

Impact case study (REF3b)

<p>Institution: the University of Manchester</p>
<p>Unit of Assessment: 2</p>
<p>Title of case study: Assessment of patient experience of NHS primary care services</p>
<p>1. Summary of the impact Improving patient experience of health services is a policy priority worldwide. The University of Manchester (UoM) has conducted research on patient experience since 1995, leading to the development of a series of validated measures for assessing patient experience of quality of care in primary care, including access to care and the degree to which services are patient-centred. Our measures have been in routine use in the NHS since 2004, sent to samples of several million patients. The data have been used to provide incentives for the highest quality practices, and to inform policy makers about current care throughout the UK.</p>
<p>2. Underpinning research <i>See numbered references in section 3.</i></p> <p>The impact case is based on research that took place at the UoM from 2000-2011. The research was conducted by the National Primary Care Research and Development Centre (NPCRDC), a Department of Health-funded policy research unit at the UoM. The key researchers were:</p> <ul style="list-style-type: none"> • Peter Bower (Professor of Health Services Research, 1995-date) • Stephen Campbell (Professor of Primary Care Research, 1993-date) • Sudeh Cheraghi-Sohi (Research Fellow, 2004-date) • Nicola Mead (Research Fellow, 1999-2010) • David Reeves (Reader in Statistics, 2001-date) • Martin Roland (Professor of General Practice, 1992-2009) <p>A key aim of NPCRDC was to develop methods to assess and improve quality of care for patients in primary health care settings. Quality of health care for individual patients can be judged in terms of ready access to care, and the effectiveness of care once it is accessed. Although scientific evidence and clinical consensus are both important methods of determining quality, there is increasing agreement that a comprehensive assessment of quality needs consideration of the views and experience of patients.</p> <p>However, reliable, valid and useable assessments of the patient experience have not always been available, which has meant that the patient voice has been largely missing from the quality improvement agenda.</p> <p>Our work involved multidisciplinary research on theory, in-depth qualitative work with patients, and large-scale quantitative evaluations. Key contributions are detailed below:</p> <ul style="list-style-type: none"> • We defined the core dimensions of patient-centredness (1). • We investigated how patients make judgments about quality of care, assessing the dimensions they can judge effectively, and those (such as clinical quality of care) that may be better assessed by other quality improvement methods (2). We also considered the relative priority that patients place on different aspects of care (3) to help decision-makers

respond more effectively.

- We designed a series of measures to provide reliable and valid assessments of patient experience of care. We progressively tested and refined these measures, through ongoing empirical and psychometric validation work, ending in the development of the General Practice Patient Survey (GPPS) (4).
- We used our measures in a series of high impact research studies exploring quality of care in primary care and the determinants of quality. This approach enabled us to better inform policy makers about current deficits in care as experienced by patients. For example, we demonstrated the mismatch between the expectations of patients and policy makers for standards of service in general practice (5). Following the introduction of a world-leading pay-for-performance scheme in the UK (the Quality and Outcomes Framework, or QoF), and consequent improvements in the quality of clinical care, we also demonstrated that patient experience of continuity of care was worsening over time (6).
- We worked closely with policy makers at the Department of Health to develop methods to use the products of this research programme within new incentive systems for practitioners to drive improvements in quality of care.

3. References to the research

1. **Mead N, Bower P** (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine* 51:1087-1110. DOI: 10.1016/S0277-9536(00)00098-8
2. Chapple A, **Campbell S**, Rogers A, **Roland M** (2002). Users' understanding of medical knowledge in general practice. *Social Science & Medicine* 54:1215-1224. DOI: 10.1016/S0277-9536(01)00091-0
3. **Cheraghi-Sohi S**, Hole A, **Mead N**, McDonald R, Whalley D, **Bower P**, et al (2007). What Patients want from Primary Care Consultations. A Discrete Choice Experiment to Identify Patients' Priorities. *The Annals of Family Medicine* 6:107-115. DOI: 10.1370/afm.816
4. Campbell J, Smith P, Nissen S, **Bower P**, Elliott M, **Roland M** (2009). The GP Patient Survey for use in primary care in the National Health Service in the UK - development and psychometric characteristics. *BMC Family Practice* 10: DOI: 10.1186/1471-2296-10-57
5. **Bower P**, **Roland M**, Campbell J, **Mead N** (2003). Setting standards based on patients' views on access and continuity: secondary analysis of data from the general practice assessment survey. *BMJ* 326:258. DOI: 10.1136/bmj.326.7383.258
6. **Campbell S**, **Reeves D**, Kontopantelis E, Sibbald B, **Roland M** (2009). Effects of pay for performance on the quality of primary care in England. *The New England Journal of Medicine* 361:368-378. DOI: 10.1056/NEJMsa0807651

4. Details of the impact

See numbered corroborating sources (S) in section 5.

