Royal College of Physicians

Improving patient feedback for doctors

In association with:

Academy of Medical Royal Colleges

Royal College of Obstetricians & Gynaecologists

The Royal College of Physicians

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Contents

Abbreviations used in this report

AoMRC	Academy of Medical Royal Colleges
CAMERA	Collaboration for the Advancement of Medical Education Research and Assessment
CARE	Consultation and Relational Empathy (Measure)
CPD	continuing professional development
GP	general practice/practitioner
GMC	General Medical Council
IT	information technology
NHS	National Health Service
ONS	Office for National Statistics
PFFAR	patient feedback for appraisal and revalidation
PREMs	patient-reported experience measures
PROMs	patient-reported outcome measures
RCGP	Royal College of General Practitioners
RCoA	Royal College of Anaesthetists
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RO	responsible officer
UMbRELLA	UK Medical Revalidation Evaluation Collaboration

Foreword

In my experience, doctors are keen to know how they are perceived by their patients and patients are keen to have their voice heard. There is a growing understanding in health systems across the world that patient feedback has huge potential to help doctors better understand their practice and improve their professional attitudes, skills and effectiveness.

During my recent review of medical revalidation for the General Medical Council, many people spoke enthusiastically about how feedback from patients helps doctors to develop their insight. But I also heard concerns that we are not giving as much weight to the patient voice as we should. Methods for gathering feedback are often limited or not easily accessible; patients are not given sufficient information or support; and doctors are not getting enough quality feedback to be able to reflect meaningfully on what they are doing well and where they could improve. Our ambition should be greater.

I want to see patient experiences playing a much bigger role in doctors' reflection and learning in the future. So I warmly welcome the research and conclusions presented in this report. The authors have set out, clearly and logically, the practical and cultural challenges involved. And they have provided solutions and a road map for change.

The improvements envisaged are ambitious and will be demanding, especially for healthcare organisations. That is why it is important that the proposals are tested, as the report suggests, in order to identify which are most efficient and effective in practice. But I have no doubt that change is needed. The recommendations in this report should be seen as part of a wider strategy to improve health outcomes by involving people in their care. And that is something everyone can support.

Sir Keith Pearson
Chair of Health Education England and independent chair of the former GMC Revalidation Advisory Board

1 Executive summary

This report is about the current challenges relating to the collection, analysis and use of patient feedback for medical revalidation. It is the result of a consultation undertaken throughout 2017 involving doctors, patient lay representatives, responsible officers (ROs), appraisal leads, medical royal colleges, providers of patient feedback tools and other key stakeholders. The work involved a literature review, a survey of ROs, workshops, meetings with key groups and individuals (including researchers, ROs and appraisal leads) and undertaking case studies.

The Royal College of Physicians (RCP) has been commissioned by the Academy of Medical Royal Colleges (AoMRC) to produce this report. It will be of interest to doctors working across all medical specialties and sectors, patients, government and regulatory authorities and policymakers such as the UK departments of health and GMC, and NHS and independent healthcare organisations.

1.1 Revalidation

Revalidation was introduced in 2012 as a regulatory process to support, and be assured of, the continuing development and competencies of doctors in the UK. As this process approached the end of its first 5-year cycle the AoMRC Revalidation and Professional Development Board was keen to review the process, learn lessons and identify where improvements could be made. In early 2017 Sir Keith Pearson's report *Taking revalidation forward* provided a valuable set of insights into this and made a number of suggestions, including a review of patient feedback for revalidation. At the same time, research from the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA) and UK Medical Revalidation Evaluation Collaboration (UMbRELLA) had identified similar themes to those highlighted by Sir Keith Pearson.

The response to revalidation has been mixed. On the one hand it has driven the uptake of annual appraisal and many doctors have valued the opportunity for discussion and reflection that appraisal provides. However, at the same time revalidation has felt burdensome to many. There is a range of perceptions of its real purpose – from regulation and catching 'bad doctors' to professional development driven by formative evaluation. Patients have been largely unaware of revalidation, and where there is awareness, there has not been clarity about its purpose or about their contribution to it.

1.2 The potential of patient feedback for appraisal and revalidation

Patient feedback has the potential to deliver unique insights into the interactions between patients and doctors, in a way that should drive improvement, transform patients' experience of healthcare for the better, and result in benefits to the NHS. There was previously no requirement for doctors to seek feedback from patients, so the current process of patient feedback for appraisal and revalidation (PFFAR) represents a positive start.

1.3 Finding ways to improve patient feedback

One of the clear findings of both Sir Keith Pearson's report and the CAMERA research is that PFFAR is difficult to do well, and in its current form, has limited value. In early 2017 the AoMRC commissioned a report from the Royal College of Physicians (RCP) supported by the Royal College of Obstetricians and

Gynaecologists (RCOG) specifically to investigate patient feedback for revalidation and how it can be improved. This report presents the findings of that investigation and makes recommendations for improvement.

1.4 Scope of this report

The focus of this report is on patients (or their families or carers) giving feedback about an individual doctor's attitudes, behaviours and skills within the framework of doctor–patient interactions. **Throughout this report it is recognised that some patients may require or wish for support to provide feedback, and that this may need to be provided with or by family members, carers or professional advocates directly involved in the interactions they have with doctors.**

The report is not about patients giving feedback on their overall experience or satisfaction of healthcare services delivered by teams or organisations, nor is it about patients feeding back on their own health status. While information from patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) are useful sources of evidence about a doctor's performance for the purposes of appraisal, they lack a specific focus on individual doctor–patient interactions and are outside the scope of this report.

This report focuses on doctors who have completed their training. The principles, solutions and recommendations found in this report may be useful for postgraduate deaneries in implementing programmes of patient feedback for doctors in training, and for medical schools in developing undergraduate curricula. The process of collecting and reflecting on patient feedback should become a normal part of practice from the outset of a doctor's career.

1.5 Key themes

1.5.1 Understanding the problems

The current requirements for patient feedback are not seen as useful. At the moment feedback is collected from 20 to 50 patients once every 5 years throughout the career of a doctor who has completed higher training. This is widely felt to be too little and infrequent to help inform doctors about how to improve their professional practice. It means that feedback is collected six or seven times during the career of a full-time consultant doctor or GP and for most this represents less than 1% of patients seen.

The type of feedback is also seen as imperfect, mostly consisting of scores or ratings made on Likert-type scales, with a tendency to a ceiling effect (ie minimal response variability). This has resulted in a lack of clarity about how a doctor might improve practice. Furthermore, there is a perceived lack of credibility (and therefore usefulness) of patient feedback among some doctors. Issues of validity and reliability of the information also affect this credibility.

Despite being infrequent, collecting patient feedback is perceived as burdensome, and for doctors in some specialties such as accident and emergency and forensic medicine, or working in full-time research, very difficult. Perhaps because of these factors (low perceived usefulness of the feedback as a result of the frequency, amount and type, and the lack of effective infrastructures for administering, collecting, analysing and reflecting on feedback), collecting feedback is frequently described as a 'tick-box exercise'.

1.5.2 Perspectives of patients

There is lack of clarity about the purpose of feedback, and how this might affect a doctor, and the patient's relationship with that doctor. In part this can be attributed to the very infrequent request for feedback, and confusion with a range of other patient surveys (eg the 'NHS Friends and Family Test' on overall health service experience), but also uncertainty about revalidation as a whole. As a result, patients are not clear about how best to provide feedback, and feel constrained by the semi-quantitative nature of rating scales, with little opportunity to comment descriptively and narratively.

At the same time, patients are consistently keen to provide feedback in order to support doctors in improving their professional practice and, in particular, are clear that they want to develop more collaborative interactions and relationships with doctors. From the perspective of many patients, their feedback was seen to be a resource and opportunity for doctors to develop professionally.

1.5.3 Seldom-heard groups and the inverse care law

Greater efforts are required to engage with seldom-heard groups (eg frail older people, those with cognitive impairments, travellers, homeless people, and sometimes those whose first language is not English) who are currently under-represented in most patient feedback processes due to actual or perceived barriers in obtaining or giving this information. People in these groups often have the greatest healthcare needs and are frequent users of services, and therefore in the best position to provide feedback about their doctor if given the opportunity. Where the opportunity arises, at present it may be compromised by a lack of appropriate tools and support in enabling them to give their feedback. The experience of greater healthcare need and little or compromised opportunities to give feedback is arguably another feature of the inverse care law – the principle that the availability of good medical or social care tends to vary inversely with the healthcare needs of the population served.

1.6 Key underlying questions

The report focuses on three key questions:

1.6.1 How can the process of patients giving and doctors receiving feedback be improved so that it becomes more normal, more valued and more valuable?

The focus of this question is on making feedback much more useful for professional development (with regulation as a less central aim), easier to collect and use, and enhancing patients' understanding of feedback in revalidation.

1.6.2 How can feedback be made more useful for doctors in their professional development?

The focus of this question is on how often feedback should be sought, what sort of feedback is likely to be most useful, and how and in what setting feedback should be used as part of a reflective cycle.

1.6.3 How can the feedback process be made easier, less burdensome and more reliable?

The focus of this question is on how the gathering, analysis, and reporting of feedback could be made more straightforward for both doctors and patients, and some principles for reflection on feedback.

1.7 Main findings

An analysis of the evidence collected for this project, the emerging themes and the relationships between these themes provides the basis for the findings and options for improvement relating to patient feedback in this report. The main findings relate to:

1.7.1 Real-time and continuous feedback

For feedback to be most useful it should happen often enough and with sufficient numbers of patients that a doctor can usefully reflect on it at appraisal, make changes and see the impact in a reasonable time frame. For patients it should happen as close as reasonably possible to the time of clinical contact.

1.7.2 Mixed methods for obtaining patient feedback

Semi-quantitative feedback from questionnaires is valuable but lacks clarity about what a doctor can specifically do differently. This is especially the case where either a problem has been identified or a ceiling of positive feedback has been reached. Both patients and doctors endorsed looking for ways to provide more qualitative feedback.

1.7.3 Engaging doctors and patients

Doctors and patients feel disengaged with the patient feedback aspect of revalidation. Both groups feel that greater clarity and better information are key factors in facilitating engagement with the process – in particular, information to answer 'what is the purpose of the feedback?', 'how will it make a difference?' and 'how will doctors or patients know?'. Easier processes, greater weight within appraisal, greater value within employing organisations and organisational support to identify how to set it up (doctors) and how to give feedback (patients) are also felt to be important factors in improving engagement.

1.7.4 Patient feedback champions

Patient feedback champions – people within organisations who are dedicated to collecting and collating feedback – are seen as playing an essential role in helping both patients and doctors to navigate this process and also to ensure that this has the right priority with employers.

1.7.5 Effective organisational patient feedback systems

There is a widely perceived lack of a coherent infrastructure for feedback to take place. This has created a disproportionate burden for doctors, and led to difficulties with the distribution, collection, analysis and reporting of PFFAR. Both patients and doctors feel that there is an urgent need for this to be developed so that feedback becomes 'normal business'.

1.7.6 Use of information technology (IT)

Harnessing the opportunities provided by advancing sophistication of IT, and learning from providers of web-based platforms that already collect patient feedback is seen as essential to the collection of more PFFAR, to ensure that it has a greater impact on professional learning, and that it happens more easily. This could be linked to other work on patient feedback within the NHS. Healthcare organisations will

need to give priority to security and confidentiality issues should IT be used in the patient feedback process.

1.7.7 Doctor–patient interactions, appraisal and revalidation

Patient feedback for appraisal and revalidation is seen as a tool for ongoing iterative improvement in attitudes, behaviours and skills demonstrated by doctors in their interactions with patients. The right place for discussion about this is seen as the annual appraisal rather than as a criterion for revalidation. Alongside this, it is felt that some skills may need to be identified and developed between appraisers and appraisees to make the best use of patient feedback information, eg when dealing with negative feedback that may feel very personal to a doctor, in a sensitive and constructive manner.

2 Key recommendations

The findings of the report give rise to a number of interconnected recommendations that have been grouped into five themes:

2.1 Purpose of feedback and engaging doctors and patients

- Feedback should first and foremost be collected to support doctors to improve their practice and stimulate medical excellence.
- As the frequency of giving feedback increases there are opportunities to ensure that both doctors and patients are aware of and clear about the purpose of it.
- Feedback should be used as part of a reflective process at annual appraisal, and where appropriate, linked to personal development plans.
- Revalidation processes should ensure that a reflective, developmental process has taken place.
- It should be accepted that in some instances, where there is no patient feedback available because a doctor's role does not involve patient or carer contact, the requirement for patient feedback in revalidation be dropped. This should only be accepted if it is part of a clear and documented agreement at the doctor's appraisal.

2.2 Frequency, amount and representativeness of patient feedback

- There should be an open invitation to all patients to give feedback in real-time with support about how to do this, eg leaflets and posters in clinical areas.
- Feedback should also be sought continuously and intentionally on a proportion of patients seen by an individual doctor.
- The mix of patients from whom intentional feedback is sought should be agreed at appraisal if the doctor has a mixed portfolio, and should reflect their scope of practice.
- Particular attention should be paid to obtaining feedback from seldom-heard groups of patients.
- Bespoke tools and processes should be developed to facilitate the collection of feedback from seldom-heard groups.
- Feedback should be analysed more or less continuously so that the impact of changes in practice can be observed.

2.3 Types of patient feedback

- Feedback should be both semi-quantitative (using questionnaires appropriate for patient groups) and qualitative (descriptive).
- There is a need for development of more bespoke questionnaires for some specific patient groups and in clinical settings where feedback may be difficult.
- Methodology and pilots need to be developed for qualitative feedback using mixed methodologies with a principal focus on these being useful for professional development. It is likely that electronic methods of feedback using IT will be the only way to achieve this.
- A suite of tools needs to be developed that professional bodies and the GMC can endorse for patient feedback.

- The decisions about which tools to use should be agreed at appraisal as appropriate for an individual doctor's practice.
- Further work is needed to explore ways to make feedback that is already being collected via social media useful for professional development.

2.4 Developing an effective infrastructure for patient feedback

- It is essential that healthcare organisations recruit and make use of patient feedback champions, to ensure that feedback processes work really well for the benefit of patients and doctors. Patient feedback champions could also be organisational advocates for patient-related quality improvement programmes.
- Healthcare organisations will need to develop or contract an infrastructure for the collection, collation, analysis, and reporting of PFFAR to doctors and to provide patients with evidence of its impact locally.
- The increased scale, frequency and diversity of feedback, and the need for collation, analysis and reporting to take place much more frequently can only be addressed by harnessing IT. The processes needed for this must be developed early in collaboration with patients and doctors.
- Parity of access for patients without the skills to use, or access to, IT will need to be assured.

2.5 Developing and piloting new patient feedback processes

- The overall recommendation is that a programme of work is undertaken over the next 5-year revalidation cycle to develop and pilot the processes, tools and organisational and IT infrastructures necessary to deliver PFFAR to the quality envisaged in this report.
- This programme of development and piloting will require sufficient investment and resources. This investment should be viewed in the wider context of a strategy of greater involvement of patients in their healthcare. The perspective of the patient is essential in understanding the quality of the individual doctor–patient interaction.
- Developing the necessary patient feedback processes, tools and infrastructure for doctors will have far-reaching benefits. Other healthcare professions (eg nurses and pharmacists) are planning to or already implementing a system of revalidation that in part involves patient feedback. An important next step will be to identify and engage with key non-medical stakeholders in health and social care to coordinate and identify the resources necessary for quality patient feedback on individual healthcare professionals.

3 Introduction and background

In 2012 the GMC introduced revalidation for doctors in the UK. Revalidation allows doctors to demonstrate they are up to date, fit to practise in their chosen field and able to provide a high standard of medical care. Revalidation requires that a doctor collect six types of supporting information for discussion at appraisal.[1] Supporting information around patient and colleague feedback and quality improvement activities is required at least once every 5 years, while information on CPD and any significant events, complaints and compliments is required annually. Reflection on this supporting information and participation in annual appraisal enables a revalidation recommendation for the doctor to be sent by a responsible officer (RO) to the GMC. The recommendation is sent once every 5 years and allows a doctor to retain his or her license to practise medicine in the UK.

