

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Minority ethnicity patient satisfaction and experience: the results of the National Cancer Patient Experience Survey in England
AUTHORS	Pinder , Richard; Ferguson, Jamie; Moller, Henrik

VERSION 1 - REVIEW

REVIEWER	Brédart Anne Institut Curie, Paris, France Cancer, quality of life, patient satisfaction, psycho-oncology, cancer genetics
REVIEW RETURNED	11-Apr-2016

GENERAL COMMENTS	<p>This paper reports the results of an exploratory study addressing differences according to ethnicity in cancer patients' satisfaction with care and perceptions' of communication with doctors, ward nurses and cancer nurse specialists.</p> <p>The data comprise two subsequent round of the National Cancer Patient Experience Survey, including 138,878 responses, 155 hospital trusts and a response rate of 63.9%.</p> <p>This study is original, relevant and present good methodological qualities, checked against STROBE statement. The limitations of the study (response rate and measure of ethnicity) are discussed. The following may be considered to improve the manuscript.</p> <ul style="list-style-type: none">• Other references relating ethnicity with cancer patients from different ethnic background could have been related to the present results (e.g.: Goldstein, Annals Oncol, 2014).• Data analyses: it could be clarified how non responses were omitted from the analyses or when it was obvious that the item was not applicable to the patient.• Results section: subtitles (overall satisfaction, experience with communication) would be helpful.• Results section (2nd paragraph): compared to men is repeated twice; adjustment variables could be provided, as adjustment is first mentioned in that section (2nd line).• 3rd paragraph/3rd line: difference (spelling error).• Discussion section (2nd line): experience may be specified (experience of communication).• Strength/weakness: the meaning of sentence "margin of error for point estimates 0.3%" could be clarified.• Table 2: a legend for IMD could be provided.• Figure 1 is missing.
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REVIEWER	Caroline Mariano University of British Columbia Canada
REVIEW RETURNED	24-Apr-2016

GENERAL COMMENTS	<p>Introduction: "more deprived backgrounds" please clarify language, does this refer to low SES?. Please review the term deprivation throughout manuscript</p> <p>Concern with primary satisfaction measure: Nearly 90% of patients reported care has excellent or very good In table 4, the measure of satisfaction was "excellent" only. Sensitivity analysis was noted, but it may be useful to characterize patients who rated care on the lower end of the spectrum, and include this in the main body of the text.</p> <p>Please describe in methods why these specific questions were chosen in the survey. Have they been used/validated in other studies?</p> <p>Finally most patients are very satisfied with care in this study and this may relate to response bias (less satisfied patients maybe less likely to respond to surveys), please review this in limitations</p>
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VERSION 1 – AUTHOR RESPONSE

Richard J Pinder
School of Public Health, Faculty of Medicine, Imperial College London.

E.1 Please add an ethics statement

Statement added in Methods/Data collection: "These datasets were anonymized at source and therefore, as a secondary analysis of national data, explicit ethical approval for the study was not required."

1.1 Other references relating ethnicity with cancer patients from different ethnic background could have been related to the present results (e.g.: Goldstein, Annals Oncol, 2014).

The fourth paragraph of the introduction has been supplemented:

"Qualitative research in to cancer patient experience in Australia has shown immigrant patients face additional challenges for their diagnosis including cultural isolation and linguistic hurdles. Ref More recently, research has suggested that immigrant patients (in particular those from Chinese backgrounds) report poorer experience than those identifying as Anglo-Australian; Ref in this study both linguistic and cultural expectations were suggested to be involved."

The above work is also referenced in the Discussion.

1.2 Data analyses: it could be clarified how non responses were omitted from the analyses or when it was obvious that the item was not applicable to the patient.

We have amended the section on non-response:

"It is not possible for us to ascertain the reasons for non-response. Firstly, while 69.4% response rate is consistent with other surveys of its type, there is a likelihood that non-response bias may mask or

exacerbate some effects: less satisfied patients may be less inclined to respond. In terms of statistical precision, estimates provided by the company that runs the survey (Quality Health Ltd.) suggest that the 95% confidence interval for point estimates is approximately +/- 0.3% for each of the two years included. Ref By compiling two years of data, this precision is further improved. Secondly, the questionnaire involves sections to be 'skipped' if the questions are not relevant to the participant. For example, patients seen only in out-patients may not be able to answer questions about ward nurses. In this way, it is not possible to account for question-specific non-response. Question-level response counts are included on Table 4."

