

# ○ Service User Feedback Tools

**AN EVIDENCE REVIEW AND DELPHI  
CONSULTATION FOR THE HEALTH  
PROFESSIONS COUNCIL**

DR ALISON CHISHOLM & HELEN SHELDON

PICKER INSTITUTE EUROPE

NOVEMBER 2011

# Picker Institute Europe

Picker Institute Europe is a not-for-profit organisation that makes patients' views count in healthcare. We:

- build and use evidence to champion the best possible patient-centred care
- work with patients, professionals and policy makers to strive continuously for the highest standards of patient experience.

© Picker Institute Europe 2011

Published by and available from:

Picker Institute Europe

Buxton Court

3 West Way

Oxford OX2 0JB

Tel: 01865 208100

Fax: 01865 208101

[info@pickereurope.ac.uk](mailto:info@pickereurope.ac.uk)

[www.pickereurope.org](http://www.pickereurope.org)

Registered charity no 1081688

Company limited by registered guarantee no 3908160

## CONTENTS

Executive summary	1
1 Literature review: approach	5
1.1 Policy context	5
1.2 Registrant characteristics	6
1.3 Service user characteristics	6
1.4 Service user assessment of 'non-technical' skills	7
1.5 Service user capacity to assess technical competence	8
1.6 Research questions	9
1.7 Review methodology	9
2 Literature review: findings	12
2.1 Instruments in use	12
2.2 Areas of professional practice covered	18
2.3 Implementation	18
2.4 Reliability and validity	20
2.5 Qualitative approaches to gathering feedback	24
2.6 Evidence for feasibility and effectiveness	25
3 Delphi consultation	33
3.1 Approach	33
3.2 Delphi findings	34
3.2.1 Delphi Round 1: incorporating service user feedback	34
3.2.2 Delphi Round 2: responses to statements	35
3.2.3 Delphi Round 3: achieving consensus	43
4 Conclusions and recommendations	47
4.1 Literature review	47
4.1.1 Formative and/or summative use	47
4.1.2 Design of instruments	48
4.1.3 Feasibility	49
4.1.4 Effectiveness	49
4.2 Delphi consultation	50
Appendix 1: literature review references	52
Appendix 2: literature review search terms	56
Appendix 3: literature review databases	57

Appendix 4: professional bodies and associations contacted	59
Appendix 5: four methodologies used by Davies et al (2009)	61
Appendix 6: Delphi Round 1 questions	63
Appendix 7: Delphi Round 2 evidence review question	64
Appendix 8: Delphi Round 2 questionnaire	65
Appendix 9: Delphi Round 2 responses	71
Appendix 10: verbatim responses to the 28 Round 2 Delphi statements	87
Appendix 11: Delphi consultation Round 3 questionnaire	108
Appendix 12: responses to the 10 Delphi Round 3 statements	111

---

# Executive summary

## Background and aims

On-going assessment is essential for health practitioners' life-long learning and the quality of the care they provide, as well as to demonstrate on-going professional competence in interpersonal and ethical spheres of practice to a public increasingly interested in evidence of professionalism. The case for the principle of obtaining service user feedback on health professionals' practice is strong, particularly for those professional groups who have direct contact with lay service users. Service-users are uniquely placed to assess many aspects of the practitioner-service-user interaction which have been demonstrated to be associated with satisfaction, engagement and clinical outcomes.

The HPC's registrants work within a wide range of settings and with a great diversity of service users. The HPC does not currently mandate the use of service user feedback as evidence of their professionalism or of the impact of CPD on their practice. This research aims to examine available evidence regarding the use and impact of service user feedback tools in healthcare, and explore the views of people within the professional bodies of those professions regulated by the HPC on the use of service user feedback with a view to informing decisions about its introduction to the practice, appraisal, CPD, regulation and/or revalidation of the HPC's registrants.

## Methods and approach

Two methods were employed:

1. A review of peer-reviewed and grey literature was carried out to identify instruments and systems developed to gather service user feedback for the professional groups regulated by the HPC. Professional associations were also approached for information they held about feedback instruments. The review identified existing tools, how they are used and evidence for their robustness and effectiveness. It covered standardised questionnaire instruments as well as more qualitative approaches, and paid special attention to "seldom heard" groups. It also drew on the more established literature on patient feedback instruments used to assess doctors, drawing lessons from this field where the state of the science is arguably more advanced.
2. A Delphi Consultation was carried out to identify areas of consensus on the use of service user feedback between individuals from organisations representing the professions governed by the HPC. They were asked about their hopes and concerns relating to the possibility of the HPC incorporating service user feedback in its regulatory processes. Next, participants were asked to indicate their level of agreement with, and to comment on, statements developed from these responses combined with the findings of the literature review. Finally, ten statements that appeared likely to generate consensus were developed from the

analysis of responses and again, participants were asked to indicate their level of agreement with, and comment on, each statement.

## Summary of findings

The search found twelve standardised instruments covering ten professional groups and a range of areas of professional practice including communication, respect for privacy, role in providing training, body language, competence in developing therapeutic relationship.

Absolute consistency in methods of administration is difficult to achieve, and is known to have an impact on the comparability of scores. Further evidence for validity and reliability of most of the standardized instruments is needed, but this work is underway and should be built on. Evidence from patient feedback instruments for doctors has highlighted the potential effects of confounding factors and the possibility for unfair discrimination.

Qualitative approaches do not allow comparisons between individuals or over time, and make it difficult to preserve anonymity. However, they have the advantages of enabling service users who are not able to complete standardized questionnaires to have a voice, and to obtain more nuanced, context-based feedback. Some have been developed for other purposes (e.g. service evaluation, consultation) and could potentially be adapted to obtain feedback on individual practitioners.

## Conclusions and recommendations

1. The HPC's registrants work within a wide range of settings and with a great diversity of service users. Some have the opportunity to forge ongoing relationships with their service users, whereas others see them only fleetingly if, indeed, at all. The service users with whom HPC's registrants work vary in their levels of abilities and disabilities. Given the wide range of settings in which, and service users with whom, HPC registrants practice, approaches to obtaining service user feedback must be:
  - tailored to the professional group and, in cases where there is variation in settings, service user groups etc, even to subsets of one professional group ;
  - designed according to judgments about the capacity and willingness of a particular service user group to respond to a particular form of assessment: a standard format questionnaire, story-telling, supported conversation, or a face-to-face evaluation, bearing in mind the costs and benefits of each.

Where possible, service users should be given a choice of how they would like to participate in feedback.

2. Existing instruments should be built on, and any work to develop systems for service user feedback should consider work being carried out in Scotland to test the validity and reliability of the CARE instrument for assessment of relational empathy in 8 professional groups.

3. No evidence was found for the capacity of the standardised instruments or qualitative methods reviewed here to contribute to the improved professional practice of those on whom feedback was gathered. In fact there was no evidence that such evidence had been sought. Research on the effectiveness of doctors' instruments shows that providing feedback does not necessarily improve practice. More must be known about the long term impact and effectiveness of the feedback process and mechanisms for effective formative feedback.

The Delphi Consultation revealed that professional bodies demonstrated a high willingness to engage with the HPC in developing methods around incorporating service user feedback in regulation. Thirteen of the seventeen organisations invited to take part played an active role in the consultation. In general there was support amongst the professional bodies that engaged in the consultation for the concept of incorporating service user – usually patient/client – feedback into the regulatory process in some way. However, there were also many doubts and concerns expressed.

The main themes around which consensus was achieved were:

- Service users have a valuable perspective on practitioners' performance but their views need to be taken in context (financial, organizational, political, environmental and the individual).
- Service user feedback can be a useful measure of a practitioners' performance but not in isolation of other feedback (eg 360 feedback) and performance measures.
- Service users should be able to choose between methods of feedback according to their communication abilities and preferences but in practice this may be difficult to implement.
- Practitioners should be given service user feedback in a supportive environment.
- Provided good systems (that include the above features) are put in place, service user feedback could be useful to inform improvements in professional practice.

There was less consensus around the following themes and panel members' responses suggest the need for further research:

- Benchmarking aspects of practitioners' performance against their peers' could help identify areas where performance could be improved.
- Service users are happy to provide feedback if there are tangible outcomes and benefits for them or those who come after them.

On the subject of patient feedback on doctors, Evans et al concluded in 2007 that *“Patients are the end-users of health care. Clinicians have been lukewarm towards feedback from users, but this cannot be dismissed. We must continue to measure patients' assessments of their experience with individual clinicians and try to understand more what they mean, how they correlate with other aspects of*

*individual performance, and how doctors can learn and improve by the assessment”*  
(p 125).

The Delphi Consultation suggests that the professional groups regulated by the HPC might be more enthusiastic about the use of service user feedback, providing certain caveats are in place.

Based on the evidence for the instruments for HPC registrants reviewed here, a similar story can be seen to emerge for the role of service-user feedback for other health and social care professionals in 2011. Although the case for measuring it is strong, the systems to do so are as yet imperfect and must continue to be developed in ways that accommodate the wide variety of contexts and service-user groups encountered by HPC registrants. More research is needed to establish mechanisms by which feedback can be incorporated into the ongoing process of professional development in such a way as to fulfill its ultimate purpose: to improve registrants' practice.



---

# 1 Literature review: approach

## 1.1 Policy context

The Health Professions Council (HPC) currently regulates 15 professions and in July 2012 will become responsible for the regulation of approximately 85,000 social workers in England. Its regulatory function includes ensuring its members adhere to its standards of conduct, performance and ethics and requirements for continuing professional development.

The HPC commissioned this research within a programme of work designed to develop the revalidation evidence base as relevant to the 15 professions that it regulates. The introduction of medical revalidation provides the wider context, alongside the HPC's ongoing need to be confident that it understands the risks that its registrants pose to the public and that its systems and processes adequately identify registrants whose fitness to practise may be impaired.

The HPC's Continuing Fitness to Practise Professional Liaison Group (PLG) 2009 report concluded that revalidation, as per the proposed medical model, was not appropriate for the professions regulated by the HPC. The HPC is however continuing to review the evidence base regarding the use and impact of different approaches to regulation and revalidation, and the potential relevance and value of other quality assurance models.

In accordance with the Government's February 2011 'Enabling Excellence' Command Paper, the focus of the HPC's evidence review is the costs, benefits and proportionality of approaches to revalidation. In particular, the HPC wishes to establish whether there is any evidence to suggest that revalidation would be likely significantly to improve the quality (safety, effective and/or experience) of care for service users, and so whether legislative change to introduce revalidation processes for any or all of the 15 regulated professions would be appropriate.

This element of the HPC's evidence review specifically examines available evidence regarding the use and impact of service user feedback tools in healthcare.

The HPC's Continuing Professional Development (CPD) standards, while not explicitly asking for service user feedback to be gathered, do require registrants to reflect on how their CPD may have benefited their practice and their service users. The CPD audit currently allows (but does not require) registrants to include service user feedback as evidence of the impact of CPD on their practice. Similarly, registrants are not explicitly required to gather, submit or respond to service user feedback on their interpersonal (i.e. other than purely clinical) professionalism.

Medical revalidation pilots are underway, with roll-out scheduled to commence towards the end of 2012. The evidence that doctors will be required to submit for appraisal and revalidation will include, where relevant, multi-source feedback (also known as 360 degree feedback) from colleagues and patients. Doctors will be

required to collect and submit patient feedback at least once in every five year revalidation cycle, with the data collected using appropriately developed and tested and independently administered survey instruments.

The inclusion of patient feedback within medical revalidation reflects the explicit recognition of the patient experience as a dimension of care quality, plus evidence that – properly developed, tested and validated – feedback tools can provide reliable evidence about important aspects of medical professionalism.

The HPC, recognising the potential value of service user feedback, wished to explore whether and how the use of patient feedback tools might be introduced into the practice, appraisal, CPD, regulation and/or revalidation of its registrants.

## 1.2 Registrant characteristics

The HPC's registrants work within a wide range of contexts and with a great diversity of service users. Some work directly with patients or clients in a one-to-one consultation style setting, within a clinic or health centre. Some work in domiciliary settings where an ongoing relationship may develop. Others are based in hospitals perhaps as part of a large team such as in an operating department, where a service user may not always be able to differentiate between different professional groups.

Some operate in circumstances that hamper the development of relationship, for example in emergency situations where preserving life is the main priority, whilst for others forging a strong therapeutic relationship is key to effective practice. Some practitioners have mostly fleeting contact with their service users, who may even be unconscious for some or all of the time they are together. The relationship of some registrants to their 'service users' is more distant still and indeed may entail no face-to-face contact, for example a clinical scientist working in a laboratory whose contribution to the end-user's care is fed back to them through a GP. In such situations, the term service user is ambiguous: is it the clinical colleague or the patient? However, in some cases clinical scientists are increasingly working in closer contact with patients

## 1.3 Service user characteristics

The service users with whom HPC's registrants work vary in their levels of abilities and disabilities. Factors such as health status, mental health status, age, capacity to communicate verbally, to read or write, and the power differential between practitioner and service user all have a bearing on the ways service users are best able to participate in feedback processes and the systems that must be put in place in order to allow them to.

Because of the variation between their service users and in the circumstances in which HPC registrants practice, there is some variability in the precise requirements of the qualities of their practice. For many, however, interpersonal skills and competence in patient engagement are crucial. Service users expect practitioners to respect their autonomy, to listen to them, to inform them, to take account of their preferences, to involve them in treatment decisions and to support their efforts in self-care (1). A growing body of evidence shows that people who are

actively involved in protecting their health and managing their healthcare have better health outcomes (2).

On-going assessment is essential for health practitioners' life-long learning and the quality of the care they provide, as well as to demonstrate on-going professional competence in interpersonal and ethical, as well as technical, spheres of practice. The public is interested in and concerned about evidence of professionalism, and it increasingly accepted that many of the core qualities of doctors' performance and, by extension, the performance of other health professionals', are best judged by the end user. Essentially, gathering service user feedback is gaining credibility as an approach to assessment (3,4).

Service users are uniquely placed to assess many aspects of the care or services they receive, particularly aspects of the practitioner-service user interaction which are often of great significance to service users, and have been demonstrated to be associated with satisfaction (5-8) and clinical outcomes, particularly where service users present with complex and often long term conditions.

## 1.4 Service user assessment of 'non-technical' skills

Areas of practice that service users are well placed to evaluate will vary given the wide range of practice, contexts and service users or the variety of HPC registrants. They will include, for example:

- interpersonal skills: instilling confidence and trust, showing empathy, considering the individual's personal situation, concerns and role preferences, being 'good with people,' caring and courteous, putting the service user at their ease, not patronising, taking them seriously, being positive and reassuring, demonstrating respect for the service user, their privacy and dignity;
- communication of information: giving clear, understandable explanations about diagnosis and treatment, and when conducting an examination, eliciting information from service users about their symptoms and concerns, letting them 'tell their story' and asking about their personal life where appropriate, being thorough in discussion, encouraging and answering questions listening carefully and sympathetically;
- engagement and enablement: helping the service user to understand and cope with their illness or condition, health and treatment; involving the service user in decisions about care and treatment; providing advice to enable service users to keep healthy; providing information to support self-care, for example about when to return for follow-up care, test results etc; helping the service user to access other sources of information or support, for example written information, helplines, websites; giving information about risk in a clear and comprehensible manner, promoting health literacy, helping service users build skills to access and interpret health information.

## 1.5 Service user capacity to assess technical competence

Whether or not service users are capable of assessing the technical competence of their practitioners depends on what aspects of technical competence they are asked to assess. This is complex. Not being a qualified health professional it is difficult for service users to assess the practitioner's performance on many of these aspects, or to give any kind of overall assessment of their competence. However, it could be argued that even if service users are not good judges of some aspects of technical competence, the fact that they think a health professional is not competent is something the latter needs to know. Although this is not an objective measure of technical competence, it could be indicative.

Service users increasingly wish to engage as healthcare partners with practitioners who recognise and actively support their contribution. Depending on their professional role, HPC registrants, in common with doctors, may need to be able to guide service users to appropriate sources of information about healthcare and how to prevent illness; be able to communicate information clearly on risk and probability; determine patients' role preferences and, where appropriate, involve them in treatment decisions; and provide support for self-care and self-management of chronic conditions (2).

Where professionals and service users differ in their ratings of practitioners' performance, this should not be taken as evidence that service users' judgments are inaccurate. Indeed they are better placed than anyone to judge some aspects of a consultation. There is some evidence that patients make more valid assessments of the doctor-patient relationship in consultations than do 'independent judges' (9). In one study which compared patients' and experts' judgments of the patient-centredness of a consultation, patients' judgments were the stronger indicator of health outcomes and efficiency of health care, as measured by the number of diagnostic tests and referrals (10).

Speers (2008) (11) cites evidence (12,13) that in the field of mental health, *"the formation of a therapeutic relationship is a necessary precursor to any other formal therapeutic approach"* (p113), and that the service user's perception of the quality of this relationship determines its effectiveness (Cape, 2000). She argues therefore that the ability to form good therapeutic relationships is an essential competency of any mental health worker and should, if feasible, be assessed by the service user. Relational empathy is defined as *"the ability to understand the patient's situation, perspective and feelings, and to communicate that understanding to the patient"* (Coulehan et al, (2000) (14) cited in Mercer & Reynolds (2002)(15)) and is assessed on the grounds that it is *"a core element in the clinician-patient relationship with profound therapeutic potential"* (p339) (16).

While systems for gathering feedback from service users at the organisation level are well developed, mechanisms for doing so at practitioner level are less well established. Yet, the use of a questionnaire, routinely collecting feedback from patients could be a cost-effective means to harness patients' views on the performance and practice of individual practitioners. The burden placed by them on service users and practitioners is low.

Such feedback could be used to improve performance. Well designed questionnaires gather data which allow practitioners to identify strengths and weaknesses in their practice and can direct them to areas where improvement is required (17). Some argue that formative assessment of doctors using credible sources of feedback is a powerful stimulus to learning (18,19). However, it should not be assumed that providing feedback will automatically lead to improvements in practice. It is important that the methods for eliciting information about service users' perspectives, and feeding them back to practitioners, are well understood in order that the exercise can be effective, credible and can ultimately facilitate improvements in professional practice.

## 1.6 Research questions

This review of service user<sup>1</sup> feedback tools examines the instruments and systems that have been developed to gather service user feedback for the professional groups regulated by the HPC. It identifies existing tools, how they are used and evidence for their robustness and effectiveness. It covers standardised questionnaire instruments as well as more qualitative approaches, and pays special attention to “seldom heard” groups. It also draws on the more established literature on patient feedback instruments used to assess doctors, drawing lessons from this field where the state of the science is arguably more advanced.

The review addressed the following research questions:

1. Which tools have been developed for obtaining service user feedback on individual professionals regulated by the HPC for the purposes of improving professional practice?
2. What areas of professional practice do they cover?
3. How are they administered/implemented?
4. Is there evidence of their measurement characteristics (validity and reliability)?
5. What evidence is there of their (perceived) effectiveness and applicability (e.g. that they lead to improvements in professional practice, improve public confidence in the profession, improve public trust, improve service user safety or provide a stimulus to learning, or that their cost/burden is acceptable)?

## 1.7 Review methodology

The following databases were searched: AMED, HMIC, CINAHL, Academic Search Complete, Social Services Abstracts, Proquest (including nursing and allied health source, psychology, health management, health and medical, applied social sciences index and abstracts (ASSIA) and social services abstracts), Cochrane Database of Systematic Reviews, Social Care Online, Web of Science, Centre for Reviews and Dissemination for English language articles published since 1991.

---

<sup>1</sup> In this review, the term service user is used as shorthand for the range of terms used to describe the people who benefit from the range of health professionals regulated by the Health Professions Council, who may be patients, clients, service users etc.

This was supplemented with a hand-search of reference lists of relevant studies and bibliographies of review articles. Appendix 2 shows the search terms used and how they were combined.

The following inclusion and exclusion criteria were applied:

### Inclusion:

1. Instruments or systems used to gather feedback on individual practitioners collected for the purposes of improving professional practice
2. Used by professional groups regulated by HPC (arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists) or social workers
3. Used to gather feedback from anyone who uses or is affected by the services of registrants, including seldom heard groups.
4. English language, including UK, Ireland, North America, Canada, Australia, New Zealand
5. Instruments/systems in current use or in development
6. All standards of evidence, i.e. not restricted to systematic reviews and Randomised Controlled Trials but including observational studies without control group
7. Papers published since 1991

### Exclusion:

Instruments or systems used to gather feedback only at super-individual, organisational level (e.g. trust or unit level) for quality monitoring of healthcare at a general level to improve organisational performance and quality assessment at an organisational level.

### Further sources of information

In addition to the search of the published literature, other sources of information were examined. The professional groups regulated by the HPC each have professional bodies and associations. Their websites were each searched for evidence of the use of service user feedback in any of their functions (e.g. accreditation of CPD activities). Enquiries were made of each of these professional bodies by telephone and email to establish whether and how they incorporate service user feedback on individual practitioners and whether they knew of any instruments used by their profession to gather such service user feedback.

The papers reviewed focus on patients and clients rather than other service users. The range of users of services provided by HPC registrants goes beyond this, to include other professionals (e.g. doctors who have requested tests by clinical scientists for their patients, or the users of services of biomedical scientists,

hearing aid dispensers, etc who will often not be 'lay' people). It did not seek to include feedback from same-profession or other profession peers, as gathered by some multi-source feedback (MSF) systems since these did not fall within our conceptualisation of service user. Neither did we seek to include feedback from other non-lay "users" of registrants' services such as students of lecturing registrants.



---

## 2 Literature review: findings

A total of 6551 studies were identified from the search strategy. 122 were retrieved for full text. 114 were then excluded because they described no method of assessing individual practitioners. Citation follow-up identified 5 further papers. In total, 13 papers met the inclusion criteria.

Table 1 and table 2 (overleaf) summarise the findings in relation to the research questions. Table 1 summarises standardised instruments designed to gather feedback on individual practitioners, and table 2 summarises three studies that illustrate approaches to obtaining feedback on services from seldom heard groups.

### 2.1 Instruments in use

This review found twelve standardised questionnaire instruments used to gather service user feedback on the performance of individual practitioners. They are shown in Table 1, along with further information about each. Of these, five were designed to obtain feedback on physiotherapists (5,8,27,28,38), one on social workers (33), three on occupational therapists (6,23,25), one for mental health workers, including psychologists (30), one for speech and language therapists (32), and one, the CARE Measure (15), being piloted with eight professional groups (podiatrists, dieticians, occupational therapists, physiotherapists, radiographers, speech and language therapists, orthoptists and orthotists). They are all designed to obtain feedback from 'lay' people. The search did not retrieve any papers describing systems to gather feedback from those who used registrants' services in a professional capacity (e.g. the GP who orders services of a clinical scientist on behalf of a patient).

No instruments, standardised or unstandardised, were found for gathering feedback on individual practitioners from "seldom heard" service users who might have particular difficulties with conventional standardised questionnaires. Although they do not fall within the inclusion/exclusion criteria, four publications<sup>2</sup> are included that gather feedback not on individual practitioners but on services, because they usefully illustrate a range of techniques and approaches to eliciting feedback from seldom heard groups: young vulnerable children in care, people with mental health problems and people with communication impairments or aphasia (34–37).

---

<sup>2</sup> This selection is illustrative, not exhaustive.



