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Academy of Medical Royal Colleges

Principles for creating digital patient feedback

A report from a Short Life Working Group

Overview

Patient[1] feedback (PF) is an integral part of Medical Appraisal and Revalidation. These principles will assist healthcare providers, digital providers and those using their services to understand the value of creating effective digital patient feedback (DPF) as part of appraisal and revalidation for doctors. Digital patient feedback can be integrated into annual appraisal cycles, and can include automated, real-time collection, collation and reporting. It is expected to reduce the burden and increase the narrative quality of patient feedback.

Desired outcomes of digital patient feedback

For patients: An opportunity to share their experience
For doctors: A unique insight into their interactions with patients, with a reduced burden of collection, collation and reporting
For professional development: Providing formative learning/development
For health teams and providers: Responding to patient experience
For medical education and training: Helping to inform training priorities
For revalidation: Providing assurance of reflective practice

This report does not address emerging opportunities or threats of AI technology, which merit separate exploration.

1. The term 'patient' is used to indicate an individual patient or carer(s) or parent(s).

Background

In 2017, following 5 years and a full cycle of Medical Revalidation, Sir Keith Pearson reported on the successes and shortcomings of its introduction on behalf of the General Medical Council (GMC).[2] Patient feedback (PF) was chief among the areas that needed serious attention. A review of this was commissioned from the Royal College of Physicians, and reported in 2020.[3]

The Royal College of Physicians found that PF approaches used at the time were seen as untimely, with insufficient numbers of patients over a 5-year cycle, and insufficiently rich in narrative content to be useful for professional development. Practical obstacles were identified in relation to collection, collation and reporting. For PF to become less burdensome, provide greater value for professional development, and help doctors to respond to the perspectives of patients in a way that will enhance their individual and collective experience, changes would be needed.

In the same year, the GMC adapted its requirements from a minimum small number of semi-structured questionnaires, with summative semi-quantitative analysis per 5-year cycle, to a wider range of feedback. This placed greater emphasis on formative self-refection on patients' experiences and perspectives across a doctor's scope of practice.[4,5] This should lead to much more useful conversations about professional development at annual appraisals. These changes have made it possible to explore options for more continuous, qualitative (narrative) feedback.

Several health providers across the four nations recognised the value of PF to their own organisations and made PF cycles a part of 'normal business', including feedback about individual doctors. However, this is not happening systematically across the UK health system. At the same time some commercial organisations started to provide similar PF opportunities usually via digital platforms, and usually with an emphasis on narrative (qualitative) feedback.

2. Sir Keith Pearson (2017) Taking revalidation forward: Improving the process of relicensing for doctors
3. Royal College of Physicians (2020) Improving patient feedback for doctors
4. GMC (2020) Revising Guidance on Patient Feedback for Revalidation
5. GMC (2020) Patient feedback (or feedback from those you provide medical services to)

Academy short life working group

In 2023 the Academy of Medical Royal Colleges convened a short life working group (SLWG) to explore the opportunities presented by digital patient feedback (DPF) for doctors and develop a set of principles. Patients, medical royal college and faculty representatives and clinicians were involved. The principles were then refined with digital providers.

The SWLG found that DPF offers an opportunity to provide near continuous semi-quantitative and qualitative feedback. Invitations to patients, collation of responses, analysis and reporting to doctors can be near to 'real-time', with reduced burden for both patients and doctors. In most situations DPF can provide solutions, despite PF being more complex than other types of feedback. However, there are significant challenges in some clinical settings and with some patient groups.

While DPF presents a huge opportunity to streamline and improve the quality of PF, it is clear that DPF cannot, and should not, be the sole method of feedback. For the time being a mixed approach is required that recognises issues of digital disadvantage, health literacy and health service inequities, and the limitations inherent in specific contexts of practice.

The SLWG noted that there is already widespread use of DPF. However, the majority of DPF is about experiences of a service or care pathway. While this is valuable and can form part of the feedback that helps doctors to develop, it is not sufficient for medical appraisal. Feedback is also needed about individual doctors. Therefore for DPF to be useful, the ability to link feedback to specific clinical interactions between a patient/carer and a doctor is necessary. It will also be necessary to send 'feedback invitations' to patients following medical encounters. These situations will require the patient and the doctor to be linked by a digital provider. Therefore, there are logistical, confidentiality, and information governance challenges that will need to be worked through and, critically, require system wide support (for example access to identifiers such as NHS numbers).

Digital providers say they can meet the principles of high-quality DPF for appraisal. There is enthusiasm from them to take this forward with motivations both commercial and altruistic, and an interest in collaborating with future pilots of DPF.

A summary of the SLWG findings is at Appendix 1.

10 principles for digital patient feedback

Ten principles for creating effective DPF were developed. The principles are not a service specification, but outline what should be considered when making effective and beneficial DPF. Having patients involved as co-creators should be 'the norm' when developing DPF.

1. The desired outcomes of DPF
2. Content of DPF and key domains for reporting
3. Process and scope of collection
4. Analysis
5. Reporting
6. Quality assurance and consistency
7. Usefulness for professional development
8. Ease of use and workload
9. Safety/confidentiality/information governance
10. Communication with patients and doctors

1. The desired outcomes of DPF

- For patients – to provide the opportunity to reflect their experience of interacting with a specific doctor to the doctor.
- For doctors – to provide the quantity and quality of feedback that stimulates reflective professional development about interactions with patients with minimal burden.
- For professional development – to provide this information at annual appraisal.
- For health teams and providers – to support quality improvement in health delivery.
- For medical education and training – to inform training needs and priorities.
- For revalidation – to provide assurance of reflective practice and improvement.

