Guidance on Revalidation in Intensive Care Medicine

The Faculty of
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Revalidation in Intensive Care Medicine

1. Introduction

1.1 The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are fit to practice.

1.2 The purpose of this document is to outline the background to the revalidation process and to define the qualities it is designed to demonstrate; to identify and explain the systems through which this is incorporated and managed (termed enhanced annual appraisal); and to provide clinicians practicing Intensive Care Medicine (ICM) with relevant advice concerning the supporting information they will need to revalidate.

2. Revalidation for the individual practitioner: Annual appraisal

2.1 Assessing readiness to revalidate involves the continuous evaluation of your ability to practice through local systems of clinical governance recorded through annual appraisal. Consequently, at this meeting you should expect to discuss your practice and performance, and to demonstrate that you continue to meet the standards for competent practice set out in the General Medical Council's (GMC's) core guidance, *Good Medical Practice* (2013).

2.2 You will be expected to gather supporting information about your practice throughout the year and provide it to your appraiser is advance of the appraisal meeting. This data should form the basis of that part of your discussion that relates to revalidation.

3. Qualities needed by all medical practitioners

3.1 The General Medical Council (GMC) has issued useful guidance [1] in the form of three documents:

- *The Good Medical Practice Framework (GMPF) for Appraisal and Revalidation* (2012);
- *Revalidation, What You Need To Do* (2013), a summary of supporting information required, including that relating to colleague and patient feedback; and
- *Ready for Revalidation: Meeting the GMC's Requirements for Revalidation* (2013).

The GMC website and these publications should be consulted by all practitioners seeking to retain a license to practice.

4. The Good Medical Practice Framework (GMPF)

4.1 The GMPF consists of four domains covering knowledge, skills and performance, safety and quality; communication, partnership and teamwork; and maintaining trust. Each domain contains defining attributes which relate to practices or principles **for the profession as whole**. The principles and values of the GMPF were adapted from the GMC's *Good Medical Practice (2013)* and are examples of the types of professional behaviors expected of all doctors.

1 http://www.gmc-uk.org/doctors/revalidation/12382.asp

4.2 The material that may be regarded as evidence of compliance with the principles and values of the GMPF may be generic and applicable to all practitioners (e.g. complaints and complements); or can be specific to individuals' clinical specialty and practice (e.g. continuing professional development, CPD).

4.3 The supporting information you supply as part of the appraisal process should indicate that you are able to demonstrate compliance with the qualities defined in the four domains:

- ***Domain 1*** (*knowledge, skills and performance*)*:* is divided into maintaining professional performance, applying knowledge and experience to practice, and ensuring that all documentation including clinical records are clear and accurate.
- ***Domain 2*** (*safety and quality*)*:* is defined by compliance with systems designed to protect patients, responding to risks to patient safety, and protecting patients and colleagues from risks posed by the practitioner's health.
- ***Domain 3*** (*communication, partnership and team work*)*:* seeks evidence that the practitioner demonstrates effective communication, and has the ability to work constructively with colleagues and to delegate effectively, and concerning their skill in establishing and maintaining partnerships with patients.
- ***Domain 4*** (*maintaining trust*)*:* requires the clinician to provide evidence that they display respect for patients, treat colleagues and patients fairly and without discrimination, and act at all times with integrity and honesty.

5. Supporting information

5.1 In order to revalidate, you must collect supporting information about your practice that is relevant to each of these domains as defined in the GMC publication *Revalidation, What You Need To Do* (2013) You should gather this throughout each year and review it with your appraiser annually.

5.2 This material should form the basis of that part of your appraisal that relates to revalidation. Whilst not all of it needs to be collected every year, some elements are required, or need to be at least reviewed, annually.

5.3 If you are unable to provide an element of the core supporting information, and/or you wish to bring alternative or additional information to appraisal in support of a particular domain and/or attribute of the GMP Framework, this will be evaluated by the appraiser and may be accepted if reasonable. Options for such alternative information might be specified in specialty guidance issued by Royal Colleges and Faculties and other relevant bodies, or could be accepted with the prior agreement of your Responsible Officer.

6. Tabulation and arrangement of supporting information

6.1 The paper or electronic record supplied to you for appraisal purposes should facilitate the recording of supporting information under the headings agreed between the Academy of Medical Royal Colleges and the GMC. These relate to:

- Information about you and your professional work.
- Keeping up to date.
- Information about you and your professional work:

- Quality improvement activity
- Significant events

- Feedback on your professional practice:
  - Colleague feedback
  - Patient and carer feedback
  - Complaints and compliments

6.2 It is recognised that amongst intensivists, details of clinical practice will vary significantly in scope and intensity and according to sub-specialty. The information set out here (Sections 7 and 9, below) is designed to apply to all those practicing clinically in the specialty for all or part of their job plan.

6.3 By providing evidence of compliance with these standards through annual appraisals performed over a five-year cycle, you will demonstrate that you have met the requirements of the four Domains and twelve Attributes of the *Good Medical Practice* Framework.

7. Other relevant material

7.1 The remainder of this guidance is designed to facilitate regular updating as the relevant processes evolve. Section 9 is designed as a prompt for you to record descriptions of the nature and scope of your professional work, provide evidence of the steps you are taking to keep up to date and to maintain and improve the quality of your professional work, and to supply feedback from colleagues and patients concerning your practice. Specific aspects of these processes are addressed in Appendices as follows:

- ***Appendix 1:*** Applying supporting information to the domains and attributes that make up the GMPF.
- ***Appendix 2:*** A matrix designed to guide Continuing Professional Development (CPD) for those practicing ICM regarding the clinical knowledge and expertise they are likely to need, and what evidence can be provided to demonstrate competence in each area.
- ***Appendix 3:*** Guidance concerning the use of Multi-Source Feedback in ICM from colleagues and peers.
- ***Appendix 4:*** Guidance concerning the use of Multi-Source Feedback in ICM from patients.
- ***Appendix 5:*** Audit and quality markers in ICM approved by the Faculty.
- ***Appendix 6:*** Suggested template for annual appraisal reflective case study review.

8. Date of Review

8.1 This document was reviewed and approved by the joint Intensive Care Society and Faculty of Intensive Care Medicine Professional Standards Committee in February 2014. It will continue to be reviewed annually. All future editions will be published on the FICM website, www.ficm.ac.uk. The Faculty reserves the right to make emergency updates to this guidance if necessary.

9. Supporting information for appraisal and revalidation in Intensive Care Medicine

9.1 The core supporting information, requirements and specialty guidance outlined here is applicable to all doctors practicing Intensive Care Medicine. It is designed to help you strategically plan how you may collect and produce the necessary information for appraisal and therefore revalidation. The information is grouped as indicated in Section 6.1.

