The Faculty of Intensive Care Medicine

Patient Feedback for Revalidation

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This statement has been reviewed by the GMC who have confirmed the content is in accordance with the latest guidance on supporting information for appraisal and revalidation.

Background

GMC revalidation for doctors was introduced in 2012. It is now embedded in medical practice with the majority of doctors working in intensive care having experienced two revalidation cycles. The patient feedback element of this has created discussion for doctors who don't have standard patient contacts in a clinic or standard ward setting.

The GMC guidance in relation to patient feedback was revised in 2020[1] to introduce more flexibility and is summarised below:

1. At least once in each revalidation cycle you must reflect on feedback from patients collected using a formal feedback exercise.
2. If you do not have patients, you should collect feedback from others to whom you provide medical services to. If you believe you can't collect such feedback, then you must agree with your responsible officer that you do not need to.
3. Feedback you reflect on should be collected in a way that is appropriate for your patients and the context in which you work.
4. At each appraisal you should reflect on any other sources of patient feedback you can access, that give you helpful information about your practice (such as unsolicited feedback)
5. You should reflect on patient feedback that covers your whole scope of practice across each revalidation cycle.
6. You must reflect on feedback and if appropriate, act on it in a timely manner and discuss how it has informed your practice at your appraisal.

Feedback in intensive care

The FICM and ICS have stated in previous guidance[2] that agreement has been reached with the GMC that individual patient feedback to intensive care doctors should not be mandatory and that other material may be used in lieu.

As part of the work of the FICM Professional Affairs and Safety Committee, a short survey was conducted in late 2018 to get a sense of the situation across the country with regard to the experience of consultants gathering patient feedback. Although the response rate was low (n=38) some consistent themes emerged from this:

- 22 of 38 respondents cited difficulties with collecting feedback for intensive care patients and 20 felt it was not reflective of their practice.
- The numbers of completed feedback forms required by reporting officers ranged from a minimum of 10 up to 34. The GMC don't specify a minimum number.
- 16 respondents felt the feedback was not of use to themselves or their appraiser as part of the appraisal process. From other comments received there was a clear indication of frustration in the requirement to do this. Comments such a s 'inappropriate' and 'pointless' were entered as responses to opinions regarding gathering this feedback. Of the 25 respondents who entered an open-ended response, none were positive as to their experience of this process.

Since this survey was completed, we have faced the COVID-19 pandemic. This has had a well-publicised impact on staff both in terms of workload and interactions with patients and their relatives. Contact with relatives has become much less face to face in most cases and bedside visiting has been limited. The ability to get feedback from relatives (as the usual surrogate in ICM) has been curtailed, making the feedback process even more convoluted. Despite many trusts slimming down their appraisal processes to reflect the pressure on clinicians, the requirement for patient feedback has not changed.

The GMC published revised guidance for revalidation in 2018 (updated 2020)[3] and although there have been no changes in relation to the requirement for patient feedback there are some new flexibilities around feedback tools and the types of feedback doctors can reflect on; it does also refer to Royal Colleges and their published advice for collecting feedback. The Faculty contributed to the consultation undertaken by the GMC that resulted in the publication of revised guidance on collecting patient feedback[1].

Faculty of Intensive Care Medicine
Churchill House, 35 Red Lion Square, London WC1R 4SG
Email contact@ficm.ac.uk **Website** www.ficm.ac.uk **Twitter** @FICMNews

Despite the previous statement from the FICM stating their lack of support for feedback from relatives or patients (given their vulnerabilities) and the revised GMC guidance allowing flexibility in patient feedback, the approach has continued to be very inconsistent from responsible officers as highlighted in the survey alluded to above.

Assessment

The COVID pandemic to date has exacerbated this issue for doctors working in Intensive Care for several reasons:

1. Doctors working in intensive care have been working at a greatly increased intensity for the last 18 months; time for other administration has been challenging. The GMC did acknowledge this by postponing revalidation for a period.
2. The ability to collect feedback directly solicited from patients has been reduced due to an increase in Level 3 patients as compared to Level 2.
3. The near cessation in visiting has meant indirect feedback from relatives has been difficult. Those relatives allowed to visit have often been allowed due to the severity (or likely death of a loved one), getting feedback about care would be wholly inappropriate.
4. Intensive Care doctors working in other specialties where feedback may be more easily gathered have in many cases reduced this work to focus on the delivery of critical care.

The team-based nature of intensive care has come to the fore over the last 18 months and acute trusts have gathered team feedback over this period particularly in relation to remote communication and reduced visiting. The FICMPAS Committee has received queries from doctors who are struggling with this aspect of the revalidation process and have not received the expected level of support or understanding from their responsible officer.

Recommendations

1. The Faculty supports the importance of collecting feedback in order to understand patient experience and encourage reflection and continual improvement.
2. The Faculty recognises the challenges in obtaining individual doctor feedback from patients or relatives in intensive care and support alternative approaches.

3. The Faculty support the use of appropriate team-based feedback in lieu of individual doctor feedback which should be supported by the responsible officer as it is within the latest GMC guidance. Sources of feedback could include:
   - Friends and family feedback for the intensive care unit (We Share or similar) as used by a number of units
   - Team feedback from intensive care follow-up clinics
   - Online or app-based feedback sought after hospital visits or telephone consultation
   - Service user data collected for CQC
   - External peer review data (Network review and the like)
   - Feedback from teams within the hospital following patient discharge from intensive care.
4. Employers should support a more flexible approach to obtaining patient feedback that is appropriate for doctors in intensive care and have mechanisms in place to support its collection. The GMC requirements for collecting patient feedback include that the patients or their representatives are not selected by the doctor, must know the purpose of the feedback, systems used should minimise bias, responses should be anonymised, and the doctor must be able to reflect on the responses and how they will impact on practice.

References

1. General Medical Council. Feedback from Patients, 2020.
2. FICM Guidance on Revalidation in Intensive Care Medicine, 2014.
3. General Medical Council. Guidance for doctors: requirements for revalidation and maintaining your licence, 2020.

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