

NHS England All England Appraisal Network Medical Appraisal Position Statement

Reference: MAPS S7

Patient feedback in non-standard situations

Relevance:

This statement is relevant to all designated bodies in England, including NHS England in its role as a designated body

Position statement:

- 1) All doctors who require a licence to practice need to participate in patient feedback to fulfil their requirements for revalidation.
- 2) All attempts should be made to gain patient feedback either from patients or patient equivalents.
- 3) Special consideration is needed in certain circumstances. These include where:
 - i. a doctor does not see patients or is not directly involved in delivery of patient care;
 - ii. a doctor is involved in direct patient care but their patients may lack capacity or be unable to give feedback themselves for example, babies, young children and the unconscious;
 - iii. a doctor is involved with patient care but may not see the patient.
- 4) It is important to consider in the broadest sense who the patient or customer is.
- 5) Where there is uncertainty, a discussion should take place between the appraiser and the responsible officer (or other person with delegated authority) to identify the patient equivalent for an individual doctor.
- 6) Ultimately it is the responsible officer's decision whether or not patient equivalent feedback should be sought.
- 7) A doctor will need to reflect on the feedback and include any development needs in their PDP.
- 8) As with any type of supporting information, it may be necessary to repeat the feedback process within an appraisal cycle if a concern comes to light.

- 9) Failure to participate in patient feedback may ultimately result in the withdrawal of a doctor's licence to practice on the grounds of non-engagement with the revalidation process.

This position is underpinned by the following principles:

- a) All doctors should value patient feedback as a core element of their work, improving patient care by enabling reflection and change in practice to take place.
- b) Developing this reflective approach to improving patient care engages patients and values their opinion. It encourages doctors and organisations to put the patient at the centre of their care and ultimately improve patient outcomes.

Rationale for position statement

Description and background

Putting patients at the centre of their care improves patient outcomes and the quality of care they receive. Doctors are one of a number of professions who will determine the patient experience and the care the patient receives. Improving care comes through feedback whether through reviewing and reflecting on outcome data, team feedback, organisational feedback, colleague feedback and feedback on individuals i.e. the doctor in this instance involved in the patient journey.

For some doctors obtaining patient feedback has been a regular part of their practice. For others this is a new undertaking and can seem a daunting task as does the practice of reflecting on the feedback received. Incorporating feedback and reflection into practice is a mandatory requirement for revalidation, and also an opportunity to change practice and patient care for the better

All doctors who wish to retain their licence to practise will have to participate in revalidation. This will require doctors to achieve the minimum standards set out by the GMC.

One of the core standards required in the first cycle of revalidation is to receive and reflect on patient feedback at least once in a revalidation year cycle. It may be helpful to consider patient feedback early in the revalidation cycle as this gives the doctor the opportunity to reflect and develop their practice through the PDP and undertake a further feedback within the same revalidation cycle if required. In future cycles and in some organisations and professional settings the expectation may be to gain more frequent and varied patient feedback.

Doctors who not directly see patients

There are a significant number of doctors who are no longer seeing patients or directly involved in delivering patient care. Many of these doctors need to retain their licence to practise, as there is an element of their roles that requires them to do so.

MEDICAL APPRAISAL POSITION STATEMENT

These doctors will therefore need to revalidate.

As a doctor not directly involved in delivering patient care at first glance it might be assumed that they do not need patient feedback. Some doctors in various groups may believe that they do not need to or are unable to get patient feedback. For example, those working in histopathology, non-interventional radiology, microbiology, leadership roles, policymaking, cremation doctors, medico-legal reporting, medical leaders and managers.

Patients can be regarded as customers or clients of health care. A doctor in a role with no patients must think broadly about whom their patients are, who can give a similar type of feedback.

Some examples might include students at all levels, families, carers, clients, or suppliers. Clients may include other services, teams and departments. The difference between colleagues and clients may be subtle. For a microbiologist who has no clinical interface with patients their clients could be those clinicians for whom the doctor has provided reports and may have had discussions about treatment options. Table 1 provides some examples of suitable patient proxies for doctors who do not directly interact with patients in a clinical sense.

Table 1: Examples of patient/client/customer proxies for doctors with no patient contact

Medical leaders – directors,	Those in the organisation that you have responsibility for or manage e.g. doctors, department leads, teams, other services, those you may be involved in contracting with or procuring from.
Educationalists, facilitators, coaches	Trainees, students, workshop participants, those you coach
Policy makers	Those you may advise, those who are involved in delivering/ managing policy that you have developed – how practical is it/how does it translate into practice?
Pathologists Radiologists	There will be individuals that you write reports for, may discuss particular patients with, give advice to so getting feedback about the service you offer, e.g. timeliness, availability, relevance, quality of report in content and commentary etc. the reflection from this feedback may change your practice i.e. the service to your customer/client which in turn impacts on patient care.