**Table 1: Standardised instruments by professional group.**

Professional group	Instrument name and reference	Measurement aim and construct / description	Scale design and no. Items	Administration method	Evidence for validity	Evidence for reliability	Required sample size
Podiatrists, dietitians, occupational therapists (OTs), physiotherapists, radiographers, speech and language therapists, orthoptists and orthotists	CARE Measure (4,15,20-22) Mercer & Reynolds 2002 UK	Communication and relational empathy in consultation, the 'human aspect' of a consultation	5-point Likert scale from 'poor' to 'excellent' (10 items)	Self-completion, post-consultation in out-patient appointments; domiciliary settings; and in-patient settings.	Concurrent, content, face validity in primary care	Cronbach's alpha = 0.92 in primary care, 0.94 in secondary care	50 for a GP in primary care, 40 in secondary care
Occupational therapists (continues)	Kealey & McIntyre 2005 (6) UK	Evaluation of domiciliary occupational therapy service in palliative care.	5 items on "communication and therapist interaction" from point of view of patient and carer. 4-point Likert from 'strongly agree' to 'strongly disagree'	Questionnaire administered in person by researcher	No data - instrument developed for this study in absence of validated instrument	No data	No data
	Mckinnon (2000) (23) Canada	Aimed to identify clients' views about OT service	5 point Likert scale (strongly agree to strongly disagree) plus 3 open-ended questions (12 items)	Telephone survey with closed and open-ended questions	No data	No data	No data

<p>Occupational therapists (continued from previous page)</p>	<p>Sixma et al (1999) (24,25)  UK/Netherlands</p>	<p>Assesses importance and experience of various aspects of OT services including some on interaction with OT</p>	<p>Importance: 4 point Likert not important to fairly important (23 items) Experience: 4 point Likert No, not really, on the whole yes, and yes, and some open ended questions (23 items)</p>	<p>Self-administered postal questionnaire. Response rate 55% (with 1 reminder)</p>	<p>Validity based on involvement of service users throughout process of development of instrument</p>	<p>Of 8 quality of care sub-dimensions, seven had Cronbach's alpha &gt; 0.75</p>	<p>No data</p>
<p>Physiotherapists</p>	<p>Beattie et al. (2002) (8)  USA</p>	<p>Guages overall patient satisfaction, with outpatient physiotherapy including items assessing quality of interaction with the therapist (time spent, explanations and instructions)</p>	<p>(10 items)</p>	<p>Mailed to patients four weeks after therapy. 20% response rate</p>	<p>Content and concurrent validity assessed</p>	<p>Cronbach's alpha for Physical therapist-patient interaction subscale = 0.9163</p>	<p>No data</p>
	<p>Goldstein et al (2000) (5)  USA</p>	<p>Instrument measures 5 dimensions of patient satisfaction with physical therapy including 'interpersonal management': warmth/friendliness of therapist, respect for patient, appropriate amount of time spent with patient, privacy</p>	<p>5 point Likert scale from 'strongly disagree' to strongly agree' (20 items)</p>	<p>Complete immediately post-consultation and leave in a locked box in clinic waiting room.</p>	<p>Content, concurrent and construct validity assessed to some degree.</p>	<p>Cronbach's alpha = 0.99</p>	<p>No data</p>

	Hills & Kitchen (2007a); Hills & Kitchen (2007b)(26,27)  UK	Measures six dimensions of satisfaction with outpatient physiotherapy care, including: Communication: therapist's role in providing teaching and training; and therapist: professional manner and personal characteristics	1-5 Likert scale 'strongly agree', 'agree', 'not sure', 'disagree', strongly disagree' (38 items)	Postal questionnaire, response rate 66% (with 2 reminders)	No data	Cronbach's alpha for 6 subscales >0.8	No data
Physiotherapists	Knight et al. (2010) (28)  Australia	The purpose of this study was to use a questionnaire based on the discrepancy model to assess the factors contributing to satisfaction and dissatisfaction with private outpatient physiotherapy services in Sydney; to identify the criteria used to assess quality.	5-point Likert scale from 'not important' to 'essential.'(12 items plus open-ended questions.)	Complete immediately post-consultation. Response rate 69.3%	Construct validity: factor analysis demonstrated client-therapist interaction accounted for 35.6% of overall variance	Cronbach's alpha for all subscales 0.8-0.9	No data
	CSP Clinical audit tool (2000) (29)  UK	Physiotherapy department audit tool	Mostly 5-point Likert scale strongly disagree to strongly agree	Handed to patient or posted with SAE	No data	No data	No data

Mental health workers (incl. Psychologists)	Hansen et al (2010)(30) UK	Originally developed in psychiatry to measure outpatient 'satisfaction' with clinician/practitioner (could potentially be used with psychologists etc). Item categories: trust, communication, exploration of ideas, body language, active listening, miscellaneous	5-point Likert scale strongly disagree to strongly agree (34 items).	Given to patient by receptionist immediately post-consultation for self-completion at clinic	Strong correlation with Verona Service Satisfaction Scale (VSSS) "Professionals' skills and behaviour" subscale - both achieved high ceiling effect with minimal variability;	Cronbach's alpha = 0.98; Good test-retest reliability reported.	No data
	Cahill et al (2008) (31) UK	Review of instruments to measure therapist-patient interactions in mental health settings.	Includes 31 patient-completed measures. None was shown to display adequate acceptability or feasibility evidence.				
Speech and language therapists	Miller et al (2011) (32) UK	Patient and carer perspectives on speech and language therapy service for people with Parkinsons disease (PD).	Not described	Paper and online, could be completed by person or carer. 'Advertised' in PD magazine, at PD society AGM, and other ways	No data	No data	No data
Social workers	Ely et al (2010) (33) USA	measure client satisfaction with pre-abortion counselling	5 point Likert scale (strongly disagree, somewhat agree, agree, strongly agree)	Post-counselling session, drop in locked box at clinic.	No data	No data	No data

**Table 2: Qualitative approaches to eliciting feedback on services from seldom heard groups**

Reference	Aim	Findings
Davies et al (2009) (34) UK	Develop methodologies to facilitate the inclusion of junior-school-aged looked-after children to reflect on their experience of participating in psychological therapy	Four methodologies matched to the children's developmental stages, using drawings, games and activities. These were called 'Bag of feelings', 'cartoon strip', 'attending therapy scenario' and direct questions in a situation resembling a TV interview. Efforts were made to address power imbalances between child participant and adult researcher. Children with disrupted attachments can be engaged in reflective discussions about mental health services when a methodology is developed specifically for them
Ennals and Fossey (2007) (35) Australia	Qualitative evaluation of Occupational Performance History Interview, using interviews and focus groups	Obtains feedback on OT services from service users with mental health problems, allowing them to tell their stories and be heard in a way that was respectful of their experiences and priorities for support. It may enhance service user satisfaction and therapist fulfilment. Therapists may need education and mentoring to put feedback into practice.
Connect (2007) (36) UK	Including People with Communication Disability in Stroke Research and Consultation	Advice for ensuring people with aphasia are able to share views and experiences in the context of stroke research and consultation. Describes "supported conversation," a range of techniques for enabling a person with communication impairments to understand and make sense of things that are said or written and to express themselves in some way in written and face-to-face encounters. It offers advice for making the content, layout and tone of written material accessible for people who have difficulty reading and understanding documents in standard format. It suggests materials should be gone through with the participant to ensure they have understood. These can be used with people with a spectrum of types and severities of communication impairment.
Law et al (2005) (37) UK	Feasibility study of a booklet held by people with communication difficulties to aid in GP consultations by providing information about their conditions, carers and communication needs.	The materials within the booklet were found to be useful by service users and doctors. The authors conclude its implementation should be widened across different care settings and different user groups, and evaluated.

## 2.2 Areas of professional practice covered

All but two (the CARE Measure and PatSat) of these standardised instruments are designed to obtain information on a clinic or service as a whole, and include a subset of questions that cover the participant's interaction with the clinician. CARE and PatSat were designed specifically to gather feedback on individual practitioners. Of the items designed to obtain feedback on individual clinicians, some aim to measure a global concept of 'satisfaction' while others measure a variety of more clearly specified aspects of practice. The standardised instruments include items variously described as communication, therapist interaction (6); time spent, explanations and instruction (8); interpersonal management, warmth/friendliness, respect for patient privacy (5); communication, therapist's role in providing teaching and training, therapist's professional manner and personal characteristics (27); trust, communication, exploration of ideas, body language, active listening (30); competence in developing therapeutic relationships (11); 'relational empathy' (15).

Although most of the instruments were designed to gather feedback on service provision rather than on the individual practitioner, the findings of all but one (32) reported that interactions and communication with the practitioner were shown to be of key importance, or were most strongly predictive of overall satisfaction.

## 2.3 Implementation

Five of the twelve instruments in this review were used in out-patient 'consultation style' appointments (5,15,28,33,39). Typically this would mean a questionnaire is handed out by a receptionist before or after the consultation to be completed immediately post-consultation and left in a locked box in clinic waiting room. In one case, the questionnaire was administered in person by a researcher, who was available to help with completion if necessary (6). For two instruments, service users are asked to take the questionnaire, and a prepaid envelope, home with them and return it by post (8,40). One was posted to users of an occupational therapy service (25). The CARE Measure is also being trialled in domiciliary settings and in-patient settings (Duncan, personal correspondence, 19/9/2011).

When instruments are being trialled and validated, efforts are made to be consistent in the way questionnaires are administered. However, in practice, absolute consistency between different settings is very hard to achieve and this is known to impact on the comparability of findings. The use of patient feedback questionnaires for use with doctors can shed some light on this issue. Figure 1 shows the strengths and weaknesses of four different methods of administering patient feedback questionnaires for doctors. These methods could be adapted for use with other groups of health professionals, and indeed approaches similar to these are already in use to administer existing questionnaires with varying levels of standardisation.

Figure 1: Examples of methods for distributing patient feedback questionnaires (from Burford et al, 2009 p 261) (41)

Kinnersley et al (42) found that questionnaires to assess satisfaction with primary care completed at home gave less favourable results than those completed immediately after consultation in the GP surgery, possibly, they speculate, because patients find it more difficult to express dissatisfaction directly to their doctors or perhaps because they have had longer to reflect on the consultation. Response

rates were lower for home completion which may also result in non-response bias (that those who respond differ systematically from those who do not, producing skewed results).

Schneider and Palmer (43) used closed-ended exit interviews and open-ended community focus groups to obtain user views of primary health providers. The focus groups provided more negative feedback compared to the exit interviews, suggesting where and how users' views are obtained has an influence on what feedback is given.

Richards et al (44) explored the influence of administration methods on the quality and comparability of data obtained. They compared questionnaires administered as 'exit surveys', postal surveys with and without reminders, and touch tone telephone surveys and found differences in response rates, item completion rates and response profiles, with touch-tone and postal surveys yielding significantly more critical ratings than the exit survey. They conclude that results must be interpreted cautiously if administration methods are mixed.

Burford et al (41) argue that the process for gathering patient feedback for formative purposes should be adapted to local organisational and clinical circumstances. More research is required to assess the fairness of patient feedback systems, taking into account the effects of different modes of distribution/administration. This is particularly important if the feedback is to be used for summative (pass/fail) judgements, but even for formative purposes it can affect the accuracy of feedback where an individual practitioner's results are presented to them in relation to the range of results of their peers (normative benchmarking).

## 2.4 Reliability and validity

### Reliability

Reliability refers to the reproducibility and consistency of results from an instrument. In other words, would repeat measurements made with the same questionnaire give the same result? There are a number of aspects to reliability, three being particularly relevant to patient questionnaires: internal consistency; assessment of characteristics by factor structure; and practitioner-level reliability<sup>3</sup>.

---

<sup>3</sup> Internal consistency assesses the extent to which the items relating to a particular scale measure 'one thing' (although this itself may have several dimensions). The most commonly used method for assessing the internal consistency of patient questionnaires is Cronbach's alpha. A low alpha coefficient indicates that the items do not belong to the same conceptual domain (Bowling 2002).

Factor structure refers to the underlying dimensions of an instrument, and is relevant to construct validation. Factor analysis can be used to define dimensions, each of which contains items which group together in a consistent way, to form a manageable set of variables that can be measured reliably.

Practitioner-level reliability is a prediction of how many observations are required with different test formats to achieve a given level of reliability. Generalisability theory can be used to estimate how many patient responses are required in order to assess a doctor's performance within acceptable limits of confidence. Adding observers and (usually) adding items will both increase generalisability (Violato et al 2003)

Conventionally, a reliability coefficient of 0.8 is desirable for 'high stakes' assessments such as certification procedures, although a lower reliability may be acceptable for other purposes (Davies and Howells 2004).



## Validity

Validity is an evaluation of the degree to which evidence and theory support the interpretations of scores entailed by proposed uses of instruments<sup>4</sup>. Construct validation draws on multiple types of evidence; those of particular relevance to patient questionnaires are: evidence based on content, on response processes, on internal structure and on relations to other variables<sup>5</sup>.

The standardised instruments reviewed here vary widely in terms of the evidence for their validity and reliability, from very little (6,33) to considerable (15). A recurrent and sometimes acknowledged problem is a tendency to show *ceiling effects*, i.e. where Likert scales are used, for the majority of responders to rate most items close to the top of the scale which compromises their capacity to discriminate between doctors. For example, where 96% tick “*strongly agree*” to “*I felt the practitioner listened closely to what I had to say,*” that item fails to distinguish between the listening abilities of all the practitioners.

A less common, but nonetheless important consideration is an instrument’s reported Cronbach’s alpha, a measure of the internal consistency of an instrument. A highly elevated Chronbach’s alpha could suggest an instrument has a very narrow focus. There is the possibility that it includes an artificially homogenous set of items that effectively ask the same thing in slightly different ways. In the context of service user feedback tools it is important to ensure that all the items in the instrument are not simply measuring a generalised like or dislike of the practitioner, rather than tapping separately into whether the practitioner is good at listening, good at giving information, good at making the patient feel at ease, etc.

---

<sup>4</sup> The Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1999)

<sup>5</sup> Construct validity is an evaluative judgment of the extent to which evidence supports the proposed interpretation and use of results from the instrument (Messick, 1995, Moss, 2007). Construct validity indicates that an instrument or procedure will produce results that would be predicted by existing research or theory. Suppose, for example, existing research shows that patients of doctors with good communication skills have better outcomes than patients of doctors with poor communication skills. If an instrument records better communication skills in the doctors whose patients have good outcomes than in those whose patients have poor outcomes, this finding could be said to support construct validity (Davies and Howells, 2004).

So-called ‘face validity’ is an intuitive judgment about the relevance, reasonableness and clarity of the items within a questionnaire, and relates to feasibility and acceptability.

Criterion validation measures the correlation between the results from the instrument and another measure (or criterion) that is itself accepted as valid (Baker & Whitfield 1992b). Two approaches to criterion validity are concurrent and predictive validation. Concurrent validation corroborates independently that the instrument measures what it intends to (e.g. against observable criteria). Predictive validation is demonstrated if the instrument predicts future changes in key variables in expected directions (Bowling 2002).

Content validation may include expert review of questionnaire items as well as input from focus groups or interviews with potential respondents.

Information from cognitive testing provides evidence of whether respondents thought processes and responses are consistent with the intended interpretation of the questions.

Construct validity is corroboration, against other measures, that the instrument measures the underlying concept it purports to measure (Bowling 2002). If an instrument has ‘construct’ validity, it will produce results that would be predicted by existing research or theory. Suppose, for example, existing research shows that patients of doctors with good communication skills have better outcomes than patients of doctors with poor communication skills. If an instrument records better communication skills in the doctors whose patients have good outcomes than in those whose patients have poor outcomes, this finding could be said to support the instrument’s construct validity (Davies and Howells, 2004).

Practitioner-level reliability (i.e. an estimate of how many service users must provide feedback in order to achieve a given level of reliability in the context of a given method of implementation, professional group and service user population) is seldom reported.

Validity is not a fixed property of an instrument and neither will reported reliability necessarily be invariant over different applications. Coyle and Williams (45) suggest that *“reliability and validity are not properties of the research tool, but a technical description of the relationship between the instrument and a set of social realities at one point in time”* (p. 1238, cited in Hopkins and Niemiec (46)) and should therefore be regularly reviewed. Schneider and Palmer (43) found that in the absence of universal standards, users evaluated services relative to others they had used in the locality, so results were highly context specific. These findings, together with the discrepancy between feedback provided in different contexts, demonstrate that service user feedback is a social rather than technical phenomenon. It is dynamic, bound to contexts and difficult to capture in single snap-shot assessments.

Again, lessons from the development of instruments to gather patient feedback on doctors can be illuminating. Recent publications highlight some of the difficulties associated with establishing the construct validity of this feedback, i.e. that it measures the underlying concept that it purports to measure and produces results that would be predicted by existing research or theory. A number of studies have found patients to be poor discriminators of doctors' performance.

Archer and McAvooy (47) compared the scores of two groups of doctors: one who had been referred to the National Clinical Assessment Service (NCAS) which assesses doctors whose performance causes concern, and another group with no known performance difficulties. They examined the two groups' scores from peer feedback and patient feedback and found that, while feedback from peer assessors (particularly if the assessors were not nominated by the doctor themselves) could distinguish between the two groups, patient feedback was consistently higher than peer feedback, and feedback for underperforming doctors was not significantly different from the comparison group. They conclude that this presents evidence of 'leniency bias' in patient feedback and challenges its validity as a method to identify poor performance. However, no reference is made to the grounds on which the doctors had been referred to NCAS in the first place. If the referral was made because of concerns about clinical practice or technical performance, it is unsurprising that a patient questionnaire which obtains feedback about the doctor's interpersonal, patient engagement or communication skills did not discriminate between NCAS referred doctors and doctors about whom no concerns had been raised. That is, the patient questionnaire may well identify different areas of underperformance than the peer questionnaires or NCAS. The discriminant validity of a patient questionnaire should not be judged to be lacking because it does not discriminate between levels of performance in an area (for example technical competence) it does not purport to measure.

With some instruments, certain factors have been shown to bear on patient feedback for doctors which appear to depend on variables other than the doctor's performance. These are known as confounding factors. Baker et al (48) found that, using the Consultation Satisfaction Questionnaire, the only doctor-related factor

associated with lower scores was increasing age<sup>6</sup>. In Kinnersley et al's (42) study, older patients reported higher levels of satisfaction than younger ones, in keeping with findings of similar studies.

Crossley and colleagues (49–51) found that children could not reliably assess doctors' performance and interpersonal skills. Their assessments were too idiosyncratic to be reliable. They argue, however, that because an adult is usually present in consultations with children, they can provide authentic and reliable assessment of doctors' performance.

Crossley and Davies' (49) literature review found a number of factors that could potentially bring into question the reliability of patient feedback: *"The studies reviewed in the literature also provided a catalogue of factors that have been shown to influence the doctor–patient interaction that could potentially confound the assessment of a doctor's performance. These include the doctor's: age, gender, training, speciality, income, social class and politics; the patient's: age, gender, health, prognosis, social class, education, health beliefs and preferences about control and risk. The length of the acquaintance between doctor and patient, and the workload and case-mix in the clinic also affect the interaction."* (p807).

Campbell et al (2011) (58) found evidence of systematic bias in assessments of doctors' professionalism arising from patient and doctor characteristics. Less favourable patient scores were doctors who had obtained their primary medical degree from any non-European country, lower proportions of white patients providing feedback, lower proportions of patients reporting their reason for the consultation was important, and where fewer patients were seeing their own doctor.

Archer and McAvoy (2011) had similarly uncomfortable findings that the only sense in which patient feedback using Sheffpat (a tool designed to obtain patient feedback on doctors (45,46)) was discriminating concerned whether doctors had graduated from UK medical schools, with those who had graduated from non-UK medical schools receiving significantly lower scores than those from UK schools. They propose *"the drivers for this discrimination need some careful consideration. It could be postulated that doctors who have trained outside the UK are less familiar with the UK health service and the cultural norms of its patients. However, all the doctors in this study were relatively senior and established practitioners"* (p892). The findings from these two studies have serious implications for the use of feedback questionnaires, particularly in summative settings.

Evans et al conclude from their 2007 review of instruments and feedback methods for doctors that: *"To be used in a summative way for decision making, the science underpinning the instruments needs to be more robust. The construct validity of these instruments in terms of correlation with other assessment perspectives needs further research."* (52)

---

<sup>6</sup> The GP's sex did not influence their score. In this study, place of graduation was not included as a factor.

## Older people

Bauld et al (2000) (59) carried out a study of older people's satisfaction with social care services (rather than of the individual social workers) and concluded that that older people are more susceptible to response bias – specifically giving responses that they believe interviewers want to hear - than other groups, and that a number of factors may be behind this response bias:

- fear of dependency or reprisal: that complaints will lead to services being withdrawn;
- reluctance to criticise individual workers: for fear that being critical of practitioner could result in undermining relationship with them;
- entitlement: users with limited resources receive services as an entitlement rather than with the 'power' that comes with being a consumer, which may reduce their willingness to criticise;
- expectations: satisfaction ratings have been found to be closely linked to expectations - older service users are often characterised as having low expectations of services, which may affect responses (Nocon & Qureshi, 1996);
- lack of knowledge: of alternatives and of what technical standards to expect;
- level of involvement: where well-established relationship with service provider who involves them in decision-making can lead to greater satisfaction.

Additionally, individual characteristics that affect responses: poor physical or mental health, depression, personality and cognitive impairment can have an impact on how older people respond to questions (Bauld et al, 2000).

## 2.5 Qualitative approaches to gathering feedback

All predominantly quantitative methods have limitations in terms of validity. By their nature, questionnaires have difficulty capturing the flux, complexity, ambiguity and contradiction of subjective reality. They can “*de-contextualise meaning and distance social action from its natural setting*” (45).

Qualitative methods are employed in four publications included in this review to gather feedback from three groups of service users: people with mental health problems (11,35) and vulnerable children (34), and people with communication difficulties (36). Less standardised, sometimes innovative, more qualitative approaches to gathering service user feedback have a number of advantages. They can mean that the views of people who are unable to respond to standardised questionnaires can be obtained when they would otherwise be under-represented or excluded. They are better able to capture the nuance and subjectivity of individuals' experience, circumstances and views and can therefore be said to be better able to represent what they purport to, that is, they have greater validity. The insights they potentially offer into the service user experience within the context of their expectations, circumstances, etc may provide richer, more readily interpreted information on which to base changes in practice. The price of the

enhanced inclusiveness and validity of non-standardised methods is that they do not lend themselves to assessments of reliability or to make comparisons between one practitioners' performance and others'. This can be a worthwhile trade-off where feedback is for formative purposes. However, they may present challenges to preserving anonymity for the service user.

### **People with communication impairment**

A report published by Connect (35) highlights how people with communication difficulties tend to be excluded from research and consultation because it can be hard to engage them, their responses may seem invalid and it may take more time.

“Supported Conversation” is the use of techniques to enable a person with communication impairments to understand and make sense of things that are said or written and to express themselves in some way. It acknowledges that standardisation is difficult to achieve when adapting methods to make them accessible, arguing for the use of modified or non-standardised techniques to allow the involvement of people who may otherwise not be heard.

