

Understanding data on patient experience of GP services

Why this research was needed?

The use of patient surveys to improve the quality of GP services is important both to inform the process of service development and innovation, and to assess the impact of such changes in practice.

Patient surveys that use standard wording to be consistent across organisations and are designed to be generalisable are currently the principal method used in the UK NHS¹. In 2008 the General Practice Assessment Questionnaire (GPAQ) and Improving Practice Questionnaire (IPQ) were replaced by the national GP Patient Survey (GPPS) and since then the NHS has carried out a systematic programme to assess patients' experience of primary care, surveying 5.6 million patients annually, though some practices continued to use GPAQ for their own purposes. The results of GPPS describe all 8500 general practices in England in terms of the quality of care their patients' experience, and results for individual practices are published on the internet (<https://gp-patient.co.uk/>). At the individual doctor level, the General Medical Council's (GMC) revalidation programme requires doctors to collect patient feedback as supporting information². In addition, GP services are required by contract to have Patient Advisory Groups (PPGs), to provide feedback (<http://www.napp.org.uk/ppgintro.html>).

Services providing a good patient experience are also more likely to be safer and more efficient^{3, 4}. GP survey results, alongside other intelligence, are used by CCGs for assurance of quality. As GP services take on new forms, it is important to understand patients' experiences of these services.

Research was funded by NIHR to examine how nationally commissioned GP survey data is used currently and how its uses can be improved.

What we found from NIHR studies

Use of national surveys

In the UK, broadly there is a widespread scepticism amongst GPs about the credibility of the results of patient surveys^{5, 6}.

Concerns from GPs are that critical or grumpy patients selectively complete surveys and that the results will therefore give a negative and biased view of the GP's care. However, in a NIHR study by Roland et al (<http://www.cchr.iph.cam.ac.uk/research/improving-patient-experience-in-primary-care>) the results suggest that the opposite is the case⁷. They found that many patients are reluctant to criticise their doctors and have difficulty in feeding back negative experiences⁷. Taken alongside patients' reluctance to criticise doctors through surveys and staff challenges to the credibility of surveys, the study suggests that additional approaches such as patient narratives are therefore needed to better capture aspects of patient experience that can be used to improve specific aspects of the quality of care.

Commissioners and regulators use GP survey data. National survey data is often aggregated at practice level and so it is difficult to ascertain problems at GP level from these surveys. On the whole, practices find it easier to engage in quality improvement activities based on survey items that related to practice management (e.g. availability of appointments, or the ease of access services by the telephone) than to issues around communication between patients and clinical staff. Given the ceiling effects of surveys, there has been growing interest and recommendations following research in this topic, *that patients should be asked about what went wrong*, as well as what went right, in order to learn where improvements are most needed^{8, 9}.

The national surveys have been criticised for not providing timely feedback⁵. One solution is the use of Real-time feedback (RTF) to collect patient experience after consultation because this enables results to be assessed and acted on quickly¹. In the UK the feasibility and acceptability of RTF in ten general practices has been assessed. 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. But direct encouragement was provided in only 5% of over 1100 patient-staff interactions that were observed in reception areas. Of patients who used RTF, 86% found it easy to use and were positive about it as a feedback method. Costs per practice for the twelve-week period ranged from £1125 (unfacilitated and with team-level feedback) to £1887 (facilitated team with or without practitioner-level feedback). The main cost was the one off provision of touch screens¹.

Responsiveness

Accessing the views of certain groups about GP services is challenging, such as patients who do not speak English, people with learning disabilities, and homeless patients. If primary care service providers are not aware of their needs, it is possible that provision will not meet their needs, leading them being underserved and disadvantaged. In the Roland study they identified that low scores were often given by South Asian patients in GP patient surveys and might reflect care which is genuinely worse, and possibly much worse, than that experienced by their White British counterparts. The researchers recommended that low scores from South Asian patients should be investigated as possible indicators of poor care.

As GP practices are increasingly encouraged to be more responsive to patients' needs in order to address these inequalities in patient experience, a study by Tarrant¹⁰ that completed in 2014 aimed to develop a measure of responsiveness in primary care, and find out what responsiveness means to staff and patient

(<http://www.journalslibrary.nihr.ac.uk/hsdr/volume-2/issue-46#abstract.>)

The study found that primary care organisations tend to think of responsiveness in terms of being reactive: responding to individual patients as they access the service, and responding to patients' complaints or suggestions, or patient survey data. The majority of GPs saw responsiveness to be about how the practice meets the expressed needs of their patients, particularly around gaining access to the care they need.

GP services have taken on wider responsibilities for population health. The study identified three components of responsive service delivery; developing an awareness of the needs of the local population through proactive population-orientated strategies; adapting systems and services to better meet these needs through reactive population strategies; and ensuring that staff are willing and able to respond sensitively and flexibly when patients use the services by employing patient orientated strategies. Interviews with GP staff indicated that responsiveness was achieved through alignment between needs and service provision. Working to improve the design and flexibility of service was important, but sometimes responsiveness could involve managing the needs and expectations of patients.

The study team developed a questionnaire, which is available in three versions for a GP surgery, walk-in centre and pharmacy version. The questionnaires are available free for use with the written permission of the University of Leicester. Please contact Carolyn Tarrant: ccp3@le.ac.uk (www2.le.ac.uk/departments/health-sciences/research/soc-sci/research-projects-1/responsiveness-study). They have been designed as a self-completion paper questionnaire in standard and Easy Read formats, but can also be interviewer-administered (including via an interpreter) or completed online. Initial evidence suggests that the GP version is a reliable and valid measure of patient experience of responsiveness, and could be used as part of a process of identifying GP practices where

there is misalignment between the needs of specific patient groups and the provision of local primary care.

How can GP services be improved using this research?

National survey data can be useful to show variation in practices, which may indicate poor care, requiring further investigation.

National survey data is most often used to improve administrative rather than patient/clinician communication issues.

Real-time feedback, provided patient use is prompted, is a promising and low cost means of gaining timely feedback.

NHS Policy context

In seeking to achieve improvement in the quality of NHS services, gathering data is important both to inform the process of service development and innovation, and to assess the impact of such changes in practice. In the UK, patient experience data has routinely been collected via the NHS patient survey programme. Annual surveys of patient experience such as the national GP survey (1.3 million patients), and the national inpatient survey (64,000) have been conducted retrospectively by mail, with response rates commonly between 30 and 40 percent.

The second Francis Report¹¹ and Berwick review¹² have both highlighted the need for collecting data that is 'real-time', or as near as possible to real-time, as a means of enabling safe care. Most recently, the focus on patient experience has been captured in the NHS Outcomes Framework which, in Domain 4, focuses on ensuring that *patients have a positive experience of care*¹³

References

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