1.3 Results section: subtitles (overall satisfaction, experience with communication) would be helpful.

Subtitles have now been added: "Principal findings"; "Gender, age and socioeconomic status"; "Ethnicity"; and "Perceptions of staff".

1.4 Results section (2nd paragraph): compared to men is repeated twice; adjustment variables could be provided, as adjustment is first mentioned in that section (2nd line).

Repetition removed. And clarification regarding adjustment is made.

1.5 3rd paragraph/3rd line: difference (spelling error).

Corrected.

1.6 Discussion section (2nd line): experience may be specified (experience of communication).

Amended to: "Patients from ethnic minority backgrounds receiving cancer care in England report statistically significant poorer satisfaction of overall care as well as poorer experience communicating with specific groups of health care professional."

1.7 Strength/weakness: the meaning of sentence "margin of error for point estimates 0.3%" could be clarified.

In terms of statistical precision, estimates provided by the company that runs the survey (Quality Health Ltd.) state that the 95% confidence interval is +/- 0.3% for point estimates for each of the two years included."

1.8 Table 2: a legend for IMD could be provided.

A note has been added: "Note. The Index of Multiple Deprivation (IMD, 2010) is the official statistic for neighbourhood-level deprivation in England and ranks each of the 32,482 neighbourhoods in order of deprivation. The IMD is a composite index comprising income, employment, health and disability, education skills and training, barriers to housing, crime, and environmental metrics. It does not include ethnicity. It is based on the patient's registered address. In this analysis, the value provided for IMD is the median centile where a higher number indicates a higher level of deprivation."

1.9 Figure 1 is missing.

This should have read "Table 1" and is corrected in Results (page 7) and in the legend of Table 4.

2.1 Introduction: "more deprived backgrounds" please clarify language, does this refer to low SES?. Please review the term deprivation throughout manuscript

We have revised the term to "...poorer socioeconomic backgrounds..." in the Introduction as this pertains to previous research.

We have added a clause to Methods/Demographic: "The Index of Multiple Deprivation (IMD), the official composite measure of deprivation in England, was derived on the basis of patient postcode ascertained from the health record; we refer to this as 'deprivation' in this paper."

Our rationale for the above is that the term socioeconomic background may suggest that the characteristics recorded are those of the participants. The use of IMD estimates deprivation on the basis of place of residence (not person), and accordingly we have used 'deprivation' in place of 'socioeconomic background'.

We have also added a legend to the bottom of Table 2 (see Ref 1.8) that sets out how IMD is determined.

2.2 Concern with primary satisfaction measure:

Nearly 90% of patients reported care has excellent or very good

In table 4, the measure of satisfaction was "excellent" only. Sensitivity analysis was noted, but it may be useful to characterize patients who rated care on the lower end of the spectrum, and include this in the main body of the text.

For many questions, the majority of responders replied "Excellent" (typically 56%) or "Very good" (typically 32%). The principal analyses dichotomised the responses at "Excellent" vs not excellent, in order to compare two large groups of responders. The sensitivity analyses combined "Excellent" and "Very good" giving similar overall results.

Only a small proportion of responders used the extreme "Fair" or "Poor" categories (about 2% and <1% respectively). We do not consider it as very useful to analyse this/these particular rare outcome(s). Indeed, due to small numbers, such analysis would have very low statistical power.

2.3 Please describe in methods why these specific questions were chosen in the survey. Have they been used/validated in other studies?

We have added a further statement to the following paragraph under Methods/Patient experience which outlines the rationale for the question selection in respect to the experience metrics:

"Five other questions regarding patient experience were selected to determine associations between ethnicity and other factors. These five questions were chosen a priori on the basis of their being related to hospital-based care and involving the respondents' interaction and perception of three discrete professional groups; we are not aware of any literature to have specifically used these questions previously. We hypothesized that patient interaction with these three professional groups may impact upon satisfaction and would potentially be of value in identifying training needs with a view to improving the quality of health care provided."

2.4 Finally most patients are very satisfied with care in this study and this may relate to response bias (less satisfied patients maybe less likely to respond to surveys), please review this in limitations We have clarified the following statement regarding non-response bias in the Discussion/Strengths and weaknesses:

“...there is a likelihood that non-response bias may mask or exacerbate some effects: less satisfied patients may be less inclined to respond.”

VERSION 2 – REVIEW

REVIEWER	Caroline Mariano University of British Columbia
REVIEW RETURNED	22-May-2016

GENERAL COMMENTS	Revisions acceptable
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