3.1 Academy of Medical Royal Colleges – Patient Feedback for Revalidation Working Group

The Academy of Medical Royal Colleges (AoMRC) set up a Patient Feedback for Revalidation Working Group in May 2015, following reports that the process of collecting patient feedback was proving difficult for many doctors, and was not always sufficiently reliable to demonstrate a doctor's fitness to practise. In early 2017, the Royal College of Physicians (RCP) was commissioned to undertake a project involving an in-depth review of the current issues, how the patient feedback process could be improved, and how resulting information could be made more useful and meaningful for appraisal and revalidation. This report sets out the findings of the review, options for improvement and recommendations on ways forward for consideration by the AoMRC working group (and other stakeholders in revalidation).

One of the GMC's core principles for revalidation is that patient feedback should be at the heart of a doctor's professional development.[1] The report supports this principle by:

- responding to the clearly expressed desire on the part of patients to be able to work in a more equal partnership with doctors around decisions and plans for their health, including providing feedback to doctors about how doctors can improve this
- recognising the challenges intrinsic to collecting, analysing, reporting and reflecting on patient feedback in the diverse clinical settings in which doctors work
- providing options – technological and non-technological – to allow healthcare organisations to develop effective systems to collect patient feedback on a real-time and continuous basis, and then to analyse and present this information to doctors working in different clinical and professional environments
- establishing what different formats (quantitative and qualitative) and types of patient feedback (about an individual doctor's professional skills, attitudes, behaviours and communication) can be useful and complementary in providing information on a doctor's strengths and areas for development in their interactions with patients
- making it easier for doctors to reflect on feedback from patients every year at appraisal, based on more useful and representative patient feedback.

3.2 Literature review

A review of the literature was completed in January 2017 to understand:

- what and how patient feedback questionnaires are currently used in revalidation
- any other current patient feedback processes in place for revalidation
- problems and challenges associated with the current process, and what published work has already been done.

Medline and Embase databases were searched via OVID, as well as the databases of the Cochrane Library, RCP Library, British Library and Health Management Information Consortium, using a variety of keywords and subject headings. Search terms such as 'patient feedback', 'patient satisfaction', 'patient views', and 'patient perspectives' were combined with terms such as 'clinical competence', 'quality improvement', 'certification', and 'revalidation'. All searches were limited to papers published in English and from 2005 onwards. In addition, searches were undertaken on Google Scholar and websites of relevant organisations.

The review was made available to the AoMRC. As a result the RCP was commissioned to undertake a project to identify options for improving the quality and process of patient feedback and making feedback more useful for doctors for professional development – in particular, through the use of information technology and patient feedback champions, and by making the process more accessible to encourage wider patient participation. These issues are explored in this report.

3.3 Feedback from family members, carers and professional advocates

When patients are very ill and/or have difficulty communicating, in reality a family member or carer is often the person who provides feedback. Healthcare professionals, eg nurses or professional advocates, may also take on the role of representative for patients in providing feedback about interactions with a doctor. This should not be confused with colleague feedback, which is a separate requirement for revalidation. For the purposes of this report, patient feedback therefore encompasses feedback from family members, carers and professional advocates.

3.4 Patient feedback questionnaires

A number of standardised patient feedback questionnaires are in use for appraisal and revalidation. Most have been designed and piloted to demonstrate reliability and validity. Piloting has helped to identify the best time to administer the questionnaire, and psychometric and statistical analysis has helped to clarify the minimum number of responses required to provide reliable and valid overall ratings of a doctor's interaction with patients. The GMC patient feedback questionnaire for example, is designed to be administered as a post-consultation or exit survey, and requires a minimum of 34 completed responses.[2–6] Different questionnaires require different numbers to be completed. For example, the RCP patient feedback questionnaire requires just 20 responses,[7] while the Consultation and Relational Empathy (CARE) Measure in use in Scotland requires 50 completed responses.[8,9]

3.5 Current patient feedback process for revalidation

GMC guidance on patient feedback was released at around the time revalidation was launched in 2012. The guidance makes recommendations about the type of content and format of standardised

questionnaires, and the process and frequency for collecting this information.[1,2,10] Compliance also requires the administration of these questionnaires (distribution, collation and analysis) to be independent of the doctor and their appraiser. For the purposes of revalidation, the activity of collecting feedback through questionnaires from a set of patients should be undertaken at least once every 5 years.

Since 2012, further guidance has been provided by the GMC through a series of case studies.[11] The studies recognise that for some doctors the collection of patient feedback is challenging and offers advice on how to respond to this. This includes how to amend questionnaires to make them more suitable for different patient groups, and advice about when it is not appropriate to collect patient feedback. Where a doctor is unable to collect the recommended number of responses for a questionnaire, the GMC recognises that the results will be less reliable but not invalid for appraisal and revalidation purposes.

3.6 Problems and challenges with the current patient feedback process

This project focused on how patient feedback for appraisal and revalidation (PFFAR) can be improved. The basis for suggesting improvements is an understanding of the problems and challenges identified with the current feedback process. A number of these were identified by the literature review and reinforced through the project process, while others became apparent during the project. Table 1 summarises the main problems and challenges. These broadly relate to:

- challenges for patients
- challenges for doctors
- reliability, validity and utility of feedback
- infrastructure, administration and logistics.

Table 1. Problems and challenges with the current revalidation patient feedback process – identified through the literature review and survey of responsible officers

Issues – category	Particular or specific problems and challenges
Challenges for patients	*Lack of clarity*: most patients are not clear why they are being asked for feedback and whether this feedback is about an individual doctor, a healthcare team or an organisation.
	Understanding and interpretation of questions: may be difficult for some patients due to the design of questionnaires and how questions are formulated.
	Type, nature or severity of illness or impairment: can make it difficult for some patients (eg on intensive care units) to give feedback.
	Intrusiveness of process: patient anxiety or psychological stress about their illness or healthcare might make it inappropriate or inconsiderate to ask for their feedback.
	Exclusion of some patients: some types or groups of patients are excluded or are seldom-heard in the feedback process (eg frail older people, those with cognitive impairments, travellers, homeless people, and sometimes those whose first language is not English).
	Free-text comments: there is minimal space in questionnaire forms for this. This may deter patients who want to give feedback in this way.

Table 1. Continued

Issues – category	Particular or specific problems and challenges
Challenges for doctors	*Limited number of patients*: particularly problematic and challenging for medical specialists working, for example, in laboratory and pathology settings. *Short or infrequent contact times with patients*: collecting feedback is particularly difficult in some specialties and settings, eg accident and emergency departments. *Limited range of professional skills and attributes covered by questionnaires*: mainly focused on communication and interpersonal skills, and may not cover other elements about which a patient would like to give feedback. *Unintended consequences*: the doctor behaves in ways that are designed to boost feedback ratings especially if the doctor is aware that the specific patient is giving feedback and/or is involved in distributing questionnaires him- or herself. *Doctors working in short-term or locum post*: where there may be barriers to collecting and collating feedback consistently.
Reliability, validity and utility of feedback	*Distribution of questionnaires by doctors*: due to lack of administrative support and possibility of selection bias, ie in 'cherry picking' patients or clinics likely to provide positive feedback. Use of nurses to distribute questionnaires for doctors is seen as an inappropriate use of professional healthcare staff. *Attribution of feedback*: patients may attribute their experience to the wrong doctor if their pathway of care involves interacting with multiple doctors. *Confounding influences*: patients may have difficulty distinguishing feedback about an individual from feedback about a team, service or organisation. *Lack of interest in providing feedback or informed feedback*: due to no or insufficient explanation given to patients about why they are being asked for feedback or how it will be used. *Reluctance of patients to provide seemingly critical feedback about their doctor*: the result, in some cases, is that the feedback given does not accurately reflect the patient's actual experience. This may be due to concerns patients have that any feedback given may adversely influence their care. *Short doctor–patient interaction times*: making it difficult for patients to confidently provide feedback about or even recall a doctor, especially when the patient is acutely unwell. *Usefulness of patient feedback for professional development and appraisal diminished*: due to the reasons listed above, and the infrequency of collection, small total numbers, lack of qualitative feedback and lack of incorporation into routine annual appraisal.
Infrastructure, administration and logistics	*Doctors working across a large organisation in several locations or hospitals*: making it difficult for an administrator to organise the distribution and return of paper-based questionnaires. *Working across two or more organisations with different infrastructures*: especially problematic for palliative medicine doctors who may work in acute, community and charitable sectors, and for locums. *Organisations under-resourced in the patient feedback process*: in terms of administration, dedicated staff and IT in managing and supporting PFFAR. Without organisational resources and support the collection of PFFAR can become very burdensome.

Box 1. Patient feedback in pathology

May I offer my own experience as an extreme example? I am a consultant histopathologist and consequently I do not normally have any direct contact with patients. However, I do occasionally meet relatives of the bereaved to discuss causes of death. My interpretation of the GMC guidance is that I should seek feedback from them. This will take a long time, as it happens only once or twice per month.

I do not think it would be contentious to suggest that the questions currently recommended by the GMC are completely inappropriate for this situation.

Such peculiar situations are, I suspect, mostly limited to specific specialties – so there is a role for specialty input by the medical royal colleges. May I suggest that the GMC ask the colleges, through the Academy of Medical Royal Colleges, to consider how best to address such unusual situations, and to review and explicitly to endorse the colleges' recommendations when they are produced?

Consultant histopathologist and lead medical examiner, NHS trust in England

The problems and challenges overlap and are interconnected. Not all will apply to every doctor, patient, or setting in which healthcare is provided. Some are less straightforward to resolve than others, in particular:

- Collecting feedback is particularly challenging in medical specialties where patient contact is limited by small numbers (eg doctors working in laboratory and pathology settings – see Box 1), episodes of patient contact are very brief, patients are too unwell to provide feedback, or for doctors working in a locum capacity.
- Patients with communication and/or information handling difficulties, including those with sensory or cognitive impairments or learning disabilities, will need adapted mechanisms for giving feedback. Although examples of these mechanisms exist, they are not widely adopted.
- Patients from seldom-heard groups (eg frail older people, those with cognitive impairments, travellers, homeless people, and sometimes those whose first language is not English) may not be asked and in some cases be actively excluded from giving feedback. This may be due to the perception that they are not able or willing to give feedback, or are hard to contact or collect feedback from.
- There are cultural issues for both patients and doctors in relation to PFFAR. Patients may have a poor understanding of appraisal and revalidation, and how PFFAR will be used. Doctors may not find the limited and infrequent feedback useful or may have concerns about judgements made by patients about aspects of their practice. As a result, the current feedback process is in danger of becoming a perfunctory (tick-box) exercise for some patients and doctors.
- The perceived usefulness of PFFAR may also be diminished by factors including selection bias and the risk of misattribution (patients providing feedback based on experiences of care that are wider than the interaction with an individual doctor).

3.7 Feedback on health status and organisational health services

Patient feedback questionnaires currently being used for the purposes of revalidation predominantly focus on individual doctors and their communication and interpersonal skills and behaviours during a consultation. This focus is necessary in obtaining supporting information about professional skills and attitudes, which are key domains in *Good medical practice*.[12] They are also qualities judged to be important by patients when accessing healthcare.[13]

Both doctors and patients recognised the importance of other aspects of the patient experience, including that of overall service delivery by healthcare organisations. Patient participants in the project were keen that feedback on these other aspects should also be sought. Some doctors felt that feedback about teams or organisations such as that derived from patient-reported experience measures (PREMs) will also reflect on the doctors involved, and could provide contributory evidence from patients about a doctor's performance and be discussed in a non-judgemental and formative way in appraisal. This is especially the case if the doctor has a leadership role in delivering and improving, or organising, team-based services and processes. As a result it was also felt that information from patient-reported outcome measures (PROMs) have value, and could be used legitimately as part of appraisal discussions around teamwork and organisational effectiveness.

Within the design of PREMs and PROMs it may not be possible to identify the specific role or impact of an individual doctor and some influencing factors will be outside an individual doctor's control (eg healthcare funding, waiting times, overbooked clinics, national guidelines etc). Since the focus of this report is about giving doctors feedback on their individual attitudes, behaviours and skills related directly to individual patient interactions, feedback through PREMs and PROMs do not form part of the discussions and recommendations of this report.

3.8 Recent national reviews of revalidation

This report also takes into account recent reviews of revalidation and the responses made by the AoMRC and medical royal colleges to these reviews.

3.8.1 UK Medical Revalidation Evaluation Collaboration

Emerging findings from a national study by the UK Medical Revalidation Evaluation Collaboration (UMbRELLA) on the impact of revalidation has confirmed the problems and challenges associated with patient feedback.[14] The study is based on survey responses from 26,586 doctors, ROs and patient representatives. Patient feedback, as it is currently constructed, was generally perceived to be inadequate because of a lack of rigour, patients fearing negative consequences as a result of giving feedback, issues of confidentiality and restrictive feedback tools. Options for improvement relating to some of these issues have been proposed in this report.

The UMbRELLA survey also found that one in three doctors who responded distributed their patient feedback questionnaires themselves, contrary to GMC guidance. While this may be a response to the logistical difficulties doctors face when trying to collect feedback, it calls into the question the validity of the process.

3.8.2 Taking revalidation forward – Sir Keith Pearson (2017)

The recent review of revalidation by Sir Keith Pearson also highlighted problems and challenges associated with patient feedback.[15] This called for a more sophisticated approach around the expectation for patient feedback and wider definition of what constitutes useful feedback. The recommendations made in *Taking revalidation forward* included harnessing technology to enable patients to provide PFFAR, and making the feedback process more real-time and accessible for patients.

Taking revalidation forward has been well received by the AoMRC, medical royal colleges and GMC. In particular, the need to improve patient feedback to make it a more effective process for helping doctors to develop their professional and consultation skills has been endorsed.[16,17] At the same time, the need for the components of revalidation not to become overly burdensome and bureaucratic for doctors was seen as very important,[18,19] especially in the context of the severe workforce pressures being experienced in some specialties, and the concerns that have been expressed about doctors retiring early to avoid the requirements set out in revalidation.[20]

4 Project methodology

4.1. Project values

The project was underpinned by an explicit value set related to the values of person-centred care. These acted as a prism through which ideas were viewed and an anchor point for recommendations.

Table 2. Project value set

Project value	Reason
Individual patient views are important.	Interactions with individual patients are at the heart of clinical medical practice. Patients have a unique perspective on these interactions that cannot be provided in any other way. Patients have the greatest personal vested interest in the outcomes of clinical interactions. Patients consistently say that they want, and expect, to be able to give feedback.
Patient feedback can help doctors to improve their practice.	The perspectives that patients provide allow reflective development of attitudes, behaviours and skills that help doctors to develop professionally and be more effective.
Patient feedback is required by the GMC.	The intention is that this should stimulate better care for patients.

4.2 Project governance

4.2.1 Project governance

A governance committee was set up with representatives from the RCP, RCOG and CAMERA. This committee provided oversight for the project, ensured timely decisions and reviewed progress against the aims set out in the AoMRC project funding agreement. The committee met monthly during the project.

4.2.2 Ethics approval

Advice about the need for formal ethics committee approval was sought from the Research and Development Department of Northumbria Healthcare NHS Foundation Trust. After consulting the NHS Research Authority and Medical Research Council online tool and based on their experience and expertise, advice was given that ethics committee approval was not required for this project.

4.2.3 Potential conflicts of interest

The RCP has developed a patient feedback questionnaire which has been licensed for use by Equiniti-360 Clinical on a commercial basis.

4.3 Project planning and logic model

The earlier literature review on patient feedback (see Section 3.2) and recent national reviews on revalidation (Section 3.8) were used as the basis for informing the areas of investigation and discussion for the project. A logic model was developed outlining the necessary inputs and activities, and intended outputs and outcomes (Fig 1).