9.2 The template has been adapted from that developed by the Academy of Medical Royal Colleges. Although the types of supporting information described are the same for all specialties, you will find (where appropriate) specific additional advice for intensivists at the end of each section (see Specialty Guidance).

9.3 Not all the supporting information needs to be collected every year, although some elements are needed (or should be reviewed) annually. This is indicated in each section under 'requirements'. If you cannot provide an element of the core supporting information in support of a particular domain and wish to bring alternative material this should be discussed with your appraiser and the approval of your responsible officer must be sought. This may be particularly appropriate for clinicians practicing wholly or substantially in academic or managerial appointments with limited patient contact, but with substantial vicarious responsibility for standards of patient care.

9.4 Similarly, in the section 'Review of Your Practice', to demonstrate that you participate in activities that evaluate the quality of your work, you will need to include at least one piece of evidence derived from clinical audit, or a review of clinical outcomes. However, if due to your personal working arrangements you are unable to provide such evidence you may as an alternative arrange with your appraiser to submit documented Case Reviews as evidence of the quality of your work. In addition, all significant events (critical incidents, serious untoward incidents and other similar events) need to be suitably recorded and presented together with evidence that these have been discussed (e.g. in morbidity and mortality meetings) and lessons learnt for future practice.

General information

Providing context about what you do in all aspects of your professional work

The supporting information in this section should be updated at least annually.

Personal details	**Description** • Your GMC number, demographic and relevant personal information as recorded on the GMC Register. • Your medical and professional qualifications should also be included. **Requirements** • A self-declaration of no change, or an update identifying changes, including any newly acquired qualifications, since your last appraisal. • The supporting information in this section should be updated annually for your appraisal. **Guidance**[2] Required in annual appraisals.
Scope of Work[3]	**Description** A description of your whole practice covering the period since your last appraisal is necessary to provide the context for your annual appraisal. Some employers may require you to include your current job plan. **Requirements** Your whole practice description should be updated annually. Any significant changes in your professional practice should be highlighted as well as any exceptional circumstances (e.g. absences from the UK medical workforce, changes in work circumstances). The description should cover all clinical and non-clinical activities (e.g. teaching, management and leadership, medico legal work, medical research and other academic activities) undertaken as a doctor and include details as to their nature (regular or occasional), organisations and locations for which you undertaker this work and any indemnity arrangements in place. The description should detail any extended practice or work outside the NHS, paid or voluntary, undertaken in specialty or sub specialty areas of practice, the independent healthcare sector, as a locum, with academic or research bodies or with professional organisations. Any work undertaken outside the UK should be identified. An approximate indication of the proportion of time that you spend on each activity should be provided.

2 Specialty Guidance should include: particular aspects of practice that should be included in each element of the core information; guidance as to what alternative supporting information should be provided if it is impossible (in the nature of the specialty) to provide any element of the core information; and details of any formal tests of proficiency or other aspects of quality control or quality assurance that are required in order to practice in the specialty.

3 The detailed requirements for this are being considered as part of the Medical Appraisal Guide (MAG) and will need to be agreed by all key parties.

	If appropriate, you should summarise any anticipated changes in the pattern of your professional work over the next year, so that these can be discussed with your appraiser. **Guidance** Some specialists will be required to present, in summary form, quantitative and qualitative information representing certain areas of their practice. Maintenance of as logbook may help with this, and is recommended by the Faculty. You should include details of the size and roles of the team with which you work in order to clarify your own role. **Doctors practicing as intensivists** A discussion during appraisal about the scope and extent of your clinical practice is essential: • Data should be drawn from personal records or logbooks, or hospital information system(s) to describe the volume and nature of your clinical activity in the intensive care and other relevant settings (e.g. emergency room, operating theatre, via outreach). Several electronic logbook systems are available and capable of producing suitable summary reports. • Outpatient activity may be summarised to include the number of existing and new patients seen. • Practical procedures carried out should be described qualitatively and quantified. Types of procedures can include, depending upon areas of clinical practice, intubations, gaining central venous and arterial access, or performing tracheostomies.
Record of annual appraisals	**Description** A signed off 'Form 4' or equivalent evidence (e.g. electronic appraisal portfolio record) demonstrating a satisfactory outcome of previous appraisal(s). Evidence of appraisals (if undertaken) from other organisations with which you work must be supplied. **Requirements** At every annual appraisal any concerns identified in previous years should be documented as having been addressed satisfactorily (or satisfactory progress made) even if you have been revalidated since your last appraisal.
Personal Development Plans and their review	**Description** Access to previous personal development plan(s) (PDPs) is required with agreed objectives developed as an outcome from previous appraisal(s). **Requirements** The current PDP should be reviewed to ensure that the agreed objectives remain relevant, have been met or that satisfactory progress has been made. Any that remain relevant should be carried over to a new, agreed PDP.

	Guidance The content of your PDP should, where relevant, encompass development needs across any aspect of your work as a doctor. **Doctors practicing as intensivists** A review of previous PDP outcomes, and development of the next PDP should take account of the principles outlined in Faculty Guidance (*Appendices 1* and *2*) and from those derived from other Royal Colleges' guidance (e.g. *Guidance to CPD,* RCoA, 2010; *Appraisal and Revalidation: Guidance for doctors preparing for relicensing and revalidation, Book 6, Continuing Professional Development.* RCP London 2007; Preparing for revalidation, e-Learning module, RCP London 2014) where relevant to your whole practice.
Probity	**Description** The GMC states that all doctors have a duty to act when they believe patients' safety is at risk or that their care or dignity is being compromised[4]. Your supporting information should include a signed self-declaration confirming that there are no probity issues and stating: • That you comply with the obligations placed upon you as set out in *Good Medical Practice* (GMC 2013). • That no disciplinary, criminal or regulatory sanctions have been applied to you since your last appraisal or that any sanctions have been reported to the GMC, in compliance with its guidance *Reporting Criminal and Regulatory Proceedings Within and Outside of the UK* (2013) and to your employing or contracting organisation if required. • That you have declared any potential or perceived competing interests, gifts or other issues which may give rise to conflicts of interest in your professional work - see the GMC document *Financial and commercial arrangements and conflicts of interest (2013*) and those relevant to your employing or contracting organisation if required (e.g. university or company).[5] • That, if you have become aware of any issues relating to the conduct, professional performance or health of yourself, or those with whom you work that may pose a risk to patients safety or dignity, you have taken appropriate steps without delay, so that the concerns could be investigated and patients protected where necessary. • That, if you have been requested to present any specific item(s) of supporting information for discussion at appraisal, if you have done so. **Requirements** Required for every annual appraisal.

4 *Raising and Acting on Concerns About Patient Safety*. GMC, London, 2012.

