FICM QA Report 2015

Introduction*

In June 2013 the Quality Assurance Working Party (QAWP) - a sub-committee of FICM Training and Assessment Committee – was formed to oversee the introduction of a robust process to assure the quality of training in intensive care medicine. Over the past two years this group has developed processes to gather and corroborate information from diverse sources to assess the delivery and outcomes of intensive care training within the UK.

Definitions and Terminology

The GMC's terminology describes three processes: quality assurance (QA), quality management (QM) and quality control (QC).

QA is the over-arching activity (QM and QC sit under this umbrella). It is the responsibility of the GMC, is based on its statutory remit, and includes the policies, standards, systems and processes used to maintain and improve the quality of medical education and training in the UK.

QM is the means by which medical schools, deaneries (LETBs) ensure that local education providers for which they are responsible meet the GMC's standards. QC is the responsibility of local education providers (for example individual training units and Trusts), who must ensure that local education delivery meets local, regional and national standards.

The place of the Faculties and the Colleges is not restricted to a single part of the process, but is integral to the effective delivery of specialty training at many levels, as shown below:

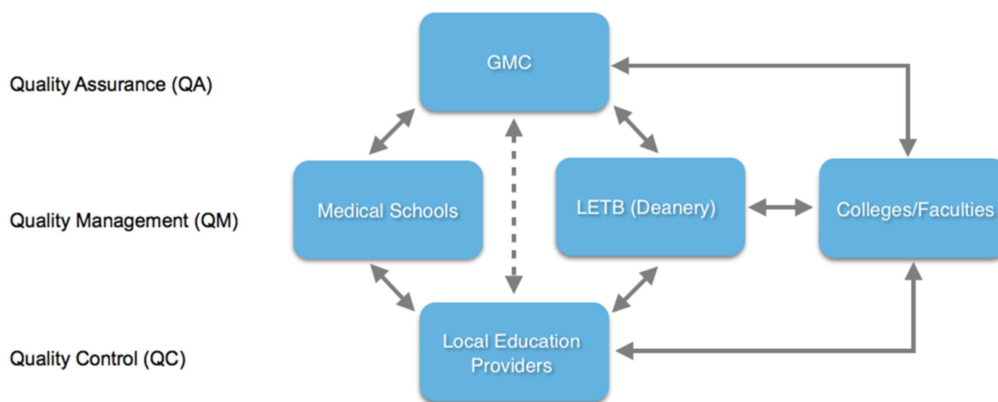


Fig 1. GMC QI Framework 2010

All QA processes (medical and otherwise) use a widely accepted 'four stage' framework:

- Adopting and setting standards
- Self assessment using collected and shared evidence
- External assessment and validation
- Reporting of outcomes

There are clearly defined standards to which all doctors working in intensive care medicine must adhere, and which are used when delivering training. These include GMC standards (for example Good Medical Practice) and 'specialty specific' standards (including the FICM training curriculum).

The QAWP has developed a process to gather evidence to use in quality management of FICM training. The processes arrived at uses data from multiple sources (including external validation of units using regional advisor reviews and trainee surveys), to feed into the self-assessment and validation parts of this process as described above.

The 'FICM Quality Nexus' is described in the diagram below. Using such a multisource approach should increase the reliability and validity of the information obtained.