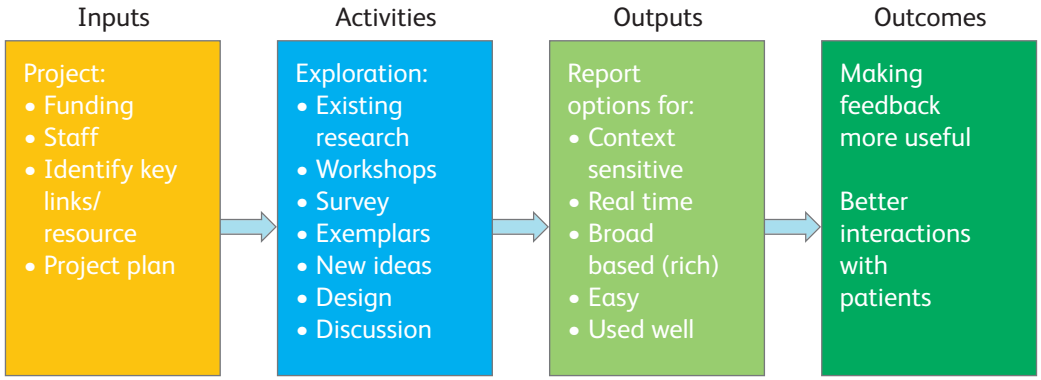

Fig 1. Project logic model

4.4 Data collection

A range of approaches were used to explore the key areas and inform the findings and recommendations of this report. These included a survey of ROs, workshops, group and one-to-one interviews, and case studies. The process was iterative, so that the findings from completed activities informed the design of subsequent activities. For example, the problems and challenges in the current patient feedback process identified in the RO survey were used as the basis for seeking solutions during the workshops held with patients and doctors, and then further discussed with key stakeholders in one-to-one semi-structured interviews.

4.4.1 Survey of responsible officers

An online survey of ROs was undertaken between 15 and 28 March 2017 to explore their perceptions and attitudes to the current patient feedback process for revalidation. The response rate was around 15% (n=90). The results of the survey[21] were shared with the AoMRC Patient Feedback for Revalidation Working Group, and have been included in the relevant sections of this report.

4.4.2 Workshops

The main approach used to explore issues and develop solutions was a series of six 1-day workshops held between 3 May and 31 July 2017. See Appendix A for details of the sessions and themes covered during the workshops. Four of these were organised by the RCP, and one each by the Royal College of Paediatrics and Child Health (RCPCH) and Royal College of General Practitioners (RCGP). The latter two workshops were attended by RCP project team members.

There were 119 workshop participants. Some attended two or more workshops, and this was helpful in providing continuity as themes developed. The attendees included patients (40), clinicians (57), representatives of professional, regulatory and healthcare organisations (13) and providers of patient feedback tools and services (9). Those attending the RCPCH workshop were young people (7) aged between 15 and 21 and their parents (2).

The workshops were designed to capture the views of stakeholders on the issue of patient feedback in revalidation. Detailed notes were recorded on flipcharts during the workshops and later analysed.

4.4.3 Group and one-to-one interviews with stakeholders

The project team were invited to discuss their work and collect further information about patient feedback processes at NHS England North Region RO and Lead Appraiser Network meetings held between 5 April and 26 June 2017. One-to-one (telephone and face-to-face) semi-structured interviews were also conducted. Interviewees included a regional RO, individuals involved in the development of patient feedback questionnaires, information technology experts, and organisations with success in collecting and collating patient feedback on a large scale.

4.5 Data analysis

The literature review, results of the RO survey and notes from the workshops and interviews were considered in their entirety. In examining these, a qualitative thematic approach was used combining deductive and inductive analysis. Commencing with the themes of technology, real-time processes, accessibility, personal reflection and appraisal (ways identified in the *Taking revalidation forward* recommendations to improve the input of patients and use of feedback to and by doctors[15]), new themes and sub-themes were added as they emerged during the analysis. The themes, and the relationships between them, were used to inform the findings and recommendations of this report. This approach is in line with qualitative methods used in health services research.[22]

5 Findings and options for improvement

An analysis of the evidence collected for this project, emerging themes and relationships between these themes provided the basis for the findings and options for improvement relating to patient feedback set out in this report. These are presented in the following seven subsections:

1. Real-time and continuous patient feedback
2. Mixed methods for obtaining patient feedback
3. Engaging doctors and patients
4. Patient feedback champions
5. Effective organisational patient feedback systems
6. Use of information and telecommunication technologies
7. Doctor–patient interactions, appraisal and revalidation

5.1 Real-time and continuous patient feedback

Sir Keith Pearson suggested the possibility of a real-time and continuous approach to patient feedback for revalidation.[15] Much thought was given during this project to what is meant by this. Real-time and continuous approaches were explored as separate concepts, in relation to the following process stages: patients giving feedback, the information being collected and collated by organisations, and doctors reflecting on and using this information.

Box 2. Real-time and continuous patient feedback

'I am interested in the concept of "real time" feedback; feedback that could take place following any or all interactions a patient has with a doctor. A number of people have suggested we need to move beyond the concept of a single feedback exercise at a particular period of time and towards a continuous approach to seeking and reflecting on feedback. Patients have said that this would be more convenient and would make the process less daunting for them. One system regulator told me that real time feedback would fit well with their approach to inspection of healthcare providers.'

Sir Keith Pearson, *Taking revalidation forward*[15]

5.1.1 More patient feedback

Real-time and continuous approaches – however defined – should allow for or would require more patient feedback to be collected on a doctor. There is a perception that the current requirement of collecting feedback once every 5 years from a relatively small number of patients only provides a brief and very occasional snapshot and does not provide enough information about a doctor to be useful or a fair reflection of practice. Box 3 estimates just how few patients as an overall proportion provide feedback for an individual doctor.

Box 3. Proportion of patients providing feedback for an individual doctor

Scenario 1 – GP
A once-in-5-year process involving 50 patients will mean that for a practice with 7,183 registered patients (average number per GP practice in 2015[23]), feedback about an individual GP is collected from just 0.7 % of these patients.

Scenario 2 – consultant surgeon
If a consultant surgeon sees 20 patients weekly for 46 weeks of each year, over 5 years this amounts to about 4,600 patient contacts. If feedback is collected on 40 patients over the 5-year revalidation cycle this represents just 0.9 % of contacts.

The results of our RO survey support the perception that an insufficient number of patient feedback responses are being collected, especially if this is for the purpose of a doctor's professional development at appraisal (Fig 2).

- Forty per cent of ROs felt that patient feedback should be collected more than once every 5 years for revalidation, with 75% responding this way if it was for professional development.
- Sixty-three per cent felt that, if feedback was being collected for professional development, it should be collected either annually or continuously, with 24% feeling that this would be necessary for revalidation as well as useful for reflective practice.
- Responsible officers felt that organisational systems and mechanisms must be in place if patient feedback was to be collected continuously or more frequently.

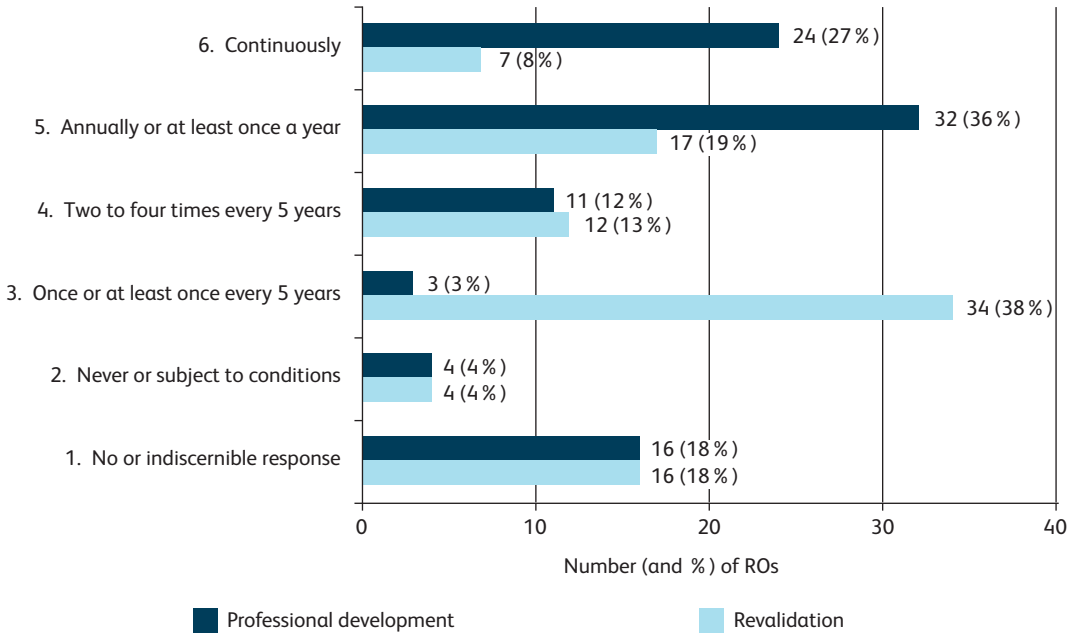

Fig 2. The frequency that patient feedback should be collected for (a) professional development and (b) revalidation – responses from ROs

5.1.2 Real-time patient feedback

Feedback can be real-time in the sense that it is given at or close to the time of a clinical interaction. It may also mean that doctors are able to access the cumulative feedback that they have received at any time during an appraisal or revalidation cycle.

Many attending the project workshops welcomed the idea of patients always being given the opportunity to provide feedback immediately, or as soon as possible, after a consultation or interaction with their doctor. This should be in the form of an open invitation to provide feedback, for example, by signposting to patients to give feedback in clinical environments. Alongside this, a continuous process of intentional planned proportionate sampling for feedback, through individual invitations by mail, email or text messaging, was seen as essential to ensure that it reflected scope of practice and did not only reflect those most and least satisfied.

Immediate opportunities for feedback may prompt more patients to take part and it may be easier for them to recall specific aspects of the clinical interaction when giving their feedback. The opportunity to feedback immediately will not always be taken up, although patients might be more likely to give feedback if there were a choice of different ways to do this using mixed-methods and formats (quantitative and qualitative). Mixed-methods of patient feedback are discussed in Section 5.2 of this report.

While more or less immediate feedback may suit some patients, there are circumstances where patients may prefer, or only be able, to give feedback later. Examples include following an acute inpatient admission or procedure requiring an anaesthetic, or after receiving bad news or care over an extended period. There will need to be flexibility to allow for context specific variation and personal preferences. Patients should be given the opportunity to pick their own most appropriate timing to give feedback.

Receiving (as distinct from giving) feedback in real-time provides current and therefore relevant and actionable information to a doctor, and can help to identify problems early on or review the impact of any changes made. This allows rapid-cycle improvement loops in the context of patient feedback to doctors and has the potential to be highly effective as has been seen in other healthcare settings. Both the Francis report[24] and Berwick review[25] highlighted the benefits of collecting patient experience data that is real-time, or near real-time, to make care better and safer.

There will need to be adequate organisational support systems and mechanisms for real-time feedback to take place. There are already examples of this happening. In a pilot programme at University Hospital of South Manchester, every time a patient is seen by a doctor the internal administration system automatically sends a questionnaire to the patient's home address;[26] and at Yeovil District Hospital some staff are equipped with tablet computers to capture and upload real-time feedback from patients while they are receiving their care.[27] The use of information technology is essential to real-time feedback allowing rapid collection, analysis and reporting.[28]

5.1.3 Continuous feedback

For real-time feedback to be effective, the information will also need to be in some sense continuous. Two possible ways emerged to think about continuous feedback:

- Continuous can mean collecting feedback from each patient a doctor interacts with. Some workshop participants saw this as an ideal as it would remove selection bias. However, it was also recognised that patients will be giving feedback on a number of other healthcare issues besides their specific interaction with a doctor, and there were concerns about patients being overloaded with requests for feedback.
- Alternatively, continuous feedback can mean that a proportion of patients are giving feedback evenly distributed throughout an annual appraisal cycle. It would be important to make sure that sufficient feedback is provided across the cycle, especially where a doctor sees a relatively small number of patients (eg in forensic units or some academic or part-time settings), and not overwhelming amounts where patient numbers are high and little might be gained from very large volumes of feedback. This way of thinking about continuous feedback has been adopted in this report.

The following perceived advantages are associated with continuous feedback:

- With either of the above meanings, a greater number or proportion of patients giving feedback than at present would provide a more complete and accurate picture of a doctor's practice and so be more useful for reflection and improvement.
- It would offer the opportunity for feedback to be proportionate from different groups of patients if a doctor works in more than one setting (for example in acute care, outpatient and endoscopic settings) and therefore fully reflecting scope of practice.
- It would allow individual patients to be able to complete smaller 'bite-sized' (less burdensome) amounts of feedback. Especially where structured feedback in the form of a questionnaire or prompted free text is being used, and if more feedback is collected over time, this can still be collated to provide an accurate reflection of a doctor's practice.

The implementation of a system of continuous patient feedback will need to take account of:

- The need for organisational support structures, including adequate staffing and information technology, to be in place to implement a system of continuous collection, collation, analysis and reporting.
- The burden of giving feedback may be significant for some patients, especially those who are seen by several doctors, and this will become a particular issue for those with frailty or multimorbidity who make up an increasing part of clinical caseloads.
- Additional information gained after a threshold has been reached (ie a certain number of patient feedback responses) may not reveal anything much new about a doctor's skills, attitudes and behaviours.

5.2 Mixed methods for obtaining patient feedback

The methods that could be used to obtain patient feedback fall into two broad groups:

- Semi-quantitative methods – ie standardised questionnaires. These are currently the primary method used to collect patient feedback for revalidation. The feedback is in the form of rating-scale scores of a doctor's skills, attitudes and behaviours.
- Qualitative methods – ie tools (including individual and group interviews) seeking free-text comments and personal narratives. These are currently used much less but both patients and doctors feel strongly that they would provide a rich source of feedback information for a doctor's appraisal, professional development and revalidation.

5.2.1 Semi-quantitative methods: patient feedback questionnaires

A number of standardised patient feedback questionnaires are in use for appraisal and revalidation. Organisations that have developed questionnaires include the GMC,[29] RCP,[30] RCPCH,[31] Royal College of Anaesthetists (RCoA),[32] Academic Departments of General Practice at Glasgow and Edinburgh Universities (Consultation and Relational Empathy [CARE] Measure),[8] and Edgecumbe Doctor 360.[33] Comparison of a selection of these (GMC, RCP, RCoA, PaedCCF, CARE Measure and Edgecumbe Doctor 360) shows similar characteristics:

- They are wholly or mainly paper-based (although electronic versions have been developed – see Section 5.6.5).
- They are predominantly reliant on scaling questions – around 13 or so (range: 10 to 20 across the sample of questionnaires examined) requiring a response on a four- to six-point scale (ie not at all satisfied to very satisfied, very poor to very good).
- Questions focus on the doctor–patient interaction – particularly the doctor's interpersonal, communication, and patient engagement and enablement skills. These are generic attributes required of doctors as specified in *Good medical practice*.[12]
- They provide space for free-text comments.

5.2.2 Issues with patient feedback questionnaires

There are issues with using standardised questionnaires including:

- Validity and reliability: although questionnaires have been designed to be valid and reliable, the process by which they are currently being used by some doctors erodes the validity and reliability of the results. The validity of any assessment result, or interpretation of those results, is affected by the actual process used to collect, analyse and report on that information.[34] For example, a survey conducted by UMbRELLA found that one in three doctors distributed their patient feedback questionnaires themselves,[14] which can introduce bias and therefore affect the validity and reliability of the results.
- There is minimal space for narrative style qualitative feedback in most questionnaires – around two to five lines of handwritten free-text comments depending on the questionnaire.
- Questionnaires are difficult for some patient groups to understand and use (for example those with learning and literacy difficulties or with cognitive impairment) and they are usually only available in English, so are potentially difficult for those without written skills in, or whose first language is not, English.
- Many patient feedback questionnaires currently in use for revalidation are not specialty specific and can be hard to use in some settings, eg peri-anaesthetic, accident and emergency departments.
- Some skill, attitude or behaviour areas that are relevant to explore may not be covered by the questionnaires currently being used. Many questionnaires were developed in readiness for the launch of revalidation and are based on the standards set out in the 2006 edition of *Good medical practice*.[35] These standards may not reflect the expectation of doctors in 2017, and therefore the patient feedback questionnaires currently being used are less appropriate.

5.2.3 Qualitative methods

The project workshops identified different methods for collecting qualitative patient feedback (Table 3).

