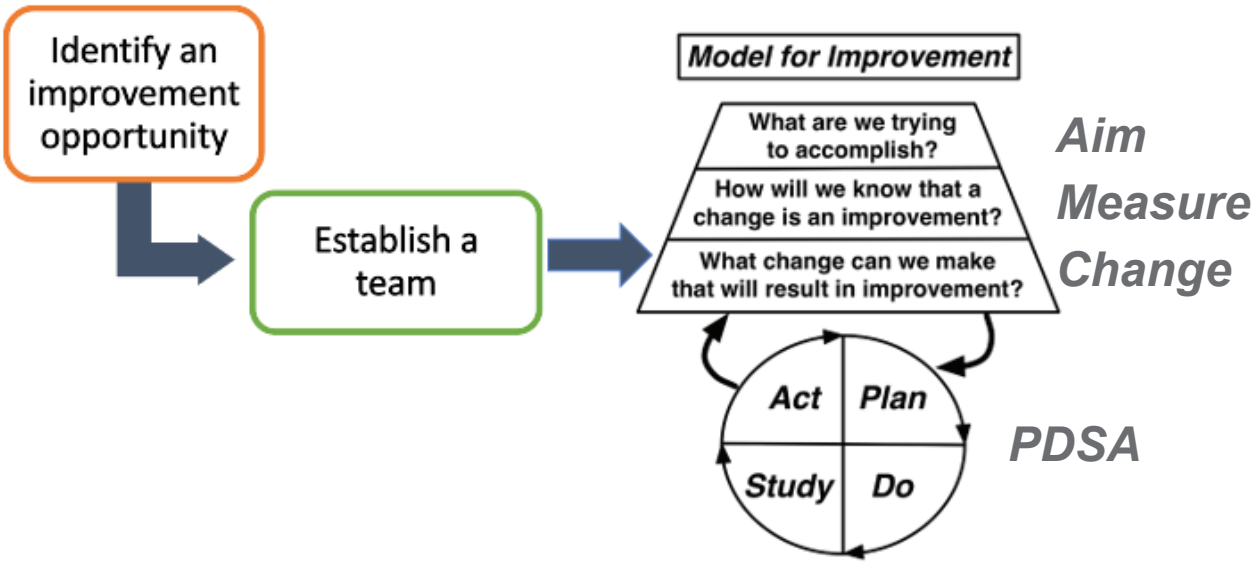
When involving consumers in quality improvement efforts, be respectful of them, their time and their data. People need to know what you are asking of them and what is involved. Is this new or existing data? If you are using existing data, are you using it for its intended purposes that were agreed to by consumers? If they are sharing new data and information, what use will be made of that data and how will it be managed? While quality improvement projects usually do not require a full ethical review, you do still need to consider ethical risks and plan how to eliminate or minimise them for participants. Team discussions and consulting professional peers are a good basis to start from. For a quick guide, you can refer to: **www.hqsc.govt.nz/our-work/leadership-and-capability/building-leadership-and-capability/quality-improvement-project-bank/ethics-guide/**.

The full National Ethical Standards for Health and Disability Research and Quality Improvement are available here: **neac.health.govt.nz/publications-and-resources/neac-publications/national-ethical-standards-for-health-and-disability-research-and-quality-improvement/**.

Model for Improvement

The improvement project process aims to answer the following three questions.

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?



Plan–do–study–act: Plan

Gather your team

Now you have clearly identified a problem and found data to support it, gather a team to help you understand and solve the problem. Developing a short description of what you have found, why it is important to address and why you need people to work with you on this (sometimes called an 'elevator pitch') can help you to engage participants more easily. The size of the team will reflect the size of your practice and the scope of the challenge you are working to improve. We generally recommend a team of four to eight people as being a good size. Make sure everyone in the team has a job because this avoids having 'too many cooks in the kitchen' and each person is helping the team.

Health entities are expected to include consumers and whānau in co-designing health system improvements as part of the consumer code of expectations. Having staff, patients and whānau working together can create ideas that will work for both patients and staff because they are not based on assumptions. If you want to learn more about co-design and developing an 'elevator pitch' to engage others, you can complete a free online learning programme on LearnOnline (**https://learnonline.health.nz/course/view.php?id=573**).

Finally, assign a leader or driver for your project to ensure follow-up and check on progress. This may be you.

Define your aim

Next, create an aim statement to clearly define what you are hoping to achieve. This is the answer to the first question from the Model for Improvement: 'What are we trying to accomplish?'. It will help you set a clear outcome measure for the project. The aim should focus on the outcome for patients. The aim statement will answer four questions shown in Table 1.