5 Please refer to GMC Guidance on this topic: http://www.gmc-uk.org/static/documents/content/Conflicts_of_interest.pdf.

	Guidance The format of the self-declaration should reflect the scope of your work as a doctor. You should consider the GMC ethical guidance documents relevant to your practice (e.g. *0-18 years: Guidance for all Doctors.* GMC, London, 2007).
Health	**Description** A signed self-declaration confirming the absence of any medical condition that could pose a risk to patients and that you comply with the health and safety obligations for doctors as set out in *Good Medical Practice* (2013), including having access to independent and objective medical care. **Requirements** Required for each annual appraisal. **Guidance** The scope of the self-declaration should reflect the nature of your work and any specialty-specific requirements. **Doctors practicing as intensivists** The Faculty recommends that practitioners in intensive care medicine are particularly aware of the dangers of contracting and transmitting infection and take every step to protect themselves and their patients from such risks (see *Good Medical Practice* (2013), sections 28-30).

Keeping up-to-date

Maintaining and enhancing the quality of your professional work

Good Medical Practice *requires doctors to keep their knowledge and skills up to date, and encourages them to take part in educational activities that maintain and further develop their competence and performance.*

Continuing Professional Development (CPD) See *also Appendix 2*	**Description** CPD refers to any learning beyond undergraduate or postgraduate training which helps you maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of your professional practice. It includes both formal and informal learning activities [6]. CPD may be: • Clinical: including any specialty or sub-specialty specific requirements [7]. • Non-clinical: including training for educational supervision, training for management or academic training [8]. **Requirements** At each appraisal meeting, a description of CPD undertaken each year must be provided including: • Its relevance to your individual professional work • Its relevance to your PDP [9] • Reflection and confirmation of good practice or new learning/practice change where appropriate. Normally, achievement of at least 50 credits per year of the revalidation cycle is expected and at least 250 credits over a five-year revalidation cycle. Where circumstances make this impossible, refer to specialty guidance. **Guidance** Your CPD activity should cover all aspects of your professional work and should cover your agreed PDP objectives. It is important to recognise there is much professional benefit associated with a wide variety of CPD including that outside your immediate area of practice. You should ensure a balance of different types of educational activity is maintained. Documentation of CPD activity should include a reflection on the learning gained and the likely effect on your professional work. You should present a summary of your CPD activities through the year for your annual appraisal.

6 *Continuing Professional Development: Guidance for all Doctors*, GMC, London, 2012.

7 Employer mandatory training and required training for educational supervisors may be included provided that the learning is relevant to your job plan, and is supported by reflection and, where relevant, practice change.

8 Faculty Fellows, Members and Associates may employ CPD recording and categorising systems developed by one of the Trustee Colleges. Alternatively, all Faculty affiliates of all categories have access to the RCoA CPD system.

9 Not all of the CPD undertaken has to relate to an element of the PDP – but sufficient should do so to demonstrate that you have met the requirements of your PDP.

Doctors practicing as intensivists

- Specified knowledge and skills that should be covered over a five-year revalidation cycle are outlined in the Faculty CPD matrix (*Appendix 2*). Guidance as how this should be organized can be found elsewhere (see e.g. CPD: Guidelines for recommended headings under which to describe a college or faculty CPD scheme, AoMRC 2012; CPD guidance framework for appraisers and appraisees, AoMRC 2013)
- In accordance with the Academy of Medical Royal College's (AoMRC) publication *Ten Principles of CPD* (AoMRC, 2007) the Faculty recommends that you obtain at least 50 CPD credits per year (250 credits over a 5 year cycle). One credit equates to one hour of educational activity. The Faculty recommends that, of these 50 credits per year, a minimum of 20 external and 20 internal credits are obtained.
- External activities are essential for ensuring doctors remain abreast of current best practice. Equally, internal activities are essential in terms of participation in local audit, clinical governance, and morbidity and mortality meetings. Evidence of participation in internal meetings should be available and, where appropriate, 'action-log' type contributions to local developments in practice should be recorded.
- Practitioners working in wholly independent practice will need to develop personal CPD targets in conjunction with their appraiser (taking into account the Faculty's CPD matrix), as internal credits may be impossible to obtain.

Other examples of CPD that may be submitted include:

- Knowledge assessments related to e-Learning.
- Training, assessment or reassessment of practical skills; established or novel.
- Evidence of compliance with your employer's mandatory training if relevant to your professional work (e.g. resuscitation skills)

Review of your practice

Evaluating and improving the quality of your professional work

For the purposes of revalidation, you will have to demonstrate that you regularly participate in activities that review and evaluate the quality of your work. The nature and balance of these activities will vary according to your specialty and the work that you do. These activities should be robust, systematic and relevant to your work. They should include an element of evaluation and action and, where possible, demonstrate an outcome or change. The supporting information in this section should be updated annually. If you work in a non-clinical area you should discuss options for quality improvement activity with your appraiser, College or Faculty[10].

Quality Improvement Activity	
Clinical audit See *Appendix 5*	**Description** You should participate in at least one audit cycle (audit, practice review and re-audit) carried out to the quality standards agreed between the AoMRC and the Healthcare Quality Improvement Partnership (HQIP)[11], within each five-year revalidation cycle. If this is not possible, other ways of demonstrating quality improvement should be undertaken. **Requirements** *National audits* Participation in national audits is expected where these are relevant to ICM. Your participation in national audits may focus on the performance of the team, but there will be elements that reflect your personal practice or the results of your management of, or contribution to, the team or service of which you are part. Your role, input and learning and response to the audit results should be reflected upon and recorded. *Personal or local audits* Improvement in the quality of one's own practice through personal involvement in audit is recommended. A simple audit of a medical record keeping against agreed standards is a recommended activity, but should be carried out as an addition to and not a substitute for, other clinical audit activity. **Guidance** The Faculty requires that your department ensures that formal programmes of audit are in place reflecting key areas of practice within the specialty. **Doctors practicing as intensivists** You should participate in at least one audit cycle (defined above) within each five-year revalidation cycle. All intensivists or the departments of which they are part should:

10 For example, if you are working in education or management your Quality Improvement Activity could include (a) auditing and monitoring the effectiveness of an educational programme, (b) evaluating the impact and effectiveness of a piece of health policy or management practice.

11 The Academy Clinical Audit Working Group. *Clinical Audit and Revalidation – report and recommendation.* AoMRC, London, 2009.