Table 3. Qualitative methods used in collecting patient feedback

Method	Example	Potential benefits	Potential limitations
Face-to-face interviews with individual or groups of patients	Interviews with patients by feedback champions or volunteers working in service areas, or via teleconferencing (eg Skype)	In-depth perceptions and views of patients gained Interviewer is independent of the doctor–patient relationship Opportunistic and real time approach if undertaken immediately-post-consultation	Not flexible in terms of time Resource intensive Not likely to be able to be done at (sufficient) scale
Direct collection of feedback by doctor	Doctor asks patient directly within or immediately after a consultation	Real-time Quick	Is not anonymous Open to strong bias Breaches current GMC guidance
Feedback kiosks	Tablet devices in clinical areas that allow patients to choose from a 'pick list' of potential descriptors (positive and negative)	Real-time Quick Semi-qualitative feedback Analysis can be automated	Limited to the descriptors chosen Requires resources to set up Requires private space in areas that may have limitations on this
Electronic means including online portals and apps (see also Section 5.6)	iWantGreatCare (IWGC) or possible GMC centralised portal, which is completed by patients and results visible and shared with ROs	Simple, easy and quick for patients to access Cheap for organisations to collect feedback once the portal has been established Could be modified to make it targeted to a specific patient and doctor interaction	Open to trolling unless appropriate safeguards are put into place Currently content on IWGC is available to all Risk to confidentiality/ security issues Selection bias Potential damage to reputation
Use of tablet handheld devices or web-based portals for people to enter comments or to choose key descriptive terms	Patients completing prompted text comments on a handheld device at end of an appointment or in hospital or being sent a link to prompted questions at home	Quick and immediate	Patient must have appropriate IT skills Resources and financial implications to set up

Table 3. Continued

Method	Example	Potential benefits	Potential limitations
Social media	Facebook, Twitter	Already widely available for use	Would need to be monitored and moderated
		Public access	Not anonymous
			Open to trolling
			Subject to unauthorised access and security breaches

Some require the use of information technology, for example online portals and apps to collect personal narratives from patients. Few of these qualitative methods have been tested or validated but the resulting free-text comments and personal narratives from patients were seen to be insightful and useful for a doctor's professional development, appraisal and revalidation. These methods require the qualitative information to be synthesised and made sense of, and this could have resource implications, although semi-automated systems are evolving fast (see Section 5.6.9).

5.2.4 Usefulness of qualitative patient feedback

The literature on the validity and reliability of qualitative patient feedback is limited. There has been some criticism that qualitative research is merely a collection of personal opinions, which may be subject to researcher bias,[36,37] and whether terms such as reliability and validity should be used in qualitative research.[38]

However, in all discussions, patient participants consistently want to have more options from which to choose how they give feedback, and doctors feel that qualitative feedback is useful for them to reflect on in order to improve their practice and interactions with patients. It is suggested that:

- qualitative feedback allows patients to express themselves more openly about what matters most to them in clinical interactions, and they are less restricted to answering questions other people, such as doctors and regulators, feel are important. It may also detect issues that may not be picked up by a standardised questionnaire
- doctors find free-text comments more useful than the semi-quantitative results in patient feedback reports
- doctors attending the project workshops are clear that qualitative feedback is useful for reflection at appraisal with a view to improving practice. This also requires appraisers to be trained to interpret and facilitate using qualitative feedback
- if qualitative feedback is to be useful, some consideration must be given to the prompts and questions used in seeking this information from patients. This could range from semi-structured interviews with patient feedback champions (see Section 5.4), to paper or electronic invitations using a broad open introductory question such as 'What are your thoughts following your contact with this doctor?', to a prompted approach using seeding questions or statements asking for comments linked to particular professional skills, attitudes and behaviours (relating possibly to the domains of *Good medical practice*[12]).

5.2.5 Observation of the doctor–patient interaction

Feedback is intended to provide information about a doctor's professional attitudes, behaviours, communications, actions and skills during a doctor–patient interaction. Another way of obtaining this information – quantitatively and qualitatively – is through direct observation of these skills, either during a real or simulated (using actors) consultation. Simulated consultations can be facilitated by patient feedback champions (see Section 5.4) and designed in advance to see how a doctor handles a routine or difficult situation with a patient.

Consultations, both real and simulated, can be recorded with a camera and this offers the possibility of review by the doctor and a third party (eg appraiser). The main limitation is that recording consultations is resource intensive, requiring equipment and time especially if the recordings are transcribed. If the consultation was real, the patient cannot be anonymised and consent would be required. Anxiety on the part of the doctor being recorded may impact on the quality of the consultation and/or alter their usual, natural, way of communicating.

Observational approaches are very resource intensive and unlikely to be done at sufficient scale to be helpful for appraisal and revalidation, although it is well established in the setting of learning communication and other clinical skills and assessing the skills of doctors in training.

In the field of education, some interesting new technologies are emerging for training teachers and assessing classroom skills that allow video recording on handheld devices and tagging of videos either by a teacher or an assessor that may have some value and need further exploration. These techniques are likely to be useful to address specific skills development identified by less labour-intensive sources of feedback

5.3 Engaging doctors and patients

The current feedback process presents problems and challenges for both patients and doctors. As this is the case, the workshops were used to identify both cultural (in the broadest sense) and practical problems and challenges, and solutions for addressing these. Some of these solutions will need to be led centrally by national bodies such as the GMC and/or departments of health and implemented locally by healthcare organisations.

5.3.1 Engaging doctors

The UMbRELLA research team's interim findings, the RO survey and meetings, and the project workshop participants, were united in the view that busy doctors find the process of collecting patient feedback difficult and burdensome. A significant proportion also feel unsupported and the UMbRELLA team found that one in three doctors are distributing feedback questionnaires themselves[14] despite GMC guidance and the obvious concerns about selection bias and influencing feedback (however unintended). Responsible officers are concerned about the possibility of 'gaming' because of the level of doctor involvement.

There is also concern about how useful the feedback is, given the small numbers of patients giving feedback on an individual doctor and the infrequency of collection. As one workshop participant pointed out this may be as seldom as once every 10 years (if feedback is collected at the end of a 5-year

Table 4. Doctors working in ways that may require special adaptations to feedback

Situation or context of practice	Why this situation is special	Potential solutions
Doctors in substantially temporary or locum roles	There is no fixed employing organisation with access to individual patients to seek feedback. It may be hard to get enough feedback.	Organisations employing locums will need to be responsible for feedback for those locums alongside regular staff as a part of locum contracts. This will then need a structured link to the locum agency so that it can be collated. It will be the responsibility of the locum to ensure that this is in place.
Doctors seeing few or no patients (eg radiologists, clinical pharmacologists, public health specialists, pathologists)	Difficult to get enough feedback. The attributes that a patient can comment on may be different.	Feedback should be sought from all patients to allow for adequate amounts of feedback. Feedback may be requested on non-clinical (eg written) interactions. Exemption from collecting patient feedback may need to be requested for a small proportion of doctors. This should be rare and must be explicitly agreed as part of appraisal.
Doctors practising with a mixed patient type (where a doctor has two or more different medical roles)	The relevant type of feedback and opportunity for feedback may be complex.	Proportionate sampling / PFFAR from all groups a doctor is involved with. Identification of appropriate feedback tools for that context from a suite of kite-marked tools.*
Doctors practising in situations where patient contact is very brief (eg in accident and emergency departments or a mainly supervisory role)	Patients may not be clear about who is being referred to when asked about a doctor.	Use of bar coding on doctor's badges (pegged to GMC number) linked to bar coded patient identifier (pegged to NHS number).
Doctors working with patients who are well (doctors employed purely to provide health checks)	May not be able to test all of the attributes sought by the GMC (eg diagnosis-related information giving).	Identification of appropriate feedback 'tools' for that context from a suite of kite-marked tools.*

*Selection of appropriate tools agreed at appraisal for the next year

revalidation cycle and then at the start of the next 5-year cycle). Another participant said of the current system: 'It feels as though it's a "tick-box" exercise to keep a regulator happy rather than an opportunity for reflective improvement in practice.' Underlying this there may be reluctance on the part of some doctors to accept that feedback from patients is itself valuable and that reflection on this feedback is worthwhile.

There are some specific situations where special attention to feedback may be needed. Some of these relate to a doctor's role or scope of practice (Table 4). Others relate to a specific patient group, whose health or communication needs require adaptation of feedback mechanisms.

5.3.2 Potential solutions for doctors

A good deal of workshop time was devoted to looking for ways to enhance engagement of doctors with patient feedback. The following key themes emerged:

Making feedback more useful

- Linking feedback to appraisal rather than revalidation. This is seen as central to engagement with the outcomes of patient feedback being a routine part of appraisal discussions. Appraisal is seen as 'protected space' to discuss professional development needs, plan what feedback tools may be appropriate for an individual doctor and what actions, if any, may need to be taken in response to feedback.
- Providing qualitative as well as semi-quantitative feedback. There is a strong perception that semi-quantitative feedback based on scaling questions is useful in identifying the broad areas a doctor might want to work on. At the same time, it is recognised that there is difficulty in knowing exactly what the doctor might want or be able to do differently without qualitative and descriptive feedback.

Making feedback less burdensome to doctors

Collecting feedback on a more continuous and real-time basis runs the risk of being overwhelmingly burdensome to doctors, so:

- feedback about doctors needs to be embedded in employing organisations' systems. It is in the interests of employers that doctors should be aware of and respond to feedback from patients. There was strong support from the research, workshops, surveys and conversations with leaders and innovators, that this should become 'normal' in the NHS, and was seen as the only viable solution to delivering real-time and continuous feedback where collection, analysis and reporting would be independent of individual doctors. There are examples of organisations giving this high priority and have shown that it is both possible and valuable.
- there is a need to ensure that doctors are able to use feedback to improve. The value of feedback will be realised where doctors are able to work with their employing organisations through appraisal and personal development plans to respond to feedback in a way that improves their practice.

5.3.3 Engaging patients

Patients have also expressed concerns around feedback, which influences their engagement with the process. Within the work undertaken by CAMERA, the workshops and conversations with patients and patient groups, a number of demotivating factors have been identified. These include:

- lack of clarity about revalidation and the purpose of feedback questionnaires
- lack of information on the outcome of the feedback given (what difference does it make?)
- concerns about anonymity, whether feedback might influence healthcare, or whether a request for feedback reflects a 'doctor in difficulties'

- feedback and survey fatigue
- lack of incentives to give feedback
- the needs of seldom-heard groups not being met.

In many of these situations, the issue is not to do with the collation, analysis, reporting of, or reflection on feedback, but to do with the tools, methods and processes for collection, and the support and information provided at this time. Adapting feedback tools for patients where giving feedback may be difficult (eg in accident and emergency departments, forensic care, following breaking of bad news, or when a patient is suffering from dementia) is a way forward.

5.3.4 Potential solutions for patients

To improve the extent to which patients provide feedback there is a need to:

- provide clearer information on revalidation and the purpose of patient feedback. This should be part of a broader agenda of promoting to and educating patients on what revalidation is, its benefits and purpose, and how patient feedback contributes. Information about anonymity should also be provided.
- provide printed explanatory information which should comply with the Plain English Campaign, Crystal Mark Standard and equality and diversity requirements.
- avoid doctors being individually and directly involved in the feedback collection process. There should be a separation of the process of inviting patients to give feedback and collecting this from the process of clinical interaction with a doctor.
- reduce the amount of feedback each patient needs to give each time they are asked. The purpose of feedback is to allow a doctor sufficient information to reflect on his or her practice. With larger numbers of patients giving feedback, smaller chunks of feedback will build up into an accurate picture of a doctor's practice, especially where questionnaires or prompted free-text are being used.
- make feedback normal. Patients are asked for feedback on all sorts of things, and only occasionally about interactions with doctors. If feedback is made more routine then it was felt that many of these concerns would be reduced.
- provide information to patients about what difference their feedback makes. Ideas about this ranged from doctors blogging online about what impact feedback has had, to organisations publishing the rates and some responses to feedback across the organisation.
- thank patients for providing feedback. If feedback were electronically provided then acknowledging that individuals have provided feedback could be automated.

5.3.5 Seldom-heard groups

Special attention needs to be paid to seldom-heard groups who may be under-represented in the patient feedback process. This may be due to people in these groups not being asked for their feedback, or being perceived as being unable to or having difficulty in providing this information, or possibly discriminated against because of their age, socioeconomic, cultural, health etc background. Table 5 lists the groups identified by project participants as being under-represented in the patient feedback process.

Not asking or hesitating to ask patients in these groups to give feedback may in part be due to lack of suitable tools, systems or infrastructure for seeking or collecting this information. Research with many of

Table 5. Seldom-heard groups

Reasons for being seldom heard	Example of groups affected
Age	Very old or frail older people
	Children and young people
Communication and information processing difficulties	Patients with cognitive impairments
	Patients with speech, language, learning, literacy or numeracy difficulties
	Patients with visual impairments
	Those who do not have English as a first language
Health issues	Patients in palliative and end-of-life settings
	Patients with mental health problems
	People in forensic settings
Socioeconomic factors	Homeless people
	Travellers
	People who are housebound
	People in detained settings, including prisons

these groups however suggests that they are not only able, but also feel strongly about having the opportunity to give feedback and wanting their voices heard alongside all other groups of patients.

This is not just a question of equality and fairness. People in seldom-heard groups often have the greatest health needs and are among the most frequent users of health services. It is arguable that these people are in the best position to feedback on their experience and quality of healthcare services including interactions with doctors, and that a greater effort should be made to collect this information.

This experience of greater healthcare need and poorer opportunity to give feedback may be seen as a feature of the inverse care law.[39] The inverse care law is the principle that the availability of good medical or social care tends to vary inversely with the healthcare needs of the population served. Therefore, in relation to patient feedback, the opportunity to give this information diminishes among seldom-heard groups who may have the greatest healthcare needs.

5.3.6 Bespoke tools

For some patient groups there is a need to develop bespoke tools, using the same principles as for the majority of patients and there are good examples of this, including the use of Talking Mats™ (Fig 3) and easy-read questionnaires (Fig 4). See Appendix B for a case study on how such tools are being used in Solent NHS Trust. The Consultation and Relational Empathy (CARE) Measure has been modified into

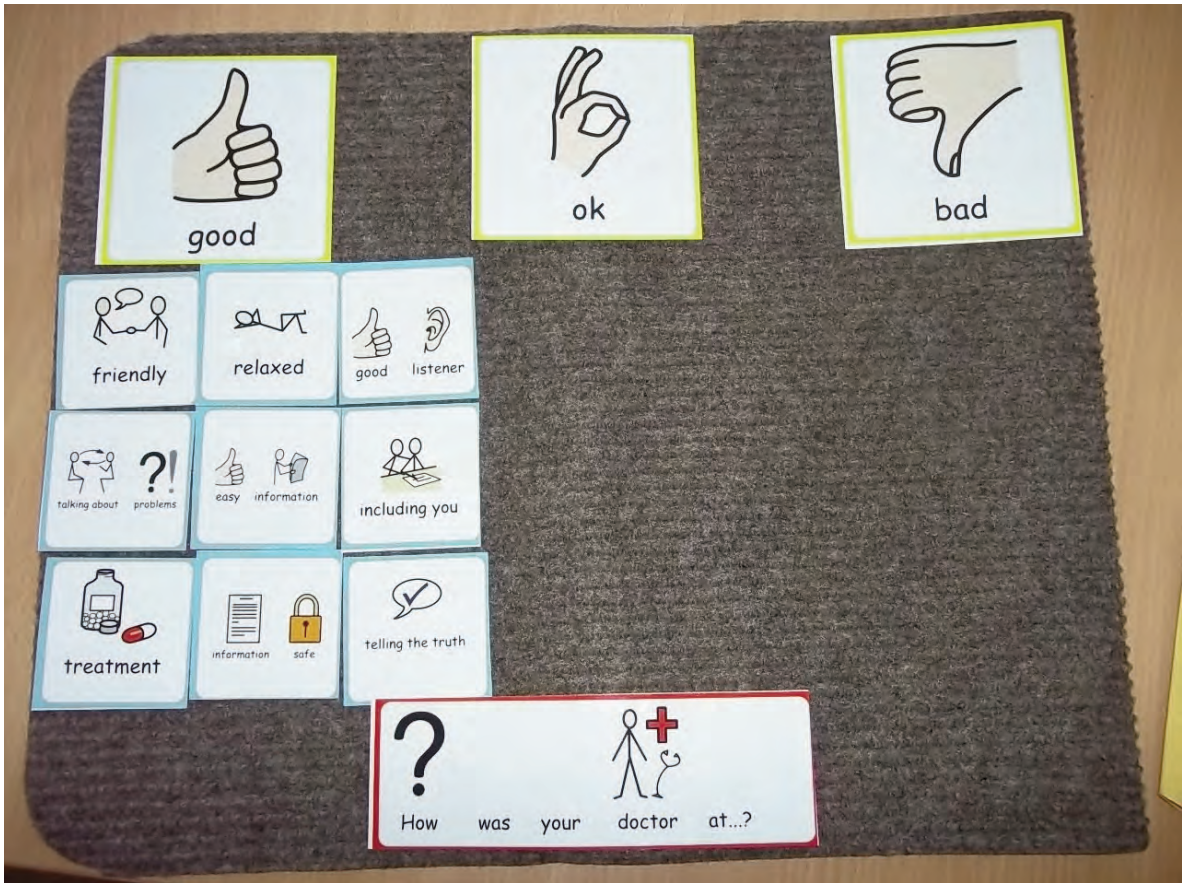

Fig 3. Talking Mats™ used in collecting patient feedback[43,44]

symbolised versions (Fig 5) using specially developed graphics to facilitate feedback from children and young adults.[40–42] For other seldom-heard groups, existing or newly-developed tools that are more widely used may need to be provided using local innovation to support administration and completion.