Table 1: Define your aim

	Elements of aim		Example
1. For whom?	Who?	Population focus	Enrolled Māori patients
	Where?	Location	'Our practice'
	When?	During what part of the process	Making an appointment
2. What?	What is it about?		Improving access to care
3. How much?	Baseline		Current measure
	Target		Desired level (increase or decrease)
	Metric used	Eg, percentage, average	Percentage
4. When?	Timeline		One year from start of project

Ideally, we start as small as possible to learn and increase the size of the project as we build knowledge. Start with a small group of patients and gradually roll out across the whole of the enrolled population. This increases the likelihood that the change will produce an improvement and reduces the risk of unsuccessful action as you learn about what and what does not work. Following our example, our aim statement could be:

> To … reduce the percentage of Māori patients in our practice reporting inability to access care when they wanted to from #% to #% by (some date in the future).

Measuring your progress

Now you and your team are clear about your aim, you will need to answer the second question from the Model for Improvement: 'How will we know that a change is an improvement?'.

We can use a time series chart from the reporting portal to see whether any changes have occurred to the baseline of X percent from quarter to quarter. Take a screen shot of this and put it into your practice action plan.

A quarter can be a long time to wait for feedback in quality improvement. Obtaining real-time and focused feedback helps you rapidly test changes, identify progress quickly and sustain motivation. Staff can get live feedback from patients using verbal feedback and a check sheet or other simple tools developed by your team for this purpose.

Next, determine what your intervention is going to be, that is, what you are going to do differently to try to achieve your aim. Try brainstorming ideas with your team and particularly consumers using survey feedback (including the comments section) or ask other people from outside your practice who might provide valuable insight.

You can also use this as an opportunity to identify the voice of a particular age, gender, ethnic group or disability status.

What changes can you make that will result in an improvement?

This is the third question from the Model for Improvement.

Depending on which example you are using, propose ideas and resources that could be used.

You will need multiple ideas because it is unlikely just one, no matter how clever, will achieve the desired result. Appendix 1 includes potential improvement ideas. Engaging consumers in your project can generate practical ideas for change that will affect the things that matter most to your patients. Consumers provide a different way of looking at things that can be useful for generating change ideas. They can provide guidance about what is important from the community, patient and whānau perspective.

We should apply a Te Tiriti o Waitangi and equity 'lens' to our improvement ideas. Apply frameworks such as the Wai 2575 principles[3] or Te Ao Māori Framework[4] to reflect on, if the changes you are considering will create more of the same or reduce inequities. Do you have local frameworks you can use to help expand your thinking?

Review your change ideas and think about which ones will have the most effect and are the easiest for you to test. Testing quick, simple change ideas is a good place to start while you work on developing high impact but more complex change ideas.

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3 See **www.uruta.maori.nz/te-tiriti-o-waitangi-principles** and **https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/** for information on the Wai 2575 principles.

4 See **www.hqsc.govt.nz/resources/resource-library/te-ao-maori-framework/** for more information on Te Ao Māori Framework.

Plan–do–study–act: Do

As you implement an intervention, that is, what it is you will be doing differently, you will want to make sure the change is occurring. Because the survey runs quarterly, the intervention your practice chooses will need to be implemented over a three-month period before the results show in the portal.

To make sure the change is occurring, look at what is happening and make sure you have local feedback processes in place. Is the new procedure being followed? Does everyone know what they are meant to be doing? Try scheduling regular meetings with the people involved to see how the quality improvement activity is going. It could be quite demotivating to find out after three months that the intervention had unintentionally been forgotten within the first two weeks. Changing processes is not always easy.

Plan–do–study–act: Study

Track the progress of your initiative at regular team meetings through the local feedback mechanisms you have set up. This could be a waiting room survey or check sheet, staff, patient, whānau and community feedback, clinical audits, practice patient management system data or whatever works best for you in your context and for your specific initiative. Regularly compare what you thought might happen against what actually happened. At the end of each survey round, once you have received the results, analyse your data and the other information gathered.

1. What happened? Check with your staff to find out how the new system is going. Has it been implemented as planned or do people need extra support?
2. What is the information telling you? Did any patients or whānau talk about the new system? Did they provide any extra feedback?
3. Is the latest survey information telling you different things for different people?
4. What worked and what didn't work? Did this work for all groups of people or just for some? Was the intervention too difficult to implement?
5 What should be adopted, adapted or abandoned? Would it be an option to provide the details of a reputable website, such as Health Navigator/Health Info, for patients and whānau who have easy internet access?

As you look to improve your practice's services, try to identify any changes from quarter to quarter. If you do not notice any improvement, you may want to review what your intervention is and see if you could try something else. Pay attention to the equity gap: has this decreased? A reduction in an equity gap is considered an improvement, even if the overall level has not changed.

