

The role of patient experience surveys in quality assurance and improvement: a focus group study in English general practice

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Abstract

Background Despite widespread adoption of patient feedback surveys in international health-care systems, including the English NHS, evidence of a demonstrable impact of surveys on service improvement is sparse.

Objective To explore the views of primary care practice staff regarding the utility of patient experience surveys.

Design Qualitative focus groups.

Setting and participants Staff from 14 English general practices.

Results Whilst participants engaged with feedback from patient experience surveys, they routinely questioned its validity and reliability. Participants identified surveys as having a number of useful functions: for patients, as a potentially therapeutic way of getting their voice heard; for practice staff, as a way of identifying areas of improvement; and for GPs, as a source of evidence for professional development and appraisal. Areas of potential change stimulated by survey feedback included redesigning front-line services, managing patient expectations and managing the performance of GPs. Despite this, practice staff struggled to identify and action changes based on survey feedback alone.

Discussion Whilst surveys may be used to endorse existing high-quality service delivery, their use in informing changes in service delivery is more challenging for practice staff. Drawing on the Utility Index framework, we identified concerns relating to reliability and validity, cost and feasibility acceptability and educational impact, which combine to limit the utility of patient survey feedback.

Conclusions Feedback from patient experience surveys has great potential. However, without a specific and renewed focus on how to translate feedback into action, this potential will remain incompletely realized.

Introduction

The monitoring and improvement of patient experience is of increasing importance in the English National Health Service, as in other health-care systems.^{1,2} Key concerns in ensuring good patient experience include respect, information and communication, physical comfort, emotional support, and access to care.¹ The provision of good patient experience is a key component of the provision of high-quality medical care: quality is a multidimensional construct including patient experience alongside clinical effectiveness and patient safety.^{3,4} Feedback on patient experience is intended to inform quality improvements by increasing the responsiveness of the health-care system to the needs of patients and carers, and by identifying areas of poor performance or organization which might benefit from change.^{5,6} In primary care in England, this culture of feedback has been embedded into routine practice in several ways. Central amongst these is the use of structured patient feedback obtained through surveys of patients' experience of care, both at national and practice levels.⁷ A direct link between patient feedback and quality improvement efforts was previously operationalized by including results arising from patient surveys as a component of the UK quality and outcomes framework (QOF).⁸ This performance management system provides financial incentives for general practitioners within the NHS to achieve agreed quality indicators covering areas including chronic disease management, practice organization and additional services offered. With the introduction of QOF, it was possible to rank practices according to their patient feedback, and results of surveys aggregated at practice level formed the basis of a pay for performance scheme between 2009 and 2011 when the UK government withdrew the pay for performance arrangements for patient experience. In addition, patient feedback also forms a current central component of the revalidation of UK doctors, including general practitioners.⁹ Whilst policy initiatives such as these highlight feedback on patient experience

as a key driver of quality improvement, evidence to date suggests patient experience has had limited impact on changes in service delivery.¹⁰ Previous research has identified that GPs and other health-care professionals may experience difficulties in making sense of survey-generated information.^{11,12}

In this paper, we draw on qualitative data to examine how teams in English general practice view and act upon feedback from patient experience surveys. In particular, we examine the role that patient feedback is seen to play in both assessing and improving standards of care. In doing so, we have adopted van der Vleuten's Utility Index model as the basis for considering potential drivers of the gap between receiving and acting on patient feedback in primary care practices.¹³ The Utility Index was originally developed as a framework for assessment design and evaluation in educational settings. Although reports of the use of the utility model have been extensive, such reports have nearly always emanated from educational settings; we felt that the model also had potential relevance when considering issues relating to the introduction and use of surveys of patients experience of care in routine clinical settings. The original model identified five domains (educational impact, validity, reliability, cost and acceptability), which might be expected to determine the potential utility of an intervention. A sixth domain – feasibility – was added subsequently.¹⁴