## **2.6 Evidence for feasibility and effectiveness**

What are the aims and methods of delivering service user feedback to health practitioners? What is the effect of feedback and how should it best be used? How do we know whether providing feedback leads to improvements in professional practice, improves public confidence in the profession, improves public trust or service user safety, or provides a stimulus to learning? Is the cost and the burden to service users, practitioners and their employers of obtaining feedback justified in terms of the benefits that result? We have found no evidence that these issues have been addressed as they relate to the instruments reviewed here. The insights from the literature on patient feedback for doctors, which has begun to address these questions, is presented here along with data from Speers' 2008 study of the feasibility of service user involvement in assessment of student mental health nurses' competence in developing therapeutic relationships (11).

### **Feasibility**

Edwards et al (2011) (53) highlight problems with patient feedback questionnaires used in general practice. Their study of GPs who had received feedback from surveys in general practice<sup>7</sup> found enthusiasm amongst GPs for the principle of gathering patient feedback, but also some strong misgivings about the process. GPs found the aggregated data difficult to interpret in the absence of contextual

<sup>7</sup> the GPAC and IPQ, the two questionnaires formerly accredited for use under the Quality and Outcomes Framework, which both gathered data about the doctor seen in a particular consultation but also about the practice as a whole

information about the consultations from which they arose, and therefore difficult to use as a basis for change in practice. Some whose score had been below the national benchmark found this to be a blow to their confidence, yet felt that the results provided insufficient information to guide changes in practice. Further, they cited a conflict between performing good medicine and satisfying their patients, implying a risk of assessment-driven practice. For example a patient who wanted the doctor to prescribe antibiotics where they were not indicated might provide more favourable feedback to a doctor who prescribed them than to one who didn't. In other words, pressure to obtain favourable patient feedback might run counter to a responsibility to practice evidence-based medicine. Similarly, nurses in Speers' study (11) were concerned about *"the potentially iniquitous position for students whereby, from time to time, they are expected to take legitimate actions likely to make them unpopular with their clients (yet may be dependent on those clients for feedback)"* (p115).

### Looked-after children

Davies and Wright (2008) reviewed qualitative literature on the experiences of looked-after children who had used mental health services. They conclude that more research is needed before the views of this seldom heard group can be incorporated in mental health service provision and evaluation. They suggest *"It cannot be assumed that looked-after children are non-defended respondents and where extreme idealised or denigratory representations of services are reported other aspects of the wider context need to be considered for example as attachment organised positions"* They recommend that further qualitative work be carried out in order to develop quantitative measures; that as much attention be paid to building good relationships with the children as to the techniques and methods used; that the ethics procedures required to obtain consent to engage looked-after children in research be simplified; that non-verbal approaches be used (such as play, arts, sculpture, story-telling); and that the views of primary school aged, and younger, children should be elicited. (Davies J, Wright J. Children's Voices: a review of the literature pertinent to looked after children's views of mental health services. Child and Adolescent Mental Health. 2008 Feb;13(1):26-31).

Davies et al (2009) (34) used four innovative qualitative methods to elicit feedback from young (aged 8-10 years) looked-after children on mental health services. They used four methodologies matched to the children's developmental stages, using drawings, games and activities. These were called 'bag of feelings', 'cartoon strip', 'attending therapy scenario' and direct questions in a situation resembling a TV interview. Efforts were made to address power imbalances between child participant and adult researcher. The interviews were analysed according to the principles of Interpretive Phenomenological Analysis (IPA).

Davies et al argue that their approach to obtaining feedback from children was successful and could be adapted for routine service user feedback. The use of multiple methodologies helped to offset the influence of children's traumatic histories, allowed understanding to be developed when children's answers were difficult to follow, and meant themes could be pursued without feeling interrogatory.



Rider and Perrin (54) found that less than 25% of doctors found patient satisfaction reports to be helpful in improving patient care or change practice. Burford et al (55) found that doctors in the early stages of their medical careers had anxieties about receiving patient feedback, particularly that their inexperience could lead to negative feedback that could be detrimental to their confidence. Evans et al (52) in their review of patient feedback tools for doctors, highlight practical difficulties with using data, particularly the variable methods for administration and sampling (see reliability, above), and uncertain policies on data ownership.

Speers (2007) (11) writes about the feasibility from the perspective of various stakeholders (service users, lecturers, mentors, ex-students and student nurses) of service user involvement in qualitative approaches to the assessment of student mental health nurses' ability to form therapeutic relationships. Her study of 24 stakeholders' (service users, lecturers, mentors, ex-students and student nurses) views of service user involvement revealed service users to be firmly in favour, with greater ambivalence expressed by nurse practitioners. Overall, service users were more enthusiastic about involvement than were nurses. There was support for the principle of feedback, which was seen to potentially enhance student learning, improve practice, be valid, and empower service users (with associated therapeutic benefits), although there were concerns about the validity of feedback due to mental state, disempowerment, transference, the potential for practitioner demoralisation, lack of anonymity, and potential harm to service users due to feelings of coercion and the burden of responsibility. Speers' findings and their implications for implementation are summarised in the Tables 3 and 4 overleaf.

Table 3: Perceived advantages and disadvantages of service user involvement in assessment (from Speers (2007), p116)

Most mentioned potential advantages	Most mentioned potential disadvantages
<p>Services users' views:</p> <ul style="list-style-type: none"> <li>• enhanced student learning</li> <li>• better patient care</li> <li>• empowerment/respect for service users</li> <li>• stronger validity of assessment as service users have the best sense of the quality of the therapeutic relationship</li> </ul> <p>Nurses' views:</p> <ul style="list-style-type: none"> <li>• potential of unmediated feedback enhancing student confidence</li> <li>• benefit to assessment validity of better triangulated evidence</li> <li>• enhanced student learning</li> <li>• philosophical 'fit' with service user empowerment/collaborative working</li> <li>• could result in therapeutic 'knock on effect' for service users</li> </ul>	<p>Service users' views:</p> <ul style="list-style-type: none"> <li>• students could be demoralised</li> <li>• feedback might not be fair/honest</li> <li>• lack of confidentiality /anonymity might cause problems</li> </ul> <p>Nurses' views:</p> <ul style="list-style-type: none"> <li>• students could be demoralised or judged unfairly</li> <li>• possible unreliability of mental health service user assessment due to mental state, disempowerment, transference etc</li> <li>• service users are not trained to give constructive feedback</li> <li>• possible harm done to services users through coercion, fear and/or burden of responsibility</li> </ul>



Table 4: Examples of the range of assessment methods recommended by interviewees (from Speers, 2007 p11)

Key findings arising from the interviews	Implications for implementation
<p>1. There should be a choice of ways in which service users could be involved in the process of assessment</p>	<p>A continuum of involvement could be offered, including:</p> <ul style="list-style-type: none"> <li>• Students asking service users informally for feedback and then using this to inform self-assessment. Feedback will provide material for reflection (with support and guidance if required).</li> <li>• Completion of simple, tick box questionnaire (which could be deliberately strengths-focused), be structured around the ingredients of the therapeutic relationship and contain space for optional additional comments). The feedback contained in the questionnaire could be explored by the mentor and student together.</li> <li>• A three-way interview between service user, student and mentor.</li> <li>• An interview between service user and mentor, with the mentor acting as a filter and conduit for feedback. Thereafter the mentor might offer support for the student, facilitating reflection.</li> <li>• The use of an advocacy worker to relay feedback from service user to mentor and/or student.</li> </ul>

<p>2. There are reservations about whether service user involvement in assessment will work in practice</p>	<ul style="list-style-type: none"> <li>• The implementation of service user involvement in assessment should be piloted for a limited period (probably for the duration of one student placement) and then evaluated.</li> <li>• Initially, service user involvement in the assessment process should be confined to giving feedback about competence <i>in making therapeutic relationships</i>, pending evaluation.</li> <li>• Students and mentors may need additional training from lecturers to prepare them, along with access to ongoing support and guidance from lecturers.</li> <li>• Lecturers would need to liaise widely with staff in the mental health service, to enlist support and answer queries prior to implementation.</li> </ul>
<p>3. Service users should be able to give anonymous feedback if this is their preference</p>	<ul style="list-style-type: none"> <li>• Questionnaires could be implemented anonymously and deposited in a designated box in the clinical area, or posted in a stamped addressed envelope if the service user is in the community.</li> <li>• Where service users have opted for the option to give feedback directly, there should be an agreement that the feedback will remain confidential to those involved.</li> </ul>

<p>4. Service users must be free to choose whether or not to be involved in the assessment process at all</p>	<p>Strategies to promote freedom of choice might include:</p> <ul style="list-style-type: none"> <li>• The practice of involving service users in the process of assessment would be made known to all service users routinely. They should be able to opt in to the scheme.</li> <li>• As no consensus was reached as to whether some service users should be excluded from the assessment process, the initial pilot should not establish criteria for excluding some service users. However, the protective factors outlined in 6 will be put in place.</li> <li>• There could be a pledge that, whatever the feedback given, care will not be affected.</li> </ul>
<p>5. The pass/fail decision should remain with the mentor</p>	<ul style="list-style-type: none"> <li>• The views of a number of service users, taken over a period of time, would help to inform the mentors' decision about competence. The final decision would rest with the mentor.</li> </ul>
<p>6. Students should be protected from 'unfair' feedback</p>	<ul style="list-style-type: none"> <li>• Mentors/lecturers could help students to put feedback in context, whilst also taking care not to 'explain away' valid negative feedback.</li> </ul>
<p>7. Feedback should refer to students individually</p>	<ul style="list-style-type: none"> <li>• See 1.</li> </ul>

## Effectiveness

Evans et al (52) examined evidence for the effect of feedback on practising doctors and found it was only reported in two of the studies they reviewed and, in those two, no improvement in practice was shown. They found reactions from doctors were mixed, with one study generating negative perceptions in the feedback group.

They found evidence that feedback from the IPQ questionnaire had a positive effect when it was used in a structured educational setting with GP registrars early in their

training, but that less effect was evident later in training. They conclude that *“this insufficient evidence does not allow more comment than that the effect of feedback can be equivocal or negative”* (52) (47, p125). They identify a potentially flawed assumption on which the feedback process is sometimes based: that professionals are sensitive to patient views on their behavior and will be motivated to change practice based on normative comparisons. This assumption, they say, is not backed up by evidence from wider organisational research which suggests such comparisons can lead to declines, as well as improvements, in performance.

The impact of a different approach to using patient feedback comes from the Netherlands, where Reinders et al (56) developed a patient feedback training programme for GP trainees (GPTs) in a system which combined patient feedback (obtained from self-completion questionnaires handed to patients by the doctor themselves) and self-assessment from a videotaped consultation. The need to combine all three elements meant the patient feedback was not anonymous. The GPTs were encouraged to compare their self-assessment with the patient feedback and to formulate ‘learning aspects’ on the same day. They found that the learning effects of the programme were limited because patients’ responses were biased towards positive feedback and that not all consultations provided appropriate feedback. They concluded that: *“To optimise the educational potential and benefits of patient feedback, GP trainees should ask for feedback from patients after challenging consultations, and should stimulate patients to be critical in their answers”* (56). A later study by the same researchers Reinders et al. (57) found that the training programme did not lead to a greater improvement in communication skills compared to the standard communication skills training, but that trainees who participated more intensively improved their communication skills relative to the less motivated trainees.

These questions regarding the feasibility, applicability and effectiveness of feedback are yet to be asked of the instruments covered in this review, but it is clear that more research is needed to establish how to translate feedback into action to improve, and how formative feedback can most effectively be given to, and used by, practitioners.

## 3 Delphi consultation

The aim of the Delphi Consultation was to involve a range of expert stakeholders in reviewing and commenting on the findings of the evidence review. In keeping with the Delphi technique the objective was to identify areas of consensus and those subjects on which there was disagreement<sup>8</sup>. Individuals from 17 organisations representing the professions governed by the HPC were identified by the HPC. These individuals were invited to take part in the Delphi consultation, with a total of 15 individuals participating either by telephone or email or a combination of the two methods.

### 3.1 Approach

#### Delphi Round 1

In the first stage of the consultation Delphi panel participants were asked to review the table of instruments for capturing patient feedback developed from the literature review and to suggest any additional items that could be included and specifically whether as an organisation they endorsed any standardised instruments. They were also asked to respond to the following question and provide details of any 'hopes or concerns' they had in relation to the HPC incorporating service user feedback in its regulatory processes:

#### **Delphi Question 1:**

Which of the following statements best describes your response to the HPC incorporating service user feedback in their regulatory processes?

- a. Wholly positive
- b. Broadly positive, but with some concerns
- c. Broadly negative
- d. Wholly negative
- e. Unable to comment

Please tell us about any hopes or concerns you have.

<sup>8</sup> For a description of the key features of the Delphi consultation method see Mohan R, Slade M and Fahy T (2004) 'Clinical Characteristics of Community Forensic Mental Health Services' *Psychiatr Serv* 55:1294-1298, November 2004

## Delphi Round 2

Based on evidence from the literature review and round 1 of the Delphi consultation a list of 28 statements was developed covering the concerns, hopes and issues relating to the use of service user feedback in professional regulation. Delphi panel participants were asked to indicate the extent to which they agreed with each statement and, if possible, to make comments to explain their response. A copy of the questionnaire is provided as Appendix 8.

## Delphi Round 3

The aim of the Delphi technique is to identify areas of consensus. For Round 3, ten statements that appeared likely to generate consensus were developed from analysis of responses to round 2 of the consultation. Respondents were asked to indicate whether they broadly agreed or disagreed with each statement and to provide comments where possible to explain their view. A copy of the questionnaire is provided as Appendix 11.

### 3.2 Delphi findings

Anonymity is a key feature of the Delphi process<sup>9</sup>. In order to preserve this feature feedback from participants was processed systematically and wherever possible terms that identified specific respondents were removed. The results of the analysis of stage 1 were used to generate the list of 28 statements in round 2. Responses to these 28 statements were in turn analysed to develop the ten statements used to seek consensus in round 3.

#### 3.2.1 Delphi Round 1: incorporating service user feedback

Participants' responses to the question about incorporating service user feedback into the regulatory process were categorised as follows:

Wholly positive	2
Broadly positive with some concerns	7
Broadly negative	1
Wholly negative	1
Not answered	6

Comments made by respondents to explain their responses were analysed and used in conjunction with evidence from the literature review to develop 28 statements.

---

<sup>9</sup> Mohan R, Slade M and Fahy T (2004) 'Clinical Characteristics of Community Forensic Mental Health Services' *Psychiatr Serv* 55:1294-1298, November 2004

These 28 statements were subsequently presented to Delphi panel participants in a questionnaire format in Round 2 of the consultation.

### 3.2.2 Delphi Round 2: responses to statements

Table 5 indicates the extent to which respondents agreed or disagreed with the 28 Round 2 statements.

Comments that respondents made in response to the 28 statements are included as Appendix 9. The Round 2 comments were reviewed in conjunction with responses to the closed questions, as set out above. On the basis of this analysis, three categories of statement were identified:

1. Those statements where there was a high degree of consensus.
2. Statements, or combinations of statements, which with modifications appeared likely to achieve a high degree of consensus.
3. Statements around which there was a lack of consensus and the views expressed varied to such a degree that it was not possible to design a modified statement that took them all into account and was likely to achieve consensus amongst all, or even most, panel members.

The second category of statements forms the 10 statements used in Round 3 of the consultation, as described in the next section (3.2.3) of this report.

Table 5: Extent to which the 13 Delphi panel respondents agreed or disagreed with the 28 Round 2 statements

Delphi Round 2 statements	Respondent agreement/disagreement		Notes
1. Service users have a valuable perspective on practitioners' performance	Strongly agree	6	<p>There was a high degree of consensus in agreement with this statement but many qualified their answer with the proviso that:</p> <ul style="list-style-type: none"> <li>the context (organisational, environmental and individual aspects) needed to be taken into account and/or</li> <li>the extent of matters on which service users could comment was limited to those aspects of practice that either directly impinged on the service user (eg communication) or were within the service users' understanding.</li> </ul>
	Agree	6	
	Neither agree nor disagree	1	
	Disagree	0	
	Strongly disagree	0	
	Not answered/unable to say	0	
2. Service users can provide a valid, or 'true', assessment of a practitioner's performance	Strongly agree	0	<p>Degree of consensus in agreement but provisos as for statement 1 concerning context and the limited subjects that patients could comment on.</p>
	Agree	8	
	Neither agree nor disagree	2	
	Disagree	2	
	Strongly disagree	0	
	Not answered / unable to say	1	
3. Service user feedback could be incorporated in formative assessment (e.g. as part of CPD)	Strongly agree	4	<ul style="list-style-type: none"> <li>Broad consensus that it could, but more doubt about whether it 'should'.</li> <li>Advantages seen in terms of informing reflective practice but many had doubts about practicality and/or benefits.</li> <li>Lack of consensus around feasibility suggests the need for further specific research.</li> </ul>
	Agree	4	
	Neither agree nor disagree	3	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	1	
4. Service user feedback could be incorporated in summative assessment (e.g. as part of performance review)	Strongly agree	2	<p>More diverging views than for statement 3, but issues similar.</p>
	Agree	4	
	Neither agree nor disagree	5	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	1	



5. Provided good systems could be put in place, service user feedback could, in principle, be useful to inform improvements in professional practice	Strongly agree	5	Almost total consensus in agreement. Minor modification to statement included in Round 3.
	Agree	7	
	Neither agree nor disagree	0	
	Disagree	0	
	Strongly disagree	1	
	Not answered / unable to say	0	
6. Questionnaire results can provide service user feedback in a form that is useful for improvements in professional practice	Strongly agree	1	Generally felt need for questionnaires to be designed by experts and that they should be used in conjunction with other methods. The need for further research indicated.
	Agree	7	
	Neither agree nor disagree	4	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	0	
7. Less structured methods (open-ended questions / interviews) can provide service user feedback in a form that is useful for improvements in professional practice	Strongly agree	3	Qualitative methods were favoured by some but thought to be prone to bias by others. Generally felt that mixed modes were preferable. Need for further research indicated.
	Agree	5	
	Neither agree nor disagree	4	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	0	
8. Benchmarking aspects of practitioners' performance against their peers' is helpful in identifying areas where performance could be improved	Strongly agree	3	Benchmarking generally thought to be useful, but difficult to achieve in practice. Statement modified to this affect included in Round 3.
	Agree	5	
	Neither agree nor disagree	1	
	Disagree	2	
	Strongly disagree	1	
	Not answered / unable to say	1	
9. Support should be available to practitioners to help them interpret and act on feedback	Strongly agree	10	There was a high degree of consensus in agreement with this statement. Need for further research to identify appropriate approaches to handling feedback to practitioners indicated.
	Agree	1	
	Neither agree nor disagree	2	
	Disagree	0	
	Strongly disagree	0	
	Not answered / unable to say	0	

10. Service users should be allowed to choose between methods of feedback according to their communication abilities and preferences for closed or open questions, and for preserving anonymity	Strongly agree	5	Almost total consensus in agreement with this statement. Modified version of statement included in Round 3.
	Agree	4	
	Neither agree nor disagree	2	
	Disagree	0	
	Strongly disagree	0	
	Not answered / unable to say	2	
11. It is <b>possible</b> to develop feedback systems for people who may not be able to respond to questionnaires (eg people with learning difficulties or communication impairments, children, people who are not literate in English)	Strongly agree	6	As for statement 10.
	Agree	4	
	Neither agree nor disagree	1	
	Disagree	0	
	Strongly disagree	0	
	Not answered / unable to say	2	
12. It is <b>important</b> to develop feedback systems for people who may not be able to respond to questionnaires (eg people with learning difficulties or communication impairments, children, people who are not literate in English)	Strongly agree	7	As for statement 10.
	Agree	4	
	Neither agree nor disagree	0	
	Disagree	0	
	Strongly disagree	1	
	Not answered / unable to say	1	
13. Service users are already over-burdened with questionnaires	Strongly agree	2	Varied responses to this statement. Some felt service users were already over-burdened but others thought the burden was 'appropriate' if it was relevant and if patients could see 'tangible outcomes and benefits' for themselves or others. Modified version of this statement included in Round 3.
	Agree	2	
	Neither agree nor disagree	5	
	Disagree	2	
	Strongly disagree	0	
	Not answered / unable to say	2	
14. Practitioners are already over-burdened with requirements for gathering service user feedback	Strongly agree	2	There was also a high level of dissensus around this statement, but analysis of the comments show that most thought that service user feedback should be gathered even though practitioners may be overburdened in general with the demands placed upon them.
	Agree	1	
	Neither agree nor disagree	6	
	Disagree	3	
	Strongly disagree	0	
	Not answered / unable to say	1	

15. Practitioners are already overburdened with feedback	Strongly agree	1	Analysis of the comments made in response to this question show that no respondents agreed that practitioners were already overburdened with relevant feedback from service users.
	Agree	0	
	Neither agree nor disagree	5	
	Disagree	6	
	Strongly disagree	1	
	Not answered / unable to say	0	
16. Feedback tends to be offered by service users who have a complaint rather than those who are happy with the practitioner's professional performance	Strongly agree	1	Well designed systems overcome the tendency for those with a complaint to be more likely to provide feedback. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	6	
	Neither agree nor disagree	5	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	0	
17. Patients are unable to assess practitioners' performance because they have no direct contact with them	Strongly agree	1	There are some parts of some professions where practitioners do not have direct contact with patients. The client in these cases tends to be other health care professionals. Need for further research indicated.
	Agree	1	
	Neither agree nor disagree	2	
	Disagree	3	
	Strongly disagree	4	
	Not answered / unable to say	2	
18. Service users may have difficulty in distinguishing practitioners of different professional groups from one another (e.g. they may not be sure whether the person they just saw was a physiotherapist or an occupational therapist)	Strongly agree	2	This statement was thought to be true in the case of many professions regulated by the HPC. It was suggested that feedback mechanisms would have to take this into account. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	8	
	Neither agree nor disagree	1	
	Disagree	1	
	Strongly disagree	1	
	Not answered / unable to say	0	

19. Service user feedback processes could lead to practice becoming more 'assessment driven' - practitioners could be tempted to work in a way that elicits favourable feedback rather than according to recognised best practice	Strongly agree	0	Although some respondents felt that service user processes might influence practitioners, this was not a problem and would be counteracted by a well designed system. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	4	
	Neither agree nor disagree	4	
	Disagree	4	
	Strongly disagree	1	
	Not answered / unable to say	0	
20. Incorporating service user feedback in practitioner regulation is congruent with a philosophy of increasing service user involvement	Strongly agree	1	Whilst there was consensus agreeing with the principal of service user involvement, there were concerns about the inclusion of service user feedback in the HPC's regulatory activities.
	Agree	8	
	Neither agree nor disagree	1	
	Disagree	1	
	Strongly disagree	1	
	Not answered / unable to say	1	
21. The subjective opinion of service users is valuable, as long as the subjectivity is not overlooked or disguised	Strongly agree	2	Almost complete consensus in agreement with this statement. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	10	
	Neither agree nor disagree	1	
	Disagree	0	
	Strongly disagree	0	
	Not answered / unable to say	0	
22. Practitioners could be demoralised by feedback that is critical of their practice	Strongly agree	1	There was a good deal of agreement that there was a danger that practitioners could be demoralised by critical feedback, but on the whole, it was felt that effective processes for delivery feedback would prevent this and lead to improvements. A statement to this affect was included in Round 3.
	Agree	7	
	Neither agree nor disagree	2	
	Disagree	2	
	Strongly disagree	0	
	Not answered / unable to say	1	

23. Confidence of practitioners could be improved by direct feedback from service users	Strongly agree	0	This was seen as possible in a well designed system and is linked to statement 9 (strong need to provide supportive feedback to practitioners).
	Agree	6	
	Neither agree nor disagree	6	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	0	
24. It is difficult to interpret feedback without knowledge of the context of service users' wider circumstances	Strongly agree	3	There was a high degree of consensus in agreement around this statement. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	9	
	Neither agree nor disagree	0	
	Disagree	1	
	Strongly disagree	0	
	Not answered / unable to say	0	
25. Service users may fear repercussions of giving critical feedback	Strongly agree	0	Most respondents agreed with this statement. Those who did not suggested effective systems would overcome this problem. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	9	
	Neither agree nor disagree	1	
	Disagree	2	
	Strongly disagree	0	
	Not answered / unable to say	1	
26. It is possible to administer questionnaires in consistent ways across different settings	Strongly agree	0	There was a high degree of variation in responses to this question. Those who agreed suggested well designed systems were feasible but a small number felt this was not possible. A statement was included in Round 3 regarding the need for questionnaires to be designed by experts.
	Agree	3	
	Neither agree nor disagree	6	
	Disagree	1	
	Strongly disagree	2	
	Not answered / unable to say	1	
27. Being asked for feedback may give service users a sense of empowerment, which may have therapeutic benefits	Strongly agree	1	Most respondents thought there could be benefits to the patient in providing feedback within an effective system, though were sceptical about the use of the terms 'empowerment' or 'therapeutic benefits' in this context.
	Agree	4	
	Neither agree nor disagree	6	
	Disagree	0	
	Strongly disagree	1	
	Not answered / unable to say	1	

28. We understand the mechanisms that allow formative feedback to lead to improvements in professional practice	Strongly agree	0	Respondents were divided fairly equally between those who agreed and thought the mechanisms were understood and those who thought they were not understood. An adapted version of this statement was included in Round 3.
	Agree	4	
	Neither agree nor disagree	3	
	Disagree	1	
	Strongly disagree	2	
	Not answered / unable to say	3	

### 3.2.3 Delphi Round 3: achieving consensus

The aim of the Delphi technique is to identify areas of consensus. For Round 3, 10 statements that appeared likely to generate consensus were developed from analysis of responses to statements in Round 2 of the consultation.

