

## Out of Hours (GP) Questionnaire

The current Out of Hours service contract is coming to an end. We would like to use this opportunity to find out if the current service is meeting your needs, and what your expectations are for obtaining healthcare when GP and community services are closed.

**Instructions:** Please answer ALL the questions that apply to you by ticking the box that most closely resembles your experience. There are no right or wrong answers. The answers provided will be used to help to influence the development of the new Out of Hours service. See instructions at end for completion and submission of forms.

**1. Do you know how to contact the Out of Hours Service?**

Yes  No Go to Question 37

**2. Have you used the Out of Hours service in the last 12 months?**

Yes  No Go to Question 37

**3. Did you contact the Out of Hours service for:**

Yourself  Your child / children  Your partner / spouse  Other relative / friend

**4. Did you wait a while before calling the Out of Hours service?**

Yes Go to Question 5.  No Go to Question 6

**5. If you did delay calling, why was this?**

- You considered the condition not serious enough
- You wanted to see if the condition worsened
- You did not want to waste anyone's time
- You were unsure where to go

Other - please state:

**6. How long do you think it took for your call to be answered?**

less than 30 secs  30 - 60 secs  More than 60 secs

**How do you rate this:**

Very poor  Poor  Acceptable  Good  Excellent

**7. Please rate the following:**

	<i>Very poor</i>	<i>Poor</i>	<i>Acceptable</i>	<i>Good</i>	<i>Excellent</i>
<b>Helpfulness</b> of the person who took your call	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much you felt <b>listened to</b> during the call	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. Were you told how long you would have to wait before a health professional called you back?**

Yes  No

**9. Did you wait for the health professional to call you back?**

Yes  No

**10. What did you do instead?**

*Went to the Walk-in Centre*  *Went to the GP the next day*  *Called an ambulance*  
 *Went to the Pharmacy*  *Went to A & E (Accident and Emergency)*

Other:

**11. How long did it take for you to receive a call from a health professional (This could be a doctor, nurse, paramedic, etc)?**

*Less than 20 mins*  *20 - 60 mins*  *More than 60 mins*

**How do you rate this?**

*Very poor*  *Poor*  *Acceptable*  *Good*  *Excellent*

**12. Did you feel able to describe your problem over the phone?**

*Definitely not*  *No, not really*  *Yes to some extent*  *Yes, definitely*

**How comfortable did you feel describing your/the patients problem over the phone?**

*Very comfortable*  *Comfortable*  *Acceptable*  *Uncomfortable*  *Very uncomfortable*

**13. What was the outcome of your most recent contact with Out of Hours service?**

*Telephone advice only*  *Walk-in Centre visit*  
 *CNCS (Out Of Hours Centre) visit*  *Home visit*

**14. Were you happy with the outcome?**

Yes  No

Please give a reason for your answer:

**15. Which health professional carried out the consultation?** (This includes telephone consultation as well as face-to-face) - *(Please tick all that apply)*

Doctor

Nurse

Paramedic

Don't know

Other - please state:

**16. How long did the consultation last?**

Less than 10 mins

10 - 20 mins

More than 20 mins

**How do you rate this?**

Very poor

Poor

Acceptable

Good

Excellent

**17. Please rate the following:**

	Very poor	Poor	Acceptable	Good	Excellent	N/A
The thoroughness of the health professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The accuracy of the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The treatment given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The advice and information given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The health professionals manner / attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much you felt you / the patient were listened to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much you felt things were explained to you / the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The dignity and respect you / the patient were shown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**18. Did the Out of Hours service give you any medication at the time of the appointment?**

Yes

No

**19. Did the Out of Hours service give you a prescription for any medication?**

Yes

No

**20. Was the medication easy to obtain?**

Very easy

Quite easy

Neither easy or difficult

Quite difficult

Very Difficult

**21. Do you think the Out of Hours staff knew enough about your medical history?**

Definitely not

Possibly not

Not sure

Yes, possibly

Yes, definitely

**22. Did you have any problems understanding the health professional? e.g. because of language barriers, explanation of the condition**