A discussion between the doctor and the responsible officer or other person with delegated authority such as a senior appraiser or appraisal lead will be helpful in clarifying the colleague/client relationship and who might be appropriate individuals to seek feedback from. The doctor's medical royal college or other professional body is likely to be able to offer guidance which will assist this discussion.

Each doctor who finds difficulty in identifying their patient equivalent should be considered on an individual basis.

Doctors who see patients who may lack capacity to give feedback

For some doctors, the nature of their clinical work presents a challenge in gaining patient feedback. This includes doctors working in paediatrics, anaesthesia, psychiatry, for example. For such doctors, their medical royal college is an important source of guidance in this matter. Use of relatives and carers is commonly helpful, but thought should always be given to developing means of obtaining meaningful feedback in a sensitive manner directly from the patient where possible. Table 2 gives some indication of the options for this group.

Table 2: Examples of patient feedback for doctors whose patients may not be able to give feedback through lack of capacity

Anaesthetists	<p>Getting feedback from patients who may lack capacity though young age, being unconscious, developmental processes or degenerative processes is not so straightforward and the doctor may be dependent on a proxy view and opinion from someone who has the patient's best interests in mind. Usually then the most appropriate person is often close family e.g. parents, a spouse, children, siblings, carers both professional and family, other family, formal advocates.</p> <p>Royal Colleges give advice on their websites for doctors in these situations e.g. Royal College of Anaesthetists, Royal College of Psychiatrists.</p> <p>It should also be noted that a person who lacks capacity in one context may have capacity in another. For example a patient with cognitive dysfunction may lack capacity in a clinical sense but may have capacity in terms of providing feedback on a doctor's attitude and care.</p>
Intensivists	
Paediatricians / CAMHS doctors	
Emergency doctors	
Learning Disability Psychiatry	

Doctors who see patients where there may be a perception of an adversarial relationship

It could be said that there is an element of stress in any clinical situation with the potential for an adversarial situation to arise. This is more of an issue in some clinical settings than others. A doctor working in a clinical area where there is a strong adversarial element may fear that predominately negative patient feedback will generate an inaccurate perception of them professionally, and possibly have a negative impact on their revalidation recommendation. It should be remembered that the prime purpose of patient feedback is to stimulate reflection on the part of the doctor. The outcome of the feedback has no direct bearing on the doctor's fitness to practise in the vast majority of case.

Where benchmarking of patient feedback is undertaken between doctors, this can provide useful mitigation in this situation. By ensuring that doctors in similar settings are benchmarked together, then parameters for normal results relative to that

context can emerge and be taken into consideration. In all cases, where an individual doctor's individual patient feedback results appear to indicate an issue of concern, this should only ever be seen as a trigger to look further, to understand the reasons more fully, and if necessary to undertake a more comprehensive review of the doctor's fitness to practise. Negative feedback in itself is not an over-riding indicator of a lack of fitness to practise. Table 3 offers some guidance in this area:

Table 3: Examples of feedback for doctors who see patients in which there may be a perception of an adversarial relationship

<p>Forensic psychiatry Doctors undertaking primarily Medico legal work Section 12 doctors Tribunal doctors</p>	<p>Doctors involved with patients in these groups may be concerned about the patient's ability to give the doctor true feedback about their practice. Doctors should include these patients and the feedback reflected on; the reflection will give the doctor the opportunity to consider the situation of the patient and the content of the feedback. The situation of the patient should not dictate that they are incapable of giving valuable feedback to the doctor. The doctor may need to discuss with the appraisal lead or RO the timing and collation of feedback</p>
--	---

When is it acceptable for a doctor to not undertake a patient feedback exercise?

Very occasionally it may be inappropriate for a doctor to undertake patient feedback. These are unusual situations and should be discussed with the responsible officer or other person with delegated authority. Each situation should be managed on an individual basis. Examples include: where concern exists about a doctor's practice that may put patient safety at risk but the doctor is permitted to continue to work in a non-patient facing role; where a doctor is currently suspended from practice and not seeing patients.

It is ultimately for the responsible officer to decide if it is acceptable for a doctor not to participate in patient or patient equivalent feedback. Such a decision should be very uncommon, and the reasoning behind it should be documented on the doctor's appraisal and revalidation record. Because this is a developing area, the decision should be revisited afresh on an annual basis.