For some patients, who are capable of giving feedback but can only do so with support and assistance due to, for example, cognitive and/or communication difficulties, a surrogate (parent, carer, support person or professional advocate) might help with feedback. However, that person must have experienced at first hand the interactions of the patient with the doctor to be able to give this sort of feedback.

5.4 Patient feedback champions

Instances of the use of dedicated staff – often called patient feedback champions – to help collect and collate patient feedback can be found in the literature[45] and were highlighted by those attending the workshops and interviewed in this project. Some healthcare organisations have already adopted this idea. The champion can help to solve the administrative and logistical problems and challenges (see Table 1 above) associated with collecting patient feedback on individual doctors. As well as organising the collection of patient feedback, they can have a proactive role in helping individual patients to express their experiences as personal narratives. One-to-one personal support for a patient, when needed, may

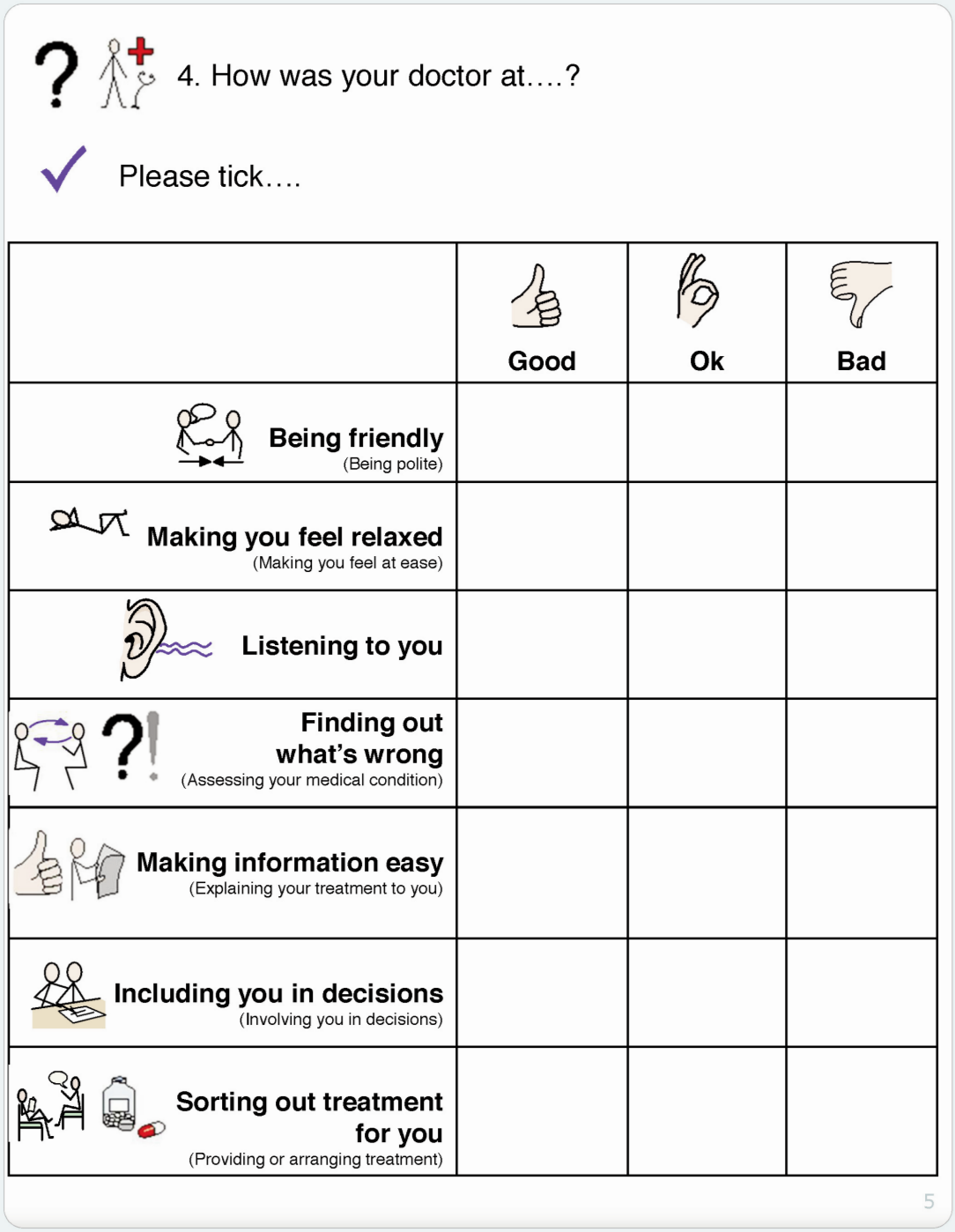

Fig 4. Easy-read questionnaire developed by Solent NHS Trust[43]

(© NHS Solent, images from Widgit Symbols © Widgit Software 2002–2012)

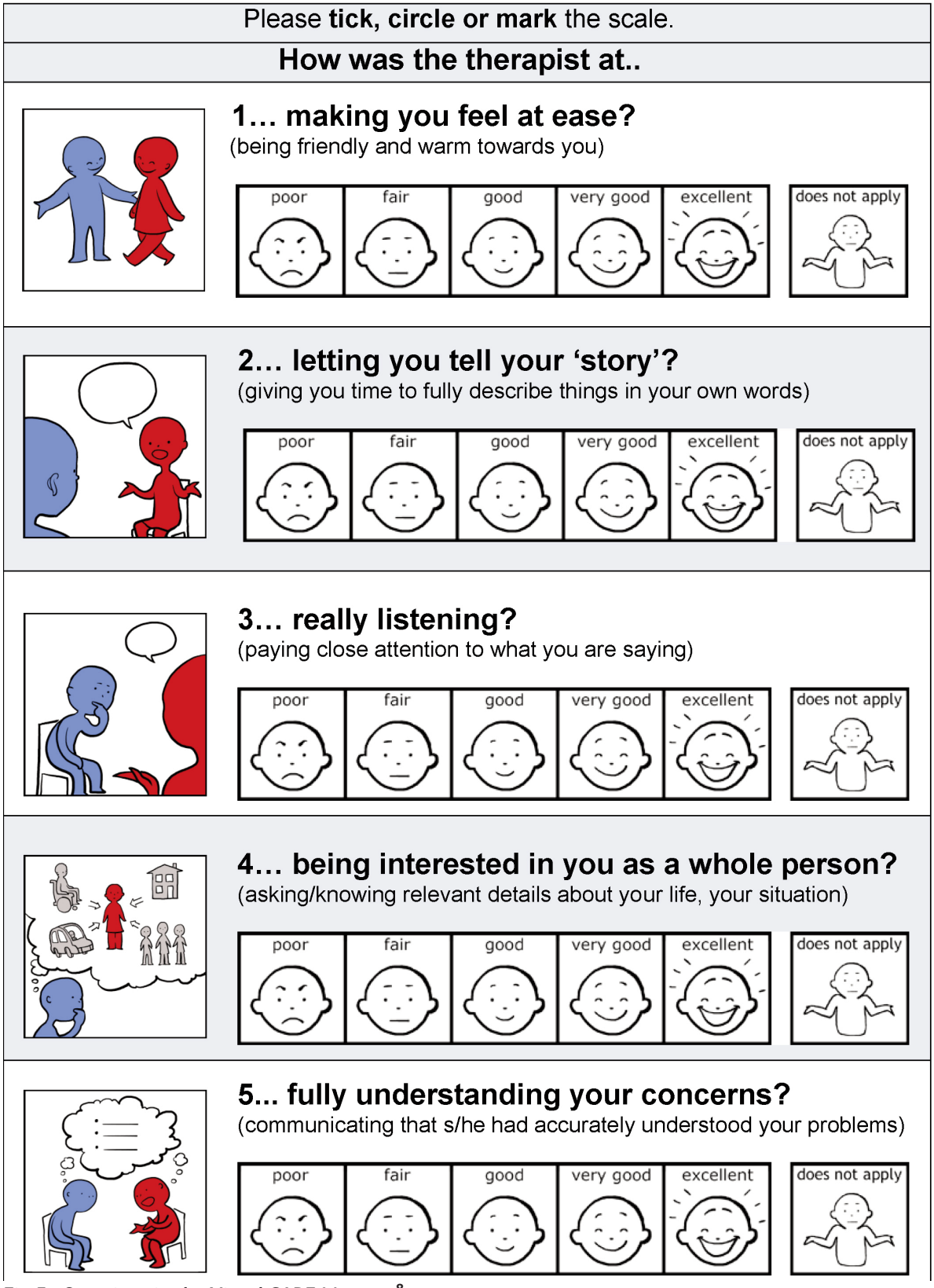

Fig 5. Questions in the Visual CARE Measure[8]

(© Stewart W Mercer 2004, images © Adam Murphy)

elicit more and richer information and insights about a doctor compared with a patient simply being given the option to 'add any other comments' on a questionnaire.

5.4.1 Current experience with patient feedback champions

Currently around 10% of healthcare organisations have people in this role according to our survey of ROs, and this is usually held alongside other roles. They could be members of an organisation's revalidation team, patient involvement managers, appraisal leads, medical education team members, support staff or those responsible for the implementation of patient-reported outcome and satisfaction measures, or lay representatives of the public and patient involvement group.

5.4.2 Roles and responsibilities of patient feedback champions

Existing and potential roles and responsibilities of patient feedback champions identified during this project included:

- Promoting the importance of the feedback process among patients, doctors and managers in an organisation.
- Helping to develop the strategy, mechanisms and processes to collect patient feedback in an organisation, especially if a real-time and continuous approach is to be undertaken.
- Managing the patient feedback process so that it is independent of the doctor.
- Helping doctors to identify the best tools for feedback for their scope of practice.
- Proactively engaging with patients, including those from seldom-heard groups, to collect and support them in giving feedback (see the case study in Appendix B, which highlights the use of dedicated staff to collect feedback from patients with communication needs).
- Helping patients to complete questionnaires, for example those with a visual impairment or who have poor English-language skills or find difficulty writing due to arthritis, tremors or health problems.
- Providing an alternative means of obtaining feedback other than through a questionnaire, ie interviewing patients, recording personal narratives.
- Act as a neutral party in obtaining feedback and reassuring patients that their responses will remain anonymous to the doctor and will not impact on clinical decision-making and care provided.
- Collating the feedback collected and presenting the results in an accessible format to doctors for their appraisal and revalidation.

5.4.3 Training

Patient feedback champions will need to be trained in order to carry out their duties effectively. Solent NHS Trust, in an initiative to improve feedback from patients with learning disabilities and mental health problems, recruited staff with a defined level of confidence and experience in supporting people with communication and information needs, and provided further specialist training in these areas including how to facilitate feedback from seldom-heard groups and deal with communication breakdown (see Appendix B). The Solent initiative is based on evidence that, with support, most patients with communication and information needs are willing and able to give feedback on their doctors.[43]

There were mixed, and sometimes strongly held, views among project participants about whether patient feedback champions should be professionals embedded in organisations, or could be volunteers working

on an ad-hoc basis, with most feeling that training, honorary employee status and appropriate (eg disclosure and barring service [DBS]) checks were the minimum requirement.

5.4.4 Feedback champions integrated within organisational system

An organisational systems approach should be taken to collecting and processing patient feedback, with dedicated staff (champions) supported by the effective use of information technology. Fig 6 below shows how patient feedback champions can be integrated in an organisation. A description of how patient feedback champions are already integrated in The Leeds Teaching Hospitals NHS Trust and Northumbria Healthcare NHS Foundation Trust can be found in Appendices C and D.

5.5 Effective organisational patient feedback systems

Real-time and continuous approaches in the patient feedback process, together with the existing challenges in collecting this information, pose logistical and administrative challenges for many NHS organisations and independent healthcare providers. An effective organisational approach may be needed for healthcare professionals other than doctors, such as nurses and pharmacists, to obtain patient feedback for continuing professional development and/or revalidation purposes. Practice-related feedback, including that from patients, is now a requirement for the revalidation of nurses for example.

5.5.1 System approach

Organisations will need to develop and implement an integrated system for collecting and processing patient feedback. The system requires technological (eg effective use of IT) and non-technological (eg dedicated staff such as patient feedback champions) components alongside each other to:

- collect, manage and analyse patient feedback and present it in a useful and meaningful way
- engage doctors and patients in the feedback process
- minimise the administrative burden for doctors and patients in the collection of feedback
- increase opportunities for patients to give their feedback
- incorporate and facilitate different ways that feedback can be given.

5.5.2 Organisational model

A potential model developed with input from participants of the project workshops incorporates patient feedback champions and information hubs to support patients giving and doctors receiving and using feedback (Fig 6).

Key features of the proposed organisational model:

- A central online web-based portal to manage and deliver different methods of obtaining real-time and continuous patient feedback, and collating, analysing and reporting this information.
- The online hub will offer a range of tools to collect patient feedback through questionnaires, handheld devices, online portals, telephone conversations, personal narratives etc. Doctors, patients, appraisers and feedback champions will have access to this hub in order to decide which feedback tools are most appropriate, and for most a combination of qualitative and more quantitative methods will be needed.

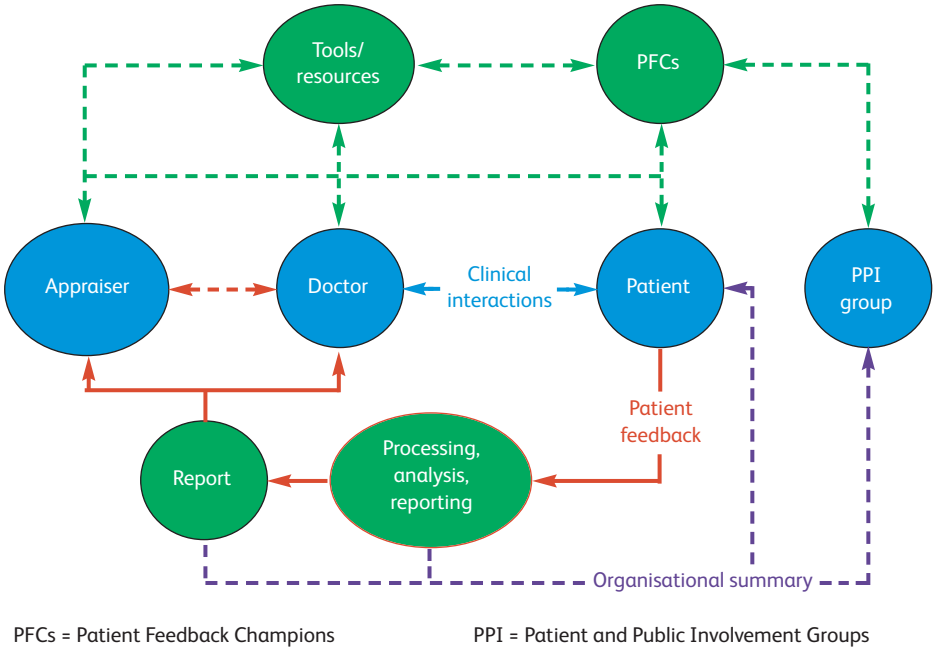

Fig 6. Proposed organisational model for patient feedback

- The outputs of the model will be reports, for the individual doctor, appraiser, medical team and organisation.
- A summary report will be specifically provided to patients who have given feedback, to assure them that their feedback is being attended to and used by doctors for reflection and learning.
- Reporting of the impact of patient feedback across the organisation and teams. Some of these approaches are already used in some healthcare organisations (eg Northumbria Healthcare NHS Foundation Trust – see Appendix D) for patient experience feedback about teams and wards.
- Implementation and management of this model will need to be undertaken by organisations supported by feedback champions, in helping doctors with their choice of feedback tools, steering patients to the ones useful for an individual doctor, and conducting face-to-face interviews if necessary. Further discussion of the roles and responsibilities of patient feedback champions can be found in Section 5.4.
- For the model to be successfully implemented it will need the active support of trust boards, practice partners and managers, ROs, appraisers, administrators and technical staff. The model is also resource dependent and requires time to develop, as well as staff, funding and leadership.