Yes

No

**23. Is English your first language? (if no, were you offered additional help?)**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No - no help was needed  |
| <input type="checkbox"/> No - help was offered within 15 minutes of ringing     | <input type="checkbox"/> No - no help was offered |
| <input type="checkbox"/> No - help was offer more than 15 minutes after ringing |   |

**24. Do you have a hearing impairment? (If yes, were you offered additional help)**

- |   |  |
|---|--|
| <input type="checkbox"/> No                     | <input type="checkbox"/> Yes - help was not needed |
| <input type="checkbox"/> Yes - help was offered | <input type="checkbox"/> Yes - no help was offered |

**25. Do you have a visual impairment? (If yes, were you offered additional help)**

- |   |  |
|---|--|
| <input type="checkbox"/> No                     | <input type="checkbox"/> Yes - help was not needed |
| <input type="checkbox"/> Yes - help was offered | <input type="checkbox"/> Yes - no help was offered |

**26. Did you have any issues regarding disabled access? (If yes, were you offered additional help)**

- |   |  |
|---|--|
| <input type="checkbox"/> No                     | <input type="checkbox"/> Yes - no help was needed  |
| <input type="checkbox"/> Yes - help was offered | <input type="checkbox"/> Yes - no help was offered |

**27. Did you have to attend the CNCS (Out Of Hours Centre) :**

- |                              |                             |                    |
|------------------------------|-----------------------------|--------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Go to question 32. |
|------------------------------|-----------------------------|--------------------|

**28. Did you have any problems getting to the CNCS (Out Of Hours Centre)?**

- |   |  |
|---|--|
| <input type="checkbox"/> Public transport | <input type="checkbox"/> Cost                                  |
| <input type="checkbox"/> Childcare        | <input type="checkbox"/> Too ill or in too much pain to travel |
| <input type="checkbox"/> Personal safety  | <input type="checkbox"/> Access to a car                       |

Other - please state:

**29. How long did it take you to travel to CNCS (Out Of Hours Centre)?**

- |  |                                       |                                       |   |
|--|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Less than 15 mins | <input type="checkbox"/> 15 - 29 mins | <input type="checkbox"/> 30 - 59 mins | <input type="checkbox"/> 1 hour or more |
|--|---------------------------------------|---------------------------------------|---|

**How do you rate this?**

- |                                    |                               |                                     |                               |                                    |
|------------------------------------|-------------------------------|-------------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Very poor | <input type="checkbox"/> Poor | <input type="checkbox"/> Acceptable | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |
|------------------------------------|-------------------------------|-------------------------------------|-------------------------------|------------------------------------|

**30. On arrival at the CNCS (Out Of Hours Centre) were you told how long you would have to wait?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**31. How long did you wait?**

- |  |                                       |                                       |                                    |                                       |
|--|---------------------------------------|---------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Less than 20 mins | <input type="checkbox"/> 20 - 39 mins | <input type="checkbox"/> 40 - 59 mins | <input type="checkbox"/> 1-2 hours | <input type="checkbox"/> over 2 hours |
|--|---------------------------------------|---------------------------------------|------------------------------------|---------------------------------------|

**How do you rate this?**

- |                                    |                               |                                     |                               |                                    |
|------------------------------------|-------------------------------|-------------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Very poor | <input type="checkbox"/> Poor | <input type="checkbox"/> Acceptable | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |
|------------------------------------|-------------------------------|-------------------------------------|-------------------------------|------------------------------------|

**32. Did you have a home visit?**

- Yes  No Go to question 35.