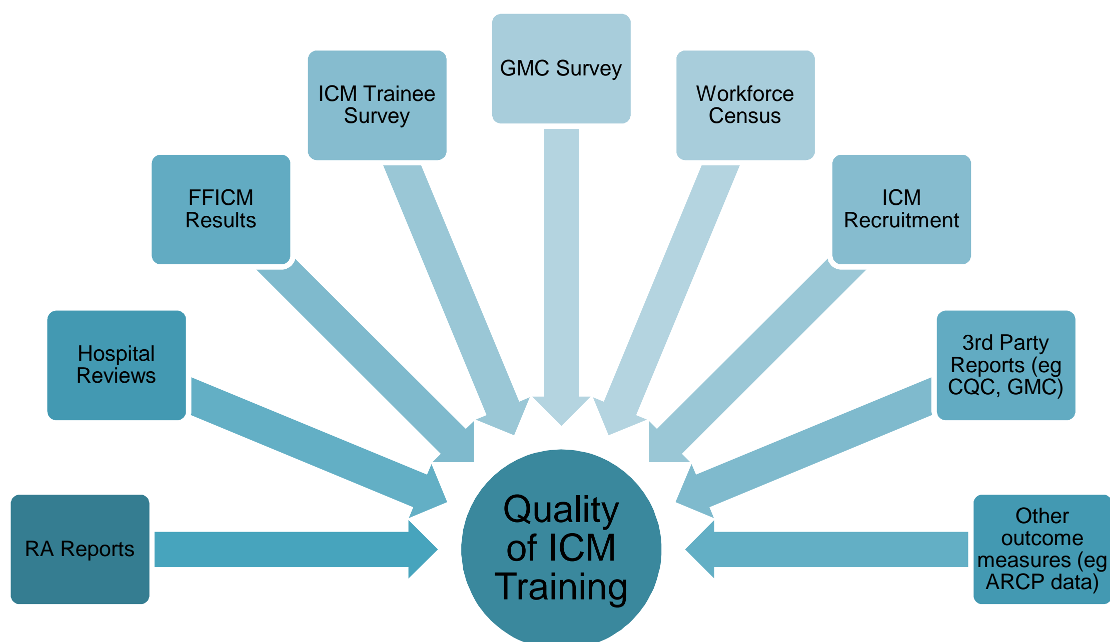


Fig 2. The FICM Quality Nexus

The aim of this process is to inform all about the quality of training nationwide. It will be used to identify areas of good practice and highlight any issues of concern, and ultimately to maintain and improve the quality of ICM training at local, regional and national levels.

Reporting the outcomes of such a process is an integral part of Quality Assurance. The information is presented in the sections presented as part of the Quality Nexus, and concludes with summary drawing conclusions from the information collected, and highlighting key outcomes.

It is hoped that the information contained will be both interesting and useful. The QAWP has now been subsumed into the new FICM Quality, Recruitment and Careers Subcommittee, which will be responsible for the production of future QA reports. This committee would like to receive feedback on this first QA report’s content and its presentation, and will use this to refine and develop the FICMs QA process.

Jonathan Goodall, August 2015

Note: This introduction was published in an earlier version in Summer 2015 edition of Critical Eye.

Regional Advisor Reports

Regions vary considerably in the way they organise ICM training: the number of large, medium and small hospitals varies notably, as does the number and distribution of trainees and enthusiastic consultants.

To maintain an accurate overview of training in the United Kingdom (UK) the Regional Advisors (RAs) send an annual report to the lead RA. Their reports, complied using information from faulty tutors, contain information on hospitals, trainers, trainees and attachments within their region, along with information on training successes and concerns. Over the last 2 years a template for action from the RA reports has been developed (figure 1).

