RCR response to GMC consultation on changes to revalidation requirements for patient feedback

1. Organizational culture and needs to be explicitly addressed
   a. Organisations need to be mandated to deliver patient feedback - otherwise it will rely on the individual to undertake this. Employing organisations are aware of the need to collect feedback but the support to do so is very variable across the country with very different mechanisms employed. Employer support for the collection of a minimum quality feedback should be mandated.
   b. By increasing flexibility there is a potential for employers to shift the burden if supporting collection to individual doctors which needs to be avoided. There is a potential conflict between “collecting solicited feedback once in a revalidation cycle” and “collecting feedback in a way that is useful for patients”. The chances of seeing improvement in feedback related to changes made from previous feedback are less if collection methods are varied.
   c. In order to provide consistency, nationally developed tools/apps would be helpful. There should be specialty input to account for different types of patient interactions/encounters between specialties which might influence the feedback obtained. Patient input would help so that what matters to them is included and that may then encourage participation.
   d. Doctors already understand the high-level principles of feedback; it is the collation of evidence using current forms that is imperfect. Enabling positive as well as negative feedback is supportive of the individual at a time when the NHS is under significant pressure and negative feedback can impact negatively on performance and patient outcomes.
   e. Just as 360 feedback is facilitated it would be beneficial to have a mechanism to facilitate patient feedback. There should be a recognized national format for formal data collection of patient feedback to enable consistency. Perhaps the GMC could develop an app similar to the CPD app for doctors to record instances that can then be collated for annual appraisal.

2. Formal feedback structure requires improvement
   a. The formal feedback exercise provides structure but this needs to be embedded in departmental structures and not reliant on individual doctors asking for feedback as currently happens. Unlikely to be prioritized in busy departments/clinics unless it is part of normal departmental routines and continuously collected, collated and analysed.
   b. How would this differ from 360 feedback where individuals in departments other than your own may be requested for feedback? What needs to be elucidated is the difference between peer feedback (360 from other doctors which would include how they view your service when you interact which we all do) and feedback from “service users” which from this consultation means “members of the public” as a proxy for patients
   c. Giving structure but flexibility does not necessarily promote collection of feedback on the specific doctor rather than the service within which they work. Guidance on the sort of feedback that demonstrably improves outcomes would be useful.

3. This may be difficult for doctors that don’t always see patients, e.g. in the setting of Clinical Radiology, where patient encounters are often fleeting, relate to the imaging investigation being undertaken and it is not always possible to communicate the results directly to the patient. This is all that the patient is interested in and therefore may not rate these interactions in the same way as they would rate more traditional ‘consultations’.
   a. Free text is important but allowing more flexibility might skew the feedback to the service aspects e.g. waiting times and car parking and estates fabric, much of which is outside the control of the doctor.
   b. Negative feedback on areas outside an individual’s control may have negative impact on morale in an already stressed workforce “the feedback I get is about things I can’t change so how can I possibly demonstrate improvement?”
c. Drivers for providing feedback vary. Often motivated to provide feedback if the experience has not been so good. Questionnaire format limits feedback from some patients so alternative ways e.g. apps in the department that are quick and easy to complete may help. Needs to be emphasized that it is anonymous.

4. **Patients who share protected characteristics**
   
a. The principles should ensure that patients understand the purpose of their feedback, how it will be used and that it will not impact on their care.
   
b. When patients decline to see a doctor of the opposite sex but this is not possible because of staffing constraints, this can impact feedback through no fault of the doctor. Difficult to collect information on protected characteristics for some staff groups e.g. radiology.
   
c. Any situation which collects personal data and feedback is potentially open to the public feeling it may be used against them despite the explicitness of any information that this will not happen. This may paradoxically reduce the willingness to give feedback across the board. Some clinicians work disproportionately (and some almost exclusively) with one group of patients e.g. those who treat only prostate cancer treat men only so this would need to be a further pressure on appraisers to understand their appraisee has not “chosen” certain patient groups to solicit feedback from.