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Multisource feedback trials.

A summary of the report prepared for the College Education Committee.

Member Learning and Development

Office of the Dean

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1. Executive Summary

Multisource Feedback (MSF) has been widely used in many parts of the world and in many organisations but it has not been widely used, nor its impact widely researched, with Physicians in Australasia. In addition, regulators in Australia and New Zealand are increasingly requiring practitioners to complete practice review and quality improvement activities like MSF.

Implementing patient and colleague feedback activities well has significant time, cost and resource implications both for the Physicians being reviewed and the teams/services involved in providing feedback. It is essential the College has a good understanding of the elements of MSF that will most likely maximise its impact.

MSF is sometimes used to describe the collection just of colleague feedback. For this report, the term MSF will be used to describe a process that includes collection of feedback from colleagues, a candidate self-assessment against the same criteria as rated by their colleagues, collection of feedback from patients, and a debrief of the MSF report with the candidate by a trained advisor.

Three MSF trials were designed to:

- Establish how the factors that have been demonstrated in the literature to affect MSF feasibility, effectiveness and sustainability are likely to impact in the Australasian setting.
- Enable the College to offer evidenced-based guidance to Fellows on completing MSF activities.

An external provider was contracted to deliver the following three trials:

1. **Fellows:** Forty-three Fellows (candidates) who have regular patient contact volunteered to undertake a full MSF cycle using validated generic tools and a process that included a debrief of their MSF report with a trained volunteer RACP Fellow (advisor). Eighty-six percent (37 of 43) of candidates who enrolled received an MSF report and debrief.
2. **OTP:** Three OTP candidates volunteered to participate as part of their peer review period and completed the full MSF cycle.
3. **AFOEM:** The Australasian Faculty of Occupational and Environment Medicine requested support for a trial with six AFOEM Fellows who completed a trial of a customised colleague feedback tool only.

The trials demonstrated MSF to be feasible and effective and, more importantly, identified the elements contributing to, or detracting from, its impact. Of the 46 candidates across the three trials who received a feedback report, a large majority were positive about the process and the feedback tools and were supportive of the inclusion of a debrief of their report. A substantial majority of 91%, (42 of 46) said they would recommend MSF to other Fellows/OTPs respectively.

On the whole, Fellows are not used to receiving specific feedback and anxiety levels about the process for many candidates was high. The trials demonstrate a clear need for: support for MSF at the institutional level (ie. support from the organisations participants work for); the College to promote the benefits of MSF to the Fellowship; MSF to be supported through use of high-quality provider/s, well trained debrief advisors and high-quality briefing and support materials for participants; and for MSF to be recognised adequately in the MyCPD framework. There are also good reasons for MSF to remain voluntary at least until it becomes a more accepted part of the health landscape in Australasia.

The trials confirmed many of the characteristics recognised in the literature that contribute towards effective patient and colleague feedback processes and the College is now able to articulate those characteristics for the information of Fellows. In particular, the trials demonstrated the value of including a debrief with a skilled advisor, with most participants identifying a quality debrief as an important element for sustainability of MSF into the future.

The trials identified that some Faculties (eg. AFOEM and AFPHM) and specialities (eg. palliative care) as well as specific work settings (eg. intensive care, locums) need changes made to the processes and feedback tools to suit their needs. It is clear one size of MSF does not suit all.

The trials also surfaced elements of MSF that require ongoing development and research. These include: changes required to the process and feedback tools to suit major differences in speciality and work setting; how to address the concern of potential ‘gaming’ of feedback processes; how to ensure MSF is not used to support bullying and harassment and; how to assess actual (as opposed to perceived) changes in practice. The initial development priorities are to ensure patient feedback tools are appropriate for situations where parents or guardians are providing the feedback and to identify cost-effective methods for seeking feedback from in-patients.

While the number of OTPs who participated in the trial was small, their feedback mirrors most of the feedback from the Fellows trial. This feedback supports the potential for MSF to provide useful, specific and actionable feedback for OTPs who are completing peer review or top-up training.

In addition, the findings offer valuable insights that support and link MSF to work being done by other areas of the college including the ‘patient centred care’ and the ‘physician wellbeing’ projects in Education Services.

