PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Patient feedback for safety improvement in primary care: Results from a feasibility study
AUTHORS	Hernan, Andrea; Giles, Sally; Beks, Hannah; McNamara, Kevin; Kloot, Kate; Binder, Marley; Versace, Vincent

VERSION 1 – REVIEW

REVIEWER	Jenny King Picker Institute Europe, UK
REVIEW RETURNED	28-Feb-2020

GENERAL COMMENTS	Related to point 5. and ethics, although ethics approval is mentioned it is not covered elsewhere in the paper. I suspect this is because it was covered in the related paper published previously but it is important to give a nod to this. Apart from the specific point above my reflections focus on details I personally would like to know more about and how the findings from this study support results from other studies which have looked at the use of patient feedback for improvement. Details I would like to know more about - 1. The paper discusses the safety improvement teams and how the multidisciplinary nature of the teams was an important factor. I wonder if the authors found any particular combinations of roles more effective other than the importance of administrative staff? 2. The authors detail the safety priorities targeted at the six practices and they can be grouped into relational aspects (such as communication) and transactional (such as equipment and waiting times) - I wonder if there was a difference seen in success based on whether an intervention focused on one of these groups? I ask as relational aspects, which involve a change in behaviours, are often trickier to tackle than transactional issues. Other reflections - A number of points detailed in the results and discussion sections are similar to those found in studies I have been involved in such as aligning improvements to existing staff priorities (rather than true co-design with patients), difficulty with measurement, and competing demands. The recent NIHR themed review titled Improving Care by Using Patient Feedback would be a useful read for the authors - https://discover.dc.nihr.ac.uk/content/themedreview-04237/improving-care-by-using-patient-feedback I enjoyed reading this paper, thank you.

REVIEWER	Jason Scott Northumbria University, UK
REVIEW RETURNED	05-Mar-2020

GENERAL COMMENTS	Dear authors This is a very interesting and we'll conducted piece of research that adheres to the study protocol. Most of my suggestions for improving the manuscript are relatively minor: 1. At the start of the methods you state the full design is 'published elsewhere'. Perhaps change to 'published in the study protocol'. 2. Within your methods (or results) you don't actual state how much data were collected. How many recordings / observations (minutes, discrete amount etc) were conducted? How many interviews were conducted and how long did they last? 3. In the findings, you state that staff reports were different to patient reports. Can you explain how they were different? Was there any more specific analysis of staff reports to support this? (eg categorisation of incidents) 4. At the end of the discussion, you claim that learning from high performing organisations mitigates the weakness of the study sample. I disagree with this statement. Whilst it is correct generally, I would argue that it does not apply for the purposes of a feasibility study, where the primary objective is not to learn about patient safety (this is a secondary outcome) but rather to determine the feasibility of the intervention. This means that the findings from this feasibility study can only be applied to other high performing organisations. I think this argument needs to be removed (unless it is framed around the secondary outcome only and not the whole feasibility study) and instead just tailor the message about the future trial to be explicit about examining implementation across a range of practice performance. 5. Table 3 - should the first * be $p<0.05$ instead of $p<0.005$? Please double check.

VERSION 1 – AUTHOR RESPONSE

REVIEWER 1	**RESPONSE**
Related to point 5. and ethics, although ethics approval is mentioned it is not covered elsewhere in the paper. I suspect this is because it was covered in the related paper published previously but it is important to give a nod to this.	An ethics approval statement is provided at the end of the methods section on page 7. We have also added the following statement to page 3/4 concerning patient consent to participate in the research project: “Patients completing the PC PMOS were provided with a plain language statement and provided informed consent to participate in the research study.”
1. The paper discusses the safety improvement teams and how the multidisciplinary nature of the teams was an important factor. I wonder if the authors found any particular combinations of roles more effective other than the importance of administrative staff?	Most of the safety improvement teams consisted of a practice manager, administration staff member, and nurses. Therefore it was difficult to make comparisons between team that had different combinations of staff. We have made this point clearer in the discussion on page 10: “Since most SITs

