

# Improving patient experience in primary care: a multimethod programme of research on the measurement and improvement of patient experience

Jenni Burt,<sup>1</sup> John Campbell,<sup>2</sup> Gary Abel,<sup>1,2</sup>  
Ahmed Aboulghate,<sup>1</sup> Faraz Ahmed,<sup>1</sup> Anthea Asprey,<sup>2</sup>  
Heather Barry,<sup>2</sup> Julia Beckwith,<sup>1</sup> John Benson,<sup>3</sup>  
Olga Boiko,<sup>2</sup> Pete Bower,<sup>4</sup> Raff Calitri,<sup>2</sup> Mary Carter,<sup>2</sup>  
Antoinette Davey,<sup>2</sup> Marc N Elliott,<sup>5</sup> Natasha Elmore,<sup>1</sup>  
Conor Farrington,<sup>1</sup> Hena Wali Haque,<sup>1</sup> William Henley,<sup>2</sup>  
Val Lattimer,<sup>6</sup> Nadia Llanwarne,<sup>1</sup> Cathy Lloyd,<sup>7</sup>  
Georgios Lyratzopoulos,<sup>1</sup> Inocencio Maramba,<sup>2</sup>  
Luke Mounce,<sup>2</sup> Jenny Newbould,<sup>1</sup> Charlotte Paddison,<sup>1</sup>  
Richard Parker,<sup>3</sup> Suzanne Richards,<sup>2</sup> Martin Roberts,<sup>2</sup>  
Claude Setodji,<sup>5</sup> Jonathan Silverman,<sup>8</sup> Fiona Warren,<sup>2</sup>  
Ed Wilson,<sup>1</sup> Christine Wright<sup>2</sup> and Martin Roland<sup>1\*</sup>

<sup>1</sup>Cambridge Centre for Health Services Research, Institute of Public Health, University of Cambridge School of Clinical Medicine, Cambridge, UK

<sup>2</sup>University of Exeter Medical School, Exeter, UK

<sup>3</sup>Primary Care Unit, Institute of Public Health, University of Cambridge School of Clinical Medicine, Cambridge, UK

<sup>4</sup>National Institute for Health Research (NIHR) School for Primary Care Research, Manchester Academic Health Science Centre, University of Manchester, Manchester, UK

<sup>5</sup>RAND Corporation, Santa Monica, CA, USA

<sup>6</sup>School of Health Sciences, University of East Anglia, Norwich, UK

<sup>7</sup>Faculty of Health & Social Care, The Open University, Milton Keynes, UK

<sup>8</sup>University of Cambridge Medical School, Cambridge, UK

\*Corresponding author [mr108@medschl.cam.ac.uk](mailto:mr108@medschl.cam.ac.uk)

**Declared competing interests of authors:** Martin Roland and John Campbell have acted as advisors to Ipsos MORI, the Department of Health and, subsequently, NHS England on the development of the English GP Patient Survey. Jenni Burt has acted as an advisor to Ipsos MORI and NHS England on the GP Patient Survey. Pete Bower has received funding from the National Institute for Health Research in addition to the programme grant.

Published April 2017

DOI: 10.3310/pgfar05090

## Scientific summary

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Programme Grants for Applied Research 2017; Vol. 5: No. 9

DOI: 10.3310/pgfar05090

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# Scientific summary

This programme had seven aims:

1. to understand how general practices respond to low patient survey scores
2. to estimate the extent to which practice-level scores mask differences between individual doctors
3. to investigate how patients' ratings on questions in the GP Patient Survey [see <https://gp-patient.co.uk> (accessed 23 January 2017)] relate to actual behaviour by general practitioners (GPs) in consultations
4. to understand patients' responses to questions on communication and seeing a doctor of their choice
5. to understand the reasons why minority ethnic groups, especially South Asian respondents, give lower scores on patient surveys than white British respondents
6. to carry out an exploratory randomised controlled trial (RCT) of an intervention to improve patient experience, using tools developed in earlier parts of the programme
7. to investigate how the results of the GP Patient Survey can be used to improve out-of-hours care.