2. Content of DPF and key domains for reporting

- A mix of quantitative/qualitative formats (both scaling and narrative feedback).
- Should reflect the doctor's scope of practice in line with GMC guidance.
- Should, where possible, reflect domains where there is existing validation (e.g. CARE measure) and should cover Engagement, Empathy, Enablement, Expertise – and may approach these in novel ways.
- Should emphasise factors that doctors have direct influence over.

3. Process and scope of collection

- Pull – all patients should have the opportunity to provide feedback.
- Push – proactive invitation of patients should be possible (intentional and intelligent representative sampling).
- Feedback should occur continuously through the appraisal cycle.
- The burden of collection, analysis and reporting should be low for patients and doctors.

4. Analysis

- It should be possible to link feedback to an individual doctor, team or pathway.
- Analysis should provide automated/semi-automated reports.
- It should be possible to 'interrogate' or 'drill down' to specific feedback items for context and detail to support clinician learning without compromising patient confidentiality.

5. Reporting

- The format and quality of reporting should be sufficient to ensure that feedback is useful, objective and clearly presented, and that quantity and granularity is manageable.
- An independently generated report should be available for discussion at annual appraisal.
- Feedback should be accessible and able to be analysed/reported throughout the appraisal cycle to support short learning loops.
- It should be clear to patients not only how DPF will be used, but also, broadly, it's impact on care.

6. Quality assurance and consistency

- DPF should be mapped to existing validated feedback domains as in Principle 2.
- There should be clarity about how DPF reports should be interpreted and used.
- Narrative content should be reported in a consistent way (e.g. explored using natural language processing).

- Feedback should satisfy GMC requirements.[6]
- DPF should seek to improve exploration of trends for individuals and professional groups.

7. Usefulness for professional development

- DPF should be able to support professional development.
- Appraisers and appraisees will need to be able to interpret DPF reports.
- Co-development approaches can be used to evaluate this.

8. Ease of use and workload

- Workload should be reduced for patients, doctors and teams.
- Options should minimise factors contributing to digital disadvantage (platform, ease of reading, font and font size, complexity of navigation etc).
- Presentation of feedback should have built in adaptability for clinician use (presentation, numerical, graphical etc).

9. Safety/confidentiality/information governance

- NHS information standards should be met for patient confidentiality/anonymity.
- Systems of provision and training for appraisers should protect doctors from digital abuse.

10. Communication with patients and doctors

- Purpose of feedback/rationale.
- Collection of feedback.
- Who/what the feedback is about (individual clinician, team, pathway).
- Analysis and reporting.
- Use of feedback by doctors and providers.
- Impact of feedback on service provision at an individual/organisational level.
- How 'difficult' feedback will be managed within local appraisal and governance processes.

6. GMC (2024) Patient feedback (or feedback from those you provide medical services to)

Other areas to consider

Digital patient feedback has a number of strengths/opportunities and also acknowledged threats/weaknesses. The list below is not exhaustive.

Strengths and opportunities:

- DPF is already being widely gathered.
- Providers that undertake DPF generally have a genuine interest in benefit accrual for care.
- Digital literacy was enhanced for many during the COVID-19 pandemic.
- Digital capture of feedback may be a relatively inexpensive and quickly available source of feedback.
- Some doctors are already using this in their appraisal.
- It offers the opportunity for more nearly real-time and continuous feedback.
- It has the potential to reduce workload related to feedback for patients and doctors.

Threats and weaknesses:

- Low levels of professional awareness of what is already being collected digitally.
- Uncertainty about the use of what is currently being collected and whether this can be used for professional development.
- Lack of consistent guidance and information standards on collecting and using DPF.
- Lack of understanding of how people become aware of, and use, DPF opportunities.
- Lack of understanding of how best to use DPF for reflective learning/appraisal.
- Some groups are digitally disadvantaged and the impact of this on the value of feedback is in terms of whether views are missed/lost or not heard accurately.
- Some professional working contexts make collection of feedback, including DPF, difficult.
- DPF offers opportunities for equality and diversity but may pose challenges for inclusivity.

For more information on this work please contact the patient and professional policy manager.

Appendix 1:
Summary of conclusions from the Short Life Working Group

- Patient feedback is required by the GMC as part of medical appraisal and revalidation and most patients welcome it as an important part of the doctor/patient relationship.
- When used appropriately it supports professional development for doctors.
- DPF can contribute to professional development and is possible from a digital provider perspective.
- In some instances, DPF is already being collected, but it is patchy and inconsistent across the healthcare landscape. Information gathered is not always useful for appraisal and revalidation.
- DPF can streamline and enhance the quality and breadth of PF alongside other methods.
- DPF can be collected, analysed and made presentable to doctors for appraisal and personal development purposes alongside routine clinical working with little burden to doctors, in a near real-time and continuous way, and can support quality improvement.
- DPF could have a formative impact on doctors' learning and behaviours, highlighting and reinforcing good practice, and identifying areas for change and improvement.
- The introduction of DPF will benefit patients by making it easier for many to articulate their experience of a doctor – something patients identify as desirable in itself.
- Including DPF in the feedback process requires clear communication with the patients, carers, and doctors involved regarding the purpose, process, anticipated benefits, and reassurances that feedback will not be misused.
- Careful attention should be paid to confidentiality, information governance and protecting doctors from digital abuse. This challenge should not be underestimated.
- It will not be possible for DPF to be implemented in every clinical setting or for every patient group and attention still needs to be given to other means of collecting feedback.
- There is both interest and expertise that can be contributed by current digital providers.