Figure 1 provides an algorithm to help assist the decision about a suitable approach in differing circumstances:

Figure 1: Algorithm for the approach to obtaining patient feedback in differing professional circumstances



Failure to undertake a patient feedback against the advice of the responsible officer

Patient feedback is a core piece of supporting information required by the GMC for revalidation. The failure to organise, arrange and participate in this process may result in deferral of a doctor's revalidation recommendation. This is a neutral act to give the doctor time to complete the exercise. Continued failure to undertake patient or patient equivalent feedback without the agreement of the responsible officer may result in a non-engagement notice and ultimately withdrawal of the doctor's licence to practise by the GMC.

Patient feedback about systems

Patient feedback about the doctor's organisation, service, or team may prove to be very valuable and also contribute to the doctor's appraisal and revalidation. However this is not a substitute for feedback on the individual doctor, as specified in the GMC guidance.

Is a licence to practise medicine required for the role?

In some cases a doctor in a role who is facing difficulty in obtaining patient or patient equivalent feedback may consider whether it is necessary to retain their licence to practice in order to continue in that role. The doctor should discuss this with their responsible officer and the GMC before making a decision. In these circumstances where a doctor relinquishes their licence to practise their underlying registration with the GMC remains intact and reinstating their licence in the future is a straightforward administrative act.

References

Good medical practice framework for appraisal and revalidation (GMC, March 2013)
http://www.gmc-uk.org/static/documents/content/GMC_Revalidation_A4_Guidance_GMP_Framework_04.pdf

Supporting information for appraisal and revalidation (GMC, March 2012)
http://www.gmc-uk.org/static/documents/content/RT_-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf

Specialty Guidance for Appraisal and Revalidation. (Academy of Medical Royal Colleges, July 2014) <http://www.aomrc.org.uk/revalidation/specialty-advice.html>

The Medical Profession (Responsible Officers) (Amendment) Regulations 2013
<http://www.legislation.gov.uk/ukxi/2013/391/made>.

The Medical Profession (Responsible Officer) Regulations 2010 (Her Majesty's Stationery Office, 2010) www.legislation.gov.uk/id/ukdsi/2010/9780111500286.

Quality Assurance of Medical Appraisers (NHS Revalidation Support Team, 2014)
<http://www.england.nhs.uk/revalidation/ro/info-docs/>

Revalidation and appraisal guidance (FMLM) <https://www.fmlm.ac.uk/leadership-landscape/challenges-ahead/revalidation/revalidation-guidance>

Supporting information for appraisal and revalidation (FMLM July 2014)
<https://www.fmlm.ac.uk/sites/default/files/content/page/attachments/Appraisal%20and%20revalidation%20doc%20-%20YL%20MJ2%20edits.pdf>

NHS England medical appraisal position statements

NHS England medical appraisal position statements are a means by which issues pertinent to consistency and quality are captured, discussed and developed, so as to develop an agreed approach across all relevant parties. Issues are passed to the All England Appraisal Network (National) group in the first instance. The network develops an initial position statement based on preliminary discussion. This statement is shared for wider discussion as appropriate, then re-drafted and re-circulated. Depending on the nature of the issue, formal approval may be obtained from various bodies or relevant individuals. The degree to which a position statement has been shared and/or approved is detailed in the governance table at the end of the document.

A position statement should be seen as a fluid document to facilitate discussion and debate. It aims to capture current thinking on an issue and describe the best agreed approach available at the time. Incremental levels of sign off and approval occur after appropriate consensus-building efforts have occurred. A position statement may therefore eventually be consolidated as policy, but while it remains a position statement it remains a vehicle for debate and discussion.

NHS England medical appraisal position statement relevance

NHS England has a dual function in relation to revalidation and appraisal: firstly as a designated body in its own right, and secondly as Senior Responsible Owner for the revalidation programme in England as a whole. A NHS England medical appraisal position statement may therefore be relevant to NHS England only or to all designated bodies in England. The relevance of an individual position statement is indicated in the title of the statement. Position statements which are NHS England-only may still be of interest to other designated bodies.

MEDICAL APPRAISAL POSITION STATEMENT

Governance table

Owner	Vicky Banks
Email	vickybanks@nhs.net
Status	Draft
Document narrative	<p>02/10/2014 – first draft by VB shared with AN(N)</p> <p>08/10/2014 – re-draft by VB, after feedback from AN(N) formatting by Maurice Conlon</p> <p>09/10/2014 – further drafting by VB and MC</p> <p>10/10/2014 – further drafting by MC and VB</p> <p>15/12/2014 (JK): Shared with ROCON on 11/12/14 for comment.</p> <p>31/12/2014 (JK): Re-formatted in NHS England style by Jenny Kirk</p> <p>31/12/2014 (JK): Distributed to responsible officers and appraisal Leads via regional offices for comment</p>