**33. If a home visit was required, how long did you have to wait?**

- Up to 1 hour  1 - 2 hours  More than 2 hours

**How do you rate this?**

- Very poor  Poor  Acceptable  Good  Excellent

**34. Do you feel you were kept informed about the home visit? e.g. expected time of arrival, if running late**

- Yes - as much as was needed  
 No - I would have liked a follow-up phone call

**35. What is your overall rating of the Out of Hours Service?**

- Very poor  Poor  Acceptable  Good  Excellent

**36. Was your case managed with sufficient urgency?**

- Definitely not  No, I don't think so  Yes, I think so  Yes Definitely  N/A

**37. How would you like to access Out of Hours service in the future?**

- As you do now  Defined opening hours for access  Drop-in options  
 Telephone access  Appointment System

Other:

**38. Where would you like to access Out of Hours care?**

- As you do now (same premises)  On transport route  Where there are good facilities e.g. parking  
 Next to / near to hospital  In the community  At home (when needed)

Other:

**39. What services would you like to see the Out of Hours service offer?**

- Shared services with A & E  Text messaging  Links to 111  
 Telephone access  Online tools  Links to other services

Other:

**40. ANY OTHER COMMENTS**

**41. Would like to continue to be involved in the Out of Hours service review, if yes, please provide your contact details below:**

- Yes - please provide your contact details  
 No

Name

Address

Telephone

Email

**The following information is collected for monitoring purposes only. It is kept in the strictest confidence and will not be shared with any other party.**

**The information required in the following questions is for that of the patient:**

**42. Please insert the first four digits of your postcode: (e.g. NG4, NG7, NG14, etc)**

**43. Would you describe you / the patient as:**

- Male  Female

**44. Please select the appropriate age category:?**

- 0-17  50-64  85+  
 18-24  65-74  
 25-49  75-84

**45. Would you / the patient describe your ethnicity as:**

- White British  Chinese  Mixed White & Black African  
 White Irish  Other Asian background  Mixed White & Asian  
 Other white background  Black Caribbean  Other mixed background  
 Indian  Black African  Traveller / Gypsy  
 Pakistani  Other Black background  Prefer not to say  
 Bangladeshi  Mixed White & Black Caribbean

Any other ethnic background:

**46. Do you / the patient have a disability?**

- Learning Disability / Difficulty  Sensory Impairment  Physical Impairment  
 Mental Health Condition  Long Term Condition  No disability

Any other disability:

**47. Are you / the patient:**

- Heterosexual /straight  Gay / Lesbian  Bi-sexual  Other

**48. Are you / the patient:**

- Married       Single       Living with partner       Other  
 Civil Partnership       Divorced       Widowed

**49. How would you / the patient describe your religion / belief?**

- Hinduism       Islam       Judaism  
 Sikhism       Jainism       Agnostic  
 Christianity       Buddhism       No religion / belief

Any other religion / belief

**50. Are you / the patient pregnant or have given birth within the last 12 months?**

- Yes       No       Prefer not to say

**51. Is your / the patients gender the one assigned at birth?**

- Yes       No

**52. Do you / the patient live and work full time in the gender role opposite to that assigned at birth?**

- Yes       No

**53. If English is not your / the patients first language, please state your preferred:**

**Thank you for completing this Out of Hours patient questionnaire.  
Your help is very much appreciated.**

**Please return the completed questionnaire to:**

**By email: Save the completed form and email to [ppi@nottspct.nhs.uk](mailto:ppi@nottspct.nhs.uk)**

**By Post: Out of Hours Survey (North)**

**NHS Nottinghamshire County, (FREEPOST RRZL-GBTT-RJUJ),  
Birch House, Mansfield, Nottinghamshire, NG21 0HJ**

**Alternatively complete the survey online at [www.nottspct.nhs.uk/my-voice/consultations](http://www.nottspct.nhs.uk/my-voice/consultations)**

**If you have any queries relating to any of the questions asked within the questionnaire, or wish to discuss further, please contact the Patient Advice and Liaison Service (PALS): Telephone 0800 028 3693**

**This questionnaire is based on one developed by CFEP - UK Surveys, University of Manchester**