

Patient Feedback



A questionnaire about the quality of our service



*Your opinion counts
...make sure it is heard!*

Patient Feedback



Committed to excellence

We value your opinion

About us

Sussex Medical Centre is a provider of independent healthcare. We provide services direct to the public and are also commissioned by the NHS to provide services on their behalf

Sussex Medical centre owns and runs a number of clinics and services including our primary medical facility Sussex Medical Chambers based in Hove. You can see more of our services on the back of this booklet.

We aim to provide the highest standards of care and treatment to all of our patients.

To help us measure our level of performance, we would appreciate your views and would be grateful if you would complete this questionnaire about our services and your experiences.

We regard your opinions and comments as very valuable and will use them to identify opportunities for improvement and to highlight areas of success. All feedback from our patients will be treated in strictest confidence and not shared unless you indicate otherwise.

Once completed, please hand back to a member of the Reception Team.

Thank you for using Sussex Medical Chambers.

Practice Manager

Your Choice - Sussex Medical Chambers (SMC)

01 What was the one main factor that made you decide to come to SMC?

- Location Choice of appointment date
 Reputation Short waiting list
 Recommendation by friend/family Recommendation by GP/Consultant (please specify (please specify) _____)
 Other (please specify) _____

02 Were you given a choice of appointment dates?

- Yes No

03 How long did you have to wait, from the date you booked your appointment to the date you were seen by the Practitioner?

- 1-3 days 4-7 days 8-14 days Over 14 days

04 Did this meet your expectations?

- Yes No

05 How organised was the appointment process?

- Very Satisfactory Disorganised

06 Were you given any pre-appointment information?

- Yes No Not applicable

If yes, please give details: _____

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Your Treatment

07 In what area of medicine was your treatment?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> GP Consultation | <input type="checkbox"/> Pathology/Phlebotomy |
| <input type="checkbox"/> Complementary Medicine | <input type="checkbox"/> Gynaecology | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Cosmetic / Aesthetics | <input type="checkbox"/> Medical Legal | <input type="checkbox"/> Psychiatry/Psychology |
| <input type="checkbox"/> Counselling | <input type="checkbox"/> Neurology | <input type="checkbox"/> Travel Clinic |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Nurse Services | <input type="checkbox"/> Urology |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Vascular |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Orthopaedics/Sports Injury | <input type="checkbox"/> X-ray |
| <input type="checkbox"/> General Medicine | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | |

On Your Visit

08 Please give your opinion on the following:

	Excellent	Very Good	Good	Fair	Poor
The greeting on arrival	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration in waiting room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpfulness of reception staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall impression of visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How could we have improved your visit? _____					

The Clinic Environment

09 Overall, how would you rate the cleanliness at SMC?

- Excellent
 Very Good
 Satisfactory
 Poor
 Very Poor

10 Overall, how would you rate the presentation of SMC?

- Excellent
 Very Good
 Satisfactory
 Poor
 Very Poor

11 Overall, how would you rate the comfort and facilities of SMC?

- Excellent Very Good Satisfactory Poor Very Poor

Your Practitioner

(Your Practitioners name) _____

12 Please give your opinion on the following:

	Excellent	Very Good	Good	Fair	Poor
The way your course of treatment was explained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way the expected outcome was explained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way your questions were answered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your overall impression of the Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How could we have improved your Practitioner care? _____					

Your Care and Treatment

13 To what extent were you involved in decisions about your care and treatment?

- Very Adequate Somewhat Not at all

14 When being examined or treated, was your privacy and dignity respected?

- Always Mostly Sometimes Rarely Never

15 Were you provided with sufficient information about your condition/treatment?

- Yes Somewhat No

16 To what extent did you have confidence and trust in the clinician treating you?

- Always Mostly Sometimes Rarely Never

Overall

17 How would you rate the overall experience you received at SMC?

- Excellent Very Good Satisfactory Poor Very Poor

18 Would you recommend SMC to your family and friends, and to what degree?

- Yes, I would strongly recommend Yes, I would recommend I would neither recommend or oppose No, I would oppose No, I would strongly oppose

19 Do you consider your experience/treatment value for money?

- Yes No

If No, please explain: _____

20 Would you like information about the SMC Membership Scheme which can save you money on consultations and treatments?

- Yes No

(If yes, please complete your address details on page 6)

About you

21 What is your gender? Male Female

22 What is your age group?

- 18-24 25-40 41-64 65+

23 Is this your first visit to SMC? Yes No

24 Name of your SMC Practitioner: _____

25 Name of your family GP: _____

Additional Comments

Please add any suggestions that might help us improve the service we provide to patients or any other comments you wish to add. You may like to mention any staff by name who gave especially good service and say what made them special.

Please tick and complete your details below if you would like a reply to comments raised.

Please tick and complete your details below if you would like our complaints policy sent to you.

Name: _____

Tel: _____

Address: _____

Please tick if you would like your feedback stored as anonymous.

....putting you first

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