Respondents were asked to indicate whether they broadly agreed or disagreed with each Round 3 statement and to provide comments where possible to explain their view.

The 10 Delphi Round 3 statements were:

1. Service users have a valuable perspective on practitioners' performance but their views need to be taken in context.
2. Service user feedback may be a useful measure of a practitioners' performance but not in isolation from other feedback and performance measures.
3. Provided good systems could be put in place, service user feedback could be useful to inform improvements in professional practice.
4. Benchmarking aspects of practitioners' performance against their peers' could help identify areas where performance could be improved but may be difficult to implement in practice.
5. Service users should be able to choose between methods of feedback according to their communication abilities and preferences but in practice this may be difficult to implement.
6. Service users are happy to provide feedback if there are tangible outcomes and benefits for them or those who come after them.
7. An effective quality improvement system includes service user feedback.
8. Practitioners could be demoralised by feedback that is critical of their practice if it is presented in the wrong way.
9. Skill is required to produce service user feedback mechanisms that elicit high quality data.
10. More research is needed to understand the mechanisms that allow formative feedback to lead to improvements in professional practice.

Participants' responses are described in Table 6.

**Table 6: Extent to which the 8 Delphi participants agreed or disagreed with the 10 Round 3 statements**

Delphi Round 3 statements	Respondent agreement/disagreement		Themes
1. Service users have a valuable perspective on practitioners' performance but their views need to be taken in context.	Broadly agree	7	<p>Seven of the eight panel responders agreed with this statement. A number of aspects of context were specifically referred to; these included the need to take account of:</p> <ul style="list-style-type: none"> <li>• Patients limited understanding of practitioners' actions</li> <li>• Practitioners subjective view of practitioners' performance that may not relate to clinical outcomes</li> <li>• Evidence about best practice</li> <li>• The purpose of the interventions and the outcomes agreed by the client and practitioner</li> <li>• Restrictions imposed by political, organisational, financial and environmental agendas</li> <li>• The views of others involved e.g. through 360 feedback</li> <li>• The patient's circumstances</li> </ul> <p>The one panel member who disagreed with the statement felt that taking account of context was too problematic and this led them to question whether service user feedback was 'valuable'.</p>
	Broadly disagree	1	
2. Service user feedback may be a useful measure of a practitioners' performance but not in isolation of other feedback and performance measures.	Broadly agree	7	<p>Seven respondents agreed with this statement, raising points about the need to take context into account, similar to those raised about statement 1: "Feedback from several sources has more validity."</p> <p>The same respondent disagreed with this statement as disagreed with statement 1. Again, this panel member questioned the use of the term 'valuable', saying 'useful' would be more appropriate.</p>
	Broadly disagree	1	
3. Provided good systems could be put in place, service user feedback could be useful to inform improvements in professional practice.	Broadly agree	5	<p>Two who disagreed with the statement, did so on the basis of difficulties in specifying a good system that was able to take account of the complexities of context mentioned in relation to previous statements. One disagreed with the statement in the context of regulation.</p>
	Broadly disagree	2	
	Neither agree nor disagree	1	
4. Benchmarking aspects of practitioners' performance against their peers' could help identify areas where performance could be improved but may be difficult to implement in practice.	Broadly agree	3	<p>The high degree of disagreement with this statement suggests the need for further work on the feasibility of benchmarking.</p>
	Broadly disagree	4	
	Not answered	1	



5. Service users should be able to choose between methods of feedback according to their communication abilities and preferences but in practice this may be difficult to implement.	Broadly agree	7	Analysis of the comment of the one panel member who disagreed with this statement shows that they are in agreement with the principal:  "Service users <i>must</i> be able to choose between methods of feedback..... The fact that this may be difficult to implement is not a consideration. Service users must be given the opportunity to provide information in a way that is enabling for them."
	Broadly disagree	1	
6. Service users are happy to provide feedback if there are tangible outcomes and benefits for them or those who come after them.	Broadly agree	5	One respondent who agreed with the statement questioned it's applicability in the context of regulation, "when the client wants direct redress for their complaint".  One panel member disagreed on the basis that service users are overburdened with demands for feedback. Another thought that not all service users would 'be happy' to provide feedback. One respondent felt unable to respond on behalf of service users.
	Broadly disagree	2	
	Not answered	1	
7. An effective quality improvement system includes service user feedback.	Broadly agree	8	All eight panel members broadly agreed with this statement, though some expressed doubts:  "Only if a mixture of positive and negative feedback is included. In regards to complaints to the HPC these will generally all be negative - but not necessarily a unbiased view."
	Broadly disagree	0	
8. Practitioners could be demoralised by feedback that is critical of their practice if it is presented in the wrong way.	Broadly agree	7	Seven panelists agreed with this statement:  "Presenting findings must always be handled carefully, variables and context must be explained and clarified and negative feedback should be balanced with positive views, where and if they are available. Whilst practitioners may feel demoralised, it is the task of the manager of the service to deal with this response amongst staff and ensure that morale is improved and staff views are also sought and considered."  Just one panel member disagreed with this statement:  "The best practitioners are reflective ones who always strive for improvement. The HPC CPD standards require AHPs to demonstrate how their CPD has sought to enhance service delivery. There is not the expectation that everything will always be perfect, rather that the intention to improve services is at the heart of professional practice."
	Broadly disagree	1	

9. Skill is required to produce service user feedback mechanisms that elicit high quality data.	Broadly agree	8	All participants broadly agreed with this statement:  “It will require a significant amount to work to achieve that purpose across each of the different registration titles. That applies to all the other answers too as each of the professional titles will have markedly different methods of working, users and stakeholders.”
	Broadly disagree	0	
10. More research is needed to understand the mechanisms that allow formative feedback to lead to improvements in professional practice.	Broadly agree	7	One panel member did not answer the question because they felt it was ambiguous:  “Not entirely sure what you mean by this question it is ambiguous. More research is needed could mean – it isn’t worth embarking on this initiative until there is a better evidence base to underpin in – in which case I disagree. OR It could mean – this initiative is a starting point and it would be worth undertaking a longitudinal study based on the results of this initiative in order to demonstrate the outcomes for service users and improvements in professional practice. – in which case I agree.”
	Broadly disagree	1	There was general consensus amongst the others that more research was needed and that this needed to involve the professional bodies affected:  “Yes, more research required, and it will need to address a wide range of settings in which AHP services are delivered. It will also need to be informed by other experts in the field of user feedback (irrespective of agency) and should not be undertaken lightly unless there is a real chance that it will, in itself, lead to improvements in service delivery. However, if the “feeling” is that whatever the outcome, service user feedback will not be useful in terms of improving practitioner performance at a national level, no further time and resources should be devoted to researching the area.”

---

## 4 Conclusions and recommendations

### 4.1 Literature review

This review examined tools and systems in place to gather service user feedback for a range of health professionals for the purposes of improving their professional practice. It identified ten standardised instruments and three qualitative approaches, and considered the literature surrounding their development. It also drew on the literature on patient feedback questionnaires for doctors, where the state of the science of patient feedback is more advanced, to learn lessons that could be applied to the development of service user feedback tools for use by the professions regulated by the HPC. The five questions it set out to address have been answered.

So, what can we conclude about the existing instruments' fitness for use? What of their validity and reliability, feasibility and acceptability, effectiveness and impact on practice, and their capacity to incorporate the voices of seldom-heard groups? What knowledge gaps remain, and what are the implications for the HPC?

#### 4.1.1 Formative and/or summative use

Evidence for the reliability and validity of the existing standardised instruments reviewed here designed for use with HPC registrants, as well as systems for standardised administration, sampling and comparative benchmarking, are far from robust enough to be confidently used to contribute fairly and with credibility to high-stakes summative decisions (pass/fail judgements) about practitioners' fitness-to-practice. There is potential for service user feedback gathered from these instruments and others like them, and from the qualitative approaches, to play a useful role in formative (to inform improvements in practice) assessments.

For use within formative systems, it is less important to demonstrate very stringent reliability than for use in summative systems, although if normative benchmarking is to be used it is necessary to demonstrate that an instrument measures the same aspects of practice from individual to individual and over time (test-retest reliability). An estimate of the number of assessors that must give feedback (practitioner-level reliability) is also valuable. Test-retest reliability and practitioner level reliability are reported in almost none. A measure of internal consistency (Cronbach's alpha) is reported for most of the instruments reviewed here, but in a few cases it is elevated to a point that suggests the instrument has a very narrow focus (i.e. it may not be measuring a wide range of attributes of practice).

Establishing the validity of the systems and instruments – that they measure what they purport to – is more crucial than reliability for formative feedback. Much more could be done to examine validity in relation to most of the standardised instruments reviewed here, i.e. whether they measure what they intend to against observable criteria, or produce results that would be predicted by existing research

or theory. It is particularly important to ensure that the feedback is free of the systematic bias uncovered in two recent studies of doctor feedback instruments (47,58) which demonstrated bias in feedback based on the country of qualification of the doctor, the ethnic group of the responding patient and whether the patient reported that they were seeing their usual doctor.

#### 4.1.2 Design of instruments

Designers of standardized instruments should be aware of the range of technical requirements of good questionnaire development. Reliability and validity are not intrinsic properties of an instrument, but are context-specific and contingent on circumstances, and so should be assessed in different settings and reviewed over time. The professionals regulated by HPC practice in a very wide variety of circumstances: thoroughness of assessments for reliability and validity must match this. Based on this review of instruments for professional groups regulated by the HPC, and lessons from patient feedback questionnaires for doctors, questionnaire developers should be particularly alert to the following issues:

1. confounding factors and potential for unfair discrimination (see p18)
2. the need for an estimate of practitioner level reliability (see p14)
3. elevated Cronbach's alpha (see p16)
4. ceiling effects (see p16).

Well designed and implemented service user questionnaires will produce data that can point to strengths and weaknesses in areas of an individual's practice and allow comparisons with the performance of their peers. However, certain groups (for example those with communication impairments) are systematically excluded from participating. Further, standardised instruments have difficulty capturing the flux, complexity, ambiguity and contradictions of real life. They can "*de-contextualise meaning and distance social action from its natural setting*" (p1238) (45), and it is this that can compromise their potential to guide practitioners' improvements in practice (53). Less structured approaches to gathering service user feedback may lack the reliability and comparability associated with good standardised instruments but instead are better able to capture the nuance and subjectivity of service users' experience, circumstances and expectations, and may make their findings more actionable. Greater sensitivity can be achieved to some extent by including some open-ended questions alongside forced choice items (and reporting the comments to the practitioner), or to a greater extent by using more open-ended approaches to gathering feedback. The insights they potentially offer may provide richer, more readily interpreted information on which to base changes in practice.

More flexible, often qualitative, methods using techniques such as interviews, open-ended questions, supported conversations, play, arts, sculpture, story-telling, have a role particularly for use with people who are often excluded from questionnaires. A potential weakness is that with these methods it becomes more difficult to preserve the anonymity of the service user.

### 4.1.3 Feasibility

The potential benefits of using service user feedback are many: most notably the opportunity to base efforts to improve practice on directly gathered information about the end-user's experiences of their practice. Service users have a unique and important perspective on aspects of health professionals' practice such as their interpersonal skills and capacity to support their efforts in self-care. Incorporating this perspective is an acknowledgement of this expertise and the value of service users' contribution to the assessment of professionalism. However, challenges persist in establishing the feasibility and effectiveness of feedback systems.

The use of standardised instruments is feasible in one important sense: that, compared to most non-standardised systems of gathering feedback, they are low-cost to administer and analyse. If comparisons (e.g benchmarking) are to be made between individual professionals, efforts must be made to be consistent in the way questionnaires are administered. However, even within some professional groups, the settings in which they practice vary so greatly that absolute consistency is, in practice, very hard to achieve, so care must be taken when comparing results.

Qualitative approaches are more resource intensive, both in their administration and analysis, but offer feasibility in that they can be more inclusive and may generate more valid and actionable findings.

Service users' preferences for giving feedback vary from individual to individual according to their capacities and values. Where resources permit, service users would ideally be offered a choice of methods of feedback, ranging from a standardised tool which is relatively quick to complete and preserves anonymity, to giving less structured written feedback to the practitioner immediately after the consultation, to being interviewed by a researcher using a range of methods appropriate to the individual situation.

### 4.1.4 Effectiveness

The major gap in knowledge about the effectiveness of service user feedback systems is in the step between practitioners receiving feedback and changing their practice on the basis of this feedback. No evidence was found that the capacity of the standardised instruments or qualitative methods reviewed here to contribute to the improved professional practice of those on whom feedback was gathered had been evaluated. The literature on patient feedback tools for doctors shows that, where questions about the capacity of patient feedback to inform improvements to doctors' practice have been asked, the findings have been inconclusive. More must be known about the longterm impact and effectiveness of the feedback process and mechanisms for effective formative feedback: how it should be provided, by and to whom and in what setting.

Points to be aware of in developing service user feedback systems include:

1. That patient feedback from standardized questionnaires can be difficult for clinicians to interpret and act on in the absence of knowledge of the context in which it was gathered (e.g. details of the consultation, the circumstances of the patient, etc).
2. There is a risk that the process of gathering patient feedback presents clinicians with the dilemma of assessment-driven practice: whether to practise in ways that they believe will elicit favourable feedback or to practise in an evidence-based way.
3. That standardised feedback, benchmarked against normative levels, which shows a clinician's practice to be sub-average can damage their confidence without offering the individual clear directions on how to improve.
4. The possibility that the feedback process could have a negative impact on (particularly vulnerable) service users, whether because they feel coerced into providing feedback, fear consequences or giving negative feedback, or feel that the burden of responsibility to do so is too great, and must be managed in such a way as to minimise this risk.
5. The possibility of seeking feedback particularly from challenging consultations, and where service users are stimulated to be critical in their answers, deserves further exploration.

## 4.2 Delphi consultation

Professional bodies demonstrated a high willingness to engage with the HPC in developing methods for incorporating service user feedback in regulation. Thirteen of the seventeen organisations invited to take part played an active role in the Delphi consultation.

In general, there was support amongst the professional bodies that engaged in the consultation for the concept of incorporating service user (usually patient/client) feedback into the regulatory process in some way. However, there were also many doubts and concerns expressed.

The main themes around which consensus was achieved were:

- Service users have a valuable perspective on practitioners' performance, but their views need to be taken in context (financial, organisational, political, environmental and the individual).
- Service user feedback can be a useful measure of a practitioner's performance, but not in isolation from other feedback (e.g. 360 degree feedback) and performance measures.

- Service users should be able to choose between methods of feedback according to their communication abilities and preferences but in practice this may be difficult to implement.
- Practitioners should be given service user feedback in a supportive environment.
- Provided good systems (that include the above features) are put in place, service user feedback could be useful to inform improvements in professional practice.

There was less consensus around the following themes, and panel members' responses suggest a need for further research:

- Benchmarking aspects of practitioners' performance against that of their peers could help identify areas where performance could be improved.
- Service users are happy to provide feedback if there are tangible outcomes and benefits for them or for those who come after them.

## Appendix 1: literature review references

1. Coulter A, Magee H. The European Patient of the Future. Maidenhead: Open University Press; 2003.
2. Coulter A, Ellins J. The quality enhancing interventions project: patient-focused interventions. London: The Health Foundation; 2006.
3. Greenhalgh T, Eversley J. Quality in General Practice: Towards a Holistic Approach. London: Kings fund; 1999.
4. Mercer SW, Maxwell M, Heaney D, Watt GC. The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Family Practice*. 2004 Dec 1;21(6):699–705.
5. Goldstein MS, Elliott SD, Guccione AA. The development of an instrument to measure satisfaction with physical therapy. *Physical Therapy*. 2000 Sep;80(9):853–63.
6. Kealey P, McIntyre I. An evaluation of the domiciliary occupational therapy service in palliative cancer care in a community trust: a patient and carers perspective. *European Journal of Cancer Care*. 2005 Jul;14(3):232–43.
7. Hills R, Kitchen S. Toward a theory of patient satisfaction with physiotherapy: Exploring the concept of satisfaction. *Physiotherapy Theory & Practice*. 2007;23(5):243–54.
8. Beattie PF, Pinto MB, Nelson MK, Nelson R. Patient satisfaction with outpatient physical therapy: Instrument validation. *Physical Therapy*. 2002 Jun;82(6):557–65.
9. Arborelius E, Bremberg S. What does a human relationship with the doctor mean. 1992;10:163–9.
10. Stewart M. Effective physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal*. 1995;(152):1423–33.
11. Speers J. Service user involvement in the assessment of a practice competency in mental health nursing -- stakeholders' views and recommendations. *NURSE EDUC PRACT*. 2008 Mar;8(2):112–9.
12. Mcallister M, Matarasso B, Dixon B, Shepperd C. Conversation starters: re-examining and reconstructing first encounters within the therapeutic relationship. *Journal of Psychiatric and Mental Health Nursing*. 2004 Oct 1;11(5):575–82.
13. Sainsbury Centre for Mental Health. The Capable Practitioner – A Framework and List of the Practitioner Capabilities Required to Implement the National Service Framework for Mental Health. London: Sainsbury Centre for Mental Health; 2001.
14. Coulehan J, Platt F, Egener B. “Let me see if I have this right...”: Words that build empathy. *Ann Intern Med*. 2000;135(3):221–7.



15. Mercer SW, Reynolds WJ. Empathy and quality of care. *Br J Gen Pract.* 2002 Oct;52(Suppl):S9-12.
16. Neumann M, Bensing J, Mercer S, Ernstmann N, Ommen O, Pfaff H. Analyzing the “nature” and “specific effectiveness” of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda. *PATIENT EDUC COUNS.* 2009 Mar;74(3):339-46.
17. Delbanco TL. Enriching the Doctor-Patient Relationship by Inviting the Patient’s Perspective. *Annals of Internal Medicine.* 1992 Mar 1;116(5):414-8.
18. Davies H, Howells R. How to assess your specialist registrar. *Archives of Disease in Childhood.* 2004 Dec 1;89(12):1089-93.
19. Crossley J, Humphris G, Jolly B. Assessing health professionals. *Medical Education.* 2002 Sep 1;36(9):800-4.
20. Mercer SW, Murphy DJ. Validity and reliability of the CARE Measure in secondary care. *Clinical Governance: An International Journal.* 2008;13:269-83.
21. Mercer SW, McConnachie A, Maxwell M, Heaney D, Watt GC. Relevance and practical use of the Consultation and Relational Empathy (CARE) Measure in general practice. *Family Practice.* 2005 Jun;22(3):328-34.
22. Mercer S, Hatch D, Murray A, Murphy D, Eva K. Capturing patients’ views on communication with anaesthetists: the CARE Measure. *CLIN GOVERNANCE INT J.* 2008 Jun;13(2):128-37.
23. Mckinnon AL. Client Values and Satisfaction with Occupational Therapy. *Scandinavian Journal of Occupational Therapy.* 2000 Nov 27;7(3):99-106.
24. Sixma H, Calnan M, Groenewegen P, Calnan S. Quality of care from the perspective of OT-users [Internet]. Kent: Nivel; 1999. Available from: [www.nivel.nl/pdf/QUOTE-OT.V23-2.pdf](http://www.nivel.nl/pdf/QUOTE-OT.V23-2.pdf)
25. Sixma HJ, Calnan S, Calnan M, Groenewegen PP. User involvement in measuring service quality of local authority occupational therapy services; a new approach. *International Journal of Consumer Studies.* 2001 Jun 1;25(2):150-9.
26. Hills R, Kitchen S. Development of a model of patient satisfaction with physiotherapy. *Physiotherapy Theory & Practice.* 2007;23(5):255-71.
27. Hills R, Kitchen S. Satisfaction with outpatient physiotherapy: A survey comparing the views of patients with acute and chronic musculoskeletal conditions. *Physiotherapy Theory & Practice.* 2007;23(1):21-36.
28. Knight PK, Alan Nai-Jen Cheng, Lee GM. Results of a survey of client satisfaction with outpatient physiotherapy care. *Physiotherapy Theory & Practice.* 2010 Jul;26(5):297-307.
29. Sumner M, Mead J, ten Hove R. Audit and Re-audit of the CSP Core Standards of Physiotherapy Practice. *Physiotherapy.* 2000 Oct;86(10):512-6.
30. Hansen LK, Vincent S, Harris S, David E, Surafudheen S, Kingdon D. A patient satisfaction rating scale for psychiatric service users. *The Psychiatrist.* 2010 Nov 1;34(11):485-8.
31. Cahill J, Barkham M, Hardy G, Gilbody S, Richards D, Bower P, et al. A review and critical appraisal of measures of therapist-patient interactions in mental health settings. *Health Technology Assessment.* 12(24).