Plan–do–study–act: Act

At the end of the PDSA test of change, act on the feedback and data results by deciding whether you should abandon the change, whether modifications are needed or you are ready to embed the change into business as usual. Keep testing different change ideas as frequent PDSA cycles until you have achieved your aim. The end of your quality improvement activity is also an important point for determining the next step. Imagine you have reached the end of the trial period of our example quality improvement activity (see Worksheet 1). You and your team have completed four survey cycles and numerous PDSA cycles and it is now [date]. Two outcomes are possible.

It worked! The survey results showed … However, by X date, the number of patients and whānau who … decreased to X percent.

It didn't work. The survey results showed … However, by X date, the number stayed fairly similar to previous quarters. What happened to the equity gap?

In both instances, consider the following questions with your team.

1. Did your action plan achieve its desired results?
2. Are you going to embed the new practice into long-term business as usual? How will you ensure the gains made can be sustained?
3. Summarise changes that took place and how they are a result of patient feedback.

Whatever happens, let your patients, whānau and colleagues know you will or will not be implementing the changes as a result of the previous year's trial period. Let everyone know the changes to the services within the practice are a direct result of patient and whānau feedback.

Tell everyone

Once you know what you are going to do and have perhaps started doing it, let other practice staff and your patients and whānau know the service changes your practice is incorporating as a result of feedback collected by the adult primary care patient experience survey. Telling patients and whānau what you are doing may even prompt them to talk to their doctor and help to embed the change.

You can communicate via posters throughout your practice, email, flyers on the waiting room table and/or telling patients and whānau what to look for when they first come into your practice. An example poster you could print and fill out is provided on page 18. Highlighting the work you are doing will signal to patients and whānau who have completed the survey that their voice is being heard, and for those yet to take the survey that their voice will be heard.

Worksheet 1: In the last 12 months, was there ever a time you wanted health care from a GP or nurse, but you couldn't get it?

Response options: yes, no

This is an overarching question on the ability of people to receive health care from their GP or nurse when they want it.

Why is this important?

Poor access to primary care is associated with inadequate prevention and management of chronic diseases, delayed diagnoses, incomplete adherence to treatments, overuse of drugs and technologies, and coordination and safety problems.[5] Delaying primary care can lead to more serious illnesses and hospital admissions.[6,7]

Previous research on access to primary health care in Aotearoa New Zealand has found Māori and Pacific peoples face barriers and have lower access to primary health care than people of New Zealand European/Pākehā ethnicity. Changes to the health system and future health policy must align with contemporary interpretations of Te Tiriti o Waitangi, to make equity a reality for Māori.[8] What equity gaps can you identify from your data?

Interpreting your results

As you are interpreting your results, be aware you are viewing the data through your own lens with your own inherent biases. Working with a wider team, which includes consumers, whānau, Māori and Pacific peoples, to interpret the data will provide different perspectives. Understanding the barriers to access through a consumer lens, te ao Māori or Pacific worldview will keep you from making assumptions from the beginning of the improvement work. Rangatiratanga or Māori decision-making is an important principle that cannot be added in later and must be embedded from the start for true partnership (pātuitanga).

Having an established team that you routinely work with to understand patient experience data from the survey, and any incidents or complaints, will help you develop an understanding as a team and build on your improvement experience together. Benefits are also gained in working with different consumers with relevant experience to share the mahi. More information on gathering your team is provided on page 10.

To find detailed data on the question you are focused on, go to the 'survey results' tab on the reporting portal. You can use the tab on the left to navigate to survey modules, for example, most recent experience, or you can use 'CTRL+F' to run a keyword search.