2. Key findings of the trials

2.1 Effectiveness:

- While not true in all cases, the MSF prompted most candidates to critically self-reflect on their practice. This resulted in identification of new insights and/or identification/confirmation of strengths and/or identification of potential changes in practice.
- Reported actual changes in practice included changes in patient communication and engagement strategies, confidentiality and agenda setting, teamwork and team communication, team management, prioritisation, and managing over-commitment, burn-out, and work-life balance.
- Three months post MSF, 96% (44 of 46) of candidates across the three trials provided follow up feedback. Most (91%, 40 of 44) agreed the process was worth the time invested. A large majority (86%, 38 of 44) identified potential changes in their practice and 75%, (33 of 44) reported having taken some steps to make the changes they had identified.
- While not unanimous, there was strong support for a debrief to remain a key component of completing an MSF and the quality of the debrief was predicted by candidates and advisors to have a major impact on the sustainability of MSF into the future. All forty-six candidates across the three trials provided feedback at the post debrief point and most (80%, 37 of 46) agreed or agreed strongly that the debrief of their report with a trained advisor was valuable, with some identifying this as the most important aspect of the process. There was a range of candidate debrief experience from disappointed to extremely satisfied, however the debrief helped most candidates actively reflect on the feedback in the report, clarify its significance and plan some action in response to the feedback. These findings support what has been identified in the literature. Debrief quality is essential to the impact of MSF and to building its reputation as an activity worth the effort. Advisors need to be selected carefully and trained appropriately to provide a consistent high quality debrief experience.
- At the post debrief point across the three trials 91% (42 of 46) of candidates agreed or strongly agreed that they would recommend the process to others as a useful tool.
- Over half the candidates reported not receiving regular feedback on their performance and most identified what they learnt through the MSF was not available to them through other processes.
- Candidates considered the MSF feedback relevant and accurate and commented that this was in part due to their perception of it being objective, constructive and anonymous.
- Candidates variously found value in both the patient and/or the colleague feedback which suggests both should be retained and promoted as valuable to Fellows.
- The generic (ie. non-physician and non-speciality specific) patient and colleague feedback tools used during the Fellows and OTP trials met the perceived needs of most candidates. Generic feedback tools could be expected to have face validity with the broader Fellowship. Exceptions to this include:
    - The need to develop customised colleague feedback tools for faculties such at AFOEM and AFPHM. Patient feedback is unlikely to be useful for most Fellows in these faculties.

    - The need to ensure patient feedback tools suit the needs of paediatricians and other specialists where parents or carers are completing the feedback.
    - Adjustments in the standard process for those in unique settings such as locums, remote areas and some intensive care settings.

- Constructive free text comments from colleagues and patients was a powerful source of reflection for some. Support materials need to be provided to colleague raters to assist them to provide appropriate and constructive feedback via free text comments.
- For some candidates, inviting feedback can lead to anxiety and if candidates are struggling at some level the MSF can be a tipping point. This may or may not have positive outcomes depending at least in part on what support resources are available and/or the skill of a debrief advisor. MSF can be a trigger that surfaces problems.
- Negative feedback was difficult for some candidates to take on board. The debrief was an essential element in managing this well. This also highlights the need for the development of a culture in health that supports giving and receiving feedback. This will help minimise the anxiety candidates feel and assist them to constructively use both positive and negative feedback.
- A small majority of candidates and advisors supported retaining a benchmark in the MSF report however there were strong responses both for and against. Further research should be done to establish the value or otherwise of benchmarks. If benchmarks are to be used there was strong support for development of an Australasian benchmark.
- Five of the six candidates in the AFOEM trial reported having taken some action to make changes in practice they identified through the MSF. This indicates MSF can potentially play an important role in providing accurate, relevant feedback to AFOEM physicians with a strong potential for that feedback to create practice change.
- Feedback from the OTPs who participated mirrored most of the feedback from the Fellows trial and in addition found the MSF offered valuable and specific feedback the OTP candidates had not previously received from the peer review process. The three OTPs agreed it was worth the time it took and strongly agreed they would recommend it to other OTPs.

2.2 Feasibility:

- Many candidates reported that the process “isn’t overly burdensome”; however, the time commitment was noted as a significant factor by some. In the Fellows trial the MSF took, on average, approximately nine hours of ‘health service time’ to complete, including the time spent by candidates, colleague raters and advisors. Both the presence or absence of administrative support for candidates, and whether the organisation has a culture of support for colleague and patient feedback, make a significant difference to ease of completion.
- No time limit for completion was set for the Fellows trial but a 12-week timeframe was recommended. It took Candidates in the Fellows trial an average of 22.3 weeks from signing onto the CFEP portal to completing their MSF debrief. The range was from nine through to 40 weeks. Significant project support via reminder emails was required by some candidates to assist them to complete. Candidates reported that other work priorities often dominated. All three OTPs were required to complete within 12 weeks between their first

and second peer review report and they met this timeline easily. In the colleague only AFOEM trial, candidates took an average of 16 weeks (range 10-27 weeks) to complete colleague only feedback and a debrief.