32. Miller N, Noble E, Jones D, Deane KHO, Gibb C. Survey of speech and language therapy provision for people with Parkinson's disease in the United Kingdom: patients' and carers' perspectives. *International Journal of Language & Communication Disorders*. 2011 Mar;46(2):179–88.
33. Ely GE, Dulmus CN, Akers LS. An Examination of Levels of Patient Satisfaction with Their Abortion Counseling Experience: A Social Work Practice Evaluation. *Best Practice in Mental Health*. 2010;6(2):103–14.
34. Davies J, Wright J, Drake S, Bunting J. "By listening hard" developing a service user feedback system for adopted and fostered children in receipt of mental health services. *Adoption and Fostering*. 2009;33(4):19–33.
35. Ennals P, Fossey E. The Occupational Performance History Interview in community mental health case management: Consumer and occupational therapist perspectives. *Australian Occupational Therapy Journal*. 2007 Mar;54(1):11–21.
36. Connect. Including People with Communication Disability in Stroke Research and Consultation [Internet]. London: Connect; 2007. Available from: [https://www.ukconnect.org/publications\\_27\\_124.aspx](https://www.ukconnect.org/publications_27_124.aspx)
37. Law J, van der Gaag A, Symon S. Improving communication in primary care: an examination of the feasibility of introducing Health Talk: Count me in. Edinburgh: Centre for Integrated Healthcare Research; 2005.
38. Chartered Society of Physiotherapy. *Clinical Audit Tools*. London: Chartered Society of Physiotherapy; 2000.
39. Hansen LK, Vincent S, Harris S, David E, Surafudheen S, Kingdon D. A patient satisfaction rating scale for psychiatric service users. *The Psychiatrist*. 2010 Nov 1;34(11):485–8.
40. Hills R, Kitchen S. Satisfaction with outpatient physiotherapy: Focus groups to explore the views of patients with acute and chronic musculoskeletal conditions. *Physiotherapy Theory & Practice*. Feb2007;23(1):1–20.
41. Burford B, Bedi A, Morrow G, Kergon C, Illing J, Livingston M, et al. Collecting patient feedback in different clinical settings: problems and solutions. *Clinical Teacher*. 2009 Dec;6(4):259–64.
42. Kinnersley P, Stott N, Peters T, Harvey I, Hackett P. A comparison of methods for measuring patient satisfaction with consultations in primary care. *Family Practice*. 1996 Jan 1;13(1):41–51.
43. Schneider H, Palmer N. Getting to the truth? Researching user views of primary health care. *Health Policy and Planning*. 2002 Mar 1;17(1):32–41.
44. Richards SH, Campbell JL, Dickens A. Does the method of administration influence the UK GMC patient questionnaire ratings? *Primary Health Care Research & Development* (Cambridge University Press / UK). 2010 Jul 14;12(1):68–78.
45. Coyle J, Williams B. An exploration of the epistemological intricacies of using qualitative data to develop a quantitative measure of user views of health care. *Journal of Advanced Nursing*. 2000 May;31(5):1235–43.
46. Hopkins C, Niemiec S. The development of an evaluation questionnaire for the Newcastle Crisis Assessment and Home Treatment Service: finding a way to

- include the voices of service users. *J Psychiatr Ment Health Nurs*. 2006 Feb;13(1):40-7.
47. Archer JC, McAvoy P. Factors that might undermine the validity of patient and multi-source feedback. *Medical Education*. 2011;45:886-93.
  48. Baker R. Characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations. *Br J Gen Pract*. 1996 Oct;46(411):601-5.
  49. Crossley J, Davies H. Doctors' consultations with children and their parents: a model of competencies, outcomes and confounding influences. *Medical Education*. 2005;39(8):807-19.
  50. Crossley J, Eiser C, Davies HA. Children and their parents assessing the doctor-patient interaction: a rating system for doctors' communication skills. *Medical Education*. 2005;39(8):820-8.
  51. Crossley J, Russell J, Jolly B, Ricketts C, Roberts C, Schuwirth L, et al. "I'm pickin' up good regressions": the governance of generalisability analyses. *Medical Education*. 2007 Oct;41(10):926-34.
  52. Evans RG, Edwards A, Evans S, Elwyn B, Elwyn G. Assessing the practising physician using patient surveys: a systematic review of instruments and feedback methods. *Family Practice*. 2007 Apr 1;24(2):117-27.
  53. Edwards A, Evans R, White P, Elwyn G. Experiencing patient-experience surveys: a qualitative study of the accounts of GPs. *British Journal of General Practice*. 2011;61(585):e157-66.
  54. Rider EA, Perrin JM. Performance Profiles: The Influence of Patient Satisfaction Data on Physicians' Practice. *Pediatrics*. 2002 May;109(5):752.
  55. Burford B, Greco M, Bedi A, Kergon C, Morrow G, Livingston M, et al. Does questionnaire-based patient feedback reflect the important qualities of clinical consultations? Context, benefits and risks. *PATIENT EDUC COUNS*. 2011;84(2):e28-36.
  56. Reinders ME, Blankenstein AH, van Marwijk HWJ, Schleypen H, Schoonheim PL, Stalman WAB. Development and feasibility of a patient feedback programme to improve consultation skills in general practice training. *Patient Education and Counseling*. 2008 Jul;72(1):12-9.
  57. Reinders ME, Blankenstein AH, Van Der Horst HE, Knol DL, Schoonheim PL, Van Marwijk HWJ. Does patient feedback improve the consultation skills of general practice trainees? A controlled trial. *Medical Education*. 2010 Feb 1;44(2):156-64.
  58. Campbell JL, Roberts M, Wright C, Hill J, Greco M, Taylor M, et al. Factors associated with variability in the assessment of UK doctors' professionalism: analysis of survey results. *British Medical Journal*. 2011;343.
  59. Bauld L, Chesterman J, Judge K. Measuring satisfaction with social care amongst older service users: issues from the literature. *Health & Social Care in the Community*. 2000;8(5):316.

## Appendix 2: literature review search terms

Key words were drawn from the research questions and synonyms identified using subject indices, topic trees and MeSH terms to produce the following clusters of search terms.

NB \* denotes truncated search term where, for example, “regulat\*” includes “regulate,” “regulation,” “regulator,” and “regulated”.

- Service user, patient, consumer, client, carer, caregiver, lay
- Feedback, view, perspective, input, questionnaire, survey, satisfaction
- Practice, professional practice, standards, performance, professional\* conduct
- Regulat\*, apprais\*, certify\*, continued professional development, CPD, professional development, continuing education, performance<sup>10</sup>
- art\* therap\*, drama therap\*, music therap\*
- biomedical scien\*
- chiropod\*, podiatr\*
- clinical scien\*<sup>11</sup>
- dietit\*, hearing aid dispens\*, occupational therap\*, operating department practi\*, orthoptis\*, paramedic\*
- physiotherap\*, physical therap\*
- psycholog\*<sup>12</sup>
- prostheti\*, orthotic\*
- radiograph\*<sup>13</sup>
- speech therap\*
- social work\*

<sup>10</sup> Did not include: review, evaluat\*, measure\*, monitor\*

<sup>11</sup> [audiolog\*, clinical biochemist\*, clinical genetic\*, clinical immunolog\*, clinical microbiolog\*, clinical physiolog\*, embryolog\*, haematolog\*, histocompatibilit\*, immunogenetics. Medical physic\*, clinical engineer\*]

<sup>12</sup> The following specific terms were not searched since ‘psycholog\*’ would bring up the same hits: practitioner psycholog\*, clinical psycholog\*, counselling psycholog\*, educational psycholog\*, forensic psycholog\*, health psycholog\*, occupational psycholog\*, sport and exercise psycholog\*

<sup>13</sup> Did not search for: [diagnostic radiograph\*, therapeutic radiograph\*]

## Appendix 3: literature review databases

The following databases of peer reviewed literature were searched:

Database name	Description
AMED	Allied and complementary medicine (Health care information service of British Library)
HMIC	Health Management Information Consortium
CINAHL	Cumulative Index to Nursing and Allied Health Literature
Academic Search Complete	Mutlidisciplinary full-text database
Social Services Abstracts	Social work, human services, and related areas
Proquest Nursing and allied health source	Nursing and allied health
Proquest psychology	Psychology journals and dissertations
Proquest health management	Health management and administration
Proquest health and medical	Clinical, consumer and health administration journals
Proquest ASSIA	Applied social sciences index and abstracts
Cochrane Database of Systematic Reviews	Systematic reviews in health care
Social Care Online	Social work and social care information
Web of Science	Citation index to multiple databases
Centre for Reviews and Dissemination	Research on health and social care interventions and systematic reviews

The following databases were searched for grey literature, including reports, theses and conference proceedings, memoranda, conference proceedings and government documents:

- King's Fund library database
- British Library Reports, Conferences and Theses
- Opengrey Repository
- Web of Science Conference Proceedings Citation Index (searched alongside WoS)
- Zetoc

The search facilities of these databases are variable. The search terms above were used in combinations appropriate to each particular search engine.

## Appendix 4: professional bodies and associations contacted

Professional body	Website
British Association of Art Therapists	<a href="http://www.baat.org">www.baat.org</a>
British Association of Dramatherapists	<a href="http://www.badth.org.uk">www.badth.org.uk</a>
British Association for Music Therapy	<a href="http://www.bamt.org">www.bamt.org</a>
Institute of Biomedical Science	<a href="http://www.ibms.org">www.ibms.org</a>
The Society of Chiropodists & Podiatrists	<a href="http://www.feetforlife.org">www.feetforlife.org</a>
The Institute of Chiropodists and Podiatrists	<a href="http://www.iocp.org.uk">www.iocp.org.uk</a>
The British Chiropody & Podiatry Association	<a href="http://www.bcha-uk.org">www.bcha-uk.org</a>
The Alliance of Private Sector Chiropody and Podiatry Practitioners	<a href="http://www.thealliancepsp.com">www.thealliancepsp.com</a>
Federation of Clinical Scientists	<a href="http://www.acb.org.uk/federation">www.acb.org.uk/federation</a>
British Dietetic Association	<a href="http://www.bda.uk.com">www.bda.uk.com</a>
British Society of Hearing Aid Audiologists	<a href="http://www.bshaa.com">www.bshaa.com</a>
British Association of Occupational Therapists	<a href="http://www.cot.co.uk">www.cot.co.uk</a>
College of Operating Department Practitioners (CODP)	<a href="http://www.codp.org.uk">www.codp.org.uk</a>
Association for Perioperative Practice (AfPP)	<a href="http://www.afpp.org.uk">www.afpp.org.uk</a>
PROPRIUS	<a href="http://www.proprius.org.uk">www.proprius.org.uk</a>
British Orthoptic Society	<a href="http://www.orthooptics.org.uk">www.orthooptics.org.uk</a>
College of Paramedics	<a href="http://www.collegeofparamedics.co.uk">www.collegeofparamedics.co.uk</a>
Chartered Society of Physiotherapy	<a href="http://www.csp.org.uk">www.csp.org.uk</a>

British Psychological Society	<a href="http://www.bps.org.uk">www.bps.org.uk</a>
Association of Educational Psychologists	<a href="http://www.aep.org.uk">www.aep.org.uk</a>
British Association of Prosthetists & Orthotists	<a href="http://www.bapo.com">www.bapo.com</a>
The Society & College of Radiographers	<a href="http://www.sor.org">www.sor.org</a>
Royal College of Speech and Language Therapists	<a href="http://www.rcslt.org">www.rcslt.org</a>
General Social Care Council	<a href="http://www.gsc.org.uk">www.gsc.org.uk</a>
College of Social Work	<a href="http://www.collegeofsocialwork.org">www.collegeofsocialwork.org</a>
CHRE	



---

## Appendix 5: four methodologies used by Davies et al (2009)

These are reproduced here verbatim from Davies et al's (2009) (34) paper because they describe in some detail innovative techniques adopted to elicit feedback from a vulnerable, seldom heard group.

**Bag of feelings:** Binney and Wright (1997) developed the 'bag of feelings' technique as a therapeutic tool. Children work with the therapist to represent 'all the feelings inside you' either by writing or drawing. This non-directive methodology was adapted to consider feelings about therapy and was the first item to be explored in the child interview. Following local experts' advice, once children had completed their bags they were shown a selection of cards each depicting a teddy bear displaying an emotion (Deal, 1995). These cards were used to achieve further discussion of the child's feelings, especially when she or he has emotional development difficulties.

**Cartoon strip:** The cartoon strip format was taken from the pictorial critical incident interview (Ross and Egan, 2004). It is a child-friendly adaptation of their 'critical incident technique' which assumes that respondents describe those aspects of an incident that are significant for them. Children were presented with a six-box cartoon strip with blank boxes except the first and last, which depict a child with an empty thought bubble arriving/ leaving the clinic. Children were asked to complete the thought bubbles and 'show me the story' of what happens as if they were the child. They were also encouraged to explain and expand on their cartoon.

**Attending Therapy Scenario (ATS):** Access can be gained to a child's internal world indirectly by asking them about the thoughts and feelings of characters in pictures (Veale, 2005). In the Separation Anxiety Test (Klagsbrun and Bowlby, 1976; Wright et al, 1995), designed to measure internal representations of attachment, children are asked about the feelings and subsequent behaviour of children in pictures depicting separations from caregivers. This was adapted for the present study: two pictures were produced of a child--in a therapy session and leaving therapy. Children were told this was a child about their age and for each picture asked, 'What do you think she might be feeling?' and 'What do you think she's going to do next?' Further prompts were used as the story unfolded. This method was also used with carers, who were asked about a child of similar age to the one they looked after. Three of the carers identified their own child with the story character but one did not. She presented a variety of alternatives based on the number of children she cared for. This reflected her varied experiences with looked after children in therapy.

**Direct questions:** Children were asked questions in a situation resembling an 'interview on TV'. Some enjoyed using the microphone to facilitate this. Questions included helpful aspects of therapy (Strickland-Clark et al, 2000), what they liked most about it, their three 'top tips' to improve therapy and which of the methods they liked and found most helpful to explain their feelings.

Previous research has noted that children find it difficult to talk about negative aspects of their experiences (Bond, 1995). Asking children how they would improve services proved less threatening to elicit areas of dissatisfaction (Rosen-Webb and Morrissey, 2005).

In the present study, 'top tips' was suggested by the local research consultation group as a preferred method to avoid unrealistic ideas.”

---

## Appendix 6: Delphi Round 1 questions

### INSTRUCTIONS

Thank you for agreeing to take part in the Delphi Consultation to inform the HPC's review of how **feedback from patients** and other service users could be incorporated in **professional regulation**.

As the first stage of the consultation we would like you to review the tables in this document and answer the two questions below. It would be helpful to have your response **before 17<sup>th</sup> October**. If you need more time, more information or if you would prefer to express your views over the phone, please **email or call me**: [contact information]

#### Delphi Question 1:

Which of the following statements best describes your response to the HPC incorporating service user feedback in their regulatory processes?

- a. Wholly positive
- b. Broadly positive, but with some concerns
- c. Broadly negative
- d. Wholly negative
- e. Unable to comment

Please tell us about any hopes or concerns you have:

---

## Appendix 7: Delphi Round 2 evidence review question

Table 1 (below)<sup>14</sup> shows the results of a review of the published literature on tools for capturing service user feedback about the service delivered by the professions regulated by the HPC. **Please help us ensure the table is complete by telling us about any additional items we should include in our review.**

The table summarises the findings of a review of published literature in relation to five research questions:

1. Which tools have been developed for obtaining service user feedback on individual professionals regulated by the HPC for the purposes of improving professional practice?
2. What areas of professional practice do they cover?
3. How are they administered/implemented?
4. Is there evidence of their measurement characteristics (validity and reliability)?
5. What evidence is there of their (perceived) effectiveness and applicability (e.g. that they lead to improvements in professional practice, improve public confidence in the profession, improve public trust, improve service user safety or provide a stimulus to learning, or that their cost/burden is acceptable)?

We are interested in approaches used to “gather feedback on individual practitioners collected for the purposes of improving professional practice of the professionals regulated by the HPC and in social work. *For example, for collecting feedback on things like:*

*communication, therapist interaction, enablement, explanations and instructions, interpersonal management, warmth/friendliness, respect for privacy, therapist’s role in providing teaching and training, therapist’s professional manner and personal characteristics, trust, exploration of ideas, body language, active listening, competence in developing therapeutic relationships, ‘relational empathy’.*

Qualitative approaches to obtaining feedback (e.g. interviews, open-ended questions, play, arts, sculpture, story-telling) for groups of people who are often excluded from questionnaires because they’re not literate in English, are too young, cognitively impaired, etc are also of interest.

---

<sup>14</sup> Table 1 as provided in section 2.1 of this report

---

## Appendix 8: Delphi Round 2 questionnaire

The literature review and round 1 of the Delphi review have highlighted the following concerns, hopes and issues relating to the use of service user feedback. Please indicate the extent to which you agree with each statement and, if possible, make comments that will help us understand your response.

*The term 'service user' is used as shorthand for the different terms that can be applied to those affected by a professional's practice (including patients, clients, etc).*

*The term 'practitioner' is used to refer to the professionals regulated by HPC and, for the purposes of this exercise, it refers to practitioners specifically from your organisation's professional group.*

Question:	Please indicate the extent to which you agree with each statement by placing a X in the relevant box						Comments to help us understand your response We are particularly interested in understanding the thinking behind your response and would be happy to record this in an interview over the phone if you prefer
	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	UNABLE TO SAY	
1. Service users have a valuable perspective on practitioners' performance.							
2. Service users can provide a valid, or 'true', assessment of a practitioner's performance.							
3. Service user feedback could be incorporated in formative assessment (eg as part of CPD).							
4. Service user feedback could be incorporated in summative assessment (eg as part of performance review).							

5. Provided good systems could be put in place, service user feedback could, in principle, be useful to inform improvements in professional practice.							
6. Questionnaire results can provide service user feedback in a form that is useful for improvements in professional practice.							
7. Less structured methods (open-ended questions / interviews) can provide service user feedback in a form that is useful for improvements in professional practice.							
8. Benchmarking aspects of practitioners' performance against their peers' is helpful in identifying areas where performance could be improved.							
9. Support should be available to practitioners to help them interpret and act on feedback.							
10. Service users should be allowed to choose between methods of feedback according to their communication abilities and preferences for closed or open questions, and for preserving anonymity.							

<p>11. It is <b>possible</b> to develop feedback systems for people who may not be able to respond to questionnaires (e.g. people with learning difficulties or communication impairments, children, people who are not literate in English).</p>							
<p>12. It is <b>important</b> to develop feedback systems for people who may not be able to respond to questionnaires (e.g. people with learning difficulties or communication impairments, children, people who are not literate in English).</p>							
<p>13. Service users are already over-burdened with questionnaires</p>							
<p>14. Practitioners are already over-burdened with requirements for gathering service user feedback .</p>							
<p>15. Practitioners are already over-burdened with feedback.</p>							
<p>16. Feedback tends to be offered by service users who have a complaint rather than those who are happy with the practitioner's professional performance.</p>							



<p>17. Patients are unable to assess practitioners' performance because they have no direct contact with them.</p>							
<p>18. Service users may have difficulty in distinguishing practitioners of different professional groups from one another (e.g. they may not be sure whether the person they just saw was a physiotherapist or an occupational therapist).</p>							
<p>19. Service user feedback processes could lead to practice becoming more 'assessment driven' - practitioners could be tempted to work in a way that elicits favourable feedback rather than according to recognised best practice.</p>							
<p>20. Incorporating service user feedback in practitioner regulation is congruent with a philosophy of increasing service user involvement.</p>							
<p>21. The subjective opinion of service users is valuable, as long as the subjectivity is not overlooked or disguised.</p>							

22. Practitioners could be demoralised by feedback that is critical of their practice.							
23. Confidence of practitioners could be improved by direct feedback from service users.							
24. It is difficult to interpret feedback without knowledge of the context of service users' wider circumstances.							
25. Service users may fear repercussions of giving critical feedback.							
26. It is possible to administer questionnaires in consistent ways across different settings.							
27. Being asked for feedback may give service users a sense of empowerment, which may have therapeutic benefits.							
28. We understand the mechanisms that allow formative feedback to lead to improvements in professional practice.							

## Appendix 9: Delphi Round 2 responses

Note: transcripts of telephone interviews were not reproduced in the tables of comments but have been included in the closed response counts and have been included in the thematic analysis presented below.

### 1: Service users have a valuable perspective on practitioners' performance

Strongly agree	6
Agree	6
Neither agree nor disagree	1

None of the Delphi panel respondents felt that service users did not have a valuable perspective on practitioners' performance:

*"It is vitally important that service users' views are fed back to practitioners; it is one mechanism by which they can review their performance and develop their knowledge and skills."*

*"Otherwise you can think you're doing a very good job but service users may have a completely different perspective that the practitioner may not have thought about."*

However, respondents, including three who strongly agreed with the statement, qualified their answer with the proviso that

a) the context needed to be taken into account and/or

b) the extent of matters on which service users could comment was limited to those aspects of practice that either directly impinged on the service user (eg communication) or were within the service users' understanding:

*"Service users will not necessarily understand the nature of practice and why, for example, it's not appropriate to carry out an... examination they think they need, or why it's important that they recover from surgery before undergoing treatment."*

*"A patient may have 'a pleasant experience' but may not be able to determine if the treatment was high-quality or not."*

The need to take into account the context in which the service was delivered was mentioned by most panel respondents. The organisational, environmental and individual aspects of context were raised:

- the operational guidelines, procedures and protocols which dictated the way in which a service was delivered due to financial and other resource constraints and/or the

evidence on best practice;

- the broad variation both within and between the different professional groups that the HPC regulates;
- people are individuals and do not always get on:

*“If a patient perceives an unpleasant experience this may not be down to poor quality treatment but could be a personality clash for example.”*

One respondent gave the following example of the importance of understanding the financial context:

*“A service user may think that they have had poor service or treatment and make a complaint against an individual practitioner. However, that practitioner might have been working in line with organisational requirements in order to reduce costs.”*

Other comments highlight differences in the environmental context in which different groups work in, both between different professions and between individual in the same profession working in different settings e.g. acute as opposed to primary care, NHS as opposed to private health facilities or patient facing as opposed to ‘backroom’ functions, clinical as opposed to non clinical:

*“Dramatherapy is a client-led intervention. The client/therapist relationship is explored with the client as an essential aspect of the therapy. The role of the clinical supervisor is to assist the therapist to ensure that this process is client focused.”*

*“There’s a strong variation between practitioners who are very forward facing with patients and service users and others who don’t actually often see what the output of their work is.”*

## 2: Service users can provide a valid, or ‘true’, assessment of a practitioner’s performance

Agree	8
Neither agree nor disagree	2
Disagree	2
Not answered / unable to say	1

Eight panel respondents felt that service users could provide a ‘true’ assessment of a practitioner’s performance. Though only two of the twelve panel members disagreed with the statement, all eight that agreed, qualified their response. As with the first theme, the service users’ perspective was said by respondents to be limited by the gap between their individual expectations, their understanding of the practitioners’ actions (some aspects of practice are too complex or intangible) and the environmental and organisational context in which the service is delivered. Respondents clarified and elaborated on the nature of these limitations:

*“They can, but only from a subjective perspective; collated service user feedback may be a useful measure of a practitioners’ performance but not in isolation of other feedback*

and performance measures.”