Methods

As part of empirical research undertaken in English primary care, we conducted a postal survey of patients who had recently seen a doctor at one of a stratified random sample of 25 practices in Cornwall, Devon, Bristol, Bedfordshire, Cambridgeshire and north London.¹⁵ Practices were approached to participate in the study in a randomized order until the quota for each stratum (based on GP Patient Survey communication score banding, GP head count, deprivation index and geographical location) was obtained. We then conducted a postal survey

Practice pseudonym	2009/2010 national GP Patient Survey scores for communication	Location	No. of practicing GPs	No. of focus group participants
Highfields	High	Rural	4	5
Church Road	High	Urban	8	15
Fieldview	High	Rural	5	9
Town Road	Medium	City	3	11
Meadow	Medium	Rural	5	13
Pilkington	Medium	Urban	3	9
The Towers	Low	Urban	2	4
Brentwell	Low	City	5	4
Crossways	Low	City	7	6
White Road	Low	Urban	2	7
Torch Street	Low	City	6	10
The Maples	Low	Urban	5	13
Fallowfield	Low	City	4	6
Beeches	Low	Urban	5	15

Table 1 Participating practices and focus group participants

of patients attending each practice for a face-to-face consultation with a participating GP within the previous three weeks. Patients were sent a patient experience survey based on the national GP Patient Survey, asking them about access, waiting times, opening hours, and continuity and interpersonal aspects of care (<https://gp-patient.co.uk/>). One reminder was sent to patients not responding within three weeks. We reported results back to practice staff at both aggregate practice level (report to all staff) and at individual family doctor level (confidential reports to each participating GP).

In the study reported here, practices who had participated in the survey were purposively approached to take part in focus groups to reflect a range of practice characteristics, including size, geographical location and practice-level survey scores for communication (a particular focus of interest for our wider programme of work). We undertook fourteen focus groups from December 2011 to April 2013. All groups were conducted following the completion of practice surveys and feedback of the findings to staff. There were between four and fifteen participants in each group: overall, 128 professionals from a range of backgrounds (40 GPs,

18 managers, 18 nurses, 20 receptionists, 13 administrators and secretaries and 19 other staff including dispensers and health-care assistant) took part. All practices were assigned a practice pseudonym to ensure confidentiality: real practice names were not used (Table 1).

Box 1 Sample focus group questions

- What do you think of patient surveys in general? What do you think the survey results are saying to your practice?
- Are the results of patient surveys circulated within your practice and if so, to whom? Have the scores encouraged you or your colleagues in wanting to change anything?
- Do you think that individual GP scores following a patient experience survey could have an impact on the practice as a whole?
- Do you think that over time, surveys of patient experience which focus on individual doctors' skills, might affect the attitude of doctors towards their patients – or the attitude of patients towards their doctors?
- To further explore the impact of individual GP performances on practice functioning, focus group participants were also invited to comment on two hypothetical situations where some doctors within the practice received less favourable scores from patient surveys than other doctors.

Focus groups were facilitated by experienced qualitative researchers and were held on practice premises. A second researcher was present at each group to take notes. Discussions lasted approximately 1 h. We piloted a topic guide (Box 1) at two non-study practices prior to beginning fieldwork. Key areas of discussion included attitudes to patient surveys, past experiences of surveys and practice procedures for dealing with survey feedback. All groups were transcribed verbatim, and participants were assigned pseudonyms to maintain anonymity.

We drew upon framework approaches to organize and analyse our data, which allowed for themes to be assigned both from *a priori* research questions and from the narratives of focus group participants.¹⁶ NVivo software (NVivo qualitative data analysis software; QSR International Pty Ltd. Version 10, 2012. Daresbury, Cheshire, United Kingdom) was used for organizing and examining the data. Analysis was undertaken by two researchers (OB and JB) and broadly took place over five stages: familiarization (reading transcripts and listening to recordings in detail to gain an overview of content), thematic analysis (developing a coding scheme), indexing (applying the codes systematically to the data), charting (re-arranging the data according to the thematic content to allow comparative analysis), and mapping and interpretation (defining key concepts, delineating the range and nature of phenomena, creating typologies, findings associations, providing explanations and developing strategies).¹⁷