	• Ensure formal programmes of audit are in place, which reflect key areas of practice, including evidence of personal performance against recommended standards (whenever possible). • Demonstrate evidence of active engagement in these local audits throughout a full audit cycle. • Use the Faculty's approved list of audits where possible (Appendix 5). A list of audit subjects approved by the Faculty and the Intensive Care Society is provided at *Appendix 5*. **Note:** *See guidance in Sections 5.3 and 9.4 for those unable to provide evidence from clinical audit to demonstrate the quality of their work.*
Review of Clinical Outcomes	**Description** Clinical outcomes that are used for revalidation should be robust, attributable and well-validated. Even when these are not available, you may wish to bring appropriate outcome measures to appraisal in order to demonstrate the quality of your practice. **Requirements** Where national registries are in place relevant to your practice you may be expected to participate in the collection of national, standardised data. Evidence of this participation should be made available for your appraisal. Nationally agreed standards and protocols may also include outcomes and you should bring these to appraisal when recommended by your specialty. Data should relate as far as possible to your own contribution. Comparison should be made with national data whenever possible. **Guidance** Some specialties, mainly interventionalist or surgical but including those academic activities in which clinical trials play a major role, which have recognised outcome measures. Where clinical outcomes are used instead of, or alongside, clinical audit or case reviews, there should be evidence of reflection and commentary on personal input and, where needed, change in practice. **Doctors practicing as intensivists** • Where available, outcome and performance data based on individual and team practice should be provided with reflection and commentary on personal input. Examples include: Intensive Care National Audit and Research (ICNARC) data, local records of adverse clinical events. • Nationally agreed performance data (See *Appendix 5* for examples)
Case review or discussion	**Description** The purpose of case reviews is to demonstrate that you are engaging meaningfully in discussion with your medical and non-medical colleagues to maintain and enhance the quality of your professional work. Case reviews provide supporting information on your commitment to quality improvement if appropriate audit/registries are unavailable.

	Requirements If you unable to provide evidence from clinical audit or a review of clinical outcomes, documented case reviews may be submitted as evidence of the quality of your professional work. Where this information is required, there should be two examples per year. Over a five-year revalidation period, the examples should be derived from the full range of your professional work and may not always relate to direct patient care. The proposed material should be discussed with a peer, another intensivist, or a member of a multidisciplinary team; or at a morbidity/mortality meeting. There should be either confirmation of good practice, or identifiable practice change. Action points should be incorporated into your PDP. **Guidance** Evidence of relevant working party or committee work (internal or external) may be included together with your personal input and reflection, including implementation of changes in practice, where appropriate. Some specialties may recommend case reviews routinely, and a number of different approaches are acceptable including documented regular discussion at multi-disciplinary or morbidity and mortality meetings. In specific circumstances, case reviews may form the main evidence provided in support of quality improvement. **Doctors practicing as intensivists** • The review should outline the (anonymised) case details with appropriate reflection against national standards/guidelines/ best practice and include evidence of discussion with peers or presentation at department meetings. Learning points and implementation of changes in practice should be included where appropriate. Involvement in a critical incident could form the basis of such a case review. The case review option should be agreed, in advance, with your appraiser. • A reflective case review template is provided in *Appendix 6*.
Significant events	
Clinical incidents, Significant Untoward Incidents (SUIs) or other similar events.	**Description** A significant incident or event (also known as an untoward, clinical, critical or patient safety incident – these terms are used interchangeably) is any unintended or unexpected incidents, which could, or did, lead to unintended harm to one or more patients. This includes incidents that did not cause harm but could have done, or where the event should have been prevented. Serious Untoward Incidents (SUI) or Significant Clinical Incidents are those events that have or could have significant or catastrophic impact on a patient and may adversely affect the organisation and its staff. Data should be collected routinely by your employer, where you are directly employed by an organisation. You should ensure you are familiar with your organisations local processes and agreed thresholds for recording incidents. It is not the appraiser's role to conduct investigations into serious events.

Requirements
If you have been involved in any significant incidents since your last appraisal you must provide details logged by you, or on local (e.g. at trust level) or national reporting systems (e.g. NRLS). A summary of all clinical incidents in which you have been directly involved, and a short anonymised description of these with reflection and learning points and action taken must be included.

If you are self-employed, you should make a note of any such events or incidents and undertake a review.

A short anonymised description of all SUIs or Root Cause Analyses in which you have played a part (including as investigator) with reflection, learning and action taken must be presented. If you have had no direct involvement in such events since your last appraisal a self-declaration to that effect should be presented.

Guidance
Incidents and other adverse events which are particularly relevant or related to certain areas of specialist practice are identified in specialty guidance (see below).

Doctors practicing as intensivists

- The descriptions provided should take into account the principles of critical incidents handling set out in nationally available documents such as *Good Practice: a Guide for Departments of Anaesthesia, Critical Care and Pain Management* (RCoA, 2006), *Catastrophes in Anaesthetic Practice: Dealing With the Aftermath* (AAGBI, 2005) and *Appraisal and revalidation: Guidance for doctors preparing for relicensing and revalidation, Book 3, Untoward Events* (RCP London, 2007).
- Your summary should provide evidence of presentation at departmental or hospital clinical governance meetings, together with evidence of reflection and changes in personal or institutional practice which resulted.

Feedback on your practice

How others perceive the quality of your professional work

Feedback from colleagues	
The supporting information in this section must be provided in all cases where the professional context permits.	
Colleague Feedback See *Appendix 3*	**Description** The result of feedback from professional colleagues from the range of professional activities, using a validated multi source feedback (MSF) tool which meets criteria set by the GMC[12]. The results should be reflected upon, and any further development needs should be addressed. **Requirements** At least one colleague-based MSF should be undertaken in the revalidation cycle normally by the end of year two to allow follow up surveys if issues are identified and addressed. **Guidance** The selection of raters/assessors should represent the whole spectrum of people with whom you work. The results should be benchmarked where data are available and accessible against other doctors in the same specialty. **Doctors practicing as intensivists** • The selection of peers to provide feedback should adhere to principles outlined in the Faculty *Guide on peer and patient feedback for revalidation* (FICM, 2011, *Appendix 3*). The results of any survey should be benchmarked, where data is available/accessible, against other doctors working in the specialty.
Feedback from clinical supervision, teaching and training	**Description** If you undertake clinical supervision and/or training of others, the results of student/trainee feedback or peer review of teaching skills should be provided for appraisal and revalidation purposes. **Requirements** Evidence of your professional performance as a clinical supervisor and/or trainer is required at least once in every revalidation cycle. Feedback from any formal teaching should be included annually for appraisal. **Guidance** Appropriate supporting activity may include direct feedback from those taught in a range of settings. Clinical and educational supervisors are required to provide evidence that they have met the minimum training requirements set by the GMC for these roles. Formal review or re-appointment as a trainer after a specified number of years may be required.

