The Faculty of
Intensive Care Medicine

Quality Management of Training Report 2018

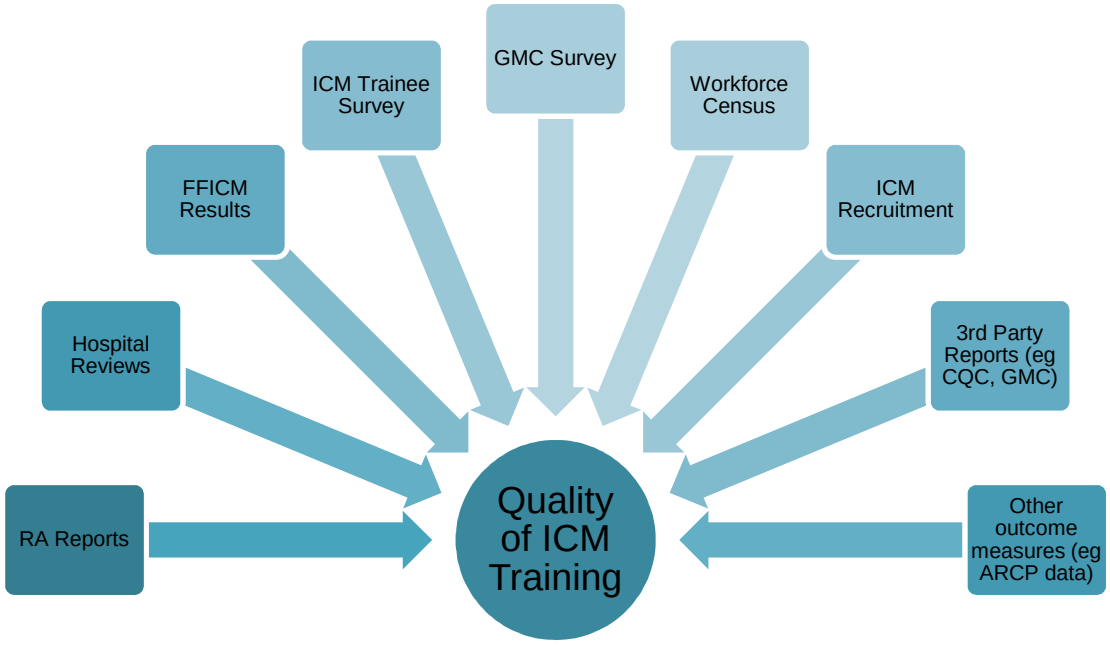
KEY MESSAGES

1. Training in ICM remains a successful scheme with a high degree of satisfaction amongst trainees
2. Stage 2 placements are problematic for some dual CCT trainees. Overall there seems to be a signal that combined attachments are acceptable for most dual anaesthetic/ICM trainees
3. Assessments and the e-portfolio continue to be a burden and this is being addressed with the new curriculum rewrite
4. There were a large volume of positive comments about the specialty
5. Local teaching has improved considerably on the GMC survey

SECTION 1: INTRODUCTION
Chris Thorpe Quality Lead

Welcome to the fourth Quality Management of Training Report from the Faculty of Intensive Care Medicine. Quality Assessment for the FICM now sits within the Training, Assessment and Quality Committee and oversees the collection of data that allows the FICM to quality manage its training programme. As with other specialties we look towards a variety of indicators to QA our programme (below). A clear link between changes in training and improvement in the quality of consultants is difficult to prove, but by obtaining data from a number of sources we can monitor the process of training, and help guide sensible and effective changes by measuring the results. In addition to the overview of UK training presented here, detailed breakdowns of data on both trainee and GMC feedback is available to Regional Advisors, and this is one of the main drivers for improvement at the regional and local level.

On a separate note, there is an increasing awareness of the need for support for trainees and the FICM are looking at elements of this along with fatigue and wellbeing. These aspects may influence both actual and perceived training responses and we may in the future be able to drill down into this element.



SECTION 2: FICM TRAINEE SURVEY 2018
Chris Thorpe Quality Lead

Each year all trainees registered with the Faculty within the new training scheme receive a link to a 'Survey Monkey' questionnaire. 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 three responses before providing a report by hospital.

The main beneficiaries are regional training programmes. Each RA gets useful information about which attachments the trainee finds helpful, and which that are less than ideal. This allows the RA to make immediate changes to the training programme.

2.1 OVERVIEW OF 2018 RESULTS

Thank you to all who filled in the trainee survey. It continues to provide us with the most accurate and detailed information on our training programme and continues to inform the training committee. This year we had 444 complete responses and a response rate of 68.7%. This goes up to 72.1% when we include partial responses.

Results are in line with previous years and from the longitudinal data, we can see that problem areas for us remain the medical attachment in stage 1 and organisation of stage 2.