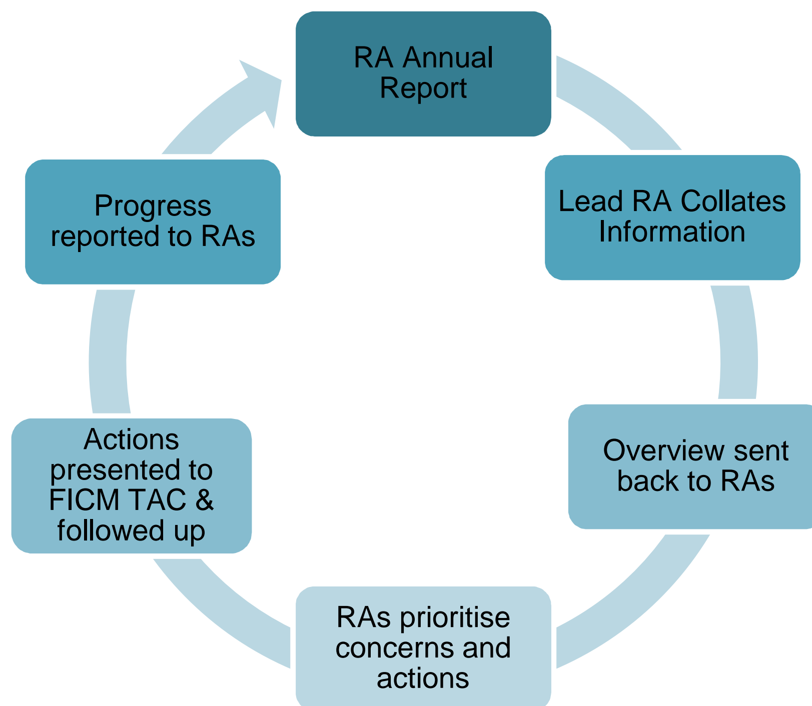


Fig 3. RA Template for Action

Having received reports from all RAs, the Lead RA organises comments into sections within an overview document, which is circulated back to RAs, thus informing RAs of training issues in all regions.

At an annual meeting of RAs issues raised are discussed and a 'priority list' is developed, highlighting issues to be pursued over the next year. Common themes emerge from the reports, which direct the Lead and Deputy Lead RA

in their discussions with FICM TAC (FICM Training and Assessment Committee) and the Faculty Board.

Progress Report 2014 (using 2013 priorities)

1. Paperwork and Competency sign off.

Problem: RAs felt the proposed sign off for Intensivists and Anaesthetists would be too labour intensive.

Outcome: Following further discussion and reworking of the forms, this issue was resolved.

2. Organising Formal Teaching in ICM

Outcome: A variety of local and regional solutions are being developed. Some regions are developing regional teaching, and trialling video-conferencing. One solution that would be useful is streaming of the ICS lectures to centres around Britain. Some technical problems remain, but if successful it would promote a degree of uniformity in the standards of ICM training and promote FICM and the ICS as a brand that actively supports 'grass roots' training throughout the UK.

3. SPA time and Job Descriptions

Outcome: Following email discussion a statement has been released by Professor Bion on behalf of the FICM Board, outlining the minimum SPA allocation for a post to be recognised by the FICM.

Further discussions on job descriptions acknowledged the balance between firm standards at a time of few resources limiting ability to enforce these standards. Discussions at the Faculty Tutors day arrived at a pragmatic solution of allowing RAs to make 'approval decisions' on posts with an ICM commitment, within an envelope of guidance from the FICM. It was recognised that such guidance will have to remain flexible and workable in the current NHS.

Approval of posts is separate to providing a FICM representative to consultant appointments committees, where the role of the FICM representative is to ensure that the appointee is appropriately trained for the job.

4. Special Skills Year; Practicalities and Service Implications

Outcome: With few trainees currently at this stage of training, it was not possible to get a firm grasp of the extent of any difficulties.

5. Recruitment

Outcome: The RAs felt this was very well managed and a great success.

Priorities for 2014-5

1. Local Limitations to Curriculum Delivery

Danny Bryden (DB) led a discussion on changing patterns of ICM care based on an email discussion. Several techniques and skills are not universally maintained amongst all consultants (e.g. tracheostomy and echocardiography; individual consultants will maintain some skills and loose others over time. Of particular concern is the imposition of rules, potentially affecting the delivery of safe patient care, and example being the insertion of chest drains, which in some hospitals has been delegated to a select number of individuals. RAs believe this may sometimes require an individual intensivist to perform a life-saving procedure on an occasional basis. In such circumstances the decision and circumstances will need very careful documentation.

2. Patient Feedback

Obtaining appropriate patient feedback is difficult in ICM; feedback will more commonly come from a patient's relatives. There are concerns around the practicalities and fairness of this approach: complaints have arisen from relatives feeling such questions inappropriate during on-going care.

The FICM recognise that obtaining patient feedback difficult and may be inappropriate, and will support individuals asked obtain such information by their employers.

3. SPA Time

RAs feel this is the single greatest threat to providing high quality ICM training. Some trusts do not recognise the value and need of paid time for such activities, often in contrast to other non-clinical roles (eg management). Declining availability of ACCEA awards means that training is may not be sufficiently supported in the future.