12 All colleague MSF tools must be validated and should comply with GMC guidance.

	Doctors practicing as intensivists Clinical supervision includes being responsible for providing clinical cover for trainees on call, or responsibilities for training and supervision during day-time programmed clinical activities. • ***Clinical supervision/training:*** Feedback, where feasible, should be derived via postgraduate deaneries' quality assurance processes for postgraduate training. Alternatively, local departments may undertake such surveys. • ***Teaching:*** Evidence of teaching quality where available should be derived from feedback collated and provided by course organisers (e.g. ALS, ATLS), medical school, school of anaesthesia or organisations responsible for postgraduate training/CPD (e.g. Local Education & Training Board, LETB) and it should incorporate both quantitative and qualitative data. An example could be data derived from an evaluation form issued to participants after a CPD event, incorporating both a rating scale and option to provide free text comments.
Feedback from patients and/or carers	
The supporting information in this section must be provided in all cases where the professional context permits.	
Patient /carer feedback See *Appendix 4*	**Description** The result of feedback from patients and, if appropriate, carers, using a validated and GMC-approved MSF tool[13]. The results should be reflected upon, and any further development needs should be addressed. For those doctors who do not provide direct patient care, guidance on appropriate alternative supporting information should be provided by their College or Faculty. **Requirements** At least one patient survey in the revalidation cycle, normally undertaken by the end of year two to allow follow up surveys if issues are identified and addressed. **Guidance** Some Colleges and Faculties have identified patient feedback tools, instruments and processes which are suitable for doctors in particular areas of practice. For some, only certain areas of practice will be amenable to patient and/or carer feedback. Where practical, a complete spectrum of the patients you see should be included when seeking this type of feedback, and particular attention should be given to the inclusion of patients with communication difficulties where appropriate. If you do not see patients as part of your practice you are not required to collect feedback from patients. However, the GMC recommends you think broadly about what constitutes a 'patient' in your practice. Thus, you may wish to collect feedback from a number of sources such as families and carers, students, suppliers or customers.

13 When used, patient feedback questionnaires must be validated and should comply with GMC guidance.

	If you believe you cannot collect feedback from patients you should discuss this (and the use of alternatives) with your appraiser. **Doctors practicing as intensivists** • At the time of writing (February 2014) the Faculty and ICS have agreed with the GMC that individual patient feedback to intensivists should not be mandatory and that other material may be used in lieu (*Appendix 4*). • Where individualised feedback is considered appropriate and is sought approved systems should be used (*Appendix 4*).
Review of complaints and compliments	
Formal complaints	**Description** Formal complaints (expressions of dissatisfaction or grievance) may come from patients, carers or members of staff. **Those received since your last appraisal should be included, along with a summary of the issues raised and how they have been managed. This should be accompanied by personal reflection for discussion during the appraisal itself.** Formal complaints[14] will normally be made in writing and activate a defined complaints response process. **Requirements** Details of formal complaints received from patients, carers, colleagues and staff – either employed within your clinical area or any other area within which you work (e.g. university) about your professional activities or for those team members for whom you have direct responsibility should be included annually. If you have received no formal complaints since your last appraisal, a declaration to that effect should be provided. **Guidance** **In all such cases you should provide** a summary of the main issues raised in each complaint, personal reflection and the learning gained, action taken and if necessary items for inclusion in your personal development plan. Rather than the nature of the complaints themselves your reflection will form the focus for discussion at your appraisal. **Doctors practising as intensivists** • Your record should take into account the principles of complaints management outlined in national guidance (e.g. *Good Practice: a Guide for Departments of Anaesthesia, Critical Care and Pain Management,* RCoA, 2006; *Appraisal and revalidation: Guidance for doctors preparing for relicensing and revalidation, Book 5, complaints.* RCP London 2007).

[14] A formal complaint is one that activates a defined complaints response process. Those considered at appraisal should be those that relate to the professional activities of an individual doctor or members of the team for whom he or she has direct responsibility.

Compliments	**Description** A summary detailing unsolicited compliments received from patients or carers, colleagues, or staff in recognition of the quality or success of your professional work or that of your team. **Requirements** Your summary should be updated annually updated. You may choose not to present details of any compliments at all during you annual appraisal and this will not hinder your progress towards revalidation. **Guidance** It is useful to reflect on success as well as problems. If compliments are to be used they should be accompanied by relevant reflection highlighting, for example, the value you attach to these in affecting your professional practice, relationships with others, or learning and development. Some colleges and faculties have developed tools and forms to help document and structure this reflection.

APPENDIX 1:

How core supporting information should be applied to the domains and attributes of the Good Medical Practice Framework

Supporting Information required (for 'whole' practice)	GMP Domains											
	1			2			3			4		
	A	B	C	A	B	C	A	B	C	A	B	C
Information about you and your professional work												
*Description of **all** professional (clinical and non-clinical) activities*												
Evidence of previous satisfactory annual appraisals												
Review of progress against previous PDP	■			■								
Current Licence to Practice, GMC Registration, Specialist Certificate												■
Medical Defence Organisation certificate												■
Self-declaration of probity												■
Self-declaration of health + immunisations						■						
Registration with a general practitioner						■						
Feedback on professional practice												
Colleague feedback *Multi-source feedback from peers/colleagues*	■	■		■			■	■	■	■		
Feedback from teaching/supervision		■					■			■		
Patient feedback *Patient questionnaire*	■	■		■			■		■	■	■	
Reflection and learning from complaints and compliments		■	■	■					■	■	■	
Review of practice												
Clinical audit and quality improvement	■	■	■	■								
Case review or documented discussion		■	■	■			■	■			■	
Reflection & learning from clinical incidents and SUIs		■		■	■				■		■	
Clinical outcomes – where validated	■			■								
External peer review / service accreditation	■	■	■					■				
Keeping up to date												
Continuing Professional Development (College/Faculty-specific)	■	■		■								
Specialty-specific knowledge and skills	■	■										
Relevant employer training (Equality/Diversity; Communication, etc)	■			■	■		■			■	■	
Training for educational supervision	■						■					
Other information to show the quality of your practice												
Compliance with GMP for research including ethical approval	■	■		■						■		■
Other clinical governance and risk management information				■	■			■				
Education, Research, Management and Leadership												
Specialty-specific supporting information defined by College or Faculty												

Notes concerning content of GMP Domains

Domain 1 **Knowledge, skills and performance**

Is divided into:
- (A) maintaining professional performance
- (B) applying knowledge and experience to practice, and
- (C) ensuring that all documentation including clinical records are clear and accurate.

Domain 2 **Safety and quality**

Is defined by:
- (A) the attributes of compliance with systems designed to protect patients
- (B) responding to risks to patient safety, and
- (C) protecting patients and colleagues from risks posed by the practitioner's health.

Domain 3 **Communication, partnership and teamwork**

Seeks evidence of:
- (A) effective communication and
- (B) the ability to work constructively with colleagues and delegate effectively, and
- (C) of the practitioner's skill in establishing and maintaining partnerships with patients.

Domain 4 **Maintaining trust**

Requires the clinician to provide evidence that they:
- (A) display respect for patients
- (B) treat colleagues and patients fairly and without discrimination, and
- (C) act with integrity and honesty.