*“Service users provide a very valid but a very particular view. To fully assess practitioners’ performance there needs to be a triangulation of evidence from service users, the organisation’s expectations and in reference to the evidence base.”*

*“It is possible to describe different scenarios which argue for and against the service user have the only valid view. Any system needs to take account of the many different settings and specialties of professional practice including research and teaching and other non patient centred employment and such confounding factors as institutional factors and the nature of commissioned services.”*

*“It has to be taken in context - they may not have the knowledge or experience to fully understand what the practitioner is doing and therefore their interpretation or even expectation of the practitioner may be unrealistic. There may be huge barriers to the client being willing to understand what they’re hearing. Where the client has learning disabilities it becomes even more difficult.”*

In expressing a similar view to that expressed in this last quote concerning limit’s to the patients’ understanding of practitioners’ actions, one respondent was critical of the scope of existing patient surveys, particularly in terms of their potential application in professional regulation:

*“There are fairly conventional patient surveys which ask patients to comment on whether the waiting room was clean and tidy, whether they were seen on time and such matters and I’ve always felt that these are largely peripheral to the core quality of the service provided, certainly by the professional being judged as to their professional competence. And so these things that the patient can comment on are not necessarily the things that are of benefit for the patient to comment on or of validity in the performance of the practitioner.”*

Another respondent also made a methodological point about forms of assessment that were already in use in the profession and whether these could be used for gathering service user feedback for professional regulation:

*“It depends on whether the assessment is based on outcomes. Outcomes and the length of time practitioners are permitted to allocate to clients may be dictated by the employing agency. Will also depend on when the feedback is requested, during or post therapy. (Practitioners) normally do ‘follow-up’ evaluations. Practitioners involved in teaching will receive feedback via university procedures.”*

### 3: Service user feedback could be incorporated in formative assessment (eg as part of CPD)

Strongly agree	4
Agree	4
Neither agree nor disagree	3
Disagree	1
Not answered / unable to say	1

Analysis of the comment made in strong agreement to this statement demonstrates the importance of taking the closed answers in the context of open comments:

*“Whether it should or shouldn’t be, I think, is a different matter, and that’s the same for question four.”*

Even some of those respondents that agreed with the statement had doubts about either the practicality and/or the benefits of incorporating service user feedback in formative assessment. In contrast, four respondents were unequivocally positive about the proposition, particularly in terms of its potential to initiate reflective practice and service improvements:

*“One side of (the CPD a practitioner needs might be demonstrating being) up to date with the technology (and) methods of clinical assessment (and benefits to patients)... That’s.... - specific stuff. But the way in which the practitioner relates to the service user... Is totally critical to (outcomes)... So the feedback from the service user in that environment is absolutely critical.”*

One respondent commented that service user feedback was already incorporated into CPD in their profession:

*“This is already done as part of the HPC CPD requirements as registrants have to demonstrate that the CPD they have undertaken has sought to enhance service delivery and to be of benefit to service users.”*

Another expressed some very specific concerns about extending the systems for service user feedback already in place to CPD:

*“(Practitioners) already use comprehensive assessment/evaluation methods and client feedback is incorporated into these forms. Client feedback incorporated as CPD would hinge on whether the client would be willing to participate and would be asking the client to take on work for the (practitioner). This could contravene codes of ethics. To incorporate client feedback into CPD comes very close to research and this means ethical clearance.”*

4: Service user feedback could be incorporated in summative assessment (eg as part of performance review)

Strongly agree	2
Agree	4
Neither agree nor disagree	5
Disagree	1
Not answered / unable to say	1

There was less agreement that service user feedback could be incorporated in summative assessment, though again one respondent said this already happened as part of the regulatory process and another said service user feedback was already included in appraisal processes in the profession:

*“The HPC CPD standards should be a core part of annual appraisal and personal development plans.”*

*“The evaluation and assessment systems already in place contribute to performance reviews.”*

Again, advantages were couched in terms of the opportunities for reflective practice and some of those who agreed with the statement expressed concerns about the feasibility of implementation. One questioned ‘Whose responsibility is this – regulator or employer?’; an issue that was described in detail by another:

*“Performance review undertaken in the context of the HPC as the regulator... Would relate to fundamental fitness to practice issues. And if that was the dynamic then emphatically I would not agree that service user feedback would readily fit in to that performance, hard end performance, you are not fit to practice kind of language.”*

Another respondent raised methodological issues:

*“This would depend on the mechanisms used to elicit feedback, the size of the sample and how this would be incorporated into the performance review.”*

Others raised issues covered in relation to the previous themes concerning limits to the subjects that patients could comment on, specifically those directly tangible or understandable to the lay person.

*“I would agree but heavily caveated by, in exceptional circumstances, only where the feedback is demonstrably valid.”*

Again as before, the need to take context into account was emphasised – the different working environments.

*“There is a lack of understanding between different modalities within the profession because its complex, let alone with lay people.”*

*“My concern is that the feedback would have to be based on a complete understanding of the process or the function of the practitioner. There could be a danger that uninformed feedback could be wide of the mark.”*

5: Provided good systems could be put in place, service user feedback could, in principle, be useful to inform improvements in professional practice

Strongly agree	5
Agree	7
Strongly disagree	1

Examination of the comment made by the one Delphi panel member who disagreed with this statement reveals that their closed response could be misleading:

*“Service user feedback is **essential** and it is not a question of whether it ‘could be put into place’. It should already be in place and be an essential component of good and safe practice.”*

On the other hand, one respondent who agreed with the statement thought it would be better to attend to the way in which “service users’ views are informing service development rather than individuals’ practice and performance.”

On this theme, one respondent refers to good practice in service user feedback in service improvement but:

*“I am not aware of any that make a direct link between service user feedback and the practice of individuals (except in relation to complaints when this tends to be more related to discipline than improvement).”*

Another respondent suggests the opportunity to draw on aspects of a ‘good system’ was already in existence in terms of using patient feedback to inform service improvements:

*“There are examples of these systems in place, driven by employers and services which recognise the need and value of information and feedback to improve service quality. If this proceeds can we make a plea for data to be collected once and used for multiple uses.”*

In a similar vein, another suggests that medical revalidation provides a valuable model for the HPC regulated professions in that, “they see the value in terms of user feedback.”

## 6: Questionnaire results can provide service user feedback in a form that is useful for improvements in professional practice

Strongly agree	1
Agree	7
Neither agree nor disagree	4
Disagree	1

One respondent, whilst strongly agreeing with the statement, made the point that, ‘Patient surveys are already used to “identify things that are going well - it’s not just about trying to improve things.” Another who agreed mentioned the need to address context and the limitations of service user feedback to inform individual practice – issues already covered in some detail in previous themes.

Analysis shows that respondents who disagreed with this statement did so because of methodological concerns about:

- the validity of data gathered through questionnaires *per se*;
- problems with particular types of questionnaires;
- the use of questionnaires as a method in isolation;
- questionnaires as a method for gathering feedback from patients with communication



impairments.

Concerns about questionnaires per se:

*“Often patients do not want to fill in questionnaires. Sometimes if a questionnaire is filled in then it may be rushed as a patient does not have the time and therefore some answers may not be that accurate.”*

Problems with particular types of questionnaires:

*“Questionnaires are not useful when given to clients to be completed in isolation. Many people have little faith in these and return rates are often low.”*

*“Questionnaire writing is an art and a science and there are many appalling examples, particularly in the service satisfaction field.”*

The use of questionnaires in isolation:

*“A range of mechanisms would be needed as well as the offer of support to complete/respond.”*

*“The validity of data is biased by the self-selection of service users to those in a particular instance who are motivated to complete such a questionnaire.”*

*“Questionnaires are an effective mechanism of collecting data from a large number of service users. This should achieve a representative sample which can be used for improvements in practice. Questionnaires are however, limited as they may lack the qualitative comments required to identify why the scores were obtained or to understand the context of care.”*

The use of questionnaires for gathering feedback from patients with specific communication needs:

*“I agree but with a caveat that a one-size-fits-all approach would not work. For many groups of service users there would need to be bespoke feedback mechanisms developed. (Practitioners) will know how to do this for different client groups. People with learning difficulties, dementia, dyslexia, brain injury, autistic spectrum disorders, aphasia, profound and multiple difficulties would need bespoke feedback mechanisms.”*

7: Less structured methods (open-ended questions / interviews) can provide service user feedback in a form that is useful for improvements in professional practice

Strongly agree	3
Agree	5
Neither agree nor disagree	4
Disagree	1

The respondent that entirely disagreed with this statement did so on the basis that qualitative methods were more prone to bias:

*“It is more likely that a patient wishing to complete open ended questions that they have something they wish to complain about rather than give positive feedback so results could be skewed.”*

Others, including some who agreed with the statement, raised other concerns about the bias associated with open ended methods. As mentioned in relation to the use of questionnaires as a feedback tool, it was felt that “a range of feedback mechanisms are needed, with the user deciding which method suits them best.” A lack of familiarity was suggested as likely to cause resistance to the use of qualitative methods for capturing service user feedback in one profession.

This statement led to one respondent raising concerns about the implications of the exercise in terms of the HPC’s remit in regulation:

*“It seems to me that this exercise is being commissioned by the HPC in some sort of expectation that they will exceed their brief and get involved in general professional practice improvement not discharge what they’re supposed to do which is establish the minimum competence of the profession to give the public confidence.... The application of patient feedback relates only to circumstances where the practitioner is facing some level of concern about their basic fitness to practice and that I think could a higher burden of specific proof on the patients’ feedback measures to be specifically and clearly valid.”*

### 8: Benchmarking aspects of practitioners’ performance against their peers’ is helpful in identifying areas where performance could be improved

Strongly agree	3
Agree	5
Neither agree nor disagree	1
Disagree	2
Strongly disagree	1
Not answered / unable to say	1

Both those who disagreed and most of those that agreed with the statement suggested it would be preferable to benchmark performance against national standards rather than against peers. The respondent who strongly disagreed felt that methods of benchmarking were flawed. One respondent described how benchmarking data would be available in their profession from March 2012.

### 9: Support should be available to practitioners to help them interpret and act on feedback

Strongly agree	10
Agree	1
Neither agree nor disagree	2
Disagree	0

There was a high degree of consensus in agreement with this statement and respondents made suggestions as to the forms this support could take. Of the two panel members who expressed any doubts at all on this theme, one suggested it “Depends on what kind of support” and another said they did not have a view as to what support would be required.

10: Service users should be allowed to choose between methods of feedback according to their communication abilities and preferences for closed or open questions, and for preserving anonymity

Strongly agree	5
Agree	4
Neither agree nor disagree	2
Not answered / unable to say	2

There was a high degree of consensus in agreement with this statement. Additionally, one of those who did not fully agree with the statement said this was ‘essential’ and another suggested this was “motherhood and apple pie”.

The two panel members who expressed doubts, explained their response by describing the need for a single system for consistency and to ensure “fairness and equity from the practitioners’ perspectives”:

*“The multiple systems need to all be measuring the same thing and coming up with the same answers.”*

*“If this is going to be a national HPC directive then all practitioners should have to follow the same policy/regulations/guidance. However some patients are not comfortable with questionnaires for example.”*

11: It is *possible* to develop feedback systems for people who may not be able to respond to questionnaires (e.g. people with learning difficulties or communication impairments, children, people who are not literate in English)

Strongly agree	6
Agree	4
Neither agree nor disagree	1
Not answered / unable to say	2

There was a high degree of consensus in agreement with this statement. Nine agreed or strongly agreed. Additionally one respondent did not tick a box but said these feedback systems were ‘essential’ and another ticked ‘unable to say’ but said this was, ‘definitely motherhood and apple pie’.

12: It is *important* to develop feedback systems for people who may not be able to respond to questionnaires (e.g. people with learning difficulties or communication impairments, children, people who are not literate in English).

Strongly agree	7
Agree	4
Strongly disagree	1
Not answered / unable to say	1

Again, there was a high level of consensus in agreement with this statement and analysis of the comments of those who ticked 'strongly disagree' and 'unable to say' shows that they were in very strong agreement with the principal.

13: Service users are already over-burdened with questionnaires

Strongly agree	2
Agree	2
Neither agree nor disagree	5
Disagree	2
Not answered / unable to say	2

Responses to this theme were considerably more varied than to other statements. Some clearly felt service users were already over-burdened but others thought the burden was 'appropriate' if it was relevant and if patients could see 'tangible outcomes and benefits' for themselves or others.

14: Practitioners are already over-burdened with requirements for gathering service user feedback

Strongly agree	2
Agree	1
Neither agree nor disagree	6
Disagree	3
Not answered / unable to say	1

There was also a high level of dissensus around this theme, but analysis of the comments show that most thought that service user feedback should be gathered even though practitioners may be overburdened in general with the demands placed upon them.

## 15: Practitioners are already over-burdened with feedback

Strongly agree	1
Neither agree nor disagree	5
Disagree	6
Strongly disagree	1

Analysis of the comments made in response to this question show that no respondents agreed that practitioners were already overburdened with relevant feedback from service users:

*“As part of our professional development, we should be seeking feedback at every opportunity to improve our services that we provide so I don’t think that a practitioner should ever think that they’re over-burdened with feedback.”*

*“There is little evidence that this is the case... Indeed, I hear many complaints about the lack of effective appraisal and development review which should be the regular opportunity to feedback on performance, and not just the perspectives of service users.”*

One respondent did however suggest that practitioners were overburdened with feedback about matters that were outside of their control:

*“Some feedback is not solely based on practitioner performance. Areas like ‘out of hours services’, waiting lists, permitted length of therapy and availability of services can impact on the clients views of the practitioner’s performance resulting in the practitioner feeling over burdened. It is not possible to examine practitioner performance in isolation from political pressure.”*

## 16. Feedback tends to be offered by service users who have a complaint rather than those who are happy with the practitioner’s professional performance

Strongly agree	1
Agree	6
Neither agree nor disagree	5
Disagree	1

Analysis of comments shows that those who agreed with the statement were thinking in terms of those who gave feedback via formal complaints processes rather than through questionnaires.

*“The current feedback mechanisms usually consist of 2 routes: via PALS which may tend towards complaints and user groups which tend to reflect a range of experiences. Anecdotal evidence suggests that there are a number of service users want to share their experiences which the aim of improving service and therefore the use of an appropriate tool and strategy for the collection of feedback should reduce the overall feedback being skewed by those service users who are dissatisfied with the care received.”*

**17: Patients are unable to assess practitioners' performance because they have no direct contact with them**

Strongly agree	1
Agree	1
Neither agree nor disagree	2
Disagree	3
Strongly disagree	4
Not answered / unable to say	2

There were some parts of some professions where practitioners did not have direct contact with patients:

*“The direct client direct client might well be the medical practitioner who’s requested the test.”*

*“There are those practicing in management, education, policy, research, etc where there is little or no direct patient contact. Having said that, their actions have effects on patients indirectly as their practice influences the practice of those on the front line (hence the need for them to retain registration).”*

Just one respondent said this was generally the case for the profession:

*“As most of (profession’s) activity is “back-room” with limited scope for direct patient / public interaction this is true for many of its professionals.”*

**18: Service users may have difficulty in distinguishing practitioners of different professional groups from one another (e.g. they may not be sure whether the person they just saw was a physiotherapist or an occupational therapist).**

Strongly agree	2
Agree	8
Neither agree nor disagree	1
Disagree	1
Strongly disagree	1

This statement was thought to be true in the case of many professions regulated by the HPC. It was suggested that feedback mechanisms would have to take this into account:

*“This could be a challenge for some people and the feedback mechanisms developed will need to take this into account. In some cases it may be more appropriate to consider feedback about the care pathway rather than about individual professionals since the multidisciplinary approach is an holistic one.”*

19: Service user feedback processes could lead to practice becoming more 'assessment driven' - practitioners could be tempted to work in a way that elicits favourable feedback rather than according to recognised best practice

Agree	4
Neither agree nor disagree	4
Disagree	4
Strongly disagree	1

Although some respondents felt that service user processes might influence practitioners, this was not a problem and would be counteracted by a well designed system:

*"I think there is just something about how we behave which says, tell me how you're going to assess me and that will influence my behaviour, but.... It would be unlikely that if I was a true professional that I would compromise best practice in order to get a better response."*

20: Incorporating service user feedback in practitioner regulation is congruent with a philosophy of increasing service user involvement

Strongly agree	1
Agree	8
Neither agree nor disagree	1
Disagree	1
Strongly disagree	1
Not answered / unable to say	1

Whilst there was consensus agreeing with the principal of service user involvement, there were concerns about the inclusion of service user feedback in the HPC's regulatory activities and one respondent felt that it would be a 'token act':

*"Yes but incongruent with a self regulation model of regulation."*

*"I think we are again confusing the idea of regulation of minimum standards where essentially the feedback of the service user is.... Is not generally relevant whereas a philosophy of increasing service users will maintain that is a generally positive thing to do."*

*"This will depend on how it is incorporated within regulation. It would seem most appropriate to include service user feedback and reflection within the requirements for CPD."*

21: The subjective opinion of service users is valuable, as long as the subjectivity is not overlooked or disguised

Strongly agree	2
Agree	10
Neither agree nor disagree	1

*"I think that's absolutely right in terms of service user involvement and looking at the philosophy within the, certainly within the NHS, you know, no decision about me without me, I think that's absolutely right, is that there is now much more geared towards making sure that we have service user involvement and feedback."*

22: Practitioners could be demoralised by feedback that is critical of their practice

Strongly agree	1
Agree	7
Neither agree nor disagree	2
Disagree	2
Not answered / unable to say	1

There was a good deal of agreement that there was a danger that practitioners could be demoralised by critical feedback, but on the whole, it was felt that effective processes for delivery feedback would prevent this and lead to improvements:

*"There is the potential for negative feedback to be demoralising therefore it is essential that: a) There are support mechanisms in place for the practitioner to interpret the feedback and develop an action plan; b) There is qualitative feedback which allows the practitioner to understand why they have received negative feedback."*

*"There is always scope for improvement and practitioners must be prepared to reflect on feedback and act on it as part of their CPD. If the feedback they receive is not 100% positive they can undertake a Significant Event Analysis piece of CPD and determine an action plan to improve the service they deliver. Critical feedback may also support practitioners to make a business case to their organisation in order to justify additional resources needed to deliver a high quality service."*

23: Confidence of practitioners could be improved by direct feedback from service users

Agree	6
Neither agree nor disagree	6
Disagree	1

*"It could, but it potentially could also have a detrimental effect on their confidence. It comes back to the how feedback is actually fed back."*

*"Ideally yes but more likely to be destructive as this is inherently a conflict situation."*



## 24: It is difficult to interpret feedback without knowledge of the context of service users' wider circumstances

Strongly agree	3
Agree	9
Disagree	1

There was a high degree of consensus in agreement around this theme:

*“The context of a service user’s care will affect their expectations and their perception of the overall experience and therefore in order for feedback to be meaningful, it is important that there is an awareness of the circumstances. Conversely practitioners should provide individualised care and therefore should have considered the service user’s individual circumstances and delivered care accordingly.”*

The one respondent who disagreed suggested that a large enough sample would overcome variations in service users' circumstances:

*“Not if enough feedback is collected, and there are consistent messages in the feedback. Rarely should action be taken on a single event unless it is of a magnitude or severity that requires immediate action.”*

## 25: Service users may fear repercussions of giving critical feedback

Agree	9
Neither agree nor disagree	1
Disagree	2
Not answered / unable to say	1

Most respondents agreed with this statement. Those who did not suggested effective systems would overcome this problem.

## 26: It is possible to administer questionnaires in consistent ways across different settings

Agree	3
Neither agree nor disagree	6
Disagree	1
Strongly disagree	2
Not answered / unable to say	1

There was a high degree of variation in responses to this question. Those who agreed suggested well designed systems were feasible but a small number felt this was not possible:

*“I would like to think this is the case, but experience tells me that it is very unlikely.”*

27: Being asked for feedback may give service users a sense of empowerment, which may have therapeutic benefits

Strongly agree	1
Agree	4
Neither agree nor disagree	6
Strongly disagree	1
Not answered / unable to say	1

Analysis of responses shows that most respondents thought there could be benefits to the patient in **providing** feedback within an effective system, though were sceptical about the use of the terms 'empowerment' or 'therapeutic benefits' in this context.

*"It might be that somebody had a negative experience and they felt that having done... Having provided some feedback that they stopped that happening to somebody else."*

28: We understand the mechanisms that allow formative feedback to lead to improvements in professional practice

Agree	4
Neither agree nor disagree	3
Disagree	1
Strongly disagree	2
Not answered / unable to say	3

Respondents were divided fairly equally between those who agreed and thought the mechanisms were understood and those who thought they were not understood. One respondent thought other professions may be able to provide guidance.

---

## Appendix 10: verbatim responses to the 28 Round 2 Delphi statements

Note: transcripts of two of the three telephone interviews have not been reproduced here but have been included in the closed response counts.

### 1: Service users have a valuable perspective on practitioners' performance.

#### Strongly agree

The service user experience within the (clinical) environment can be significantly affected by the actions of practitioners and therefore such feedback enables practitioners to consider their performance especially with regard to non-clinical skills, for example communication. This is just one element, however. There will also be a peer perspective that would need to be considered in relation to evidence based practice and the organisational perspective that will have implications for finance and other resources. To illustrate: A service user may think that they have had poor service or treatment and make a complaint against an individual practitioner. However, that practitioner might have been working in line with organisational requirements in order to reduce costs.

It is vitally important that SU's views are fed back to practitioners ; it is one mechanism by which they can review their performance and develop their knowledge and skills

(Practice) is a client-led intervention. The client/therapist relationship is explored with the client as an essential aspect of the therapy. The role of the clinical supervisor is to assist the therapist to ensure that this process is client focused.

The purpose of professional practice is to provide a high quality services to service users and therefore by the very nature of the interaction they have a valuable perspective

Otherwise you can think you're doing a very good job but service users may have a completely different perspective that the practitioner may not have thought about. There's a strong variation between practitioners who are very forward facing with patients and service users and others who don't actually often see what the output of their work is.

#### Agree

As the nature of practice is focused on delivering health care to service users, it is entirely right that they will have valuable perspectives on practitioners' performance. However, there are limits as service users will not necessarily understand the nature of practice and why, for example, it's not appropriate to carry out an... examination they think they need, or why it's important that they recover from surgery before undergoing treatment.

I'm really quite committed to having feedback from the service users across many of the service industries, particularly those around health because we're in a much more service user driven economy. I can be fairly competent in my job but I still might not be delivering an appropriate service, so I'm very keen that we do pick up issues in terms of service user perspective.

Service users directly experience the service provided by the deliverer of the service and that in healthcare terms can have a relevance to the way in which the practitioner is judged to be performing the service.

Confidence in the healthcare professionals involved in their care is a key component of the patient-healthcare professional interaction. The quality of such interaction and any issues that compromise that confidence are therefore of interest to both the professional practitioner themselves and to their employer.

### **Neither agree nor disagree**

This depends on the patient. A patient may have 'a pleasant experience' but may not be able to determine if the treatment was high-quality or not. On the other hand if a patient perceives an unpleasant experience this may not be down to poor quality treatment but could be a personality clash for example.

## **2: Service users can provide a valid, or 'true', assessment of a practitioner's performance.**

### **Agree**

Service users can provide a true assessment of the practitioner's patient-centered skills, however this will be measured against the service user expectations.

As above - service users provide a very valid but a very particular view. To fully assess practitioners' performance there needs to be a triangulation of evidence from service users, the organisation's expectations and in reference to the evidence base.

They can, but only from a subjective perspective ; collated SU feedback may be a useful measure of a practitioners performance but not in isolation of other feedback and performance measures.