5.5.3 Organisational leadership

One of the main lessons from the NHS Patient Feedback Challenge – a programme initiated by the NHS Institute for Innovation and Improvement in 2012 – is that success in the delivery of any patient feedback project is dependent on the buy-in and visible commitment of senior leaders in an organisation.[27,46] To be implemented, the proposed organisational model will need the support of senior leaders. These individuals will also need to recognise and promote the value of giving and collecting patient feedback, as the basis for organisational quality improvement and individual professional development. One of the recommendations of *Taking revalidation forward* was that the GMC should set

out expectations for board-level engagement of revalidation.[15] Support for the value of patient feedback and models in collecting this information should be one of these expectations.

5.5.4 Evaluating the effectiveness of organisational systems

An audit of patients, doctors and administrators should be carried out to determine whether a healthcare organisation is delivering an effective system of patient feedback. The audit could be of a sample of individuals involved in the feedback process and undertaken annually should resources allow, and form part of a review of how well revalidation is working in a healthcare organisation.

5.6 Use of information and telecommunication technologies

The effective use of information and telecommunication technologies will be essential to an integrated and affordable approach to high-quality patient feedback. Information technology (IT) can assist with and greatly improve the process of collecting, collating, analysing and reporting of real-time and continuous feedback, compared with manual and paper-based processes using questionnaires. In addition, the use of IT can help to engage both doctors and patients, through making patient feedback in healthcare normal, routine and easy.

5.6.1 Patient feedback through IT and non-IT routes

Project participants highlighted that some patients lack IT skills or access, or are reluctant to provide feedback via an electronic device. Taking account of these patients and allowing them to feedback via non-IT routes must still be available. Particular thought needs to be given to the 10% or so of households for whom, according to recent data from the Office for National Statistics (ONS),[47] lack of internet access or use may be an obstacle.

Many of those taking part in this project felt that providing feedback using hardware devices and via online software, apps and platforms is the way forward for PFFAR. This is not surprising given the widespread use of the internet in the UK. Data from the ONS show that 80% of adults use the internet every day, and 88% every week, in the UK in 2017.[47] A recent report by the Nuffield Trust found that 75% of the UK population go online for health information and 50% use the internet for self-diagnosis.[48] The public, in general, is familiar with using IT to access and provide information.

5.6.2 Harnessing IT for patient feedback

One of the recommendations of *Taking revalidation forward* was to consider how technology could be harnessed in the patient feedback process.[15] This project examined how IT hardware and software and telecommunication devices are already used or could be applied at the different stages of the process. Project participants drew on their real-life experiences of how technology was already used to collect and process feedback, whether as patients in a healthcare environment or as consumers in other settings.

In applying technology, organisations will need to take account of the following process stages:

- prompting and encouraging patients to give feedback
- giving and collecting patient feedback
- managing the collection, collation and storage of feedback

- analysing, reporting and presenting quantitative and qualitative feedback
- notifying patients of the use of their feedback.

5.6.3 Prompting and encouraging patients to give feedback

Emails and mobile phone (SMS) text messages can be sent by healthcare organisations to prompt and remind patients to give feedback. Patients can either respond directly to the email or text with their feedback, or alternatively click onto a link to access an online questionnaire or form. The process of sending emails and text messages will need to be automated, ie all or a proportionate sample of patients are automatically sent a request for feedback after their consultation with a doctor and/or at the end of the care pathway or journey. For this to happen there need to be links with an organisation's electronic patient record system, human resource databases of doctors employed, and information systems recording professional activities of doctors. A recent report by the AoMRC on information and digital technologies in the NHS envisages that by 2020 all personal health records will generate automatic prompts in seeking patient feedback.[49] These links could be enhanced by the use, for example, of quick response (QR) codes or other machine-readable optical labels on the name badges worn by doctors.

5.6.4 Hardware devices – giving and collecting of patient feedback

The use of fixed-point computer terminals (including those in kiosks) and mobile handheld devices (tablets and smartphones) were identified during the project as ways for patients to give feedback. These carry resource and practicality implications that healthcare organisations will need to take into account, in deciding how they are going to collect patient feedback electronically. These implications include:

- Financial: providing fixed-point and/or mobile devices may incur purchase or leasing, set-up, maintenance and technical-support costs. GPs attending the workshops highlighted that they would have to pay for any hardware themselves (and any service provider used to collate and analyse the feedback collected). Healthcare organisations will need to make cost-benefit judgements whether, and to what extent, they invest in this area. If, for example, a GP practice or list size is small, other ways of getting feedback (such as paper-based questionnaires or one-to-one interviews) may be more attractive, or working with other GPs as part of a consortium in negotiating for reduced IT costs from suppliers.[28] At the same time, personal ownership of computers, smartphones and telephones in the population is extensive, and many people would find it acceptable to provide feedback using their own devices.
- Staffing: some patients will require direction or assistance in providing feedback using fixed-point devices. Kiosks – containing public access computers, some allowing for audiovisual information to be given or recorded – waiting for opportunistic use are unlikely to command the attention of a large number of patients. Staff may need to be able to direct patients to these kiosks and provide help when required.[50] This might be a role for reception or administrative staff, and/or patient feedback champions and volunteers (see Section 5.4). Some patients already require this help if they have difficulties when using the self-registration terminals now found in many GP surgeries and outpatient areas of hospitals.
- IT infrastructure: organisations will need IT support, cabling, access to secure servers and Wi-Fi to adequately support the collection of electronic patient feedback.
- Security: support staff must be available to hand out and ensure the return of mobile handheld devices. Other security concerns include storage and tracking of these devices.
- Location: the appropriate physical siting of kiosks in relation to where patients are in a hospital, or

movement through the premises, can positively influence the usage rates for these devices.[50–52] Privacy could also be an important factor in encouraging use especially when patients want to enter sensitive information.[50,53] Organisations may need to pay attention to their physical space if kiosks are to be installed, to maximise their usage and at the same time ensure privacy for users.

5.6.5 Software

Project participants highlighted how software can be applied in enhancing current patient feedback processes and also developing new ways to collect more useful qualitative feedback and insights about a doctor.

- Electronic versions of questionnaires: readily available software packages allow for the conversion of paper-based questionnaires into electronic ones. An example of this already happening can be found in the RCoA revalidation patient feedback guidance[54] (see Appendix E). The questionnaires could be delivered electronically, or via an online link, or through a specially developed app. Smartphone apps, with questions embedded, have been developed for use at Sheffield Teaching Hospitals NHS Foundation Trust[55] and University Hospital Bristol NHS Foundation Trust[56] to collect staff feedback, but the same principle could be applied to collecting feedback from patients.

  Responses via electronic questionnaires can be directly, accurately and independently collated in real-time onto a server. With paper-based questionnaires the responses made by patients: a) could possibly get misplaced as the forms are manually returned, and b) will need to be manually entered onto a computer by an administrator or the doctor him or herself, and therefore subject to the risk of error (possibly deliberate). Technology will help to enable the distribution of questionnaires to patients and bypass the doctor for whom feedback is being sought. In addition it can help prevent inappropriate behaviour, for instance if a doctor decides to complete his or her own patient feedback forms or deliberately enters information that has not been supplied by the patient.
- Enhancing the usability of questionnaires: well-designed interfaces to enhance usability and user-friendliness of questionnaires (and indeed other ways to capture electronic feedback) should encourage patients to respond. Software can be used to present the content of questionnaires so that they are user-friendly, simple and quick to use. Individual questions can be presented on separate screens, which some patients may find less daunting compared with seeing the questions all at once. Graphics can be used in several ways, for example to symbolise and make clear the intention of a question, or make them appear less formal if aimed at children (eg using 'smiley-faces'). Talking Mats™ communication picture symbols (see Section 5.3.6 above) can be digitalised and used as the basis for constructing questionnaires hosted on mobile tablet devices for use by patients with communication and cognitive impairments.[44] Speech-to-text and voice recognition software can be used instead of written text to enable participation by patients with certain visual impairments.
- Recall of doctors: One of the problems identified during the workshops is that when patients are asked to provide feedback they sometimes fail to recall or identify which doctor they saw in a consultation or during an assessment on a ward, or in areas where contacts are very brief such as in accident and emergency departments. If the right linkages are made, the questionnaire could be embedded with an electronic image of the doctor to help patients to recognise the relevant doctor.
- Personalisation of questionnaires: software enables questionnaires to be adapted and individualised around the patient or doctor. For example, patients with a visual impairment could be allowed to generate a large type font version of an electronic questionnaire or even spoken questions and voice recognition answers. The presentation of non-English language version of a questionnaire could also

occur in the same way. The content of questionnaires could be modified to reflect specialty-specific patient interactions. It is possible to envisage an online bank of generic and specialty-based questions, and pull through only those questions relevant to clinical context to be selected by the patient.

- Providing personal narratives: online platforms already exist dedicated to allowing patients in the UK to provide real-time detailed personal narratives (or stories) of their experiences with doctors and health services. Several examples were discussed during the workshops, including iWantGreatCare[57] (which focuses on individual healthcare professionals including doctors) and Care Opinion[58] (focusing on health services). Fig 7 provides an example of such an online platform in which narratives submitted by patients about a doctor are in the public domain. Patients have always described their healthcare experiences qualitatively in narrative form with family and friends, and are now willing to share publicly online.[59] Online sharing of personal narratives about healthcare (and indeed other societal activities such as travel) is unlikely to stop. Online platforms as described cater for and may encourage this trend and provide doctors and organisations with a continuous flow of patient feedback in narrative form. The technology used by these online platforms will no doubt be further improved and it is possible to envisage the use of speech recognition software to make it easier for patients to record their feedback. This could potentially be useful for a doctor's reflective learning and appraisal. Discussion about qualitative patient feedback can be found in Section 5.2.

  Some ROs, responding to our survey, were concerned that feedback about doctors provided via online platforms could be falsified, manipulated, misleading or based on supposition. Online platforms in the public domain, which protect the identity of those submitting information, are open to abuse. To manage these concerns, online platforms such as iWantGreatCare have implemented automated and manual processes of moderating feedback submitted on doctors (see Appendix F).

5.6.6 Managing the collection, collation and storage of feedback

Organisations implementing real-time and continuous approaches to the feedback process will need information management systems for collecting, collating and storing information from patients. These will need to ensure that a patient is not overburdened with requests for feedback about doctors and health services, or being repeatedly asked for feedback on the same doctor. It is possible that feedback could be from different sources, for example a structured electronic questionnaire on the doctor, and a patient satisfaction survey and personal narratives from an online platform, and therefore consideration must be given to the interoperability of different systems.

5.6.7 Security and confidentiality of information

When feedback is collected it will need to be stored in a secure server, subject to IT governance policies on the handling of confidential data, and attributed to an individual doctor. For some workshop participants security and confidentiality of information were real concerns if websites or social media platforms were being used. Responsible officers and healthcare organisations will need to ensure that security and confidentiality issues are addressed.

5.6.8 Analysing, reporting and presenting quantitative feedback

The current patient feedback questionnaires used in revalidation mainly collect semi-quantitative information through patients rating the doctor's professional skills and attributes on a fixed scale (eg 1 to 6,

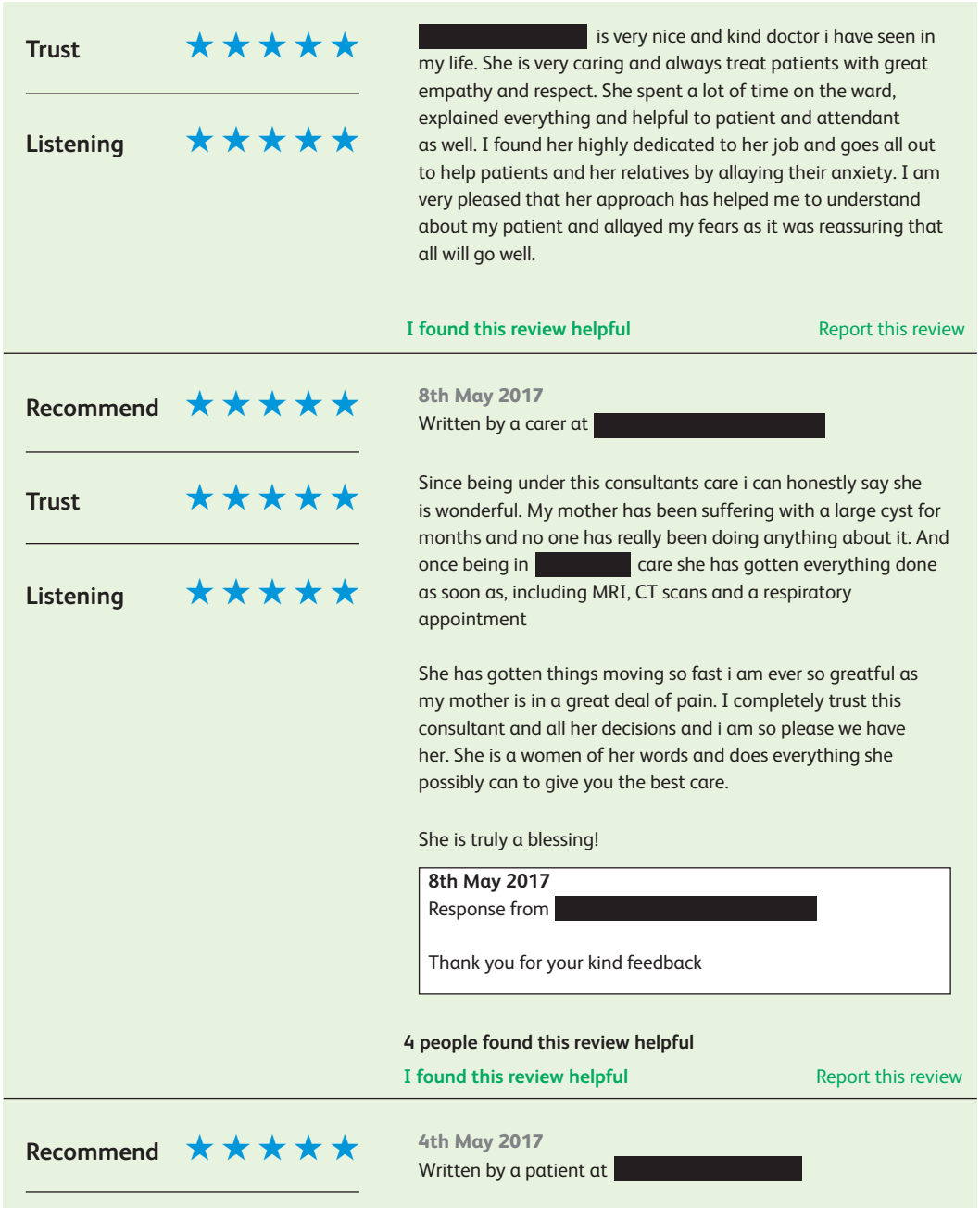

Fig 7. Example of an online patient feedback platform

representing very poor to very good). As the ratings are numerical, software can be used to easily collate and summarise this information (the mean score is often used) into a graphical results report issued to the doctor. Some providers of patient feedback questionnaire services benchmark the results in the report to the results of all other, or a particular (usually specialty) group of, doctors using the same questionnaire. The report – containing the results and benchmarking information – is then used as the basis for reflection and appraisal.

The same software could be used to summarise and present the results of quantitative patient feedback and calculate benchmarks at any point in time. This will allow doctors to reflect on their results on a regular (although not necessary an ongoing) basis if patient feedback is to be collected continuously over a period of time, such as 6 or 12 monthly. Some hospital doctors could have feedback from 40 or more patients per week and it would be more practical to review a collation of this information at regular intervals rather than on an ongoing basis. Regular review of feedback collected is also useful for team-based quality improvement or audit activities.