The FICM will actively support any member in negotiations with their trust, and has had success. The option of removing trainees from sites where training is not supported is an unpalatable option for the unit concerned, so solution by negotiation is still the best option.

Fortunately there remains a strong cohort of enthusiastic trainers within the specialty who continue to deliver ICM training to a very high standard.

Chris Thorpe

RA Hospital Review ('Virtual Visits')

Visiting of units can be disruptive to service. Many other organisations undertake such reviews (for example CQC and LETBs), and the FICM does not encourage additional visiting.

Despite this, it is recognised as being important that information about individual training units is part of the working knowledge required by an RA in ICM. In place of visits, the use of a paper based 'hospital review' may provide RAs with the understanding of the training units within their region required to fulfil their role.

Over the past year, new paperwork has been developed by the QAWP, which it is hoped will align, improve and streamline this process across the UK. Designed to be completed by faculty Tutors, RAs can also use the information contained within these 'hospital reports 'when compiling their Annual Report to the Lead RA; in turn it is hoped they will form a useful part of the QA nexus. Information gathered using this process will be included in QA reports in future years.

The current version of the form is included in this document as Appendix A.

GMC Survey

The GMC survey, includes feedback on training in every medical specialty, including ICM.

A link to the most recent report is included below. Along with the ICM Trainees survey, it provides useful training feedback on the training received during ICM training in the UK.

GMC Trainee Survey 2015

ICM Trainees' Survey

Trainee feedback is an essential part of the Quality Assessment of training.

Each year all trainees registered with the Faculty within the new training scheme receive a link to a 'Survey Monkey' questionnaire. The survey incorporates feedback from all training attachments: in anaesthetics, ICM or medicine.

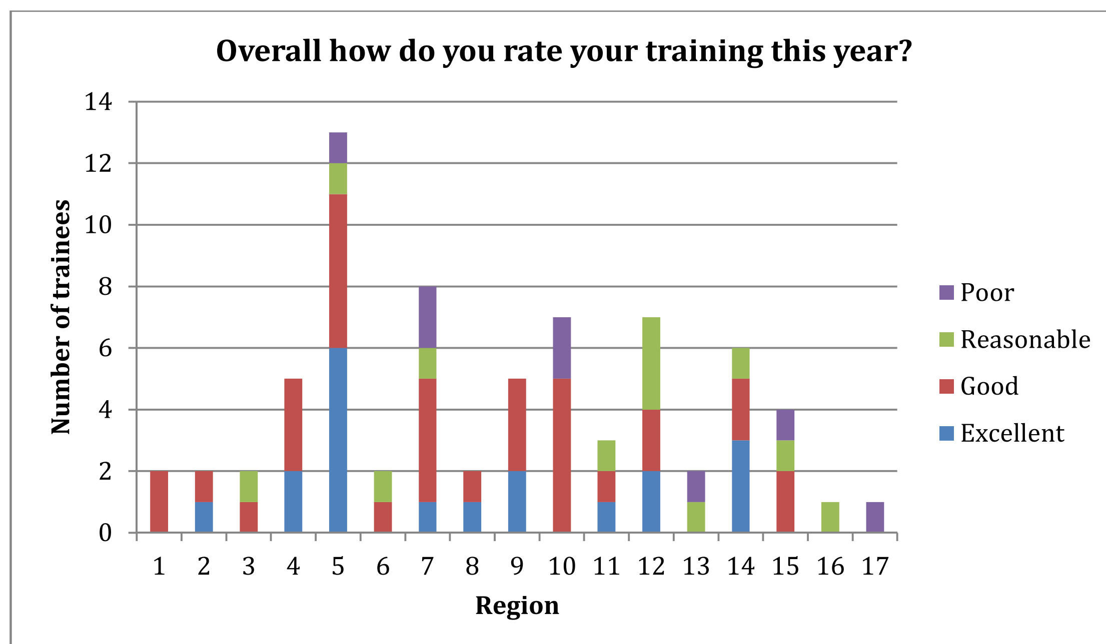
Unlike the GMC survey (which collects data at only the one point in the year), the FICM survey collects detailed data on all attachments undertaken that year. Neither does it have the GMC's requirement of > 3 responses before providing a report by hospital: helpful due to low numbers of ICM trainees currently on the scheme.