This is a little more complex as there are many aspects to a practitioners performance - the visible and tangible such as communication and interaction with the service user and the cognitive or invisible ( if we assume an intervention with a patient) did the practitioner perform the right intervention at the right time with the right patient for the right reasons. The service user can say what felt right for them and if they were involved in the decision making. It is possible to describe different scenarios which argue for and against the service user have the only valid view. Any system needs to take account of the many different settings and specialties of professional practice including research and teaching and other non patient centred employment and such confounding factors as institutional factors and the nature of commissioned services.

I agree with that but it has to be taken in context of their ability to do that because they may not have the knowledge or experience to fully understand what the practitioner is doing and therefore their interpretation or even expectation of the practitioner may be unrealistic. There may be huge barriers to the client being willing to understand what they're hearing. There may be significant barriers to understanding that you just can't overcome. Where the client has learning disabilities it becomes even more difficult.

What you get with service user feedback is a particular perspective on that practitioners' performance. For example, I may go in to have my appendix out and I have a view about the scar that I'm left with and the fact that my appendix has come out. It doesn't actually tell me anything about the quality of the surgeon who performed the operation. I haven't said I strongly agree because I don't know what the definition of a true assessment would be.

The validity of the service user's response has to be clearly and specifically established otherwise it is not relevant assessment. For example, the practitioner has to carry out an assessment of the patient, now the validity of that assessment is in large measure beyond the competence of the patient to determine.

There are fairly conventional patient surveys which ask patients to comment on whether the waiting room was clean and tidy, whether they were seen on time and such matters and I've always felt that these are largely peripheral to the core quality of the service provided, certainly by the professional being judged as to their professional competence. And so these things that the patient can comment on are not necessarily the things that are of benefit for the patient to comment on or of validity in the performance of the practitioner. (Provides lengthy example relevant to own profession).

There is a dynamic there between the patient, the equipment and the clinician which could produce judgements of validity of performance which may not be useable in the context of regulation. My overall scepticism that patient feedback is actually of any great use in a fitness to practice you know performance assessment context will come through.

#### **Neither agree nor disagree**

It depends on whether the assessment is based on outcomes. Outcomes and the length of time practitioners are permitted to allocate to clients may be dictated by the employing agency. Will also depend on when the feedback is requested, during or post therapy. (Practitioners) normally do 'follow-up' evaluations. Practitioners involved in teaching will receive feedback via university procedures.

#### **Disagree**

Service users (taken to mean the public or patients) can provide a valid assessment only of aspects of practice involved in the direct interaction. Most will not be able to give a valid assessment of other aspects of practice.

There are some things they are well placed to judge, for example social and behavioural skills (has the practitioner been welcoming, and put them at ease as far as is possible, etc) but they do not know the technical parameters of practice and can't judge whether these have been carried out properly.

### **3: Service user feedback could be incorporated in formative assessment (eg as part of CPD).**

#### **Strongly agree**

Service user feedback would be particularly valuable as part of CPD reviews as practitioners could use this to initiate reflection.

This is already done as part of the HPC CPD requirements as registrants have to demonstrate that the CPD they have undertaken has sought to enhance service delivery and to be of benefit to service users.

That's a good way of getting a different perspective - being able to reflect and review on your own practice.

#### **Agree**

Yes, but only regarding the direct interactive elements of practice.

### **Neither Agree nor Disagree**

While this might be possible, I think there are big questions to answer before I would agree with this, especially the 'how' question.

Of course, it could but I am not convinced of its value except as part of a feedback mechanism to the individual practitioner to offer them a SU view of their performance

### **Disagree**

The impact on the client-therapist relationship needs to be considered seriously here. This may put extra pressure on the client. As (practitioners) already use comprehensive assessment/evaluation methods, client feedback is incorporated into these forms. Client feedback incorporated as CPD would hinge on whether the client would be willing to participate and would be asking the client to take on work for the therapists. This could contravene codes of ethics. To incorporate client feedback into CPD comes very close to research and this means ethical clearance.

### **Unable to say**

Unsure of what question is asking

## **4: Service user feedback could be incorporated in summative assessment (eg as part of performance review).**

### **Strongly agree**

The HPC CPD standards should be a core part of annual appraisal and personal development plans.

### **Agree**

Yes, but only regarding the direct interactive elements of practice. We anticipate issues obtaining a fair, objective assessment.

If the feedback is used in a constructive way to enhance and improve care with reflective practice.

Whose responsibility is this - regulator or employer?

My concern is that the feedback would have to be appropriate - based on a complete understanding of the process or the function of the practitioner. There could be a danger that uninformed feedback could be wide of the mark. There is a lack of understanding between different modalities within the profession because it's complex, let alone with lay people.

### **Neither Agree nor Disagree**

Again, while this might be possible, there are big questions to answer first, notably the 'how' question.

Again it certainly "could" and may allow the opportunity for the practitioner to review their feedback with their supervisor in order to gain another perspective.

### **Disagree**

The evaluation and assessment systems already in place contribute to performance reviews.

### Unable to say

This would depend on the mechanisms used to elicit feedback, the size of the sample and how this would be incorporated into the performance review.

## 5: Provided good systems could be put in place, service user feedback could, in principle, be useful to inform improvements in professional practice.

### Strongly Agree

I agree but the caveat is good systems and especially the link between service user feedback and improving professional practice. There is some good practice.... For getting feedback from service users but I am not aware of any that make a direct link between service user feedback and the practice of individuals (except in relation to complaints when this tends to be more related to discipline than improvement).

There are examples of these systems in place, driven by employers and services which recognise the need and value of information and feedback to improve service quality. If this proceeds can we make a plea for data to be collected once and used for multiple uses. Provided good systems could be put in place. But I'm not sure what those good systems are.

### Agree

Yes but only regarding the direct interactive elements of practice.

Yes but if looking at systems then it might be best to consider how service users' views are informing service development rather than individuals' practice and performance. It could certainly be used to promote discussion of service improvements at a service/team level

### Strongly disagree

Service user feedback is *essential* and it is not a question of whether it 'could be put into place'. It should already be in place and be an essential component of good and safe practice.

## 6: Questionnaire results can provide service user feedback in a form that is useful for improvements in professional practice.

### Strongly agree

We do use some patient satisfaction surveys within my branch of the profession and they can be very useful to identify things that are going well - it's not just about trying to improve things.

### Agree

Questionnaires are an effective mechanism of collecting data from a large number of service users this should achieve a representative sample which can be used for improvements in practice. Questionnaires are however, limited as they may lack the qualitative comments required to identify why the scores were obtained or to understand the context of care.

Except often patients do not want to fill in questionnaires. Sometimes if a questionnaire is filled in then it may be rushed as a patient does not have the time and therefore some answers may not be that accurate.

I agree but with a caveat that a one-size-fits-all approach would not work. For many groups of service users there would need to be bespoke feedback mechanisms developed. (Practitioners) will know how to do this for different client groups. People with learning difficulties, dementia, dyslexia, brain injury, autistic spectrum disorders, aphasia, profound and multiple difficulties would need bespoke feedback mechanisms.

Yes, at the level of a whole service/whole group of staff, and more about the overall experience than about the effectiveness (or not) of the outcome of (a test or intervention). Sometimes, too, feedback may be critical of practitioners because they are adhering to local practices and protocols that patients don't like – for example, not being able to give the patient the (results of) the examination or not having an identified (practitioner) to refer to during their course of (treatment).

#### **Neither agree nor disagree**

The validity of data is biased by the self-selection of service users to those in a particular instance who are motivated to complete such a questionnaire. Questionnaires are not useful when given to clients to be completed in isolation. Many people have little faith in these and return rates are often low. There is a long history of this in professional and NHS practice but questionnaire writing is an art and a science and there are many appalling examples, particularly in the service satisfaction field

#### **Disagree**

A range of mechanisms would be needed as well as the offer of support to complete/respond

### **7: Less structured methods (open-ended questions / interviews) can provide service user feedback in a form that is useful for improvements in professional practice.**

#### **Strongly agree**

The level of detail that these methods can illicit regarding the service user experience is invaluable in improving professional practice. This also allows the information to be placed in the context of that individual service user's experience which is important.

There is good examples of different qualitative methods being used to inform improvements in practice

#### **Agree**

Agree that there is a potential to avoid bias but data is likely to reflect only the most recent interaction. There are considerable resource implications in using this method to obtain a statistically significant amount of data. In practice within our professions the patient experience and quality of care is more the result of actions of the full team rather than of individual professionals.



Yes – provided these are in line with service users' needs and that service users have a clear choice about the type of feedback mechanism they would prefer to use.

All information is potentially useful but again it has to be taken in context and be relevant. The way the question is phrased will influence the response, so getting the right people to actually formulate those questions is extremely important. Our profession tends to be much more quantitative than qualitative and the qualitative aspects of the work we sometimes find more difficult. Because they're not used to doing it and they don't understand the methodology employed necessarily, they'd probably be less receptive to accepting the results

#### **Neither Agree nor Disagree**

Possibly, but to be meaningful, there needs to be real dialogue which takes time and may not be useful in terms of improving practice. The interviews would probably need to be done by a third party so would be subject to the quality and faithfulness of the summarising of the interview, and would not capture tone and context easily. Semi-structured questionnaires take time and some service users may not be able to complete them for a wide variety of reasons, including time pressures, literacy skills, fear of reprisal, learning difficulties, etc. They may also be biased in that those with a 'beef' may be more likely to take up the option of completing such a questionnaire.

As previously stated, a range of feedback mechanisms are needed, with the user deciding which method suits them best

Interviews are more useful. However, the interviewer should be independent –this could create problems for private practitioners who would need to employ an extra person

#### **Disagree**

It is more likely that a patient wishing to complete open ended questions that they have something they wish to complain about rather than give positive feedback so results could be skewed

### **8: Benchmarking aspects of practitioners' performance against their peers' is helpful in identifying areas where performance could be improved.**

#### **Strongly agree**

Depends on the aspects of performance being measured. Objective measures such as clinical outcomes are very suitable (with some qualification). Qualitative or subjective measures require more careful handling and probable triangulation and substantial quantity of evidence. The difficulty with it is deciding what to benchmark against; benchmarking is notoriously difficult and time consuming - making sure that you're comparing like with like. A practitioner working in one area may have very different constraints e.g. the difference between a physiotherapist working in a GP's surgery and one who's working in an acute oncology cancer centre. Within my branch of (the profession) it is incredibly difficult to get any benchmarking data at all.

#### **Agree**

We agree that a structured benchmarking approach provides more robust data however benchmarking demands considerable resources to ensure equity and comparability. Comparison with peers does not yield absolute performance measures unless benchmarking is against clearly understood universal standards.

The RCSLT has developed a quality self-evaluation tool for its members so that they can determine the strengths and areas for improvement within their services. We are now in the 3<sup>rd</sup> year of running this and will begin benchmarking from March 2012. We don't think its feasible to set benchmarks unless there is 3 years worth of data. The tool we have does include questions on how service users' views inform service development. This is one of the first areas we envisage benchmarking so it would be very good if we could tie this in with your initiative.

Yes, this is possible and, to an extent, takes place very informally now (he/she is a 'good' (practitioner)'; he/she is not very forthcoming in terms of going the extra mile', etc. However, to develop a fair, objective and robust system may well be difficult and would need to be coupled with a significant culture change.

It can be helpful but I think more evidence is needed to support the notion, and that appropriate mechanisms are explored in order to ensure that meaningful benchmarking is achieved.

### **Disagree**

It would be preferable to benchmark practitioners performance against defined best practice and policy/standards rather than peers. This will still allow the identification of areas for improvement but in a consistent manner.

This can prove helpful as long as this is done in a constructive manner, however benchmarking against peers only determines where an individual stands amongst peers which if the standard is low then it will need to improve performance of all.

### **Unable to say**

Not sure of the meaning of 'peers' or 'practitioners' performance in this context. Dramatherapy is both an art-form and a form of psychotherapy and as such, generally, the process between client-therapist is confidential and not necessarily comparable with other client-therapist processes.

## **9: Support should be available to practitioners to help them interpret and act on feedback.**

### **Strongly agree**

It is essential that practitioners have the support to develop and improve their skills or to disseminate their identified good practice.

Poorly or mis-understood feedback is almost useless and potentially damaging. Many may need help understanding how to improve practice.

This would be imperative and the word 'support' would be key rather than criticised.

Yes, definitely!

Without a shadow of doubt, and support must initially be positive. Indeed, any scheme that uses service user feedback needs to be positively framed and carrot rather than stick focused. Having said that, there will need to be clear guidance/rules for dealing with those practitioners who simply can't or fail to respond to consistent adverse feedback over time. This could be actioned through practice supervision and dependent on the nature of the issues could be the most effective situation to address issues

Feedback, even if it is negative in terms of its message, providing it's given in the right way can be a very positive and empowering thing. But if it's given in the wrong way it can have absolutely the reverse effect. So it's incredibly important to make sure that that's done properly.

**Agree**

Goes without saying!

**Neither agree nor disagree**

Depends on what kind of support.

**10: Service users should be allowed to choose between methods of feedback according to their communication abilities and preferences for closed or open questions, and for preserving anonymity.**

**Strongly agree**

This is crucial for service users and particularly relevant for people who may have speech, language and communication needs and for whom conventional feedback mechanisms are not accessible.

Seems self evident

It's very important not to exclude particular categories of population just because they have different communication abilities. There are issues in dealing with patients who have very severe physical problems that restricts their ability to communicate. It's very important to get their view point because it's critical to the delivery of the service.

**Agree**

Attention should be given to be inclusive of the full spectrum of the service user population. It would be difficult to disagree with this statement. However, fairness and equity from the practitioners' perspectives also needs to be considered. So the multiple systems need to all be measuring the same thing and coming up with the same answers.

**Neither agree nor disagree**

If this is going to be a national HPC directive then all practitioners should have to follow the same policy/regulations/guidance. However some patients are not comfortable with questionnaires for example.

This choice is *essential*. As we pointed out in the first round we use a range of arts-based interventions which are client-led fundamentally involving client choice.

**Unable to say**

In principle, allowing service users a choice will increase the number of responses; however it is important that some qualitative information is obtained to allow an accurate interpretation of the feedback. This will therefore depend on the proposed tools and methods.

**11: It is *possible* to develop feedback systems for people who may not be able to respond to questionnaires (e.g. people with learning difficulties or communication impairments, children, people who are not literate in English).**

**Strongly agree**

Yes. You need speech and language therapists to help with this as they are experts in this area. RCSLT can help to co-ordinate this and to recommend suitable SLTs.

Again both self evident and there are examples in, for example, learning disability services It may be very labour intensive but it certainly should be possible.

**Agree**

It should be possible to adapt the feedback tool to meet the needs of all service users. We feel sure there are appropriate experts in such fields. The views of these parts of the population are important precisely because they represent a challenging sub-set. Feedback systems can be in large print, Braille, in different languages or completed by a guardian on behalf of the patient if the patient is unable to complete themselves

**Neither Agree nor Disagree**

I suspect anything is possible and a better question might be is it practical. I can't envisage a feedback system that would be useful for an unconscious patient, a young child, an elderly person with dementia, etc (although it may be that families and carers, etc might be able to give feedback on their behalf. In which case, care would be needed re the emotional involvement and stress of the service user's representative.

**12: It is *important* to develop feedback systems for people who may not be able to respond to questionnaires (e.g. people with learning difficulties or communication impairments, children, people who are not literate in English).**

**Strongly agree**

It is imperative that there is a mechanism to collect feedback from all service users not just those able to complete a questionnaire. It would be valuable for practitioners to gain feedback regarding their skills to effectively communicate with a range of service users.

Very pleased to see this in here.

If you are using SU feedback to improve the service delivery offer, then it must be accessible to all

**Agree**

Indeed it is ethically and morally important to assure equity and avoid disenfranchisement of these vulnerable and challenging sub-sets of the user population.

Feedback from all patients would be relevant regardless of their ability to respond to questionnaires.

If other service users are to be enabled to give feedback, then those who are disadvantaged in some way should also be enabled to have the same opportunity. In a humane society, an individual with learning difficulties has the same rights as one who hasn't when it comes to having (tests) or treatment for breast cancer. So this is important (but also concerned about

practicality).

**Strongly disagree**

It is *essential* to have these feedback systems.

**13: Service users are already over-burdened with questionnaires**

**Strongly agree**

Yes and many feel that their answers make no difference to provision. But we cannot speak for another group of people. It would be better to ask them.

**Neither agree nor disagree**

Depends on the patient

I think service users are happy to respond to questionnaires, especially if there are tangible outcomes and benefits for them or those who come after them.

Depends on setting. Would argue that there are simpler methods to collect feedback than yet another questionnaire. Having experienced the NHS patient survey I am particularly biased against questionnaires in this field- they ask the q's the service wants answered, not the q's that are important to services users.

**Disagree**

Having used a range of NHS services recently I don't feel overburdened

From my perspective I don't think so. When I've seen user groups that have involved patients and the public, they have been very enthusiastic to participate.

**Unable to say**

Can only be answered by service users themselves.

**14: Practitioners are already over-burdened with requirements for gathering service user feedback .**

**Strongly agree**

Practitioners working in the NHS and the Independent Sector are completely over-burdened with forms in general and this could influence their attitude.

**Neither agree nor disagree**

KPIs are a fact of professional life particularly in a "people" business. However organisations need to acknowledge that there is a cost to collecting data.

Depends on the practitioner particularly in the NHS

While this is a growing feature of practice, and it gives rise to many moans and groans, an effective service is one that builds in this to its quality improvement regime as a normal part of service delivery and service delivery monitoring.

This is a growth area within services and a policy drive within NHS – if not true now, may soon be

### **Disagree**

At present there is limited collection of specific service user feedback by practitioners; feedback collected tends to be generic in nature.

Practitioners may feel overburdened with requirements for cutting costs and demonstrating efficiency but gathering and acting on service user feedback should be a piece of team CPD annually.

I think practitioners are overburdened with what they do but I don't think they're overburdened with questionnaires.

## **15: Practitioners are already over-burdened with feedback.**

### **Strongly agree**

Does this mean feedback from clients? If so, we would disagree but some feedback is not solely based on practitioner performance. Areas like 'out of hours services', waiting lists, permitted length of therapy and availability of services can impact on the clients views of the practitioner's performance resulting in the practitioner feeling over burdened. It is not possible to examine practitioner performance in isolation from political pressure

### **Neither agree nor disagree**

Depends on the practitioner particularly in the NHS

I think feedback from questionnaires is somewhat patchy at the moment, I gather that the percentage return is low generally

See above

### **Disagree**

Engaged practitioners would welcome it provided it is fair. Principles of natural justice need to be followed if feedback amounts to accusations.

### **Strongly Disagree**

There is little evidence that this is the case, at least in the radiography profession. Indeed, I hear many complaints about the lack of effective appraisal and development review which should be the regular opportunity to feedback on performance, and not just the perspectives of service users.

**16: Feedback tends to be offered by service users who have a complaint rather than those who are happy with the practitioner's professional performance.**

**Agree**

This seems to be an inevitable consequence is feedback is left to the initiative of service users.

From my experience, this has been the case

People who have a complaint tend to be more vociferous and want something done. You have to do something about complaints - there's quite a bit of work involved in dealing with a complaint. They're more visible and more apparent and for that reason they probably have more effect on the practitioner.

**Neither agree nor disagree**

The current feedback mechanisms usually consist of 2 routes: via PALS which may tend towards complaints and user groups which tend to reflect a range of experiences. Anecdotal evidence suggests that there are a number of service users want to share their experiences which the aim of improving service and therefore the use of an appropriate tool and strategy for the collection of feedback should reduce the overall feedback being skewed by those service users who are dissatisfied with the care received.

Maybe sometimes. But many practitioners and services will receive thank yous from service users and it would be excellent for them to be able to record this formally in order to demonstrate the efficacy of their service.

This can be a phenomenon, and positive compliments tend to be fewer. Methods of gathering feedback can be instrumental in exacerbating or reducing this phenomenon, though.

While there may be a tendency to complain, positive feedback is often given, just in different ways and less often collated

**Disagree**

Not if all service users views are sought. This is a consequence of a passive approach by providers.

**17: Patients are unable to assess practitioners' performance because they have no direct contact with them.**

**Strongly agree**

There are several areas where that may be the case - the patient never sees the practitioner. They have a direct impact on patient care but their direct client might well be the medical practitioner who's requested the test.

**Agree**

As most of (profession's) activity is "back-room" with limited scope for direct patient / public interaction this is true for many of its professionals.

**Neither agree nor disagree**

The majority of service users... would have direct access to a practitioner.

Generally, this would not be true in (profession), although there are those practicing in management, education, policy, research, etc where there is little or no direct patient contact. Having said that, their actions have effects on patients indirectly as their practice influences the practice of those on the front line (hence the need for them to retain registration)

**Disagree**

The vast majority of patients receiving care... will have contact with (practioners).

Patients do have direct contact; would be against allowing access to CPD or appraisal records of practitioners if this is where it is leading

**Strongly disagree**

Patients do have direct contact with the practitioner

We always have direct contact, even in research posts.

**Unable to say**

Don't understand the statement! Perhaps it refers to services offered via technology (i.e. over the phone) rather than on a face to face basis? If so, I strongly disagree

**18: Service users may have difficulty in distinguishing practitioners of different professional groups from one another (e.g. they may not be sure whether the person they just saw was a physiotherapist or an occupational therapist).**

**Strongly agree**

As most of (profession's) activity is "back-room" with limited scope for direct patient / public interaction this is true for many of its professionals. The service is largely delivered by the team rather than one individual professional. Service users, including medics, sometimes don't really understand what the role of the practitioner is. A member of the public would have very great difficulty in distinguishing the difference in their role of an OT and a physio.

**Agree**

Anecdotal evidence suggests that service users.... Do find differentiating between different professional groups very difficult and therefore collecting feedback specifically about (practitioners) may prove challenging. It may be beneficial to collect feedback relating to the different areas within the environment however this would not necessarily identify specific professional groups.

This can happen frequently

This could be a challenge for some people and the feedback mechanisms developed will need to take this into account. In some cases it may be more appropriate to consider feedback about the care pathway rather than about individual professionals since the multidisciplinary approach is an holistic one.

It is getting better but many patients still think in terms of doctors and nurses... even today even though the individual will have introduced him/herself!



Although it may not be distinguishing between the professional, but rather the service

### **Neither agree nor disagree**

And what about multi-professional teams where many practitioners may carry out similar tasks and may be dressed similarly

### **Disagree**

The instructions above are that we should respond as *practitioners specifically from your organisation's professional group*. We therefore cannot comment on other professions difficulties. We see clients for a period of time and they would know our name and profession.

## **19: Service user feedback processes could lead to practice becoming more 'assessment driven' - practitioners could be tempted to work in a way that elicits favourable feedback rather than according to recognised best practice.**

### **Agree**

This is almost unavoidable – but surely feedback systems must be based on best (or at least 'good' practice). A system that gives a tick because the (practitioner) smiled and spoke kindly – but did the wrong examination or treated the wrong body part would be worse than useless! Because there's not an evidence base for everything that's done in healthcare, there might well be a tendency for practitioners to err towards the favourable response, particularly in the areas where there is more than one recognised method of best practice.

### **Neither agree nor disagree**

The feedback tool should be designed in such a way that it reflects best practice, practitioners should not have to compromise best practice in order to achieve positive feedback.

This should not make a difference but in practice this may happen. However this creates a danger of patient led 'want' rather than clinical need.