APPENDIX 2: Matrix for Continuing Professional Development

Please note that Level 3 of the CPD Matrix below is for consultants practicing either **solely in ICM *or* in ICM and a dual specialty that is not anaesthesia**. Anaesthetist intensivists, in covering their whole scope of practice, should refer to Levels 1 and 2 of the RCoA CPD Matrix (which has been agreed in consultation with the Faculty and is reproduced below) for guidance, **as well** as Level 3 of the FICM Matrix.

Level 1

	A	B	C	D	E	F	G	H	I
	Scientific Principles*	**Emergency Management and Resuscitation**	**Airway Management**	**Pain Medicine**	**Patient Safety**	**Legal Aspects of Practice**	**IT Skills**	**Education and Training**	**Healthcare Management**
01	Physiology and biochemistry (1A01)	Anaphylaxis (1B01)	Airway assessment (1C01)	Assessment of acute pain (1D01)	Infection control (1E01)	Consent (F101)	Use of patient record systems (G101)	Roles and responsibilities of clinical supervisors (H101)	Critical incident reporting (I101)
02	Pharmacology and therapeutics (1A02)	Can't intubate, can't ventilate (1B02)	Basic airway management (1C02)	Management of acute pain (1D02)	Level 2 child protection training† (1E02)	Mental capacity and deprivation of liberty safeguards (F102)	Basic search methodology (G102)	Personal education and learning (H102)	Team leadership and resource management (I102)
03	Physics and clinical measurement (1A03)	Basic life support (all age groups and special situations) (1B03)			Protection of vulnerable adults (1E03)	Data protection (F103)			Human factors in anaesthetic practice (I103)
04		Advanced life support (relevant to practice) (1B04)			Blood product checking protocols (to comply with local requirements) (1E04)	Equality and diversity (F104)			Understanding of complaints process (I104)
05					Venous thromboembolism prophylaxis (1E05)	Ethics (F105)			Quality improvement (I106)

Level 2

DOMAIN
The specialist has expertise in…
Assessment of the critically ill patient (2C01)
Initiation and management of ventilatory support (2C02)
Diagnosis and management of shock, infection and sepsis (2C03)
Support of threatened and failing organ systems (2C04)
Sedation techniques for ICU patients (2C05)
End of life issues and organ Donation (2C06)
Management of the ICU (2C07)

Level 3 (3C00)

DOMAIN	EXAMPLES OF EVIDENCE
Domain 1: Resuscitation and management of the acutely ill patient	• ALS certification • Appropriate CPD approved course attendance • Clinical and case mix database • Case review meetings
Domain 2: Diagnosis, Assessment, Investigation, Monitoring and Data Interpretation	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning
Domain 3: Disease Management	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning
Domain 4: Therapeutic interventions / Organ support in single or multiple organ failure	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning
Domain 5: Practical procedures	• Procedure log book • Trainee supervision of DOPS • CPD approved course attendance • MSF • Critical incident reviews
Domain 6: Perioperative care	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning • Review of case mix audit data
Domain 7: Comfort and recovery	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning • Review of case mix audit data • MSF • Follow up clinics
Domain 8: End of life care	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning • Review of case mix audit data • MSF

Domain 9: Paediatric care	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning • Review of case mix audit data
Domain 10: Transport	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning • Review of case mix audit data • MSF
Domain 11: Patient safety and health systems management	• CPD approved course/meeting/conference attendance • CPD approved examiner role • Case review meetings • CPD approved self-study/learning • Review of case mix audit data • MSF • Local infection control data • Participation in guidelines group • Local critical incident data
Domain 12: Professionalism	• MSF • Participation in regular team meetings on clinical governance • Feedback on teaching and training • Participation in audit or research programmes • Critical incident reporting • Appointed Supervision of trainees

APPENDIX 3:
Multi-Source Feedback in Revalidation: Peer Review

1.0 Choice of questionnaire

1.1 A Multi-Source Feedback (MSF) tool which complies with GMC guidance must be used by all intensivists at least once in a five-year revalidation cycle to measure feedback from colleagues and peers.

1.2 Suitable tools are available via the General Medical Council (GMC) and a number of commercial organisations. Those employed must have been appropriately piloted and provide detailed feedback; and the doctor, appraiser and Responsible Officer (RO) should have no involvement in the collation of the results.[15]

1.3 Trusts are permitted to use any system which complies with GMC guidance. In those where this service is not provided, the Lead Appraiser for the Department and/or the Clinical Director should recommend a single system to be used by all consultant staff. It is the responsibility of the Lead Appraiser to ensure that Consultants within their department use an MSF tool which complies with GMC guidance, and where benchmarking against other intensive care practitioners is provided as part of the feedback.

2.0 Selection of colleagues and peers to provide feedback

2.1 Guidance on the number of colleagues who should be asked to provide peer feedback for an individual consultant should be available from the MSF provider, and based on the results of pilot evaluations of the tool. The minimum number of evaluations returned as part of MSF should be ten; it is therefore suggested that 15 people are invited to respond. However, the precise numbers of questionnaires distributed and their representation will depend upon the extent of the clinical practice undertaken (see Section 2.2).

2.2 The choice of individuals providing peer feedback should include at least one representative of the following professional groups where relevant:

2.2.1 *Consultants in intensive care:* no more than three individuals, and to include at least one who trained in appraisal (to be selected from a list made available in each department by the Lead Appraiser).

2.2.2 *At least one allied healthcare professional:* which might include a critical care nurse or practitioner, biomedical engineer or physiotherapist.

2.2.3 *Trainees:* at least two but no more than four trainees in intensive care and related areas (e.g. base specialty, pain medicine) in training trusts.

2.2.4 *Managerial or administrative staff* (e.g. secretarial staff, service managers).

2.2.5 The list of individuals providing MSF feedback should reflect your entire practice; therefore, in addition to the above, the following recommendations are made based on the major areas of likely clinical practice.

2.2.6 *For those intensivists also practicing in surgical and/or obstetric anaesthesia:* At least three allied health professionals (e.g. theatre, recovery or pre-assessment clinic

15 http://www.gmc-uk.org/Colleague_and_patient_questionnaires.pdf_41683779.pdf

nurses, midwives, operating department practitioners); at least one but no more than three Consultant surgeons and/or obstetricians.

2.2.7 *For those intensivists also practicing anaesthetics with direct clinical care activity in pain management:* At least two allied health professional (e.g. pain nurses, theatre staff for interventional pain procedure lists); at least one colleague providing referrals for pain management (e.g. GPs for Anaesthetists providing chronic pain management or Consultants in other hospital specialities for Anaesthetists providing acute pain management).

3.0 Feedback

3.1 The results of MSF evaluations to individual intensivists must be delivered by those who have received training in the delivery of MSF feedback. A list of such trained individuals should be provided in every department.

3.2 Training in feedback facilitation is available from a variety of sources including Royal Colleges (RCoA, RCP) and commercial providers of MSF tools.