As can be seen, the majority of training is good – where there are problems, the themes are fairly similar to previous years. There is still dissatisfaction with a number of medical posts at stage 1. In some cases this arises from the lack of understanding of the ICM trainee's needs by supervisors, and in some the medical attachment itself is not of a high enough quality.

For 2018 I would like to look in detail at two points of interest: detail on attachments in stage 2 and general comments about the programme.

Stage 2 attachments

This year we looked at a breakdown of the stage 2 specialist attachments. There have been consistent comments that this year has been awkward to deliver, with some trainees finding that it did not meet their needs. Attachments can be in anaesthetics alone, critical care alone or a combination of the two and we were interested in whether there was a signal that trainees had a better experience in a particular organisation of the three-month block.

Although numbers are small, it looks as though a combination of anaesthetics and ICM provides reasonable training. Attachments in critical care alone did not fare as well in cardiothoracic and neurosciences. Comments on the reason for attachments being inappropriate focused on a lack of formal teaching, limited opportunities for intervention as a non-anaesthetist, lack of theatre experience and a lack of differentiation between different grades.

Cardiothoracic attachments

	Anaesthesia	Anaesthesia/ICM	ICM
Excellent	0	15	10
Appropriate	3	17	20
Inappropriate	1	1	6

Neurosciences attachment

	Anaesthesia	Anaesthesia/ICM	ICM
Excellent	1	10	14
Appropriate	7	18	21
Inappropriate	0	2	1

Paediatrics attachment

	Anaesthesia	Anaesthesia/ICM	ICM
Excellent	8	7	15
Appropriate	9	5	21
Inappropriate	0	2	6

Comments on the ICM programme

Secondly, I would like to focus on the general comments about the ICM training programme. Thank you very much to all the trainees on giving us such detailed information.

This is particularly valuable at the moment as we are currently changing the curriculum, and have an opportunity to change things for the better

All comments have been anonymised and circulated to the curriculum development group. Here are some example comments:

1. Assessments and the e-portfolio: a huge amount of comments on this – by far and away the most problematic area for many trainees.

The volume of paperwork required for ICM and commonly the repetition is a significant factor in training. It can be arduous and eats into clinical training time, especially without dedicated time to complete the growing paperwork required. This is even more apparent when dual training and has led to some of my colleagues leaving the ICM programme.

The burden of paperwork and non-clinical commitments weighs heavily on ICM trainees

The curriculum/e-portfolio/logbook requires so much time spent on it that it detracts from the time I should be spending educating myself about the clinical needs of my patients.

The requirements are too onerous. By the time you finish ticking the boxes no one wants to talk about anything of significance.

Overall very happy with my training but the numerous competencies continue to be a burden and continue to detract from training.

The portfolio is difficult to use and completing the extensive list of curriculum items is a laborious process which I don't think is a useful process to a trainee.

It's a real bind having to duplicate paperwork for ICM and anaesthesia between the e-portfolios. A more efficient way of downloading single WBAs would be helpful.

The part of ICM training that impacts most significantly on my life is the balance of the two, non-interactive portfolios. The ICM one is quite cumbersome at times and the inabilities to link between the two specialties' portfolios makes a lot of extra work for us, added on top of our clinical commitments, exams, QUIPs, audits and other CV enhancing essentials. In my experience, it appears to be a significant detraction to a lot of would-be dual trainees and a significant burden to current dual trainees.

FICM is currently exploring new providers for the e-Portfolio system and realises that addressing the burden of assessment for both trainees and trainers is crucial. FICM's Curriculum Working Group are currently revising the curriculum in line with the GMC's new standards for postgraduate curricula that will significantly reduce the number of assessments.

2. Exam comments

I have thoroughly enjoyed my special skills year in NICU, PICU and CTCC. This is an excellent development in the training programme. (However) demanding (the exam) is achieved within stage 2 adds additional stress to trainees working a demanding job with high out of hours requirements. Please reconsider what is hoped to be achieved with this exam and why a constraint of passing within stage 2 has been added.

Stage 2 is challenging and enjoyable but very busy. I am strongly of the opinion that the FFICM MCQ should be sat in stage 1. The constant studying for exams in stage 2 is a distraction to the specialty posts we are assigned to and I would have got more out of training in this time if I only had one exam to sit.

It has been very difficult to do the exams and complete two separate electronic portfolios that in no way interact with each other. There should definitely be more flexibility as some things are just impossible to achieve if not in a dedicated ICM post when in the other speciality.

The timing of the FFICM exam has been discussed at the FICM's Training, Assessment and Quality Committee and they will be submitting a proposal to the Examinations Committee regarding increasing the flexibility for trainees.

What do you enjoy most about working in critical care?