	comprised a practice manager, administration staff and a practice nurse, it was difficult to make comparisons about the effectiveness of teams that had different combination of staff roles."
2. The authors detail the safety priorities targeted at the six practices and they can be grouped into relational aspects (such as communication) and transactional (such as equipment and waiting times) - I wonder if there was a difference seen in success based on whether an intervention focused on one of these groups? I ask as relational aspects, which involve a change in behaviours, are often trickier to tackle than transactional issues.	The authors agree that tackling relational aspects of safety through behaviour change is more difficult than addressing transactional issues. However, in this study we did not find any real differences in success between these two types of interventions. The relational and transactional interventions were equally successful or unsuccessful. Other mediating and contextual factors in the practice environment were attributed to the success or failure of safety intervention by staff. A statement explaining this has been added to page 9: "There were no differences observed in success of interventions that addressed either relational (communication, behaviour change etc.) or transactional issues (data cleaning, equipment and supplies etc.). Other mediating and contextual factors in the practice environment were attributed to the success or failure of safety interventions by staff."
Other reflections - A number of points detailed in the results and discussion sections are similar to those found in studies I have been involved in such as aligning improvements to existing staff priorities (rather than true co-design with patients), difficulty with measurement, and competing demands. The recent NIHR themed review titled Improving Care by Using Patient Feedback would be a useful read for the authors - https://discover.dc.nihr.ac.uk/content/themedreview-04237/improving-care-by-using-patient-feedback	Thank you for this useful resource. We have added this reference to our discussion regarding difficulty with to engage with and use patient feedback on safety on page 15 (reference 57).
REVIEWER 2	**RESPONSE**
1. At the start of the methods you state the full design is 'published elsewhere'. Perhaps change to 'published in the study protocol'.	This has been amended on page 3 to state "published in the study protocol" as suggested.
2. Within your methods (or results) you don't actual state how much data were collected. How many recordings / observations (minutes, discrete amount etc) were conducted? How many	A statement providing information about how much data were collected has been added to page 5: "Approximately 31 hours of audio was recorded with participants at workshops (2 x 3

interviews were conducted and how long did they last?	hours), action planning meetings (6 x 1.5 hours), and semi-structured interviews (16 hours – 13 discrete individual or group interviews)."
3. In the findings, you state that staff reports were different to patient reports. Can you explain how they were different? Was there any more specific analysis of staff reports to support this? (eg categorisation of incidents)	We did not undertake any specific analysis or categorisation of the staff reports. Many of the staff reports lacked sufficient detail to undertake this kind of analysis. The type of incident and any patient demographic data (age, gender) were cross checked with the patient reports to assess for similarities or differences. A statement explaining this process has been added to page 6: "Due to lack of detailed data provided on the register, specific analysis or categorisation of the safety incidents was unable to be performed. However, the type of incident and any patient demographic data (age, gender) were cross checked with the patient reported safety incidents on the PC PMOS to assess for similarities or differences."
4. At the end of the discussion, you claim that learning from high performing organisations mitigates the weakness of the study sample. I disagree with this statement. Whilst it is correct generally, I would argue that it does not apply for the purposes of a feasibility study, where the primary objective is not to learn about patient safety (this is a secondary outcome) but rather to determine the feasibility of the intervention. This means that the findings from this feasibility study can only be applied to other high performing organisations. I think this argument needs to be removed (unless it is framed around the secondary outcome only and not the whole feasibility study) and instead just tailor the message about the future trial to be explicit about examining implementation across a range of practice performance.	This section of the discussion has been amended on page 16. The argument for learning from high performing organisations mitigates the weakness of the study sample has been removed. The limitation section now reads as "A limitation of this study was the sample. The practices were from one regional area, which may limit the generalisability of the findings. However, the diversity within the practices was considered adequate for this feasibility study. All practices had participated in one or more of the Australian Primary Care Collaborative Program waves previously. Their commitment, interest, and understanding of safety and quality improvement processes was potentially already elevated prior to study commencement when compared with other practices. Results suggest the merit of conducting a larger scale effectiveness-implementation trial to determine the translatability of this intervention program and safety outcomes to primary care practices more generally."
5. Table 3 - should the first * be $p<0.05$ instead of $p<0.005$? Please double check.	Thank you for picking up this typo. The p value has been amended to: * $p<0.05$.