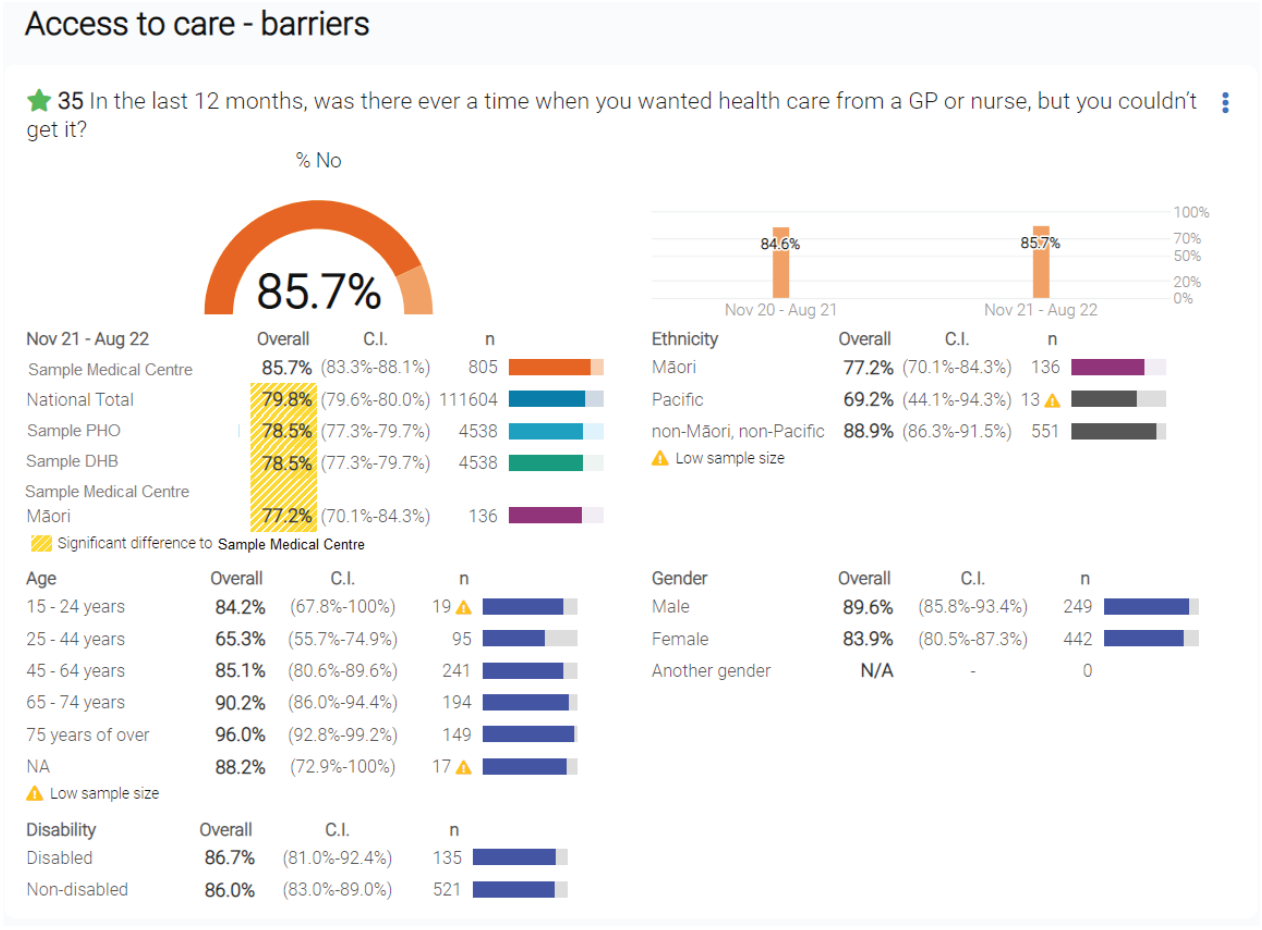
5 Schneider EC, Sarnack DO, Squires D, et al. 2017. *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care.* URL: **www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and** (accessed 10 October 2022).

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

7 Jeffreys M, Lopez M, Russell L, et al. 2020. Equity in access to zero-fees and low-cost Primary Health Care in Aotearoa New Zealand: Results from repeated waves of the New Zealand Health Survey, 1996–2016. *Health Policy* 124(11): 1272–9. DOI: 10.1016/j.healthpol.2020.08.009.

8 Jefferys M, Smiler K, Ellison Loschmann L, et al. 2021. *Prevalence and Consequences of Barriers to Primary Health Care.* URL: **www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/barriers-to-primary-health-care/prevalence-and-consequences-of-barriers-to-primary-health-care.pdf** (accessed 10 October 2022).

Figure 8: Results for Access to care – barriers



The portal indicates where differences are statistically significant compared with the national total. In the example in Figure 8, the practice's overall result is significantly higher than the national, district and primary health organisation results. Overall, their patients are more likely to report receiving care when wanted. However, the practice's Māori patients report significantly worse ability to access care, compared with the non-Māori, non-Pacific practice population (77.2 percent compared with 88.9 percent overall).

- Looking at the age breakdown, those aged 25–44 years are significantly more likely to report not being able to get care when they wanted it than any of the age groups 45 years and above (the confidence intervals do not overlap).
- Disability status does not appear to have an effect.

Next steps: in the example in Figure 8, this practice could look at its results for this question by age and ethnicity, to see which of its Māori patients are reporting worse access. This information can then be used to design a PDSA cycle focused on this cohort. A template is provided on pages 19 and 20 for you to use. The data explorer in the portal allows users to view results by age and ethnicity, or, if you prefer, you can download it into an Excel spreadsheet.

Review your results

Are your patients more or less likely to report being able to access care when wanted?	
Overall	Compared with: National average: lower/not significantly different/higher District average: lower/not significantly different/higher Primary health organisation average: lower/not significantly different/higher
Age	Are younger people: lower/not significantly different/higher Are older people: lower/not significantly different/higher
Disability status	Are disabled people: lower/not significantly different/higher than non-disabled people?
Ethnicity	Are Māori: lower/not significantly different/higher than non-Māori, non-Pacific? Are Pacific peoples: lower/not significantly different/higher than non-Māori, non-Pacific?
Gender	Are females: lower/not significantly different/higher than males

Based on these findings

Do the results of this question suggest room for improvement exists for your practice? Is the national average good enough or does everyone need to improve? Just because you are no worse than any other practice, this does not mean this is satisfactory performance. What do your consumers and staff say about what matters to them?