Guided by this approach, we drew on transcripts from the first focus groups to develop an initial coding framework, which included 48 codes grouped loosely into headings including validity of surveys, interpretation of survey feedback, organizational changes and performance comparison. Our coding framework went through a process of application, discussion and revision until all transcripts were coded using the final agreed version. Codes were subsequently grouped into four overarching analytical themes: survey validity and interpretation, practice dynamics, leadership and interprofessional decision making, and

improvement strategies. The coding of each theme and subtheme was further triangulated by two researchers against a selected number of transcripts and discussed within the wider research team. The study was guided by an advisory panel including four patient and public involvement members, who provided input into study design and conduct and interpretation of findings.

Findings

In this paper, we present data on the organizational response of practice staff toward patient surveys. We outline two key areas of discussion. First, we focus on how practice staff understand and engage with surveys and survey feedback: that is aspects of survey design, conduct and reporting of results which together influence their perceived utility. Second, we consider three dimensions of potential and actual change which appear to have been driven, in full or part, by surveys: redesigning front-line services, managing patient expectations and managing the performance of GPs. The generation and subsequent coding of these dimensions was driven largely by within-group discussions and not by *a priori* questions. In the discussion, we place our findings within the context of the Utility Index model to consider how the utility of surveys to practice staff may influence their uptake as either quality assurance or quality improvement mechanisms.¹³

Understanding of, and engagement with, surveys

All practice teams had extensive, first-hand involvement in surveying their patients, and in receiving feedback from the English national GP Patient Survey. Attitudes to patient surveys were markedly contradictory. Recent experiences of payments linked to survey results under the quality and outcomes framework had caused resentment for many, particularly those who had lost out financially. Overall, practice staff found it difficult to trust surveys to reflect 'reality'. Yet, their expressed

ambivalence about surveys was often mixed with an interest in and engagement with the findings. We explore these ideas in more detail below.

Credibility of surveys

Practice teams spoke broadly about the perceived weaknesses of survey methods, singling out issues around their design, administration, representativeness, reliability, sample size, bias and the political ends which they were intended to serve:

The surveys only take a snapshot. (Nurse, Torch Street).

Only people with strong views complete them. (Receptionist, Crossways).

You need to have sufficient sample size and a meaningful way of comparing across different GPs in order for someone to get some useful knowledge out of it. (GP, Fallowfield).

Practice staff sometimes struggled with the concept of quantifying patient experience, voicing concerns that the complex reality of health-care interactions could not be measured using such rigid methods:

And a lot of this data that's collected in a measurable kind of way doesn't really represent reality. There's kind of a fixation on measurable outcomes, but they don't really tell us what's going on, they're just measuring that *thing*. (GP, The Maples)

Discussions often distinguished between the utility and relevance of different types of surveys, from in-house surveys conducted by receptionists handing out questionnaires, to the national survey programme. Local surveys were highlighted as enabling practice staff and patients to have greater control over the perceived relevance of the questions, but teams were often cynical about their robustness:

And some practices can manipulate their patients that they survey, so they will only hand out the questionnaire to nice patients and patients they know, they won't do it on duty day when doctor is maybe running behind or very busy. (GP, Church Road)

Criticisms levelled at the current national GP Patient Survey included its distribution to a sample of all patients registered with a practice regardless of whether they have consulted recently, the focus on feedback at practice rather than individual practitioner level, and the lack of inclusion of free text comments. Surveys that encompassed these elements were frequently regarded more positively:

We want to see data tailored to individual practitioner, because we all practice differently. (GP, Town Road)

Other sources of patient feedback, such as complaints, were often framed as a more useful source of information to understand where the problems lie:

And I think we learn a lot more from patients that write to us individually with complaints. (Administrator, Town Road)

Engaging with surveys

Despite these concerns, the importance attached to patient feedback via surveys in today's health-care system was well recognized and broadly accepted:

I think we must not be too negative about surveys because they are part of the way we do things nowadays [...] I think if you look at how general practice changed particularly over the last 20 years, it has become a lot more patient focussed and those things did not happen by accident, they have happened by design, and patient surveys have been a tool to drive that. (GP, Highfields)

However, whilst participants (in particular GPs and practice managers) paid attention to and positively engaged with survey findings from year to year, contradictions and tensions were still evident, for example in relation to the validity of patient's reports:

I think it is the only way to find out exactly what's going on is to do a survey. The only way you really find out what the patients think. They are not always honest. Well, they are not always honest on the survey either. (Nurse, Beeches)

I think it is useful for the extremes, but personally, I don't think it is particularly useful for any middle ground. [*Later in focus group*] I think it's very useful, when it compares against national average. I find that really, really helpful. (GP, Beeches)

For practices that scored below national benchmarks, engaging with survey findings was often an emotional experience for staff:

It can be a bit disheartening at times though, if you feel that you're really doing your best and then you get negative feedback. (Receptionist, Torch Street).

The functions of surveys

In general, practice staff valued feedback from surveys as a source of information about their performance. Participants suggested that patients, individual GPs, and the practice as a whole could all benefit from surveys: for patients, for example there may be a therapeutic function, 'the chance to get something off their chest and . . . to then move on.' (GP, Highfields). For GPs, the function of surveys was often to fulfil the requirements for appraisal. For practice staff, surveys could have a clear 'improvement' message, including the potential to highlight under-performing GPs:

It helps to highlight areas of improvement, to make sure that we're continuing to do as well as we think we're doing and it prevents us becoming complacent and assuming that you're doing well. I mean if we are doing well, then it confirms that we are doing well, if we're not doing well then it identifies areas that hopefully we can change. But not always. (GP, Highfields).

You can argue over the validity of surveys but if over three/four years someone is consistently scoring low in certain areas, you can start making assumptions about the doctor performing not very well in the practice. (GP, Brentwell).

Changes driven by survey feedback

The processing of survey feedback by practice staff was the essential first step in making any changes, which could encompass re-designing frontline services, managing patient expectations, and managing the performance of GPs.

However, variation was evident in how transparent practice staff were in sharing survey information within the team, and in whether practice-level feedback was circulated between GP partners, to just a few practice decision-makers, or to all of the staff. In a small number of practices, results had been fed back promptly by staff to their patient participation groups (comprised usually of patients, the practice manager, and one or more GPs, such groups are convened by practices to discuss and review the services offered and how improvements may be made to these). Inevitably, the level of transparency impacted on the understanding of and engagement with patient feedback by practice staff.

Redesigning front-line services

Practice staff often described changes they had made to front-line services and systems as a result of patient preferences, including modifications to their facilities, appointment systems, and to staffing issues such as staff training. For example, car parks had been extended, GP triage introduced and new call management programmes installed. Staff in three practices clearly articulated the incorporation of suggestions from patient surveys into an annual action plan. However, in most practices changes were rarely attributable directly to survey feedback, the survey having provided a 'nudge' to action in areas practice staff had been already been considering:

- | | |
|--------------|---|
| Nurse | We did a change to open extended hours Thursdays, so that is a good thing – a benefit from last year's I think, or was it the year before? |
| Receptionist | Yeah, a year now. |
| GP | Although it wasn't really a response to a survey, that, it was a response to an initiative from. . . It was a response to the fact that there was funding available from the PCT for extended hours. (Torch Street) |

Managing patient expectations

For staff in some practices, survey feedback raised issues about how to communicate change

to patients, how to shape expectations, and how to raise patient responsibility. Practice staff often felt they struggled to respond to patient demands and to increase understanding amongst their patients about how the system worked:

Facilitator Was there anything in the feedback where you kind of, you thought maybe you wouldn't respond?

GP1 Opening Sundays.