The main beneficiaries are regional training programmes. Each RA gets useful information about which attachments the trainee finds helpful, and those that are less than ideal.

Survey in Detail

The survey is divided into sections. The first provides an overview of the year's training, and includes generic questions about the year. Overall, it appears that the training scheme is doing well, but there is room for improvement.

Of 72 replies, 19 rated their training as excellent, 33 as good, 12 as reasonable and 8 as poor. The following table shows responses to the question 'Overall how do you rate your training this year?' by region. (anonymised for this report):



The second section looks at individual training attachments taken in the previous year. To be able to target areas for improvement, each RA needs to know which aspects were good or less so; subsequent sections address each of the attachments separately.

As almost all currently appointed trainees are currently in Stage 1 training, the separate attachments are in ICM, Medicine and Anaesthesia.

The question set is identical for each of the posts, allowing comparison to be made, with most responses graded along the lines of ‘poor’, ‘reasonable’, ‘good’ or ‘excellent’.

In 2014 (and in 2013) ICM trainees were happier with training provided in Anaesthetic and ICM blocks, than in medicine, which had more ‘poor’ responses. Such information will allow appropriate review of posts which fail to meet appropriate training needs.

	Medicine	**ICM**	**Anaesthetics**
Poor	34/112 (30%)	40/392 (10%)	30/408 (7%)
Reasonable	19/112 (17%)	86/392 (22%)	64/408 (16%)
Good/Excellent	59/112 (53%)	266/392 (68%)	314/408 (77%)

The survey goes on to examine specific aspects of training, including consultant support, training ethos, responsibility, formal and informal teaching, achievement of training goals and ARCP support. Again the Medicine attachments are frequently not meeting training targets in many areas, as illustrated in the tables.

How well were you supported by your trainers in your attachment?			
	Not well supported	Supported	Well supported
ICM	8.3%	28.5%	62.5%
ANAESTHETICS	0%	35.2%	64.7%
MEDICINE	41.6%	8.3%	50%

Did you receive an appropriate level of responsibility?			
	Too little	Too much	Just right
ICM	10.2%	4%	85.7%
ANAESTHETICS	7.8%	3.9%	88.2%
MEDICINE	41.6%	8.3%	50%

How do you rate the training ethos within the attachment?				
	Poor	Reasonable	Good	Excellent
ICM	12.2%	24.4%	32.6%	30.6%
ANAESTHETICS	5.8%	23.5%	31.4%	39.2%
MEDICINE	43%	36%	7%	14%

ICM Training

Overall satisfaction with training in ICM is good, with positive feedback for consultant support and for appropriate responsibility. Themes of concern included difficulties with new paperwork, with obtaining formal teaching and with achieving expected training goals.

Trainees are also unhappy with the guidance documentation required for ARCPs: around 50% expressing some concern. Consultants are still adapting to the new paperwork and the e-portfolio. Formal teaching suffers due to small numbers of trainees, and RAs are addressing this by various measures.

As is often the case, the free text comments are illuminating. Some examples are shown below:

- *My ICM placement at this hospital wasn't up to the standard. It lacks structure and training benefit for an ICM trainee.*
- *The training experience was excellent. I had a good level of responsibility and had good exposure to the wards and Resus. The Consultants were keen to teach and supported my clinical development with enthusiasm.*
- *Fantastic placement, excellent support especially coming from a medical background. Couldn't have asked for a better rotation.*

- *The department offers excellent teaching but the consultants are not particularly engaged with recent training requirements e.g. need to complete e-portfolio.*

Conclusions

The FICM trainee survey is well positioned to provide invaluable information on the training attachments undertaken by our trainees. Most trainees do not seem to be inhibited in giving detailed responses when required. Currently the small number of responses may limit the interpretation of results, but repeated problems documented over time will provide more robust evidence of need for improvement.