As with the example practice, even if your overall result is above average, are there groups that have a worse experience that you need to pursue achieving equity with?

If we apply the Wai 2575 principles, then we could consider the following.

- Who do we need to **partner** with to understand this more and/or to make effective change?
- How can we ensure **tino rangatiratanga** or Māori decision-making is supported?
- What culturally and consumer and whānau-focused accessibility **options** can be developed?
- What resources do we need to put in place as **active protection** and where are they needed to achieve **equity**?

Further analysis including free-text

Question 36: Why could you not get health care from a GP or nurse when you wanted it during the past 12 months?

People who answer the above survey question negatively are asked a follow-on question to explain why they could not get care. Responses to this question will help you understand possible areas for improvement, this includes a free-text (qualitative) option.

Your staff, consumers and their whānau and community networks may be able to provide additional insight.

Annual results

Figure 9: Example of Annual results

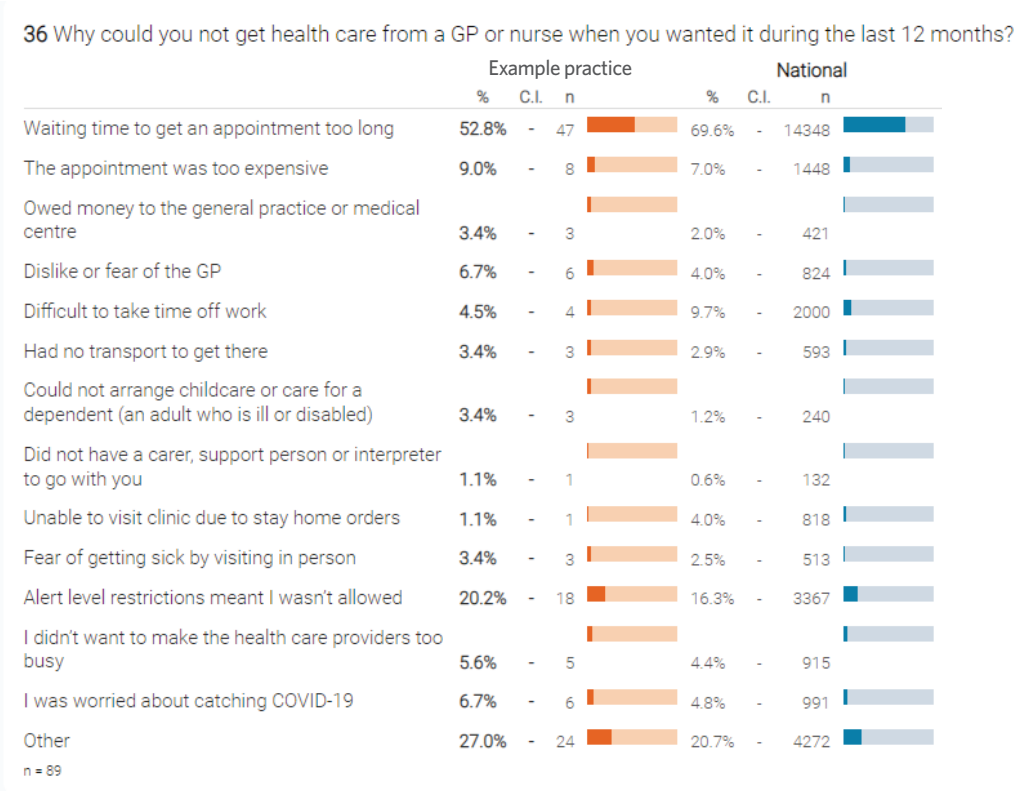


Table 2: The most common reasons for not getting health care when wanted in the past 12 months were as follows

Reason	Sample medical centre (percent)	National (percent)	Reason
Waiting time to get an appointment too long	52.8	69.6	Waiting time to get an appointment too long
Alert level restrictions	20.2	16.3	Alert level restrictions
Difficulty taking time off work	9.0	9.7	The appointment was too expensive

Other reasons

Other issues around appointment availability relate to the ability for people to see their usual doctor at short notice; the wait time for the appointment once they reach the clinic; and clinic hours not being compatible with work hours. This is particularly a problem when people urgently wanted care. Cost and a lack of transport were reported less frequently.

To access the full list of comments, we recommend downloading a survey answer export from the data collection portal. The How-to Guide for this is available here: nz.ipsos.com/patientexperience/APCS_Download_Raw_Data_How-to-guide.pdf.