In this report, we group our results under three headings:

1. understanding patient experience data (aims 3 and 4)
2. understanding patient experience in minority ethnic groups (aim 5)
3. using data on patient experience for quality improvement (aims 1, 2, 6 and 7).

We conducted empirical studies in general practices (varying in location, deprivation and performance on patient experience measures) and out-of-hours providers nationally. A total of 47 general practices and 11 out-of-hours providers participated in the programme of work, although some were involved in more than one study. We additionally completed multiple analyses of GP Patient Survey data and, for an experimental vignette study, collected data from the general public.

## 1. Understanding patient experience data

Patient surveys are widely used in many countries, yet comparatively little is known about what experiences actually lead patients or service users to respond in particular ways when completing them. We approached this issue in two studies in which we (1) used video elicitation interview methods to ask 52 patients directly about how they chose certain questionnaire responses while showing them a video of their consultation and (2) used statistical analyses to compare assessments of videoed consultations by 56 patients with those of expert raters using standardised assessment instruments.

The first study showed that, although patients readily criticised their care when reviewing consultations on video, they described how they had been reluctant to be critical when completing a questionnaire. Reasons for this included the need to maintain a relationship with the GP, gratitude for NHS care that they had received in the past and power asymmetries. We concluded that patients find questionnaires to be limited tools for feeding back concerns about consultations.

The second study reinforced our conclusion from the first study. When trained raters judged communication in a consultation to be good, patients generally did the same. However, when trained raters judged communication in a consultation to be poor, patients' assessments varied from 'poor' to 'very good'.

The tendency for patients to choose positive responses suggests that absolute survey scores should be treated with caution; they may present an overoptimistic view of GP care. Surveys can be used to look at relative scores: scores for a GP that are lower than those in comparable practices are likely to indicate a problem.

We spoke to GPs about their survey results through both focus groups and face-to-face interviews. They reported that, although positive about the concept of patient feedback, they struggled to engage with and make changes under the current approaches to measurement.

A second aspect of care that we identified as being of importance as part of our programme of work relates to patients' ability to see a doctor of their choice. Our analyses of GP Patient Survey data showed that for all age groups most patients have a particular GP whom they prefer to see. However, up to 40% of people who have such a preference are unable regularly to see the doctor of their choice. This is a significant quality issue for the NHS.

In out-of-hours care we found that patients reported worse experiences when the service was run by a commercial provider than when it was run by a not-for-profit or NHS provider.

## 2. Understanding patient experience in minority ethnic groups

Minority ethnic groups provide consistently low scores in English surveys. In this study, our analyses of GP Patient Survey data focused on South Asian respondents and on questionnaires completed in English. Although the GP Patient Survey is available in 15 languages, fewer than 0.2% of surveys are completed in languages other than English. First, we showed that Asian respondents to the GP Patient Survey tend to be registered in practices with generally low scores, explaining about half of the difference between South Asian and white British patients in their experience of care. Then, using item response theory, we found no evidence that South Asian respondents used the scales in a different way from white British respondents.

We then conducted an experimental vignette study for which we filmed 16 simulated consultations based on transcripts of real consultations using various combinations of white and Asian doctors and patients, half scripted to be 'good' and half scripted to be 'poor' for communication. We showed three randomly sampled videos to each of 1120 people (half white British, half Pakistani, equally split between those aged < 55 years and those aged  $\geq 55$  years) and asked them to score the consultation using the communication items from the GP Patient Survey. If the low scores of Pakistani patients in real-life settings were the result of higher expectations of care, then we would expect them to give lower scores in the experimental vignette situation. In fact, the reverse was observed. When viewing the same consultation, Pakistani respondents gave scores that were much higher when adjusted for sociodemographic characteristics than white British respondents. This suggests that the low scores given by Pakistani patients in surveys such as the GP Patient Survey reflect care that is genuinely worse, and possibly much worse, than that experienced by their white British counterparts.