5.6.9 Analysing, reporting and presenting qualitative feedback

Current patient feedback questionnaires collect a limited amount of free-text (qualitative) comments. The total amount of free-text feedback is limited by the number of completed responses required – 34 in the case of the GMC questionnaire – and the space given in questionnaire forms for free-text, usually around two to five lines of handwritten text. Analysing and interpreting this amount of information only once every 5 years is very manageable.

If a continuous approach is applied to the patient feedback process, which encourages more free-text comments and personal narratives from patients, the process of directly reviewing large amounts of text would potentially be difficult to manage. This problem was considered in the IT-themed workshop. Helpfully, software is already starting to be used that allows computer-mediated analysis of large amounts of qualitative information.

The basis of this software is human-initiated algorithms, which in turn are based on linguistics, statistics and machine learning protocols. The software enables:

- the detection and classification of different sentiments (attitude, feeling, emotion, etc) expressed by patients, and whether the expression is negative or positive
- the identification of common themes across a large body of text
- mapping of text to issues deemed important to patients and doctors, and embedded in the algorithm.

This software is already being applied in the health service setting. The University of Manchester is involved in a research initiative to develop automated text-mining and analytic techniques for software for use on personal narratives collected from patients with long-term musculoskeletal and mental health conditions.[60] The software is part of a toolkit, which also includes a component to summarise and visualise sentiments, themes and issues in graphical form. Infographics are also used by Care Opinion to present the results of analysis undertaken through the use of similar software on personal narratives from patients on their experiences of health services (Fig 8).

5.6.10 Notifying patients about the use of their feedback

Information technology can help to inform patients that their feedback is being used and how. This completes a feedback loop, which is seen as important in motivating patients to provide information on their doctor and healthcare services. One example found in the literature is the application of word-cloud generating software based on free-text comments received in a NHS paediatric setting, to generate weekly graphical representations of key themes for a hospital's online social media platform.[61]

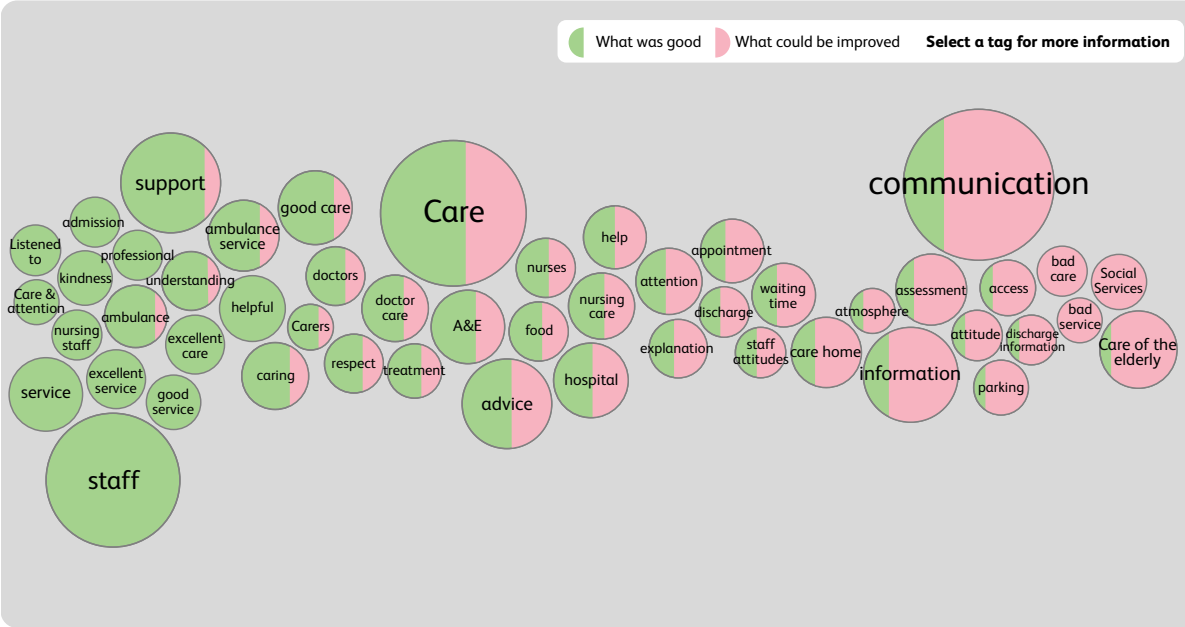

Fig 8. Interactive graphical representation of summarised patient feedback

5.7 Doctor–patient interactions, appraisal and revalidation

Revalidation requires doctors take part in annual appraisal. During the appraisal doctors discuss elements of their practice and performance and use supporting information to demonstrate that they are continuing to meet the requirements of *Good medical practice*.[1,12]

5.7.1 Patient feedback, appraisal and reflection on doctor–patient interactions

Project participants discussed the connections between patient feedback, appraisal and reflection on the doctors' interactions with patients, and how this links with revalidation. The following key themes emerged:

- Reflection on interactions with patients should form a routine part of doctors' appraisals.
- Much of the literature and guidance on patient feedback for revalidation has focused on practical process requirements, such as the number of questionnaire responses to collect, when and how often, and the need to produce a 5-yearly report. Compliance with these has become the main focus for doctors, adding to the tick-box culture around patient feedback.
- Instead, the focus should be on reflection on the attitudes, behaviours and skills that patients experience and identify in their interactions with individual doctors, and exploring ways for the doctor to improve their practice. Different types and formats of PFFAR support this.
- There is an important difference between orientating this part of appraisal towards reflection, learning and improvement, rather than a 'satisfactory score'. *Good medical practice* encourages doctors to establish collaborative partnerships with patients,[12] and appraisal, based on sound feedback, offers the opportunity to identify ways to do this.

5.7.2 Different types and formats of patient feedback are potentially useful for reflection and appraisal

Consideration was given to whether measures of organisational or team effectiveness, patient experience of clinical services (as opposed to individual doctors), patient-reported experience measures (PREMs) or patient-reported outcome measures (PROMs) should form part of patient feedback. Some participants felt that this might reduce the burden of collection. These are important measures and the resulting information should help doctors to develop their own and their team's practice. However, they lack specific reference to individual interactions with patients that only patients can provide and so were not seen as an alternative to the patient feedback described in this report.

5.7.3 Using appraisal to incorporate different types and formats of patient feedback

Revalidation currently requires patient feedback to be collected once every 5 years, meaning that a doctor is only routinely required to reflect on patient feedback with this frequency. However, if patient feedback is to influence a doctor's way of working with patients, this is clearly insufficient and too infrequent.

Annual appraisal should include discussion of how different patient feedback tools can be used to meet the reflective development needs of an individual doctor. Discussion should be around the use of patient questionnaires and other types and formats of feedback provided on a real-time and continuous basis. A list of suitable tools, possibly approved by the GMC or medical royal colleges, will be useful in planning how to collect patient feedback. We expect that these professional bodies will want to play an important part in developing such tools. The plan for feedback, like other plans within an appraisal discussion, is then embedded into the doctor's next annual information gathering processes and, if action is thought to be required, forms part of a personal development plan. This can be reviewed each year.

Real-time and continuous collection of different types and formats of patient feedback does not necessarily mean a continuous process of handling and reflection of this information by doctors, but doctors wanting to make changes might want to review feedback more often than once a year. For this to happen, the 'invisible background' process of collection, analysis and reporting needs to be cumulative and continuous so that the doctor can break into it for information when needed. Computer software programmes offer the possibility to help with this process and are discussed earlier in this report.

5.7.4 Linking patient feedback at appraisal to revalidation

In the current revalidation-focused structure, the need for patient feedback is to meet the summative (judgemental) requirements of revalidation, but is much less useful for the formative (developmental) appraisal process. This is not ideal, since the summative aspect is associated with results, assessment and, from a doctor perspective, is a 'high-stakes' process. Our workshop participants told us that this is unhelpful to the way some doctors engage with PFFAR. For many, the perception persists that patient feedback is part of a pass or fail process linked to performance.

The view that emerged from the workshops and discussions was that the summative judgement in appraisal should be based on whether the doctor has adequately taken part in the patient feedback process, reflected on this information and developed a plan to address any concerns. The summative judgement should not be based on the results from patient feedback questionnaires or other forms of patient feedback *per se*.

5.7.5 Reflection on the quality of interactions with patients should be a key element in appraisal every year with a focus on professional development

Most of those taking part in this project, both doctors and patients, strongly endorsed the main purpose of patient feedback as being for a doctor's professional development. One patient representative remarked: 'It is about capturing the moment when you do not want to complain but there is something the doctor should know about him or herself and do something about.'

One participant suggested that part of the annual appraisal should routinely be dedicated to reviewing patient feedback. Questions used during the discussion to facilitate reflection could include:

- How was the patient feedback process for you?
- What have you learnt?
- Has it altered your practice?
- Have there been any problems?
- How can we improve the feedback process?

The GMC also recognises the formative value of patient feedback in providing doctors with insight into what they do well and where they can improve the skills and attributes that foster good doctor–patient interactions.[62] Realising the formative potential of patient feedback in the context of appraisal will involve:

- considering and reflecting on patient feedback and interactions a doctor has with patients prior to appraisal
- using tools such as the HEE *Person-centred approaches in healthcare framework* to aid reflection[63]
- thoughtful discussion about PFFAR during appraisal, so that it helps to improve practice where there is opportunity
- appraisers and appraisees with the training and skills to make use of PFFAR.

5.7.6 Trained and skilled appraisers

Appraisers require training in order to acquire the necessary skills to be able to deliver excellent and quality-assured appraisals.[64] Among ROs and appraisal-leads participating in this project there were concerns that not all appraisers have the full range of skills, sensitivities and/or insights necessary for this role. Some doctors can receive persistent, and/or have the tendency to focus on, negative patient feedback. Managing these situations in appraisal can be demanding for appraisers. Some appraisers will need to undertake additional training.

The necessary appraiser skill set for patient feedback was identified during the project and some of the elements will require psychological insights that appraisers may need to develop in order to:

- be a strong advocate of patient feedback as a resource for professional development
- facilitate a reflective discussion on patient feedback collected and what it might mean for the appraisee
- help the doctor to identify any appropriate changes
- help the doctor set objectives for the personal development plan where needed

- handle any negative feedback in the appraisal in a sensitive and constructive manner, and follow up as needed
- be alert to any unintended consequences of the patient feedback process, including the possibility of a doctor changing behaviour inappropriately
- manage situations where the independence of the process has been compromised, for example through doctors influencing patient selection
- manage situations where a doctor demonstrates unacceptable behavioural standards and attitudes in relation to receiving and accepting the results of patient feedback, such as unwillingness to accept that there is a need for change where this exists.

5.7.7 Benchmarking

The value of benchmarking against other doctors is a matter of debate among those participating in the project. Systems that use a quartile and median approach to place a doctor in relation to his or her colleagues will mean that 50% of doctors will be below the average, even though most are performing at an acceptable level, including those in the lower quartile. Being perceived as being below average may be demotivating for doctors, and affect their professional work as well as their engagement with the patient feedback process, professional development planning, appraisal and revalidation. Some project participants saw value in benchmarking, although in some cases there were calls for adjustments in how the process is done. The following comments by ROs illustrate these views:

> 'Being able to put this data in context so, for example, using the Royal College of Psychiatrists 360-feedback means that the doctor's data is compared to a database of doctors who do similar work, eg forensic psychiatry or child and adolescent psychiatry.'
>
> 'Recalibrate GMC benchmarking data in real-life and for subspecialties, eg it is impossible to score highly as an inpatient consultant psychiatrist where the sectioning of patients sets up an adversarial dynamic.'
>
> 'The current system makes collecting benchmarked patient feedback from non-English speaking or illiterate patients difficult.'

As alternatives or in addition to benchmarking against other doctors, those participating in the project made the following suggestions to enhance the formative potential of the patient feedback process for doctors:

- Benchmarking over time – report current against previous patient feedback scores for a doctor to see if there has been a decline or improvement.
- Benchmarking against self-ratings – to see if there is a mismatch between own and patients' perception of the professional skills and attributes of a doctor.
- Benchmarking against a pre-defined standard or standards – with indicators stating whether the doctor's patient feedback scores have reached the standard, eg acceptable, acceptable but room for improvement etc.

6 Implementation and piloting of improvement options

This report reflects the consensus views of all those who took part in the patient feedback for revalidation project. This includes patients, carer and patient representative groups, doctors, those responsible for delivering revalidation, professional representative bodies and healthcare provider organisations. We have had significant support from the GMC. It is recognised that in order to obtain high-quality patient feedback about doctors a radical rethink is required, around the purpose and value of this feedback, and the content and systems for it to be effective. This should not be seen in isolation but should be as part of a wider strategy across health and social care to involve patients in a more collaborative way in their care at every level.

6.1 Cultural shift in patient feedback

The solutions that have been proposed and presented in this report will require a cultural shift both in the value attached to patient feedback and the responsiveness to it by doctors and wider health and social care providers. In other words, patient feedback in general will need to become 'everyone's business'.

6.2 Developing the infrastructure for patient feedback

It is clear that there will need to be significant work around developing the infrastructure – including the tools, processes and potentially training – for patient feedback. Since there is also a need for this infrastructure to be developed to support changes taking place elsewhere in health and social care around working in partnership with patients, valuing and learning from their experience, co-developing services and introducing revalidation for other health professional groups, a robust set of processes will be required for all of these. This means that there is an opportunity for patient feedback specifically for medical revalidation to be a 'laboratory' to support these changes and to be integrated into them.

6.3 Implementing the proposed solutions – piloting and testing

Over the next 5-year revalidation cycle, work will need to be undertaken that will both pilot and test the proposed solutions to improving patient feedback for medical revalidation. This should also contribute to the coherent and coordinated strategy for patient feedback in relation to health and social care provider organisations, services, and specific professional groups (doctors, nurses, pharmacists). Flexibility and interoperability will need to be at the heart of this work, based on a clear set of principles as outlined in this report – namely that feedback should be continuous, real-time, valid and used for individual clinical, service, and organisational improvement. A programme of implementation of feedback for medical professional development offers the chance to test many of the elements of what is needed for this wider strategy.

The piloting work may seem daunting, but as the examples in the report illustrate, most, if not all, of the elements required, have been developed piecemeal in different places already. What is lacking is the organisational and IT infrastructure to hold all of these elements together in any one place. This suggests that the proposed approach is not only desirable but achievable.

6.4 Cost of implementation

It has not been possible as a part of this project to be clear about the costs or cost-benefit balance of implementing the proposed solutions detailed in this report. This will only be possible through the piloting of solutions. A good deal of thought has been given to ways of delivering feedback that, while requiring considerable effort and some investment to set up, will be minimally burdensome and low cost once in place. Furthermore, taking the long-term view, since there is a need for high-quality, low-cost and low-burden ways of capturing and using patient feedback, initial investment in making sure that this is done really well, and in an integrated way, is likely to be the most cost-effective approach.

6.5 Recommendations for piloting the improvement options

One of the important next tasks will therefore be to identify healthcare organisations keen to take part in the development of patient feedback systems, at the same time as identifying funding streams for this key piece of work.

The proposed organisational model for patient feedback (see Section 5.5) identifies the key elements that will need to be developed or refined for feedback , tested in real-life clinical settings and costed, with the learning from pilots then shared, adapted for both locality and clinical context and used to support wider roll out.

6.5.1 Specific recommendations in piloting the patient feedback solutions

- There is no immediate change in the requirement for feedback over the course of the next 5-year revalidation cycle while new approaches are developed and tested.
- Over the next 2 or 3 years, pilot work is done on all of the elements of the proposed organisational model at a limited number of pilot sites, to include costing and the assessment of impact for both professionals and their employing organisations.
- Pilot sites should be selected from a range of healthcare settings, including GP practices, acute trusts, community settings, private providers and locum agencies, and involve doctors with a range of roles to ensure the generalisability of findings.
- Over the next 2 years we recommend that the solutions developed are scaled up and embedded across healthcare providers.
- Priority will need to be given to developing the organisational infrastructure for patient feedback. This should include the processes that a GP practice, trust, health board, independent healthcare provider or specialty group will need in order to collect feedback about individual interactions between patients and doctors, which minimise burden and optimise engagement for both patients and doctors.
- Priority will also need to be given to developing the IT infrastructure to support patient feedback. This needs to test what is required for organisations to make giving feedback (both semi-quantitative and qualitative) easy for doctors and patients, through automation of collation, analysis and reporting, use of unique identifiers and existing patient administration systems to link patients and doctors in specific contacts, and development of bespoke feedback tools for different clinical contexts where needed.
- Clear criteria will be needed to measure success in participating pilot sites. This should be linked to the quality of feedback, the ability and obstacles to collecting continuous and real-time feedback, the opportunity and burden for patients and doctors, and the extent to which this supports professional development of doctors and influences the quality of care.