Resources

Patient experience survey feedback poster

Date:

YOU TOLD US:	WHAT WE DID:

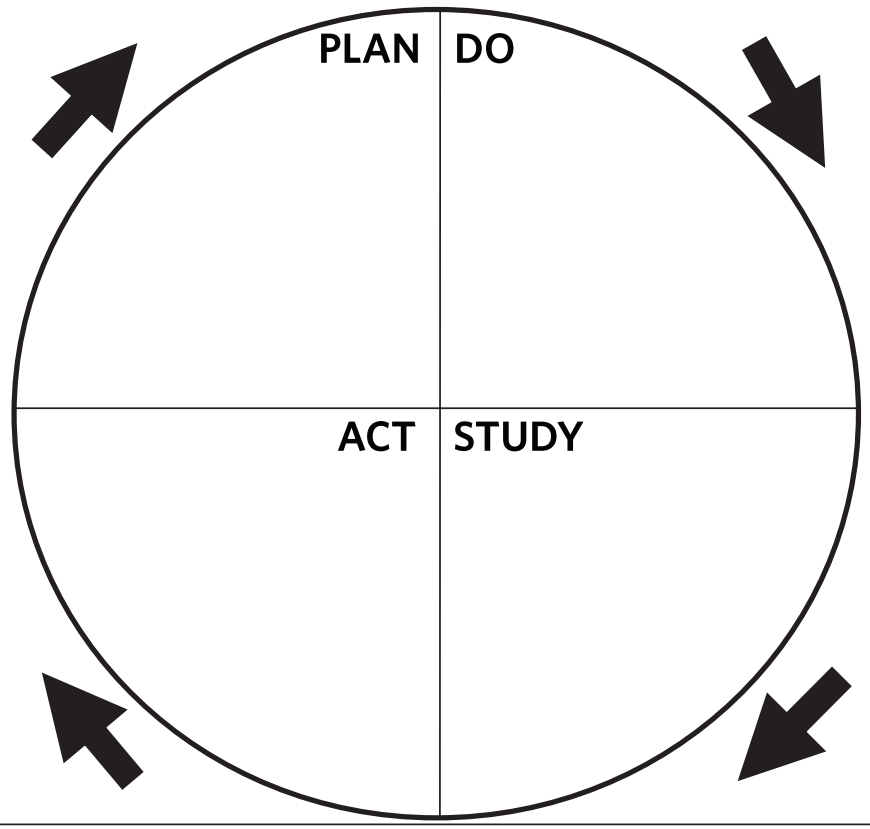
WHERE WE'RE UP TO:	WHERE WE WANT TO GET TO:
	BY WHEN:

PDSA#	PDSA title:	PDSA date:	Owner:

Objective of this PDSA:

Change idea:

Questions:



Predictions:

Measurements

Plan–do–study–act template

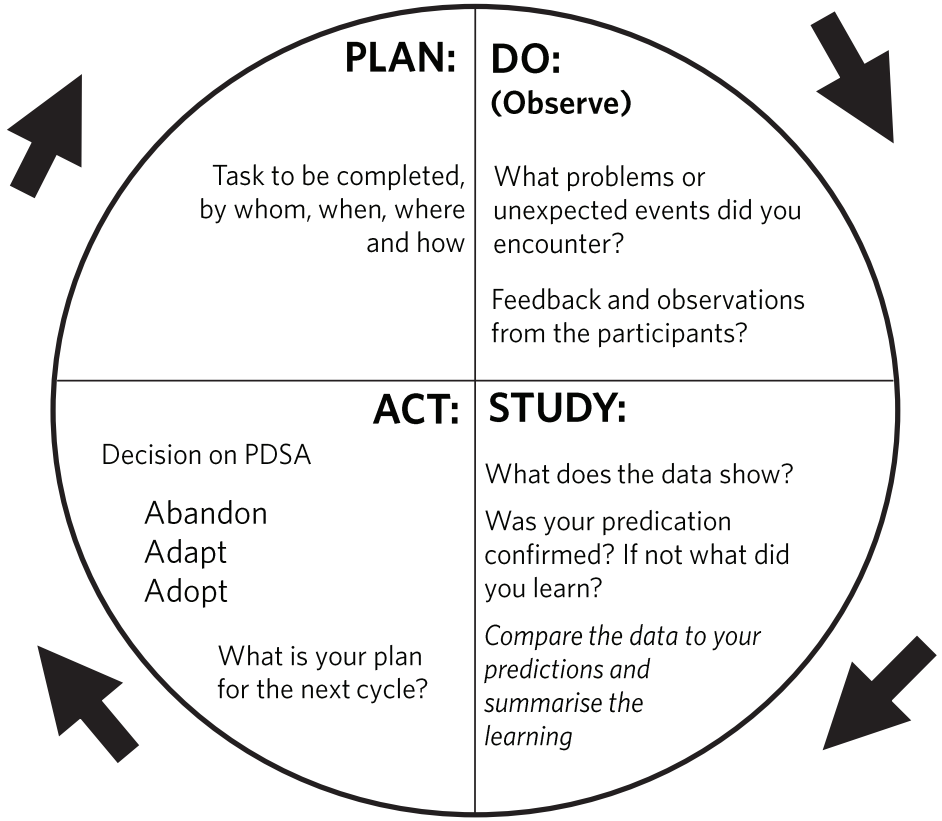
PDSA #	PDSA title:	PDSA date:

Objective of this PDSA:

Change: Briefly describe the specific change you plan to test

Questions

What question(s) do we want to answer on this PDSA cycle?



Predictions

What do you think will happen?

Prediction on change:

Prediction on question(s):

Measurements: What data will you need to test your prediction(s)? How will you collect it.

Useful links

Aotearoa New Zealand adult primary care patient experience survey: **www.hqsc.govt.nz/our-data/patient-experience/adult-primary-care-patient-experience**

Code of expectations for health entities' engagement with consumers and whānau: **www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau/**

Consumer engagement in primary care: **www.hqsc.govt.nz/resources/resource-library/progressing-consumer-engagement-in-primary-care-te-whakakoke-i-te-whai-wahi-a-te-kiritaki-ki-te-tiaki-hauora-tuatahi/**

Engaging consumers and whānau: **www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/**

Understanding co-design. Open access to co-design learning modules: **www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/co-design/**

Primary care co-design case studies: **www.hqsc.govt.nz/our-programmes/partners-in-care/work-programmes/co-design/#2020/2021**

Primary care quality improvement case studies: **www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/co-design/**

Resources for providers starting quality improvement projects: **www.hqsc.govt.nz/our-work/improved-service-delivery/primary-care/resources-for-providers-starting-quality-improvement-projects/**

New Zealand patient experience survey programme refresh 2019/20: **www.hqsc.govt.nz/resources/resource-library/new-zealand-patient-experience-survey-programme-refresh-201920/**

Measuring culturally safe care through the patient experience surveys: **www.hqsc.govt.nz/resources/resource-library/measuring-culturally-safe-care-through-the-patient-experience-surveys/**

Te Ao Māori Framework: **www.hqsc.govt.nz/resources/resource-library/te-ao-maori-framework/**

Wai 2575 principles: **www.uruta.maori.nz/te-tiriti-o-waitangi-principles** and **https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/**

Feedback

Please provide feedback on this workbook and your experience of using it to **survey@hqsc.govt.nz**.

Appendix 1: Possible improvement actions for people reporting not being able to get care when wanted

Action or questions to explore	Contributory measures
What are the reasons locally that people report as access barriers? How do patients make contact, and what does the front door of the practice look like? What is the use of patient portals and telehealth? Is the whole health care team used, for example, is an appointment the right solution? Who is most likely to report being unable to access care when it is wanted? Undertake further analysis of patient responses to create a priority list of barriers people report.	When you made the booking, how quickly were you able to get an appointment (same day, next day, within a week, over a week)? (Primary care survey question)
	Percentage of patients reporting they can get an answer about something important on the same day. (Primary care survey question)
	Time to third next available appointment.
	Complaints related to accessing services over time. Are they reducing or increasing?
	What reasons do people cite for going to the emergency department that relate to general practice, for example, GP or after-hours too expensive, waiting time to get an appointment was too long at usual medical clinic. (Primary care survey question)
	Emergency department attendance rate for health conditions that could be managed in primary care.
Wait times. One driver of long wait times could be workforce constraints. • What is the current full-time equivalent (FTE), FTE mix and how does it compare? • What is FTE by patient need? • Staff turnover, absenteeism and vacancies. • What are your GP and nurse use rates? • What is workforce retention like? • How is workforce wellbeing managed? • Is a workforce strategy needed? • What proportion of practices have closed books? • What options are offered to patients unable to enrol in a practice close to home? • What training and development is resourced?	FTE by profession and ethnicity (GP, nurse, nurse practitioner, practice nurse, other).
	FTE by patient need (FTE high need versus general).
	Staff absenteeism, sick leave usage.
	Staff turnover.
	Long-term vacancies (vacancies unfilled for longer than x months).
	Use of locums.
	GP use. Consults per year, raw and standardised for age and sex.
	Nurse use. Consults per year, raw and standardised for age and sex.
	Output: a workforce strategy implemented by [timeframe].
	Refer to indicator district health board contracted FTE per 100,000 population.