The 2015 survey will need to be adjusted to take into account feedback from ST5 modules. Attempts to identify and include trainees out of the ICM programme (and within a partner specialty) will also be made.

Chris Thorpe

ICM National Recruitment 2015

Interviews for candidates applying for FICM posts this year were held at The Hawthorns, West Bromwich Albion's football ground from 13th to 15th April 2015.

As part of new initiatives for 2015, a quality assurance process was developed to review the recruitment process. As this was the first time that an attempt had been made to QA FICM selection those involved learned and refined the process over the course of the 3 days.

Each day 4 or 5 interviewers were assigned to QA duties. Each individual was assigned to review one aspect of the selection process: clinical station, presentation station or one of the two portfolio stations allocated to each interview stream (of which there were 4 in total). A QA timetable ensured that each station in each stream was QA'd at least once each day. In addition, each candidate was interviewed at a station that was being quality assured at the time of his or her interview.

Key Principle of ICM Recruitment

The aim of the QA process was to ensure that the interviews were conducted using the following key principles, using the form attached at the end of this section of the report.

- *Was appropriate supporting paperwork for interviewers available?*
- *Had appropriate training been available for all interviewers*
- *Had interviewers received equality and diversity training within the previous 3 years?*
- *Were there candidates with special requirements?*
- *Were all candidates were treated with fairness, politeness and respect?*
- *Was there discussion around calibration and scoring before the interviews started?*
- *Was all scoring appropriate and fair?*
- *Were the published guidance criteria followed?*
- *Did the interview panel provided feedback on suitability of questions?*
- *Were mechanisms in place highlight probity issues?*

Number of QA Assessments Conducted

	Presentation	Clinical Scenario	Portfolio
13/4/15	4	4	8
14/4/15	7	5	8
15/4/15	4	4	8
Total	15	13	24

Note: The reflective practice and task prioritisation written stations were double marked, but were not subject to rigorous quality assurance in 2015.

Outcomes

It was noted that one interviewer on one day of the interviews had not attended interview training or read the interview briefing documentation. The second interviewer in that station was experienced in the FICM recruitment process.

In 100% of interviews observed during this process all the other key principles were adhered to.

As with many QA processes, comments made by those observing the interviews are enlightening and are included below. Of particular note, the lay chairs involved were very impressed that a formal review of the interview process was being made.

Comments recorded by QAAs during the process

Clinical Scenario

Positive comments:

- *High degree of consistency*
- *Scenario is challenging and the diverse nature of the clinical decisions required interviewers to adapt the follow up questions*
- *Fair and consistent*
- *Appropriate probing throughout*
- *Allowed appropriate discrimination between candidates of different standards*

Comments suggesting a need for improvement:

- *Is this an interview or an exam?*
- *Interviewers happy with scenario but some found the marking scheme challenging*

- *Many of the candidates spent a long time regurgitating the information they had been given which is not an important skill to test*
- *The clinical information should be available in the room – it is not a memory test!*
- *Did not allow appropriate discrimination between different standards of interviewees*

In general those QA assuring the station felt that station that only minimal changes were needed to the clinical station, with the clinical information being available in the interview room for reference.

Portfolio Station

Positive comments:

- *Interviewers allowed candidates to demonstrate their skills and attributes appropriately.*
- *Interviewers good at putting candidates at ease (x several)*
- *Timing about right*
- *Some panels used a single interviewer as questioner for the whole interview, others took it in turns for the station; either method worked effectively*
- *It was recognised that the station worked best where interviewers let the candidate drive the station with minimal effective questioning by the interviewers.*
- *The was much variability in folder layout which was able to be reflected in the 'global rating' scores effectively*

Comments suggesting a need for improvement:

- *Achievements outside medicine difficult to judge objectively as so disparate.*
- *The audit question needs further clarification in the scoring matrix (eg 3 marks requires the candidate to close the audit cycle; this is not specified for 4 marks)*
- *ARCP paperwork not on lists of information which need to be provided at interview on the FICM website; some candidates ahd not brought this evidence*
- *It was noted that there needs to be an increased 'spread' of scores for publications and the quality of these*
- *Similarly there needs to be an increased 'spread' of scores available when marking workplace based assessments and outcomes from multi-source feedback.*
- *Several interviewers felt that the supplemental questions did not add much to the station and could be removed*

- *Interviewers sought clarification on whether one piece of work can count for several domains*
- *Further clarification is needed on scoring of teaching qualifications (including the value of a generic instructors course lasting 2 days)*

Presentation Station

There were fewer comments for the presentation station, which was felt to work well. Some suggestions for improvement were made:

- *A stopwatch or clock is needed in each room and this must be visible to the candidates to aid timekeeping*
- *The deanery invigilators need to be accurate with their timings*
- *'Difficult to tease out information for all the scores in the time available'*
- *'The guidance sheet doesn't match the questions asked'*
- *Some of the presentation questions were ambiguous and open to misinterpretation by the candidates – need to be clear what is being asked.*

General comments about the Interview Process

- *Very fair*
- *Although there was some variation in scoring between rooms and on different days, this was minimal and was within an acceptable range*
- *It was noted that interviewers made attemtps to calibrate themselves and their scoring.*
- *All streams and all days were polite and respectful to all candidates at all times.*

It was noted that those allocated to QA the interviews should be given the same information as those conducting the interview, and should attend the interview briefing session for their allocated station. A QA assessor pack with detailed instructions along with a QA briefing is also recommended.

Conclusion

QA of the recruitment process worked well; the initiative was commended by the lay representatives observing the interviews. It provided information that will inform further development of ICM recruitment process. In 2016 the process will be extended to include the written stations.

Jonathan Goodall

FFICM Examination

The FFICM Final examination has been mandatory for ICM trainees appointed to the new ICM CCT programme (from August 2012). Trainees currently in training on the old 'Joint CCT' programme are also eligible to take the examination (although it is not compulsory for such trainees).

Outcome in the FFICM examination is an objective measure of the training programmes success, and forms an essential part of the ICM quality nexus. Statistics from the examination, along with annual reports from the Chairman of the Examiners can be found by following the link provided.

http://www.ficm.ac.uk/fficm-examination/fficm-examination-general-information

Workforce Census Data

Information on the Intensive care workforce is vital to assuring quality of training in the specialty: without an adequate number of trainers training will not remain at its current high standards. Such information is provided in the recent report from the Centre for Workforce Intelligence's (CfWI) review of the Anaesthetic and ICM workforce and can be downloaded by following the link included below.

As noted on the FICM website, proposals and comments made in the report include the following:

- *That HEE should continue to training current numbers of anaesthetists and intensivists to minimise the risk of short term undersupply.*

- *That "HEE may wish to support the flexibility required to meet the needs of the future workforce by training an appropriate mix of specialists with single and dual CCTs*

- *The report suggests that based on current recruitment patterns the future ICM service is likely be delivered mainly by doctors with Dual CCTs."*

- *The report acknowledges that anaesthetists provide a notable level of service to ICM if this were to change there would need to be associated increases in the provision of ICM by other appropriately trained doctors*

- *This assessment of the ICM workforce will be repeated on an annual basis.*

Anaesthetics & ICM Workforce CFWI Review 2015

3rd Party Reports & Other Outcome Data

Data from these sources may be included in future QA reports.

Summary

This is the first FICM QA report. It has brought together information from different sources in an attempt to inform the quality of training currently offered to ICM trainees.

This data shows that ICM Training is in robust health. RAs and Tutors support training enthusiastically, often with little time allocated in their job-plans to do so. The FFICM exam shows excellent pass rates. Data from two national surveys of the Faculty’s trainees shows them to be happy with most aspects of their training, particularly so when considering training in ICM. For the first time the recruitment and selection of ICM trainees has been subject to a review, the outcome of which showed the process to be just, fair and reproducible.