3.3 Provision of MSF feedback may occur as a separate process to the annual appraisal. Consultants are required to provide evidence during their annual appraisal that they have received this feedback, and to provide a copy of the report to their appraiser.

3.3 If the feedback identifies concerns based on the result of MSF, these must be communicated to the appraiser. An appropriate development plan will be required and MSF repeated within 2 years to assess if performance in the relevant areas has improved.

APPENDIX 4:
Multi-Source Feedback in Revalidation: Patient Review

The following letter was sent to the GMC from the ICS Executive in November 2012:

intensive care society
care when it matters

Mr Niall Dickson
Chief Executive
The General Medical Council
Regent's Place
350 Euston Road,
London, NW1 3JN

12 November 2012

Dear Mr Dickson

Re: Revalidation

Thank you for your letter reminding us that revalidation is starting for UK doctors from December. As a professional organisation, we strongly support the programme and believe that it is an important development to assure that high standards in the medical profession are maintained. However, we would not like this to become a 'box-ticking' exercise and feel it must be robust and valid to maintain credibility among our professional colleagues. With that in mind, we have some concerns about using 360-degree patient appraisal that we would like to share with you.

The intensive care unit (ICU) treats and cares for the sickest patients in the hospital. Twenty to 25% of patients who are admitted to UK intensive care units die. Many patients do not remember most of their stay on intensive care and most lack mental capacity to participate in decision-making, much less assessment of the care they are receiving. For their families and friends it is a time which is highly stressful. Many patients and relatives experience symptoms of post-traumatic stress disorder at times during and after their hospital stay. Care for these patients is delivered not by one consultant, but by a team of consultants providing 24/7 care. For these reasons, we as a professional body feel that collecting 360-degree appraisal data from this group of patients and relatives will lack both face validity and criterion-related validity correlated to outcome. We also feel that it could be seen as intrusive and coercive in the ICU environment when patients are so vulnerable and dependant on the care they receive, as are their relatives.

Previous studies (Wright et al, Acad Med 2012) suggest that there are inherent biases in questionnaire data, meaning that caution should be used in interpreting and acting on this type of information. While we embrace the principle of multi-source feedback and 360-degree appraisal, we would encourage consideration of garnering this from other users of the intensive care service better able to form a dispassionate judgment. For this, we would suggest seeking feedback from other specialist users of the service including multi-professional feedback. We feel that patient and relative feedback of the whole of the multi-disciplinary team caring for the patient may be a useful marker of quality of the individual intensive care units, but that assessments of the individual doctors working on the unit would not be valid. We would feel more comfortable with the process if the GMC could clarify that there may be circumstances where collecting this type of data from patients may be less useful than others and that common sense should be used by appraisers and those appraised.

Yours sincerely,

ICS Executive Committee

Dr Bob Winter
President

Professor Mark Bellamy
President Elect

Dr Jane Harper
Honorary Secretary

Dr Kevin Gunning
Honorary Treasurer

Dr Jonathan Goodall
Incoming Honorary Treasurer

The GMC subsequently provided the following response:

General Medical Council

Regent's Place
350 Euston Road
London NW1 3JN

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

5 December 2012

Dr Bob Winter
President
The Intensive Care Society
35 Red Lion Square
London
WC1R 4SG

Dear Dr Winter

Thank you for your letter of 12 November 2012 about patient feedback and revalidation. Please accept my apologies for the delay in replying to you. As you can imagine, this has been a pretty busy period for us with the run up to the introduction of revalidation on 3 December 2012.

I fully understand your concerns about the administration of multisource feedback, and patient feedback in particular, in the context of an intensive care unit. Clearly, the comfort of patients and their relatives must be the absolute priority of doctors who work in the intensive care environment and there should be no question of their being expected to do anything that would compromise that.

In general, we believe that multisource feedback has an important place in a doctor's appraisal for revalidation, whatever the nature of their practice. However, our guidance on colleague and patient feedback has been deliberately formulated in general terms to accommodate the wide variety of settings in which doctors work. In fact, it specifically allows for the possibility that some doctors may not be able to collect patient feedback, or may need to collect it from individuals to whom they provide a service, but who are not patients in the strict sense. As with any of the other types of supporting information for revalidation, we are not being prescriptive about the detail. Individual doctors will need to agree the best and most suitable approach for them with their appraiser/responsible officer.

I also understand your concerns about the 'validity' of patient feedback. We are very clear that such feedback is not intended to represent some kind of high stakes test or measure for the doctor concerned. The exercise is essentially about providing doctors with useful material for reflection on their professional practice and performance, based on the perceptions of those they work with and treat. This reflection, in discussion with the doctor's appraiser/responsible officer, should then inform their continuing professional development. Our view is that patient and colleague feedback is just one of the types of supporting information that doctors are expected to bring to their revalidation (along with evidence of CPD, quality improvement activity, review of significant events and review of

Continues > >

complaints and compliments). The responsible officer will make their revalidation recommendation to the GMC based on the whole of a doctor's supporting evidence, and we are not placing a greater emphasis on patient and colleague feedback than on any of the other types of information.

You also ask about whether team feedback might have a place here. There is no reason why evidence of team feedback could not be used to supplement individual feedback or, indeed, to replace individual feedback because of the nature of the doctor's practice. We suggest in our guidance that doctors should reflect on what any team based information might mean for them and their practice. We also suggest that this approach should be agreed locally with the appraiser or responsible officer.

Finally, you may find it useful to look at the relevant guidance, which can be found in the revalidation area of our website:

http://www.gmc-uk.org/doctors/revalidation.asp

I would particularly refer you to sections 4 and 5 of the 'Supporting information for appraisal and revalidation'. In addition, there are links to guidance on the administration of the GMC's own questionnaires, and to some background information on the research behind their development (where the question of potential bias is also covered).

I hope this goes some way to addressing your concerns but I would be more than happy to meet up to discuss this if you think that might be helpful.

Yours sincerely

Una Lane
Director
Registration and Revalidation

1.0 Introduction

1.1 Where appropriate intensivists should provide patient feedback at least once in every five-year revalidation cycle in the form of individualised feedback, although departmental systems may be employed depending upon the practitioner's scope of practice (Section 3).

2.0 Individualised feedback

2.1 *360 degree patient feedback tools (evaluating communication skills):*
For intensivists with outpatient clinic responsibilities (e.g. critical care follow up; base specialty clinics) the GMC patient feedback tool or a validated commercially provided alternative can be used.

In accordance with GMC guidance, the questionnaires should be administered to patients as soon as possible after the consultation they are being asked to feed back upon. The surveys should be distributed and collected by third parties, and feedback must be delivered by a trained facilitator[16].