I'm aware of a tendency to develop services to meet targets at the expense of other, less high profile services but I struggle to identify a professional practice that would elicit positive feedback but not be good practice

### **Disagree**

As previously stated feedback would need to be considered in light of the service users, the evidence base and the requirements of the organisation – this is a triangulation of data not considering one aspect in isolation.

I think this is unlikely because I would expect that any SU feedback would only form a PART of practitioner assessment

### **Strongly disagree**

(Practitioners) are required to engage in on-going clinical supervision and this kind of issue would be 'picked up' by the supervisor.

**20: Incorporating service user feedback in practitioner regulation is congruent with a philosophy of increasing service user involvement.**

**Strongly agree**

To me, that's self-evident.

**Agree**

In principle, yes; however this will depend on how it is incorporated within regulation. It would seem most appropriate to include service user feedback and reflection within the requirements for CPD.

That is logical. However feedback is likely to be more about the performance of the team rather than one individual professional

This would increase patient involvement  
Yes,

It would be hard to argue against this statement. The big question, though, is HOW.

**Neither agree nor disagree**

Yes but incongruent with a self regulation model of regulation

**Disagree**

To be honest, I think it would be rather more of a "token" act and doesn't really indicate true SU involvement

**Unable to say**

Only if service users agree. Ethical issues need to be considered.

**21: The subjective opinion of service users is valuable, as long as the subjectivity is not overlooked or disguised.**

**Strongly agree**

You have to be aware of subjectivity and not be swayed by a forceful rather than a logical argument.

**Agree**

Hence the importance of developing a robust system for data collection which considers context of care and potential for subjectivity.

And as long as it is considered alongside evidence based practice.

I think I've covered this in previous comments.

**Neither agree nor disagree**

The unconscious processes that inform relationships are an important part of the therapy process.

## 22: Practitioners could be demoralised by feedback that is critical of their practice.

### Strongly agree

Goes back to the way in which feedback is returned. Even if it's a bad message, if it's put forward in a positive way that the practitioner can see would be of benefit to changing the way they did something, that's a positive result. But if it's negative feedback and it's fed back in the wrong way, that could be extremely demoralising. Nobody likes to be criticised. But that's an important part of professional practice - being reflective and looking at what you are doing and listening to people who use your service. I think reflective practice sometimes comes with some difficulty to scientists because again it's around the qualitative rather than the quantitative outputs.

### Agree

There is the potential for negative feedback to be demoralising therefore it is essential that:  
a) There are support mechanisms in place for the practitioner to interpret the feedback and develop an action plan; b) There is qualitative feedback which allows the practitioner to understand why they have received negative feedback.

Depends very much on the approach of managers and management. If such feedback is used to justify withholding pay increments without proper process, then yes, very demoralising. Or a practitioner could use the feedback constructively to enhance performance and patient care.

True, but feedback mechanisms won't always deliver good news and practitioners will no doubt recognise that

### Neither Agree nor Disagree

This will depend on how feedback is given and whether it's used and given positively (see some of my previous comments that relate to this).

### Disagree

It depends on how it is presented. There is always scope for improvement and practitioners must be prepared to reflect on feedback and act on it as part of their CPD. If the feedback they receive is not 100% positive they can undertake a Significant Event Analysis piece of CPD and determine an action plan to improve the service they deliver. Critical feedback may also support practitioners to make a business case to their organisation in order to justify additional resources needed to deliver a high quality service.

Practitioners should be open to feedback - important and actively seek to improve their performance. However, feedback needs to be in areas that the practitioner can change

### Unable to say

Many practitioners are already demoralised by the current state of provision. Client feedback is essential, this not in question, but negative client feedback given in a climate where (practitioners) are being expected to bear increased workloads and perform to targets set by managers are likely to be demoralised when they are aware that negative feedback is created by circumstances outside their control.

### **23: Confidence of practitioners could be improved by direct feedback from service users.**

#### **Agree**

Positive feedback would be beneficial to a practitioner's confidence; however it must be recognised that each service user is different and therefore may respond differently to the same care hence it is important practitioners recognise this and do not become complacent upon receiving positive feedback.

Positively framed and given feedback, even if negative in nature, can boost confidence. However, I think the more pertinent question is whether it improves competence – I do not want practitioners who are confident but incompetent!

This is likely but confidence is improved via a range of mechanisms and just as positive feedback shouldn't be over valued and seen as a single sign that all is well, neither should negative feedback

#### **Neither agree nor disagree**

It could work either way.  
Practitioners already receive feedback.

It could, but it potentially could also have a detrimental effect on their confidence. It comes back to the how feedback is actually fed back. If it's a positive experience it's all fine but when it's a negative experience, that can be very difficult to deal with.

#### **Disagree**

Ideally yes but more likely to be destructive as this is inherently a conflict situation.

### **24: It is difficult to interpret feedback without knowledge of the context of service users' wider circumstances.**

#### **Strongly agree**

Because it is the wider context. The service user has a lot of other influences on them and it will depend on their particular scenario. Some will be in very acute situations, some will be in non-acute but none the less they might see them as very urgent. Without knowing that context that is difficult.

Self-evidently. Knowledge and proper appreciation of such contexts relevant to the healthcare interaction of service users may be an important component of the interaction

#### **Agree**

The context of a service user's care will affect their expectations and their perception of the overall experience and therefore in order for feedback to be meaningful, it is important that there is an awareness of the circumstances. Conversely practitioners should provide individualised care and therefore should have considered the service user's individual circumstances and delivered care accordingly.

A patient may give negative feedback if they have had other problems with another healthcare professional for example.

Could be true but we have to start somewhere to demonstrate how service users' views inform service development and feedback mechanisms can be refined over time so 'context' shouldn't be a deal breaker in respect of getting this underway

This may not always be the case but context will be important at times. I think I've said this in another way previously.

Of course feedback can be analysed at face value but in the context of health and social care, other factors will have an influence

### **Disagree**

Not if enough feedback is collected, and there are consistent messages in the feedback. rarely should action be taken on a single event unless it is of a magnitude or severity that requires immediate action

## **25: Service users may fear repercussions of giving critical feedback.**

### **Agree**

Such fear should be unfounded but as service users represent a very wide group this is inevitable in some.

If questionnaires were used then they would need to be anonymous and the patient reassured of this.

This is a recognised phenomenon.

Vulnerable people who are dependent of services may well feel unable to give critical feedback

Some will not but I'm sure there will be an element that will think if they shout out that something's not right, that may be detrimental to the care that they're given. That may then influence their feedback - they might, they might give positive feedback when actually they want to give negative feedback or they might not give any feedback at all.

### **Neither agree nor disagree**

I think it depends on individuals, the process developed, the reassurances given and safeguards that are in place.

### **Disagree**

It is important that service users are offered assurance that this would not be the case. Also the timing of the collection of feedback could prevent these concerns.

Services users should be facilitated to give anonymous feedback

### **Unable to say**

As (practice) is both an art-form as well as a psychotherapy this may well be an area addressed during the therapeutic intervention.

**26: It is possible to administer questionnaires in consistent ways across different settings.**

**Agree**

Provided the data methodology has been carefully considered to ensure consistency this should be possible.

This takes skill, expertise and effort in their design to elicit high quality data, e.g. inclusion of consistency checking questions. However such skills exist. There is risk when “amateurs” design questionnaires.

**Neither agree nor disagree**

This could differ from an NHS setting and a private setting.  
You need to get expertise in this area to advise how best to achieve this

I have very strong doubts that this is possible but I am open to persuasion!

I would like to think this is the case, but experience tell me that it is very unlikely

**Disagree**

It ought to be possible but I think it is very difficult to do it consistently in different areas just because of the differences.

**Strongly disagree**

This not possible. The questions must relate specifically to the client group.

**27: Being asked for feedback may give service users a sense of empowerment, which may have therapeutic benefits.**

**Agree**

Inviting service user feedback will promote a sense of involvement with the development of service. This may also elicit a wider spectrum of feedback as at present service users have to initiate feedback and therefore are more likely to do this if they have negative comments. Inviting feedback may increase the positive feedback as all service users will have equal opportunity to share their views.

Ideally yes.

**Neither agree nor disagree**

Possibly.

Not sure about therapeutic benefits - it may be a claim too far if there is no clinical evidence to back it up.

This is possible –but in my experience that empowerment is after a long and very difficult interaction and carries personal costs and suffering as well as some empowerment and therapeutic benefit (almost empowerment in spite of rather than because of a wholly negative experience)

I think this may be overly hopeful, there are many feedback systems in place for SUs. Empowerment is more than having the opportunity to give feedback!

It might be that somebody had a negative experience and they felt that having done... Having provided some feedback that they stopped that happening to somebody else.

### **Strongly disagree**

Empowerment is one of main purposes of therapy, so would not be a valid reason for requesting feedback outside the therapy

## **28: We understand the mechanisms that allow formative feedback to lead to improvements in professional practice.**

### **Agree**

We do understand a number of these mechanisms for a range of types of formative feedback; however these may need revision to incorporate service user feedback effectively. We have evidence of this from the quality self evaluation tool that we have developed for our members.

### **Disagree**

I think that the feedback mechanisms and methodologies in terms of where I sit are poorly understood.

### **Strongly Disagree**

Who is 'we'? I probably do but I'm not at all convinced that most (practitioners) do - it doesn't feature in their training and development at all highly.

More thought, appreciate enquiry and research needed I fear! Perhaps other professional groups have this taped, in which case, maybe we can improve our understanding by talking to them and examining their systems and processes

### **Unable to say**

Only in part. Such skills should be part of the effective clinical leadership agenda and should be part of relevant (clinical) management development. We would expect there is a body of social science research literature to support effective mechanisms.

Who is 'we'??

## Appendix 11: Delphi consultation Round 3 questionnaire

Analysis of responses to round 2 of the Delphi review have highlighted the following ten issues around which there is a high level of consensus. Please indicate the extent to which you agree with each statement and, if possible, make comments that will help us understand your response.

*The term 'service user' is used as shorthand for the different terms that can be applied to those affected by a professional's practice (including patients, clients, etc).*

*The term 'practitioner' is used to refer to the professionals regulated by HPC and, for the purposes of this exercise, it refers to practitioners specifically from your organisation's professional group.*

Question:	Please indicate the extent to which you agree with each statement by placing an X in the relevant box		Comments to help us understand your response We are particularly interested in understanding the thinking behind your response and would be happy to record this in an interview over the phone if you prefer
	BROADLY AGREE	BROADLY DISAGREE	
1. Service users have a valuable perspective on practitioners' performance but their views need to be taken in context.			



<p>2. Service user feedback may be a useful measure of a practitioners' performance but not in isolation of other feedback and performance measures.</p>			
<p>3. Provided good systems could be put in place, service user feedback could be useful to inform improvements in professional practice.</p>			
<p>4. Benchmarking aspects of practitioners' performance against their peers' could help identify areas where performance could be improved but may be difficult to implement in practice.</p>			
<p>5. Service users should be able to choose between methods of feedback according to their communication abilities and preferences but in practice this may be difficult to implement.</p>			

<p>6. Service users are happy to provide feedback if there are tangible outcomes and benefits for them or those who come after them.</p>			
<p>7. An effective quality improvement system includes service user feedback.</p>			
<p>8. Practitioners could be demoralised by feedback that is critical of their practice if it is presented in the wrong way.</p>			
<p>9. Skill is required to produce service user feedback mechanisms that elicit high quality data.</p>			
<p>10. More research is needed to understand the mechanisms that allow formative feedback to lead to improvements in professional practice.</p>			

## Appendix 12: responses to the 10 Delphi Round 3 statements

### 1. Service users have a valuable perspective on practitioners' performance but their views need to be taken in context.

#### Broadly agree

Context is all: patients will not have the information or understanding to comment appropriately on clinical performance

The context must include the purpose of the interventions and the outcomes agreed by the client and therapist as well as any restrictions imposed by political agendas.

It may be very difficult for the user to know the extent to which performance could impact on their perception of the service the practitioner is providing.

It is a perspective but it is only one Better to involve wider feedback e.g. 360 feedback

As users of a service they have an absolute right to provide feedback on the service they have received. However for some service users there is likely to be a highly subjective and possibly emotional view on practitioners' performance e.g. I don't want to go to the physiotherapist the exercises hurt too much or I don't like the dietician because I'll get told off for what I ate at the weekend. There will be elements of clinical practice and practitioners' performance that might be painful, uncomfortable, boring or an unpalatable truth but that may be the most appropriate, evidenced based treatment that is appropriate professionally and clinically but from the service user's perspective may be unpleasant. The views of service users themselves and the views of their family/carers' may also differ in respect of a practitioner's performance. For example, a parent may think that the practitioner has not done enough. However, the teenage may have reached a point where they feel they can manage their condition as well as they want and it is not a problem for them anymore.

It would be important to factor in the effect of organisation and its limitations (ie: funding cuts, reduction in staffing levels, amount of changes) in order to give a accurate context

Service users' views of the service they have received is vital information (on a number of fronts). It has real meaning for the SU, the person providing the service, their manager and the agency they work for. However, the need to contextualise their views is vital in what is an increasingly

“personalised” arena of practice. Services that are truly needs led and client centred will be shaped according to the individual SU, and an understanding of that SU personal circumstances will be vital to the analysis of their views and feedback on the service they have received

### **Broadly disagree**

Valuable is perhaps too strong a word. They will have a perspective of a practitioner's performance but may not be valuable as this can be a biased negative view if complaining to the HPC rather than a well balanced objective view which could then make a patient's perspective inappropriate

## **2. Service user feedback may be a useful measure of a practitioner's performance but not in isolation of other feedback and performance measures.**

### **Broadly agree**

Particularly important as client feedback will often be tinged by client's perceptions of level of support/motivation from their practitioner. Client and therapist responses and feedback to each other constitute the heart of the therapy and this needs to be recognised as a primary source of the measure of therapist performance.

It should be but the difficulty is in either a broad range of users to feed back so that it does not just capture those who are more willing to complain or those who have unrealistic expectations of the outcome of their clinical management

Can give feedback on personal experience but is not necessarily informed viewed i.e. may be the correct thing professionally but did not meet service expectations and so feedback is adversely influenced

SU's feedback SHOULD be seen as a useful tool to measure provider's performance, but vulnerable people are often receiving services from a range of agencies, and there are often a number of “variables” that govern how their service is valued on any given day. SUs often do not experience consistent days, and their feedback may therefore vary- as such it should not be viewed in isolation of other feedback streams

Service users have their very valid view. However, to measure outcomes/ practitioner performance it would be best to do this within the context of the evidence base. Increasingly budget holders are another strand of practitioners' performance. Whilst public funds must be spent effectively it may be that different weightings need to be given in considering how well a practitioner has performed. For example if a practitioner knows that clinically specific resources or time is required in order to achieve the best outcomes for service users but the budget holder restricts the resources and time available then it would be unfair on the practitioner if the service user were to deem that their performance was poor as the practitioner might not have had any direct control over the resources and would have been acting in line with the budget holder's requirement.

Feedback from several sources has more validity

**Broadly disagree**

Again the word 'useful' may not really be the correct terminology of a patients interpretation of a practitioners performance for the same reason as above.

**3. Provided good systems could be put in place, service user feedback could be useful to inform improvements in professional practice.**

**Broadly agree**

Certainly. Good user feed back should not only impact on practitioner performance but also on service use as a whole. It is essential that practice improvement includes the views of users.

Yes – provided service users have information about planned service improvements in a format that is accessible to them. For many service users a business plan/scoping analysis would not be documents they could relate to or to provide input on.

Yes but there needs to be an agreement about fair systems and systems that allow for the wide range of areas in which practitioners work.

**Broadly disagree**

This could have value at an individual or service level, or possibly an agency level, but not at a national level because of local context and delivery model variation. Additionally, it could only outline areas of practice improvement, I am not sure how much validity it would have in terms of determining change

What 'good systems' are you referring to??

**Neither agree nor disagree**

Broadly agree with this statement in a learning and development environment. But disagree if applied in a regulatory context.

**4. Benchmarking aspects of practitioners' performance against their peers' could help identify areas where performance could be improved but may be difficult to implement in practice.**

**Broadly agree**

Yes, and also benchmarking groups and departments. The difficulty is in deciding and agreeing the parameters to be used for benchmarking. Within profession for example there is precious little detail on benchmarking departments let alone down to the individual level.

Comparing the performance of people in a team, serving a similar population could yield useful comparative data, and perhaps reveal areas for improvement, but the context must be understood and identifying common areas for improvement across cases, which are not dependent on the SU's personal circumstances, may well be tricky

The RCSLT will be able to do this for speech therapists from March 2012. For the past 3 years we have been asking SLT services to complete a quality self evaluation questionnaire on-line so that they can demonstrate how they meet professional standard and so they can see how they compare against other similar service types. Benchmarking is entirely possible and SLTs have welcomed the use of this resource and have found it invaluable in respect of demonstrating the effectiveness of their services

**Broadly disagree**

"benchmarking" is neither relevant nor achievable in this context

Concerned re which aspects and which benchmarks. May not act as driver for improved performance but encourage mediocrity. Also I am assuming that there will be a spread of performance and not everyone can be in top quartile - may be disengaging rather than supportive of drive for highest standards

This is potentially divisive

Comparing performance with peers can be helpful but not if the peers chosen are all low in performance then improvements would be minimal.

**Not answered**

This would depend on the definition of 'peers' and whether this definition refers to practitioners working with similar client groups or in similar settings. It is impossible to answer this question without this information.

**5. Service users should be able to choose between methods of feedback according to their communication abilities and preferences but in practice this may be difficult to implement.**

**Broadly agree**

It is important that feedback is gained. Some people may be intimidated by a questionnaire and so the feedback method should best suit the individual and this may vary.

It will require investment in time and resources and sensitive handling to ensure the SU is offered information regarding their feedback in an appropriate manner

Self-evident!

Service users will have individual feedback preferences and abilities. Any feedback process must allow equity of feedback otherwise its validity can be challenged. I am not sure how difficult this really is in practice as many others have been doing it for years and we should be able to learn from their experience

There are many different methods and tools developed to enable less able service users to communicate

This would not be difficult to implement providing there is profession specific input from the start of developing feedback mechanisms so that the most effective methods of communication for service users can be used.

Yes, that should be self evident but the ability to provide a range of communication methods based on user needs may be difficult to implement if the resources required to do it are high and or limited

**Broadly disagree**

Service users *must* be able to choose between methods of feedback..... The fact that this may be difficult to implement is not a consideration. Service users must be given the opportunity to provide information in a way that is enabling for them.

**6. Service users are happy to provide feedback if there are tangible outcomes and benefits for them or those who come after them.**

**Broadly agree**

Agree, but doubtful applicability in regulatory situations, when the client wants direct redress for their complaint.

In general service users are always willing to respond if they feel that what is asked of them is of benefit. This is very clear in many aspects of health and social care where users readily engage with researchers where there may not be any tangible benefit to themselves but there is a benefit in increasing evidence based practice.

And providing the feedback mechanisms are appropriate for them to use.

**Broadly disagree**

I'm afraid people are not always so altruistic! My view is that at this time SUs are overly exposed to demands for feedback and are not always inclined to participate. In addition, there is a risk that they offer feedback on a service different to that provided by the requester. Whilst future service improvements may act as a motivator for some, I'm not sure this generalization is accurate

It depends on the patient – some will some won't.

**Not answered**

We cannot answer question on behalf of others. Service users need to be asked.

**7. An effective quality improvement system includes service user feedback.**

**Broadly agree**

Agreed, it is part of a range of useful information that can help share and improve service delivery

It should do but that is predicated on the answers to 8 & 9. It cannot be stressed to highly that there must be systems in place to ensure that the feedback is appropriate and measured in relation to the expertise of the practitioner.

Only if a mixture of positive and negative feedback is included. In regards to complaints to the HPC these will generally all be negative – but not necessarily a unbiased view.

There is no point in even bothering with quality assurance unless service users views are central to the process



This is not news.....

Yes, but as part of the intervention, as the process of Dramatherapy is a relational dynamic between client and therapist.

#### **8. Practitioners could be demoralised by feedback that is critical of their practice if it is presented in the wrong way.**

##### **Broadly agree**

...neither is this....(see previous comment)

Absolutely. In any situation, inappropriate feedback can lead to de-motivation. If that is inappropriate or unintentional then it is highly undesirable. Presenting findings must always be handled carefully, variables and context must be explained and clarified and negative feedback should be balanced with positive views, where and if they are available. Whilst practitioners may feel demoralised, it is the task of the manager of the service to deal with this response amongst staff and ensure that morale is improved and staff views are also sought and considered

See previous comment

Yes- particularly if the practitioner feels misrepresented.

##### **Broadly disagree**

The best practitioners are reflective ones who always strive for improvement. The HPC CPD standards require AHPs to demonstrate how their CPD has sought to enhance service delivery. There is not the expectation that everything will always be perfect, rather that the intention to improve services is at the heart of professional practice.

#### **9. Skill is required to produce service user feedback mechanisms that elicit high quality data.**

##### **Broadly agree**

...or this (see previous comment). The skill, certainly in hearing care interventions, is to establish the meaningful patient-experienced outcomes and set and collect the data to measure them. It is far too easy to fall into the trap of defining relevant feedback by that which can easily be measured.

A very difficult task

Agreed, gathering data and analyzing it, including user feedback, irrespective of the agency, is a skilled task. If sufficient care is not taken, the time and effort of service users and staff are wasted and there is a risk that change is sought inappropriately

The skill will come from working with practitioners

Yes, and the correct methodology applied. With out that the adage garbage in garbage out applies and it will require a significant amount to work to achieve that purpose across each of the different registration titles. That applies to all the other answers too as each of the professional titles will have markedly different methods of working, users and stakeholders

#### **10. More research is needed to understand the mechanisms that allow formative feedback to lead to improvements in professional practice.**

##### **Broadly agree**

Agreed, and this is a task for professional bodies

However not sure what research has already been done. Unsure how many people and who was involved with this questionnaire or others?? I am unaware of any significant research in this area that relates to own profession and therefore good quality work would be beneficial to not only establishing all the mechanisms but also the reliability and repeatability of such measures in different scenarios

Yes, a great deal more research and a great deal more time for participants in the research process to respond to questions.

Yes, more research required, and it will need to address a wide range of settings in which AHP services are delivered. It will also need to be informed by other experts in the field of user feedback (irrespective of agency) and should not be undertaken lightly unless there is a real chance that it will, in itself, lead to improvements in service delivery. However, if the "feeling" is that whatever the outcome, service user feedback will not be useful in terms of improving practitioner performance at a national level, no further time and resources should be devoted to researching the area

##### **Not answered**

Not entirely sure what you mean by this question it is ambiguous. More research is needed could mean – it isn't worth embarking on this initiative until there is a better evidence base to underpin in – in which case I disagree. OR It could mean – this initiative is a starting point and it would be worth undertaking a longitudinal study based on the results of this initiative in order to demonstrate the outcomes for service users and improvements in professional practice. – in which case I agree.

**Picker Institute Europe**

Buxton Court  
3 West Way  
Oxford OX2 0JB

Tel: +44 (0)1865 208100

Fax: +44 (0)1865 208101

Email: [info@pickereurope.ac.uk](mailto:info@pickereurope.ac.uk)

Website: [www.pickereurope.org](http://www.pickereurope.org)

Charity Registration no: 1081688