[laughter]

GP2 I think another thing that was highlighted, for instance, is the question of marketing. I think we probably haven't, in spite of having additional extended hours on Saturdays, and I think that was, was one of the things we had a big conversation about the MORI survey. At that point, we were offering all sorts of extended hours, but patients didn't seem aware of it. (The Maples)

Practice staff often felt that a perceived lack of understanding of systems and services was evident in 'demanding' patients who could never be pleased, whatever effort was made. Furthermore, issues that suited one group of patients (music in the waiting room, telephone consultations) ran the risk of provoking dissatisfaction in others. As for relationships with GPs, individual patient preferences for doctors were not always fulfilled because many GPs worked part-time.

Practice staff felt that patients had a role to play in smooth and efficient functioning of primary care services. Staff spoke about increasing patient accountability and engaging patients in the feedback process through patient participation groups.

Managing the performance of GPs

Individual GP performance was regarded as an important factor in determining overall practice scores. Several managers in low-scoring practices admitted that, practically, it is very hard to tackle individual doctor's (poor) performance:

Manager If the survey results are between (the survey providers) and the doctor, and he knows that or she knows it, there's

absolutely no reason for them to change their ways, is there? What is the motivation to change, what is the driver to change when they have been rude or pretty lazy? Nobody knows that, let's get on and continue as before. It is only when this information becomes available to, perhaps, the practice, that things could start to change. And when I say practice, who in that practice I don't know, it could be the executive partner. But I think somebody ought to know and somebody ought to discuss these issues.

Nurse What's the point in doing the survey anyway? If nothing is going to happen, is no point in doing that if doctor...

Manager Nothing is going to change.

Nurse ...got the bad score and they keep it to themselves. (Brentwell)

The idea of having an 'outlier' doctor, whether it was a high or a low performer, was familiar to practice staff. Both scenarios could have an effect on the running of the practice, for example when patients found it difficult to obtain an appointment with a particularly popular doctor. In addition, the complexity and interlinking of factors influencing patients' responses was highlighted: patients' overall impression of the surgery and of the appointment system was perceived to influence their reports regarding consultations, and possibly the performance of the doctor too:

Looking at the way people have access, the way the practice is organized, that they have access to facilities within the practice, the hours that the practice is open, the stage of the practice, the receptionist, how the admin is done, virtually how the sort of machinery of the practice works... I would not be surprised that where you had a poorly organized practice, poor machinery, if you like, you also had poor doctors, because I think doctors are influenced by the machinery in which they work, as well as influencing the machinery themselves. (GP, Pilkington).

The majority of teams stressed that they would support a doctor who consistently received negative patient feedback, although they did raise concerns about the difficulty of having an 'unmanageable' GP in the practice.

Suggested internal mechanisms of support ranged from mentoring by a team member, role-plays and peer support sessions, to interventions by a partner and/or manager. Creating a supportive environment was described as an important enabler, although it was not always clear what the concept of 'supportive environment' actually meant for the participants. There were no doubts that doctors who were put 'at the bottom of the pile' by survey results could perceive any intervention as threatening. In three low-scoring urban practices, staff were supportive of making the doctors' scores publicly available, identifying a responsibility to maintain patient safety.

Barriers to improvement

Discussions on potential improvements most commonly focussed on changes to the practice premises and organizational aspects of the delivery of care. Even for such changes, which may have been at least in part precipitated by patient survey feedback, staff in most practices felt there was little long-term impact on patient opinion:

We've done a number of things and the Mori poll results have been remarkably stubborn in terms of the change in perception by patients. That's been quite slow. (Manager, Beeches).

As one respondent highlighted, survey fatigue and the feasibility of being able to make relevant, meaningful changes was a persistent problem:

The cynicism that [Dr Ahmed], has quite rightly identified as being the problem with the surveys, is the fact that we have been surveying, and patients have been surveyed, for several years, the questionnaires are inevitably similar, the responses are inevitably similar, but the consequences of the survey are depressingly zero. So there may be a request from patients, for example that old chestnut, the Saturday morning surgery, but that has never been, and never will be, as far as I'm aware [...] funded to take place. So, you then question the validity, the point of actually having the survey. (GP, Church Road)

Staff highlighted a wide range of barriers to implementing changes which may have been

requested by patients, most particularly expressing concerns around funding and staff capacity. A distinction was made between patient 'needs' and patient 'wants', with identification of an on-going struggle to meet unrealistic expectations:

It is a bit like opening on Saturday issue. Would you like the surgery to be open on Saturday? Yeah. Would you like us to go 24 hours? Yeah. Are you going to pay more taxes to have it open on Saturday? No. Are you going to use appointments during the week when you are able to make it? Mmm, not sure. But if the question is would you like to have it open on Saturday? Yeah. Consumerist. (GP, Church Road)

There was far less discussion and agreement on how to effect changes to interpersonal aspects of care, if survey feedback highlighted issues relating to a particular GP. Issues included confidentiality and the 'unlikely' situation of GP feedback being shared with other practice staff ['self-learning and training, then I think that's more of a personal issue rather than being shared with the practice' (Practice Manager, Highfields)], and the idea that practice staff may need to recognize a balance in a GPs' interpersonal abilities and other aspects of their professional practice ['maybe that doctor is not a great communicator but they are great at doing something else, you know' (GP, Church Road)].

Ultimately, staff in many practices felt there was little external support for making changes in response to patient feedback:

... we need more support in this area [...] one of my concerns up until now is that sometimes services have come out and there has been very little support from anyone to say, right this is how you can improve things that might help, or we understand why you might be having problems, which ways we can help you with that. It has always been: here is your survey results, it is up to you how you sort it. (GP, Highfields)

Discussion

We suggest there are two primary purposes of large scale surveys of patient experience. First,

surveys may be used to endorse and affirm good clinical practice or service organization. Second, in line with the aspirations of policy-makers, surveys may provide evidence to inform improvements in health-care provision.⁶ Our findings suggest that staff in English general practice broadly view the role of patient feedback as one of quality assurance, providing evidence of whether they are offering an acceptable level of care to their patients. However, the role of surveys in quality improvement appeared less certain amongst participants. Whilst we identified *potential* dimensions of change (including front-line service improvements, management of patient expectations and management of GPs' performance) which could be informed by survey feedback, actual changes were usually confined to 'easy targets' for modification such as décor or playing music. Practice staff frequently oscillated between questioning the credibility of survey findings and taking them at face value: as we observed, respondents could be critical of survey methods whilst being pleased their practice had 'done well'. For those who had performed less well, pathways to change were not often clear. These organizational responses to patient experience surveys were, inevitably, dominated by GPs and practice managers – within our focus groups, receptionists and administrative staff were far less vocal. Whilst not reported within this paper, our analyses suggest important variations in the extent of the influence of practice managers, and the dynamics between practice managers and GPs, on how practice staff as a whole reflect and act upon patient feedback.

Strengths, limitations and implications for future research

This study benefits from drawing on a large sample of primary care practitioners providing care in a range of practice settings in England. Participants represented a range of primary health-care professionals. Fourteen focus groups, of varying size, acted, we believe, as an effective means of capturing a range of participant views. The topic

appeared of interest to participants. Participants were drawn from socio-demographically and geographically diverse areas, although all in England. Future similar research might usefully explore approaches to the impact of more immediate feedback, determining the extent of bias in response associated with varying response rates, and exploring motivations associated with changing (or not changing) practice in response to patient survey feedback.

The Utility Index

Van der Vleuten's Utility Index was originally developed to consider assessments within an educational context (for example, the provision of feedback on progress to medical trainees or the conduct of examinations for specialist training), yet this model also has value in exploring the utility of patient surveys in service contexts. Any expectation of quality improvement from patient surveys is framing feedback from such undertakings as an intervention aimed at stimulating action. Examining our emerging findings through the utility lens, which we undertook as a post hoc exercise, suggested that the overall value of patient feedback from surveys (and thus its potential to drive significant quality improvements) is undermined by a combination of variable attitudes to its credibility, and challenges for practice staff in identifying and bringing about meaningful changes (Fig. 1).