- Speciality, work setting and location all impacted in various ways on how difficult it was to gather patient feedback (eg. inpatients/outpatients, private/public) and colleague feedback (eg. small settings, regional locations, solo practice). These factors impacted differently for different candidates. The number of clinicians seeking feedback in an institution at the one time will need to be carefully managed to avoid rater fatigue.
- Across the three trials, most debriefs (80%, 37 of 46) occurred over the phone or via videoconference/skype. A large majority of these candidates found the debrief easy to organise and while they acknowledged potential advantages of a face to face debrief they believed telephone/ videoconference was adequate and did not impact the quality of the debrief. Some preferred the sense of anonymity a telephone debrief offers.
- Participants raised the future challenge of managing a debrief when the results are poor and/or contain difficult feedback. This could be particularly difficult if the debrief is being done over the phone or via skype.
- Most candidates were debriefed by a physician and felt this was important. Those debriefed by a skilled non-physician however reported the debrief to be just as valuable. Advisor expertise/knowledge did impact the quality of the debrief and the importance of advisor selection, preparation and monitoring was raised by candidates.
- AFOEM candidates indicated a preference for an MSF process that:
    - Involves colleague feedback only as FAFOEMs do not always have a therapeutic relationship with patients and the FAFOEM's role in making decisions that impact on patient and referring organisation may bias the feedback.
    - Uses a customised colleague feedback tool. The feedback tool developed by the Faculty of Occupational Medicine in the UK was preferred by 5 of 6 participants over the colleague feedback tool used in the Fellows trial and further customisation is recommended.
    - Includes a debrief by another AFOEM physician.

2.3 Sustainability:

- Participants indicated that MSF is most likely to establish itself as a valuable and transparent process if its main purpose remains formative. There is also value in MSF remaining voluntary at least initially as processes and feedback tools are improved and become regularly used and trusted by the broader Fellowship. Participants acknowledged this could mean that those who would benefit most may not choose to participate.
- It the OTP trial the focus remained primarily formative however the results were included as one element in the peer-review decision making process. Participants, especially the OTP candidates, were still strongly supportive indicating the MSF had provided more specific feedback than was generally available to them.

- Transparency, including transparency of who had access to the data and how it was used, was an essential element in building Fellows' trust in the process. Confidentiality of results was seen by some as vital to their participation and/or the quality of their engagement in the process (ie. they would have been less honest if others such as supervisors or health service management had access to the report).
- MSF was challenging for some to participate in and this suggests the benefits need to be actively promoted to the Fellowship if it is to gain acceptance as a valuable CPD activity.
- There was support for MSF to be significantly rewarded in the RACP CPD framework.
- Five years was the most commonly identified appropriate interval between rounds of MSF.

3. Trial limitations:

The following limitations occurred across the three trials:

- The candidate group were all volunteers and were motivated and positive about the potential of MSF. The participants were generally high performing physicians.
- The trial size in each case was small which makes it difficult to make generalisations to the broader fellowship – especially to Fellows/OTPs who may be strongly resistant to this kind of feedback activity.
- There was significant project support offered and this would not be available once MSF becomes a business as usual activity.

4. Conclusion / Future direction:

While not all participants found the MSF valuable there were high levels of effectiveness reported. Given an apparent feedback void for the majority of Fellows, and the clear indication from regulators of a requirement for peer review of performance, the results indicate there is value in encouraging Fellows and OTPs to consider engaging actively in well implemented MSF processes. Fellows should be encouraged to maximise their involvement by choosing to debrief their MSF with a skilled advisor.

Identification of providers that can deliver a high-quality MSF (using well trained advisors); customisation of feedback tools and processes where necessary (eg. for faculties such as AFOEM and AFPHM and for Fellows working with a high level of patients requiring parental/carer support); developing support resources for all participants; further research into and development of Australasian benchmarks; marketing the benefits of MSF and; ongoing research to ensure continuous improvement in MSF processes will increase the likelihood of Fellows successfully engaging with MSF.

This summary is taken from the report prepared for the RACP's College Education Committee by staff members in the Office of the Dean:

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