16 http://www.gmc-uk.org/Colleague_and_patient_questionnaires.pdf_41683779.pdf

2.2 Within the critical care setting, it is accepted by the GMC that the mode of administration (in particular, patient selection and timing), validity, reliability, and benchmarking of currently available patient and carer/relative feedback tools is imperfect (see above). The Faculty accepts that 360 degree patient feedback may therefore not be easily available, but recommends that it should be obtained where possible (e.g. from Level II patients or those patients about to be discharged from Level III care).

2.3 GMC published guidance[17] advises that:

> "We recommend that you think broadly about who can give you this sort of feedback. For instance, you might want to collect views from people who are not conventional patients but have a similar role, like families and carers, students, or even suppliers or customers."

Responsible Officers should bear this in mind when revalidating intensivists. This advice is also mirrored by the NHS England guidance for Responsible Officers.[18]

3.0 Departmental feedback

3.1 *Patient experience measures:* For trusts that participate in the NHS inpatient survey, the Faculty has determined that the results of any questions pertaining to intensive care may be used as a measure of departmental performance for revalidation.

3.2 *A validated family/carer satisfaction survey(s):* Where these are employed to provide department-level feedback on the patient (or surrogate) experience of intensive care, the Faculty has determined that results may be used by individual Intensivists for revalidation purposes.

Practical guidance concerning the use of such surveys will be provided by the Faculty after the results of studies are available. Thus, the FREE (Family Reported Experiences Evaluation) study led by ICNARC (underway 02.14) is designed to inform the valid, representative and cost-effective use of a family satisfaction questionnaire in the ICU in quality improvement programmes.

3.3 *Patient reported clinical outcomes for those also practising in anaesthesia:* Interim recommendations regarding patient reported outcome measures / patient satisfaction tools are:

3.3.1 Departmental audits of clinical outcomes (such as pain, success in regional blockade etc) may be used. While local resources may limit the ability of departments to provide individual feedback to anaesthetists, departments should work towards being able to provide this.

3.3.2 Patient satisfaction tools, which have been developed and validated to measure several domains of anaesthetic care in a single questionnaire, are currently being evaluated by systematic review of the literature. When the results of the review are known, further recommendations regarding the suitability of these questionnaires to measure patient reported outcome after anaesthesia will be provided.

17 *Supporting Information for Appraisal and Revalidation*, p.10. GMC, London, 2012.

18 *FAQs Regarding Medical Revalidation*, p.15. NHS England, 2014.

APPENDIX 5:
Audit topics approved by the Faculty of Intensive Care Medicine and the Intensive Care Society

National *ICM Audit Recipe Book*

Chapter 10 of the 3rd edition of The Royal College of Anaesthetists *Audit Recipe* Book[19] contains a list of 16 audits relating to Intensive Care Medicine. However, the Faculty is working with the Intensive Care Society (ICS) to produce the first national *ICM Audit Recipe Book*.

Whilst numerous audit topics might be included both the FICM and ICS want to focus the attention of colleagues upon core audits which are underpinned by an evidence base that shows a positive effect on patient outcome, to which end we surveyed colleagues in the Autumn of 2013 regarding audits that met this criterion. The result of the survey was published in *Critical Eye*[20] and the top 5 suggestions are summarised in the table below:

Audit title	Reason for audit	Suggested measures/indicators
Tracheostomy in the ICU	Not many tracheostomies are done each year in individual units. In order to highlight any problems with the kit or post-op complications at an earlier stage, pooling of data from as many units across the country will help.	• What techniques are used? • Is capnography routine? • Is USS neck routine? • Is bronchoscopy routine? • What proportion is percutaneous vs surgical? • Complications - early and late
Central Venous Catheter Insertion and Management	Frequently performed procedure on ICU	• Audit of insertion practice based on recommendations from Department of Health and other professional bodies • Audit of ongoing management • Complication rates • Rate of catheter-related bloodstream infections
ARDSnet ventilation compliance	There are very few strategies or drugs used in critical care that have been proven to improve patient outcome. Lung protective ventilation is one of them.	Audit of ventilator parameters in intensive care patients, either prospectively or retrospectively. Data may be collected at 4 pre-defined times over a 24 hour period. Standards and data to be collected: • Ideal body weight calculated and recorded for 100% of ventilated patients. • Delivered tidal volume no more than 8 ml/kg ideal body weight at all times • Plateau airway pressure maintained below 30 cmH2O at all times

19 Royal College of Anaesthetists' *Audit Recipe Book*, 3rd Edition.

20 Wong A. 'National ICM Audit Recipe Book. Survey of members'. *Critical Eye* Issue 5, Winter 2014.

Evaluation of the long term risks of percutaneous tracheostomy, i.e. stenosis	Despite the large number of procedures performed there is little hard data on long term risks.	The frequency of symptomatic and asymptomatic airway problems after tracheostomy.
Renal Replacement Therapy Dosage on ICU	Is Renal Replacement Therapy Dosage on ICU matching the standard unit prescription?	• Patient identification details • Ideal body weight • Duration of RRT dependency • Hours receiving RRT during period of dependency • Hourly exchange achieved (in mls) • Reasons for interruption of RRT Outcomes and targets: • Demographics of RRT provision N/A • Average exchange dose delivered during dependency period 20-35 ml/kg/hour • Average exchange dose delivered during first 12 hours of each RRT session 35 ml/kg/hr • Average exchange dose delivered during continuous RRT 35 ml/kg/hr

The recipe book will be a compendium of audits with the relevant background information and research, suggested methodology and the relevant references provided in a standard format. In time, each pack will also have the relevant data analysis tools to permit inter unit and possibly collaboration. An example of such a template will be included.

Trainee networks such as those established in the specialties of anaesthesia and surgery could play a crucial role in the process. Such groups include representatives working at all of the trusts in a given region and make it possible to co-ordinate activity across a much wider geographical area. Representative trainees from each trust are given the responsibility of leading the audit process within that trust and of getting the approval of the local anaesthetic and critical care department.

Clinical audit is at the heart of good clinical governance. It ensures that we are delivering the best possible care to all patients at all times and highlights areas of excellence as well as revealing areas that require improvement. It forms the basis of quality improvement projects supported by new knowledge gained from clinical research. The ultimate goal of the audit recipe book is to provide a framework for clinical audit that maximises local enthusiasm and commitment to high-quality patient care.

APPENDIX 6:
Annual Appraisal Reflective Case Study Review Template

Name of appraisee:	
Clinical specialties practiced:	
Appraisal cycle: (*Years*)	**Case study No:**
Diagnoses:	
Points of learning:	
Narrative: (*Anonymised where notes or clinical material is used*)	
Reflections from multi-disciplinary meeting reflections: (*Where appropriate*)	
Reflections from Morbidity & Mortality meetings: (*Where appropriate*)	
References and further reading completed:	

The Faculty of
Intensive Care Medicine

www.ficm.ac.uk