Action or questions to explore	Contributory measures
Wait times. Could changing the model of care reduce wait times? • Is a formal planned system in place for triage? • What options are available for acute care during office hours? • What care is available after-hours and do patients know how to access it? • Are other models an option, for example, nurse practitioners or pharmacist prescribers? • Would virtual consults reduce wait time? • Is clinical pharmacist support available in practices? • Does the general practice provide a range of services, for example, skin lesion removal or IUD insertion or removal? • Is point of care access and coordination provided?	Implement a formal triage system by [timeframe]. Percentage of patients reporting not being able to get an answer to an important question on the same day. (Primary care survey question) Percentage of patients who attend the emergency department reporting that after-hours availability was a reason for not being to access care. (Primary care survey question) Number and percent of consults offered by: a. phone b. video c. different primary care workforce.
Difficulty taking time off work. Are opening hours meeting patient needs, especially those who are working? • Review clinic opening hours. Have patients been involved in selecting these times? • Do clinic hours meet patient need? • Are extended clinic hours offered?	Percentage of patients reporting that clinic opening hours are a barrier. Percentage of primary care hours when the general practice is open outside of normal business hours. How long do patients wait once they arrive? (Primary care survey question) What percentage report the wait is unacceptable? (Primary care survey question)
Is appointment cost a barrier? • Does your population know how to access relevant subsidies? • Is community services card information visible at the practice?	Percentage of patients reporting that appointment cost is a barrier. (Primary care survey question) Percentage of patients reporting that prescription cost is a barrier. (Primary care survey question)
Is the service culturally safe? (As an important aspect of access to services) • Is the workforce supported to provide culturally safe care? Is development needed? • Understand differences in care by ethnicity, for example, audits of care provided and self-reflection on own biases. • Review cultural safety question set. Are there questions where Māori, Pacific peoples or other minority groups respond less positively?	Did you feel your cultural needs were met? (Primary care survey question) Was your name pronounced properly? (Primary care survey question) Did the [health care practitioner] ask you how to say your name if they were uncertain? (Primary care survey question) If you want to, are you able to have family and whānau involved in discussions about your treatment and care? (Primary care survey question)

Action or questions to explore	Contributory measures
Does the service provide access based on Te Tiriti o Waitangi principles? For all providers: • Is culturally safe and responsive care available in places accessible to whānau? • Would having trusted people in the community, such as community support workers, improve access? • Are there linkages with Iwi Māori Partnership Boards? • Use data to know where whānau are accessing services and identify gaps. • Audit and review to see whether the quality of care provided to Māori is the same as non-Māori.	What percentage of Māori patients report being unable to get care? What are the main reasons cited?
	Co-design and deliver projects with providers to address access barriers.
Are digital services used to provide care in people's homes? • How could communities be upskilled and empowered to manage care at home? • What can be learnt from the COVID response in managing support and recovery at home? • Is telehealth available and offered, where appropriate? • Is technology in the home available, for example, pulse oximeters and heart rate and blood pressure monitors?	Question 3: In the past three months, how have you had an appointment, advice, or health information from your GP/nurse clinic for your own health (in-person visit/video call/phone call/email/text message/other)? Proportion of patients reporting using phone or video calls.
	FTE community support workers.
Do people have access to integrated primary and community services? • What access to community services is there? – Can doctors refer direct to ultrasound and other diagnostics? – Is there information so people know how and where they can access services in the community? – What services can people self-refer to, for example, contraception or midwifery? • Are alternatives to acute care, such as hospital at home, available? • What are the transport options to access services? Consider travel distance, available transport options, how convenient they are and the cost.	

Action or questions to explore	Contributory measures
People with long-term conditions are more likely to report difficulty getting care when they wanted it. Would providing those with long-term conditions or high needs with additional support improve their access to care? • Do patients with long-term conditions have a care plan? • Are outpatient consults offered in general practice? • Stratify high-risk patients to ensure they are receiving effective medicines support. • Would pharmacy involvement in long-term condition management improve support?	Do you have a shared treatment or care plan agreed with a health care professional to manage your conditions? (Primary care survey question)
	Co-design with communities to agree on service specifications to standardise service delivery in pharmacies.
Youth (15–24 years) are more likely to report barriers to access than those aged 45 years and over. • What are the most common reasons this age group reports as barriers? • Co-design with youth ways to improve access based on the most common barriers. • Are marae, use youth one-stop-shop and school-based services linked to localities? Better integration is important. • Review youth access to services: sexual health; mental health and wellbeing; alcohol and other drugs; oral health use. • What mental health services are available? (Link to primary access and choice initiative.)	Percentage of youth reporting that the health care practitioner recognised and/or understood any mental health needs they might have had. (Primary care survey question)
	Chlamydia testing coverage for ages 15 to 24 years.
	Self-harm hospitalisations for ages 12 to 24 years, total and intentional.
	Alcohol-related Emergency Department presentations for ages 10 to 24 years.
	Adolescent oral health use for school year, for ages 9 to 17 years.

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