Drawing on both our work and others' work, we suggest that the notion that survey feedback alone will stimulate major changes in care is an unrealistic expectation.^{18,19} Whilst we saw evidence of changes to minor modifications such as car parking, décor and (slightly more challengingly) appointments systems, issues such as the management of GPs with evidence of poor communication skills, or responding to other 'interpersonal' aspects of professional practice, were much harder to tackle. Whilst patient experience will no doubt be improved by making general practices more accessible and more pleasant, significant aspects of experience linked to better clinical outcomes, including the quality of

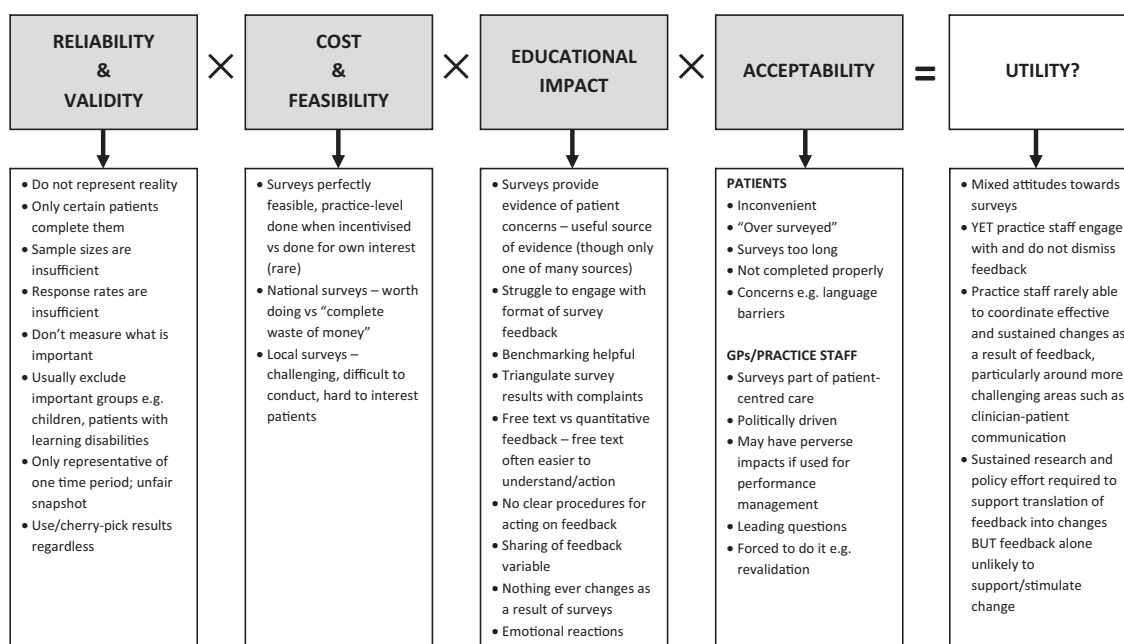


Figure 1 The ‘Utility Index’ of patient experience surveys in primary care – perspectives of practice staff.

nurse- and GP-patient communication and trust and confidence in clinical staff, risk being left outside the focus of improvement work undertaken by practice staff.

There are six dimensions of the Utility Index (reliability, validity, cost, feasibility, educational impact and acceptability) which may determine the potential utility of an intervention, including patient experience survey feedback. All have relevance for how general practice staff view the current role of patient surveys:

Our identification of issues with the credibility of surveys, and difficulties in the interpretation of feedback, clearly echoes previous work in both primary and secondary care, which suggests widespread scepticism about the robustness of patient surveys.^{11,12,20,21} Practice staff were more likely to view results positively if their scores were stable over time, were above average, and corroborated other sources of feedback such as complaints and compliments.