It is sometimes suggested that survey scores should be adjusted for the ethnicity of the respondents to be able to compare practices with high or low proportions of minority ethnic patients. Our results suggest that this should not be performed. Rather, low scores from South Asian patients should be taken at 'face value' and investigated as possible indicators of poor care.

## 3. Using data on patient experience for quality improvement

We carried out a patient experience survey to explore assessment of care conducted at practice level compared with assessment of care carried out at individual GP level. We used focus groups and interview studies to investigate the views of GPs and practice staff on the survey results. Finally, we carried out a qualitative interview study with out-of-hours staff responsible for collecting and acting on patient feedback to explore the same issues, alongside other work on measuring patient experiences of out-of-hours care.

By conducting a patient experience survey at individual doctor level, we demonstrated that practice-level ratings of GPs' communication skills can mask considerable variation between GPs within a practice.

This is particularly the case in poorer-performing practices in which patients may experience wide variation in communication skills between individual doctors.

Across both settings, staff neither believed nor trusted patient surveys. Concerns were expressed about their validity and reliability and of the likely representativeness of respondents. Staff expressed a preference for free-text comments as they provided more tangible, actionable data. It was easiest for practices to engage with office functions such as appointment systems and telephone answering. Addressing an individual doctor's performance (e.g. communication skills) was much more difficult.

In interviews, doctors expressed markedly ambivalent views about surveys. However, despite their concerns about surveys, they expressed broadly positive views about the importance of patient feedback in monitoring and improving services.

These results led us to consider how patient feedback might be obtained and delivered in a way that would engage doctors to use patient surveys for quality improvement. We conducted a preliminary evaluation of a real-time feedback (RTF)-based intervention in general practice, using touch screens that patients could use to leave feedback following a consultation. As RTF has not been widely used, an exploratory RCT and qualitative study were conducted to answer questions about feasibility, estimate likely response rates, obtain patient and staff views on RTF and estimate the costs to a practice of introducing RTF. We also included facilitated feedback in one arm of the exploratory trial. In our exploratory trial, only 2.5% of consulting patients left any RFT without prompting; however, if encouraged to use RTF by staff, as many as 60% of patients did so. Of patients who used RTF, 86% found it easy to use and were positive about it as a feedback method. Lack of awareness of the screens and lack of time were the commonest reasons for not giving feedback.

Practice staff were broadly positive about using RTF and practices valued the ability to include their own questions in the survey. Practices that had open communication between staff members tended to be more positive about using patient feedback. Practice staff identified clear benefits from having a facilitated session for discussion of patient feedback and having protected time to discuss the results.

Our programme of work was supported by two study advisory groups consisting of lay members and health-care professionals. One was based in Cambridge and provided support across all streams of work except for the out-of-hours research; the other was based in Exeter and was convened specifically to provide input to the out-of-hours workstreams.

## Implications for practice

The work that we have carried out over the 5 years of the programme grant has clear implications for practice.

### *The importance of patient experience*

Our research supports the continuing emphasis on obtaining patient experience feedback as an important means of informing NHS care. Although continuing efforts should be invested in refining the most effective and meaningful mechanism to capture patient feedback, the key challenge remains to provide primary care staff with the support and means to enable them to act on patient feedback.

### *The need for action on the quality of care for minority ethnic groups*

There has been much speculation whether the lower survey scores reported by minority ethnic groups are 'real', reflecting poorer quality of care, or an artefact of the questionnaires used or higher expectations of care. Our series of studies strongly suggests it is the former, with patients from South Asian backgrounds experiencing considerably poorer communication with GPs than their white British counterparts. Effort should be invested to ensure that lower scores on patient experience surveys from such groups are investigated as markers of poorer quality of care.

