

Practice ID GP ID Patient ID

The General Practice Assessment Questionnaire (GPAQ)

Dear Patient

We would be grateful if you would complete this survey about your general practice and your visit today.

The doctors at your practice want to provide the highest standard of care. Feedback from this survey will enable them to identify areas that may need improvement. Your opinions are therefore very valuable.

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

Thank you.

Because part of the survey is about the doctor you saw today, please write the doctor's name below:

The person I saw today was Dr or Nurse _____

1 In the past 12 months, how many times have you seen a doctor or nurse from your practice?	None or twice <input type="checkbox"/> 1	Once or four times <input type="checkbox"/> 2	Three or six times <input type="checkbox"/> 3	Five or seven times <input type="checkbox"/> 4	Seven times or more <input type="checkbox"/> 5
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2 How do you rate the way you are treated by receptionists at your practice?	Poor <input type="checkbox"/> 1	Good <input type="checkbox"/> 2	Excellent <input type="checkbox"/> 3
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3 a) How do you rate the hours that your practice is open for appointments?	Poor poor <input type="checkbox"/> 1	Good <input type="checkbox"/> 2	Excellent <input type="checkbox"/> 3	
b) What additional hours would you like the practice to be open? (please tick all that apply)	Early morning <input type="checkbox"/> 1	Evenings <input type="checkbox"/> 2	Week- ends <input type="checkbox"/> 3	None, I am satisfied <input type="checkbox"/> 4

4 Thinking of times when you want to see a particular doctor : (please tick one box only)					
a) How quickly do you usually get to see that doctor?	Same day <input type="checkbox"/> 1	Next working day <input type="checkbox"/> 2	Within 2 working days <input type="checkbox"/> 3	More <input type="checkbox"/> 4	Does not apply <input type="checkbox"/> 5
b) How do you rate this?	Poor <input type="checkbox"/> 1	Good <input type="checkbox"/> 2	Excel- lent <input type="checkbox"/> 3	Does not apply <input type="checkbox"/> 4	

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5 Thinking of times when you are willing to see **any doctor**: (please tick one box only)

a) How **quickly** do you usually get seen?

	Same day	Next working day	Within 2 working days	More	Does not apply
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

b) How do you rate this?

	Poor	Good	Excellent	Does not apply
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

6 If you need to see a GP **urgently**, can you normally get seen on the same day?

	Yes	No	Don't know / never needed to
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

7 a) How long do you usually have to **wait** at the practice for your consultations to begin? (please tick one box only)

	5 minutes or less	6-10 minutes	11-20 minutes	More
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

b) How do you rate this?

	Poor	Good	Excellent
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

8 Thinking of times you have **phoned** the practice, how do you rate the following:

a) Ability **to get through to** the practice on the phone?

	Poor	Good	Excellent	Don't know/ never tried
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

b) Ability to **speak to** a doctor or nurse on the phone when you have a question or need medical advice?

	Poor	Good	Excellent	Don't know/ never tried
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

9 This question asks about your **usual doctor**. If you don't have a 'usual doctor', answer about the one doctor at your practice who you know best. If you don't know any of the doctors, go straight to question 10.

a) In general, how often do you see your **usual doctor**?

	Almost always	Some of the time	Never
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

b) How do you rate this?

	Poor	Good	Excellent
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

10 Thinking about **your consultation with the doctor or nurse today**, how do you rate the following:

	Poor	Good	Excel- lent	Does not apply
a) How thoroughly the doctor or nurse asked about your symptoms and how you are feeling?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b) How well the doctor or nurse listened to what you had to say?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c) How well the doctor or nurse put you at ease during your physical examination?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d) How much the doctor or nurse involved you in decisions about your care?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e) How well the doctor or nurse explained your problems or any treatment that you need?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f) The amount of time your doctor or nurse spent with you today?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
g) The doctor or nurse's patience with your questions or worries?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
h) The doctor or nurse's caring and concern for you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Finally, it will help us to understand your answers if you could tell us a little about yourself:

12 Are you: 1 Male 2 Female

13 How old are you? _____ years

14 Do you have any **long-standing illness, disability or infirmity**? By long-standing we mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. 1 Yes 2 No

15 Which **ethnic group** do you belong to? (please tick one box)

<input type="checkbox"/> 1 White	<input type="checkbox"/> 4 Mixed
<input type="checkbox"/> 2 Black or Black British	<input type="checkbox"/> 5 Chinese
<input type="checkbox"/> 3 Asian or Asian British	<input type="checkbox"/> 6 Other ethnic group

16 Is your **accommodation**: (please tick one box)

1 Owner-occupied/mortgaged? 2 Rented or other arrangements?

17 Which of the following best describes you? (please tick one box)

<input type="checkbox"/> 1 Employed (full or part time, including self-employed)	<input type="checkbox"/> 5 Looking after your home/family
<input type="checkbox"/> 2 Unemployed and looking for work	<input type="checkbox"/> 6 Retired from paid work
<input type="checkbox"/> 3 At school or in full time education	<input type="checkbox"/> 7 Other (please describe) _____
<input type="checkbox"/> 4 Unable to work due to long term sickness	_____

18 We are interested in any other comments you may have. Please write them here.

Is there anything particularly good about your health care?

Is there anything that could be improved?

Any other comments?

Thank you for taking time to complete this questionnaire.

We are always keen to get feedback, if in future we are not meeting your expectations, please let us know. If we are doing something well, please let others know too.