- We suggest that pilot sites should be recruited by open invitation to become part of a collaborative to develop and test solutions. Priority should be given to those that have already developed elements of the feedback model successfully.

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Appendix A: Project workshops – sessions and themes

Workshop	Workshop sessions or themes covered
RCP workshop 1 *3 May 2017*	Improving the use of patient feedback questionnaires Non-questionnaire methods of patient feedback Using patient feedback within appraisals
RCP workshop 2 *31 May 2017*	Mixed methods for obtaining patient feedback Role of patients in supporting feedback methods Overcoming cultural challenges to patient feedback
RCP workshop 3 *28 June 2017*	Engaging seldom-heard groups of patients Supporting doctors with limited or atypical patient contact Motivating patients to provide feedback Motivating doctors to collect, reflect on and use patient feedback
RCPCH workshop *26 July 2017*	What is revalidation? Why give feedback on doctors? How do we want to give feedback? What do we want to happen after we have shared our feedback?
RCP workshop 4 *27 July 2017*	IT solutions for collecting patient feedback Using IT to engage patients and doctors Collating, analysing and reporting patient feedback using IT
RCGP workshop *31 July 2017*	Improving the patient voice in appraisal and revalidation Role of patients and carers in building GP resilience New ways of collecting patient feedback Increasing patient involvement and engaging hard-to-reach groups Expectations of the patient feedback process

Appendix B: Inclusive approaches to patient feedback – Solent NHS Trust

Dr Clare Mander, clinical lead for accessible information, Solent NHS Trust

Solent NHS Trust specialises in providing high-quality community and mental health services. Many of our services support patients with a range of communication and information needs. With the right support, many more patients with these needs are willing and able to give feedback on their doctor. In 2014, we conducted a project aimed at piloting and evaluating inclusive approaches to facilitating patient feedback within two of our services – Older Persons Mental Health and Learning Disabilities. Initially, insights were gained from the two patient groups. The importance of patients feeling confident and safe to give feedback was highlighted, as well as the need for communication support from a familiar staff member.

The new accessible versions of the questionnaire needed to map to the standardised GMC questionnaire for revalidation purposes. Therefore the standardised questionnaire was used as a template to develop two additional levels of feedback as described below:

Talking Mats™

Talking Mats™ provide individuals who have communication and cognitive impairments with a clear framework within which to structure their thoughts and express their ideas. The nine core performance evaluation items from the standardised GMC questionnaire were used as the basis for the Talking Mats, ensuring that the key element of the standard questionnaire could still be mapped to a centralised system. Complex language and concepts were broken down into their simplest components to aid comprehension, eg 'explaining your condition and treatment' became 'giving easy information'.

Easy Read questionnaire

Sections were separated and visual information was added alongside the text. Symbols from the Widgit symbol software (Widgit, 2002–2012 - www.widgit.com) were used to align with the trust-wide easy read literature. The five-point response scale was reduced to three options 'very good', 'ok' and 'poor'. Also, some of the words within the questions were paraphrased to use easier language, eg 'polite' was replaced with 'friendly', and 'honest' was replaced with 'tells the truth'.

In addition to the development of the resources described above, project feedback champions were trained to facilitate and deliver the accessible feedback resources and provide communication support where needed. Overall, the delivery of the accessible resources was improved by the training. There were a number of practical challenges encountered when setting up and carrying out the feedback sessions. There was some variability in the feedback champions' ability to judge (based on available information within the medical notes) whether participants were appropriate to be involved and what level of feedback the patient needed to use (Easy Read versus Talking Mats™).

Since conducting this pilot in 2014 there have been a number of significant changes. The provision of accessible information and communication support now sits within a legal framework as outlined in the

'Accessible Information Standard' published by NHS England. Since the publication of the standard in 2015 there have been system-wide changes to practice to ensure that accessible information needs are identified and supported through the patient journey. As a result, some services now have accessible information champions with a broader set of skills and competencies, surpassing the training provided to the feedback champions. An increase in accessible information screening is starting to provide clarity about individuals' communication and information needs as well as the prevalence of needs across our services. As a result, it should now be easier to identify which level of feedback is most appropriate for individual patients.

The trust now uses an external service provider to capture multi-source feedback, and we are working with the company to support data collected from the accessible versions of the questionnaire. In addition, we are also hoping to work with the service provider to develop a function that indicates the ratio of patient feedback that has come from the standard questionnaire versus the accessible versions, thus allowing targets to be set between the doctor and their appraiser. For example, if you are a doctor who specialises in adult learning disability, 90% of your patient feedback would need to be in an accessible version given the prevalence of communication and information needs within this population.

Appendix C: Patient feedback champions – The Leeds Teaching Hospitals NHS Trust

Dr Matthew Law (consultant anaesthetist) and Ms Vicki Crane and Ms Debbie Tinsdale (Patient Feedback Team), The Leeds Teaching Hospitals NHS Trust

Funding

The anaesthetic department in the trust has created funding allowing for the employment of two patient feedback champions, each working on a less-than-full-time basis (18.75 hours per week). Consultant anaesthetists are each asked to work an extra 5 hours per year. This reduces locum spend and the money saved is used to employ the feedback champions. In return, the feedback champions facilitate the process of obtaining high-quality patient feedback on a real-time basis for the consultants in the department.

Attributes and qualities of patient feedback champions

The following attributes and qualities were listed in the job description for these posts:

- Knowledge of the type of work involved: The work is a combination of patient contact and office based work (compiling reports etc). Not everyone who works in an office environment would be comfortable visiting patients in clinical areas, especially places such as theatre pre-wait areas or an intensive care unit. Equally, people who may be comfortable working in a clinical environment may not be comfortable with the level of detail and type of work that is involved in analysing data and producing the reports.
- Communication and interpersonal skills: The key to getting good quality, in-depth feedback is developing a good rapport with the patient and often this is in quite a short time frame, especially within anaesthetics where patients may be called to go to theatre at any time. The champion may also have to create an atmosphere where the patient feels confident to give their honest feedback rather feeling under pressure to 'say the right thing' or give the answer that they think you want to hear.
- Knowledge of the specialty: This might be more specific to anaesthetics but patients often have questions about their experience, which they sometimes ask, because either they feel embarrassed to ask another member of staff or perhaps they don't want to bother them. Knowledge of the process from the patient's perspective is essential so the champion can answer their questions and provide reassurance where necessary, or point them in the right direction for further information. Not everyone has this knowledge or experience to begin with (depending on their own medical history/experiences), so training and development play a key part in this.
- The ability to build relationships quickly: The champions visit a variety of areas throughout the trust's hospital sites. Ward and clinic staff are sometimes concerned that the champion is there to 'check up' on them, so building rapport and developing good working relationships with staff in different areas is vital, especially as staff can be very helpful in locating patients.
- IT skills and ability to generate reports: Some degree of IT skills is useful at various stages in the process.

- Ability to identify trends and/or potential problems and act on it: The need to be able to identify where a negative pattern may be emerging or identify other potential problems and to be confident to do something about it, ie escalate it via the appropriate channels or procedures.

Collecting and collating feedback

The patient feedback champions are equipped with tablet computers containing an electronic (SurveyMonkey) version of the patient questionnaire developed by the Royal College of Anaesthetists. Feedback is then collected from patients after their pre-operative assessment by the consultant and before they go into theatre for surgery. A photo of the consultant is stored on the tablet and is shown to the patient to ensure that they know who they are giving feedback on.

Once feedback has been collected from 15 patients the champion produces an interim report that is sent to the consultant and his or her appraiser. The results are benchmarked to the results of others in the department. A final report is produced when 30 patients have provided their feedback.

Advantages for the department

The employment of dedicated patient feedback champions has certain advantages that include:

- allowing for a real-time and continuous process of collecting patient feedback. This in turns allows for any possible concerns about a doctor to be identified and acted upon at an early stage
- improving the patient feedback response rate. Nearly all patients who are approached by the feedback champions agree to take part in giving their feedback
- enabling a greater depth of patient feedback to be collected through the champions elaborating on the information being provided and recording qualitative personal narratives
- doing away with the administrative burden faced by doctor in collecting patient feedback
- ensuring that the feedback process is independent of the doctor and in turn minimising any potential bias in the collection of this information
- empowering patients and the feeling of being listened to when being asked for feedback by someone in person. The perception of being listened to, feeling valued and expecting any concerns to be acted upon potentially reduced the risk for formal complaints being made against the hospital.

Appendix D: Patient experience team – Northumbria Healthcare NHS Foundation Trust

Ms Annie Laverty (director of Patient Experience Service), Ms Janice Hutchinson (lead for service improvement) and Mr Paul Drummond (data analyst)

The Patient Experience Team has developed an organisational culture and system for patient feedback, which is supported at trust board level, as part of a broad strategy for quality improvement. The team is led by the director of quality and includes a lead for service improvement, data analyst and patient experience coordinators.

A model of collecting feedback from patients in both inpatient and outpatient areas is embedded into the organisation. Collecting patient feedback has become established as part of the normal practice and daily routine of the trust. Consultants do not have the option to opt out of the process of having feedback collected on them. Patient experience feedback is collected, which includes information on team and organisational delivery of services. Paper questionnaires are distributed to patients by a contractor approved by the NHS National Patient Survey Programme managed by the Care Quality Commission.

The results of patient feedback activity are also made transparent and available in public areas on posters and the trust's website. Free-text comments received from patients are displayed on public notice boards. The patient experience feedback model is very much supported and valued by staff and patients, and there is a real culture within the trust to learn from this information in improving the quality of healthcare being provided.

All doctors in the trust receive individualised feedback from the questionnaires to support their appraisal, personal development and revalidation. A senior medical staff member reported that, when looking at the feedback, he was surprised at some of the scores and comments that were provided. On the basis of this he sought out colleagues with expertise in consultation skills for advice, changed his practice and then used a more detailed feedback tool to assess the impact of this change. He felt this approach was both valuable to his patients and professionally rewarding.

Appendix E: Online version of the Royal College Of Anaesthetists' Patient Feedback Questionnaire

Case study extracted from: Patient and colleague feedback for anaesthetists: revalidation guidance series. London: Royal College of Anaesthetists, 2014

I have successfully obtained patient feedback for patients seen in the pre-assessment clinic of a small district general hospital. We used an electronic version of the RCoA patient feedback questionnaire created using secure online questionnaire and survey software. The questionnaires were distributed to 35 consecutive patients by the pre-assessment clinic administration staff. Of these patients, 15 completed the questionnaire in the pre-assessment clinic immediately afterwards, 10 patients were given the web address of the questionnaire and asked to complete it at home and 10 patients completed paper versions of the questionnaire which were then uploaded to the online site. Patients were also surveyed about the acceptability of the use of electronic media to complete the form.

There was a very low return rate of only 40% from patients who were asked to complete the questionnaire at home. Administration staff had to undertake significantly more work to upload the paper responses onto the online survey software. 89% of patients who completed the electronic format of the questionnaire found it to be acceptable and none found it unacceptable. 74% of patients would not have preferred a 'paper format' of the questionnaire, or were neutral, and only 26% would have preferred a paper format. 60% of the patients who completed the paper version included obviously incorrect information or did not complete 'compulsory' fields. This did not happen in any of the electronically completed questionnaires due to the electronic processes requiring an answer before progressing to the next page.

At the end of the survey period a report is generated by the online survey software and sent to the anaesthetist and their appraiser for inclusion in their appraisal documentation. This report provides an easily interpretable summary for each of the questions, along with anonymous open-ended responses.

I believe that electronic completion of the questionnaires is easier for patients, for staff (fewer forms to hand out and nobody is required to enter the results into a database and then analyse them) and also for the anaesthetists (who get a report at the end together with the comments made by the patients). It should make the system less open to abuse as data is collected securely online reducing the potential and opportunity to tamper with the results. Anonymity is well protected. Data collection is more complete with fewer errors and incomplete sections. There are also environmental benefits of not using three sheets of paper for each questionnaire.

Appendix F: iWantGreatCare Review Moderation System

Ms Jenny Heelis, iWantGreatCare

Automated moderation

All reviews are subjected to an automated scoring system. The automated system examines every review at the point in time they are confirmed (ie when the reviewer clicks on a link sent to them in an email), or uploaded (in the case of offline reviews). The automated system examines all aspects of the review including:

- who is being reviewed and the details of the reviewer
- where the review was added from
- the scores and free-text comments provided.

Each of these elements is examined both in isolation and also together by a series of components. Each component scores the review and then a composite score is generated for the review by summing together the component scores. The system then uses a straightforward cut-off above which reviews are placed live on the iWantGreatCare website, and below which the review is placed into the manual moderation queue.

Manual moderation – following automated moderation

When a review is determined to require further examination by the automated system it is placed into a queue of reviews to be looked at by a member of iWantGreatCare staff. The member of staff is presented with all the information the reviewer entered, including their email address and the computer from which the review was added. Using this information the reviewer determines whether to approve the review, in which case it will be placed live on our website, or reject it, in which case it will be deleted from our system.

Manual moderation requires the moderator to examine the review in order to determine its veracity, appropriateness of the information provided and its compliance with our terms of use. In particular (but not exclusively) the moderator will examine the review and attempt to determine whether the:

- review is timely (that it refers to an episode of care within the last 3 months)
- use of language is appropriate (no profanities, etc)
- review is not part of a campaign either for or against a doctor/hospital etc
- reviewer has not written anything defamatory
- reviewer is not, nor has been involved in making a complaint or taking any form of legal action against the entity being reviewed.

Following a user submitted report

Whenever a review is presented on the iWantGreatCare website a link is placed alongside the review which allows any member of the public to report the review to us for examination. The reporting process requires the user to enter their email address and then confirm their address by clicking on a link sent to them in an email. Once that link is clicked then the review is hidden from public view and the review is added to the queue for manual moderation. The actions available to the moderator and the criteria they use to determine the action are the same as those used described in the 'Following automated moderation' section.

Appendix G: List of contributors to the project

We would like to thank the many people and organisations who contributed to the patient feedback for revalidation project, through attending our workshops, inviting us to meetings, completing surveys, being interviewed, providing case studies and commenting on early drafts of this report. So many people have helped with this project that it is beyond us to thank everyone individually, but we do know that it would not have been possible without all of these contributions.

Groups directly consulted:

Academy of Medical Royal Colleges	Patient and Lay Committee
Academy of Medical Royal Colleges	Patient Feedback Working Group
Academy of Medical Royal Colleges	Revalidation and Professional Development Committee
General Medical Council	Revalidation Oversight Group for Work Stream 1 (Patient and Public Involvement)
NHS England South Region	Responsible Officer and Appraisal Lead Network
NHS England North Region	Responsible Officer and Appraisal Lead Network
Royal College of Physicians	College Officers Forum

Interviews and site visits:

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- Professor Stewart Mercer — Chair in Primary Care Research

Patient Experience Team, Northumbria Healthcare NHS Foundation Trust
- Ms Annie Laverty — Director of Patient Experience Service
- Ms Janice Hutchinson — Lead for Service Improvement
- Mr Paul Drummond — Data Analyst

Solent NHS Trust
- Dr Clare Mander — Clinical Lead for Accessible Information

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- Dr Matthew Law — Consultant Anaesthetist and Honorary Senior Lecturer
- Ms Vicki Crane — Patient Feedback Team

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This report is about the current challenges relating to the collection, analysis and use of patient feedback for medical revalidation. It is the result of a consultation undertaken throughout 2017 involving doctors, patient lay representatives, responsible officers, appraisal leads, medical royal colleges, providers of patient feedback tools and other key stakeholders.

The Royal College of Physicians was commissioned by the Academy of Medical Royal Colleges to produce this report. It will be of interest to doctors working across all medical specialties and sectors, patients, government and regulatory authorities and policymakers such as the UK departments of health and General Medical Council, and NHS and independent healthcare organisations.

Royal College of Physicians