Whilst respondents felt national patient surveys were perfectly feasible, there were concerns about the challenges of undertaking local practice surveys. Issues included the time taken to undertake such work and how best to ensure in-house surveys were conducted

robustly. There were also mixed attitudes about the cost-effectiveness of national survey programmes, in part due to the perceived difficulties in acting on feedback. We are aware of no studies which have explored the cost-effectiveness of large scale patient feedback surveys. This reflects recent discussions amongst GP leaders calling on national surveys to be banned on account of generating irrelevant and overly expensive data.²²

We found a consistent lack of impact of surveys at practice level, driven by factors including an absence of coordinated action and difficulties in making sense of survey feedback.^{23,24} Benchmarking data were seen to be useful, although it was not always easy to make sense of.²⁵ Likewise, practice staff welcomed free text comments from patients as providing more specific information about their opinions.^{26,27} Most commonly, when change did happen, survey findings were only one of the spurs to action to address an already-acknowledged problem. Changes, however, usually focussed on service organization or facilities and not on individual practitioner behaviour. There remains little evidence that patient feedback alone has any impact on the behaviour or skills of medical

practitioners, with a number of trials having little demonstrable influence on subsequent patient feedback.^{18,19,28} The provision of facilitated feedback of results may be more effective in engendering engagement and action, as recent evidence in the secondary care setting demonstrates.²⁹ However, the emotional toll of negative patient feedback on staff is also relevant here: staff reported how disheartening it could be to receive consistently poor comments. The potential to see patient feedback as threatening and harmful, both at individual clinician level and at practice level, is an additional barrier to acting on such data, and further suggests the potential for facilitated reflection in assimilating feedback.

Practice staff worried that an endless cycle of surveys was inconvenient and burdensome for their patients. Nevertheless, surveys appeared to be broadly accepted as part of the new paradigm of patient-centred care, and welcomed in that role. However, lingering concerns over the linking of patient feedback to pay-for-performance and the external imposition of surveys on general practice (along with a long list of other activities) tempered the acceptance of current surveying practices, particularly for GPs.

Drawing these components together, we suggest that key drivers of the gap between conducting surveys and implementing changes relate to the difficulties of practice staff in trusting and making sense of survey findings, coupled with a lack of support for identifying and making changes to practice.

Policy implications

Whilst practice staff predominantly view feedback from patient experience surveys as a mechanism for affirming good or detecting poor service delivery (i.e. as a quality assurance mechanism), the current direction of policy targets a higher aspiration of providing evidence to inform changes in practice (a quality improvement mechanism). The question remains as to how patient experience survey data can become a key driver of service improvement. Evidence suggests that securing feedback alone

is insufficient to stimulate change,¹⁹ and our findings point to primary care practices being left to be responsible for developing their own implementation mechanisms. GP contractual arrangements prior to 2009 offered incentives to primary care practices to discuss the findings of patient feedback surveys with patient representatives, for example through the use of patient participation groups. Although now withdrawn, such an approach may have substantial merits in facilitating change, as well as acting as a means of responding to the need for active patient and public participation in informing the design and configuration of services.

Recent work in secondary care highlights the potentially important role of facilitators in enabling staff to review survey results and, most importantly, act on them.²⁹ Within primary care, such initiatives are lacking. Practice staff need to be supported to reflect on patient feedback; this will need dedicated resources on top of those committed to collecting patient experience data. Quality assurance of survey development, data collection and reporting of results is of vital importance if the findings of surveys are not to be dismissed out-of-hand on the grounds of credibility, or to become the subject of discussion aimed at diverting rather than promoting action and change.

Where surveys highlight the need for change, formal processes for planning and delivering change are required, covering both minor modifications and more challenging problems such as reported problems with the quality of clinician–patient communication. In the current climate of scarce resources, a commitment to developing patient experience surveys as quality improvement mechanisms would therefore displace other competing priorities, and policy-makers and practitioners must be realistic about what can be achieved. However, until then, it is our view that the full potential of patient feedback will not be achieved.

Conclusions

We have identified a number of key reasons for the gap between the receipt of patient feedback

and acting on that feedback. Addressing the concerns of primary care providers across all aspects of patient surveys – reliability, validity, cost, feasibility, impact and acceptability – and supporting them to reflect on the meaning of such data will be important if we are to draw on such evidence in quality improvement programmes. Alongside this, however, we need to develop a realistic understanding of where surveys may be expected to drive change, and where they may not.

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Conflicts of interest

The authors report no conflicts of interest.

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