Traditionally, assessment of quality of care in health services has been limited to professional perspectives, with little central collection of data and minimal consideration of patient perspectives on service delivery. We ensured that patients were at the heart of quality improvement activities,

Impact case study (REF3b)

through the development, validation and implementation of measures of patient experience, and their adoption and collection on a national scale. Our impact has been to raise the profile of patient experience and link it to quality improvement activity across the UK.

Raising the profile of patient experience

Policy documents have highlighted the critical role of information on patient experience. The White Paper 'Equity and excellence: Liberating the NHS' (S1) sought to 'encourage more widespread use of patient experience surveys and real-time feedback' to inform choice and drive quality improvement.

The NHS centralised the use of standardised measures in the assessment of patient experience in 2007-2008, sending our GPPS measure to samples of patients in a rolling programme of quality measurement. This has resulted in GPPS being completed by millions of patients, with their views assessed and analysed on a large scale and a sustained basis over time (S2).

Collection of data on patient experience is not simply for the benefit of managers and policy makers. All NHS patients can now access information on GPPS scores of their local general practices from a website (www.gp-patient.co.uk/faq/accessing/), to help them assess the quality of care and make choices about local services.

Linking patient experience to quality improvement

Much research has shown how simple provision of information is insufficient for securing change. To ensure appropriate impact from patient experience measures, in 2004, use of one of our earlier patient experience measures (GPAQ) was linked to payments in the early version of the Quality and Outcomes Framework (QOF).

The QOF represents a unique programme for quality improvement and the results have been of interest worldwide. Early in the development of the QOF, general practitioners were incentivised to conduct surveys on their practice population, and to respond to these surveys with appropriate quality improvement activities to enhance patient experience and ensure that their services were responsive to the needs of their local population. Between 2004 and 2009, the vast majority of practices (>90%) undertook such activities.

To support this activity and enhance value for money, we disseminated written guidance for practitioners to interpret the GPAQ data and use it to target these quality improvement activities at a local level (S3). Twenty three thousand copies of the guidance were disseminated, to stimulate and guide quality improvement across the United Kingdom.

Although initial incentives linked to patient experience were largely for the use of surveys, later versions of the QOF significantly raised the level of achievement required. In 2009, £68 million pounds worth of general practitioners' pay were linked to actual patient reports of their ability to gain ready access to care, such as getting an urgent appointment and being able to book ahead (S1). These targets were harder to meet, with around 70% of practices achieving maximum performance on these more stringent targets between 2010 and 2012.

The national regulator, the Care Quality Commission (CQC) used patient experience scores as

part of their performance assessment of Primary Care Trusts undertaken by the predecessor of the CQC (the Health Care Commission). Current CQC documentation includes patient experience surveys as an indicator of standards to be expected of all GP practices (S4,S5).

Department of Health reports list the other activities it has conducted in response to the data collected by patient surveys, including the GPPS (S6,S7). This has ranged from public dissemination to encourage responsiveness of patient experience among Primary Care Trusts, review of the needs of marginalised groups such as ethnic minorities, and establishment of teams to respond to practices and PCTs with the lowest scores.

5. Sources to corroborate the impact

- S1. Department of Health (2010). *Equity and excellence: liberating the NHS*, The Stationery Office, London
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_17794.pdf
- S2. **Roland M**, Elliott M, Lyratzopoulos G, Barbiere J, Parker R, Smith, P, **Bower P**, Campbell J (2009). Reliability of patient responses in pay for performance schemes: analysis of national General Practitioner Patient Survey data in England. *BMJ*. 339:b3851.
 DOI: 10.1136/bmj.b3851
- S3. Carter M, **Roland M**, **Bower P**, Greco M, Jenner D (2004). Improving your practice with patient surveys. University of Manchester. NPCRDC/CFEP.
- S4. Care Quality Commission (2010). Essential standards of Quality and Safety.
http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf
- S5. Care Quality Commission (2013). What standards you have a right to expect from the regulation of your GP practice.
http://www.cqc.org.uk/sites/default/files/media/documents/standards_to_expect_gp.pdf
- S6. Department of Health (2011). GP patient survey: guidance 2007/08 for strategic health authorities, primary care trusts and GP practices.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081109.pdf
- S7. Data on the use of patient experience surveys by general practices and associated incentives within each year the Quality and Outcomes Framework can be found
<http://qof.hscic.gov.uk/index.asp>