There are aspects for development, including the use of further data to support this QA process (particularly the inclusion of data from 3rd parties such as the Care Quality Commission and GMC). Despite this, the QAWP hopes that this report will achieve its main objective, this is to demonstrate that training in ICM is currently being delivered to a high standard and where there are issues, we are quick to act.

Key Outcomes:

1. ICM Training is felt to be good by the trainers (RAs and Tutors) in ICM as shown by the RA reports.

2. Results of trainee surveys support this view, particularly when training in anaesthesia and intensive care medicine. Some aspects of training in medical specialties need to be reviewed and improved.

3. The success rate in the FFICM examination would support effective training is being delivered.

4. There are no notable regional differences in training opportunities.

5. Little time is allocated in job-plans to deliver training in ICM.

6. Provision of formal teaching sessions for trainees can be difficult; the use of novel technologies and development of national courses may address this concern.

Appendix A.

The Faculty of
Intensive Care Medicine

Hospital Review for the Purpose of Assessing Training in Intensive Care Medicine

Hospital:

Region:

HEE:

Date HRF Completed

Please complete and return to the Regional Advisor in Intensive Care Medicine by:

1. Hospital Details

Hospital Name	
Address (including postcode)	
Telephone Number	
Telephone Number (ICM Secretary)	
Regional Advisor ICM (name & email)	
TPD ICM (name & email)	
Faculty Tutor (name & email)	

2. Unit Demographics

2.1 Size of Unit

Level 2 beds:

Level 3 beds:

2.2 Specialist Services

General	Yes	☐	No	☐
Neuro	Yes	☐	No	☐
Cardiac	Yes	☐	No	☐
Paediatrics	Yes	☐	No	☐
Burns and Plastics	Yes	☐	No	☐
Liver	Yes	☐	No	☐
Obstetric Critical Care	Yes	☐	No	☐

If available at other sites as part of your training programme, please provide details :

2.3 ICM services available in your hospital?

Follow Up Clinic	Yes	☐	No	☐
Outreach	Yes	☐	No	☐
Other (specify below)	Yes	☐	No	☐

3. ICM Medical Staffing:

3.1 Consultants in ICM

Name	Qualifications	Other Specialty	PAs to ICM/Week

Total Consultant PAs to ICM:

3.2 SAS Doctors

Name	Qualifications	Other Specialty	PAs to ICM/Week

Total SAS PAs to ICM:

3.3 Trainee Medical Staff

Name	Grade	Stage	Single/Dual

3.4 Current Trainee Rotas:

Tier 1: Number on Rota
Banding

Tier 2: Number on Rota
Banding

Additional information:

Please append a copy of the current trainee rota

4. Statistical Information Relating to ICM Service

4.1 Clinical Activity:

Number of admissions: Level 2 Level 3

Most Recent ICNARC Data Report Available:

C-Quins Achieved:

QA Dashboard Reviewed and up to date?

4.2 Does the ICM Service have the following facilities?

Facilities	Y/N
Separate office accommodation	
Access to library with up-to-date ICM therapy texts and journals	
Trainee's office with dedicated facilities for IT and internet access	
Consultant and SAS doctor office(s)	
Administration staff (state whole time equivalents)	
Clerical staff (state whole time equivalents)	
Secretarial support (state whole time equivalents)	
Audit assistant/clerk (state whole time equivalents)	

5. Facilities for ICM Education and Training

Facilities	Y/N	Details
Twice daily ward rounds with consultant		
ACCPs		
Induction		
Formal teaching sessions (duration and number each week)		
Clinical Governance Meetings		
Audit meetings (state frequency)		
Regular case discussion/MDT and/or journal review meetings (state frequency & type)		
Library facilities		
Internet Access		
A role in training of medical students		
A role in the training of nursing students & other healthcare professionals		
A role in the training of other healthcare professionals		
Active research programme		
Follow up clinics (provide details)		

6. Management of ICM Services

6.1 Clinical Director for ICM (name & email):

6.2 Clinical Governance Lead (ICM):

6.3 QI/Audit Lead (ICM)

7. Declaration

7.1 Name of Faculty Tutor

7.2 Signature:

7.3 Date

7.4 Email address