***Patients give overly positive responses when rating their care***

Our results highlight the difficulty that patients have in feeding back negative experiences in questionnaire surveys. However, patients' reluctance to criticise a doctor or provider with whom they have to maintain an ongoing relationship will not be addressed simply by changing the survey method. Providers and managers need to understand that absolute scores paint an optimistic picture of patients' true views.

***Surveys are not sufficient to fully capture patient feedback***

Across primary and out-of-hours care settings, staff members view patient surveys as necessary but not sufficient. Alternative methods for gaining more qualitative feedback were commonly used to supplement survey scores, with free text viewed as providing more actionable data than responses to standard survey questions.

***The need for individual-level feedback for doctors***

Reporting patient experience at the practice level masks substantial variation in performance within practices for aspects of care related to individual doctors (e.g. doctor–patient communication). However, if a practice has an overall high score for doctor–patient communication, it is unlikely that it contains a low-scoring doctor. Robust mechanisms are needed to help lower-scoring practices identify and support doctors whose individual patient feedback identifies areas for potential improvement.

***Patient surveys need to become more meaningful to staff***

Practices found it easier to engage with items on surveys that related to practice management (e.g. availability of appointments, ability to get through on the telephone) than to issues around communication between patients and clinical staff. Effort should be invested to focus the attention of staff on the whole range of feedback provided by service users and on making available suitable support and learning opportunities to act on such feedback.

Immediacy of feedback, regularity of feedback and having some control over the questions asked were all aspects of our experiment with RTF that were valued by practices and had the potential to make feedback more useful. However, a number of important questions remain before RTF could be recommended as a replacement for postal questionnaires.

***The value of surveys in monitoring national trends***

Despite their limited value in stimulating quality improvement, surveys are important for monitoring national trends. For example, the GP Patient Survey is the only source of data which demonstrates that, year on year, from 2010 to 2015, patients have had increasing difficulty in terms of seeing a doctor of their choice. For out-of-hours services the GP Patient Survey is the only way of monitoring trends. However, when national surveys are used to monitor trends in care it is important that the questions (such as questions on access in the GP Patient Survey) do not keep changing. Much smaller sample sizes are required to monitor national trends: tens of thousands of participants rather than millions.

***Development of surveys in out-of-hours care***

Out-of-hours services are required to audit patient experience but are provided with no information on how to do this, leading to diverse and non-comparable data. Our work shows that, subject to minor amendments, the GP Patient Survey *is* suitable for the national monitoring of out-of-hours care. However, it is not sufficiently detailed to support quality improvement and is unlikely at present to replace in-house approaches, leading to duplication of effort.

**Concluding remarks**

Large-scale postal surveys are likely to remain the dominant approach for gathering patient feedback for the time being, although a range of other methods are being developed. These include RTF, focus groups, online feedback, analyses of complaints, practice participation groups and social media. In the final section

of our report we outline recommendations for research and identify the criteria that any new methods will need to meet to become useful quality improvement tools.

## Future work recommendations

Alternative feedback methods to better support patients to identify poor care should be considered. Investigation into the factors driving poorer experience of communication in South Asian patient groups; further investigation of how best to deliver patient feedback to clinicians to engage them and foster quality improvement; and further research to support the development and implementation of interventions aiming to improve care when deficiencies in patient experience of care are identified are recommended as areas for future work.

## Funding

Funding for this study was provided by the Programme Grants for Applied Research programme of the National Institute for Health Research.





# Programme Grants for Applied Research

ISSN 2050-4322 (Print)

ISSN 2050-4330 (Online)

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## This report

The research reported in this issue of the journal was funded by PGfAR as project number RP-PG-0608-10050. The contractual start date was in October 2010. The final report began editorial review in December 2015 and was accepted for publication in June 2016. As the funder, the PGfAR programme agreed the research questions and study designs in advance with the investigators. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The PGfAR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

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