There were also a large number of positive comments about the individual attachments and clearly trainees are still enjoying and getting the most out of their training. As an extra this year, we asked the trainees what they enjoy most out of critical care.

	Numbers	Ranking
Variable and challenging case mix	307	1
Feeling like you make a difference to the care of patients and their families	73	2
Working in a multidisciplinary team	39	3
Supportive colleagues	15	4
Research Interests	3	5

So variable and challenging case mix gets the prize – however, there were plenty of comments that they wanted to tick more than one box!

Rest Facilities

Lastly, we also looked at the availability of rest facilities, a very important part of safe working for shift work. It is great to see that most attachments provided facilities for rest – and important for those that do not provide facilities (16.45%) to know that most others do and they are falling behind.

How would you rate the standard of training in this placement?

		Number	Percentage	**2017**	**2016**
Intensive Care stage 1	Excellent	**57**	**36%**	47%	45%
	Appropriate	**91**	**58%**	46%	44%
	Inappropriate	**10**	**6%**	7%	10%
Anaesthetics stage 1	Excellent	**49**	**44%**	47%	49%
	Appropriate	**57**	**51%**	50%	36%
	Inappropriate	**5**	**5%**	3%	15%

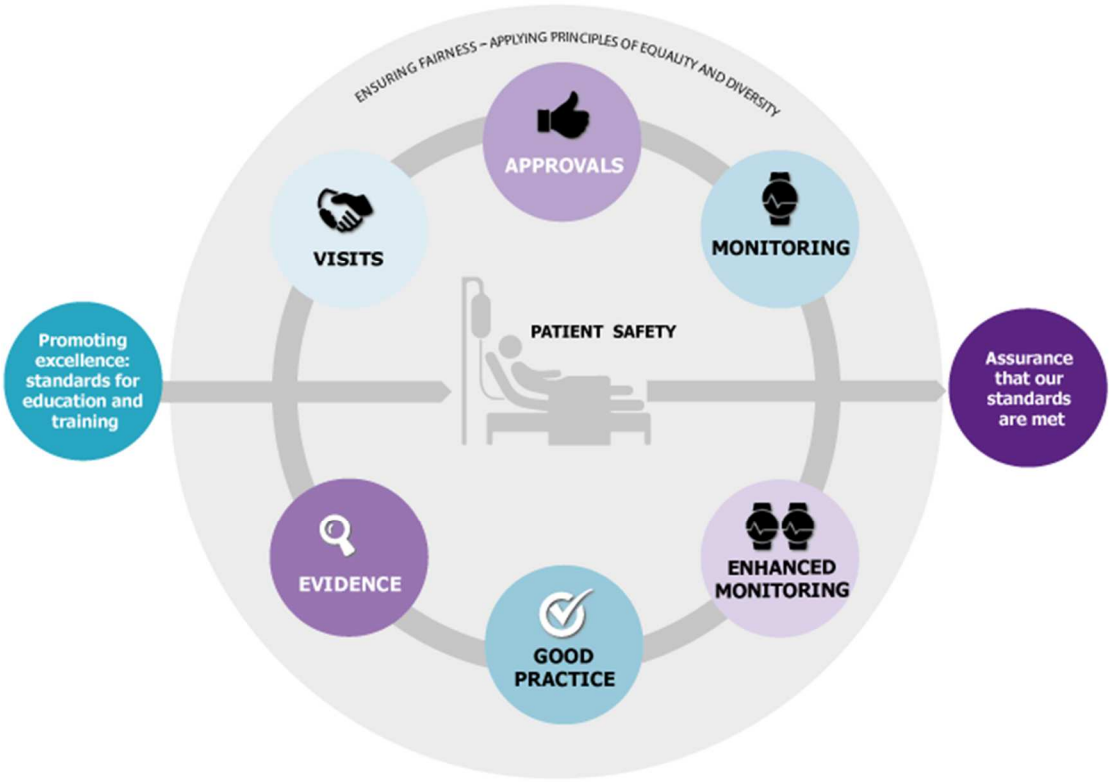
Medicine stage 1	Excellent	**8**	**16%**	16%	24%
	Appropriate	**24**	**48%**	54%	72%
	Inappropriate	**18**	**36%**	30%	12%
Cardiothoracic stage 2	Excellent	**25**	**34%**	29%	18%
	Appropriate	**40**	**55%**	62%	65%
	Inappropriate	**8**	**11%**	9%	18%
Neurosciences stage 2	Excellent	**25**	**34%**	37%	45%
	Appropriate	**46**	**62%**	55%	50%
	Inappropriate	**3**	**4%**	8%	5%
Paediatrics stage 2	Excellent	**30**	**41%**	33%	42%
	Appropriate	**35**	**48%**	56%	52%
	Inappropriate	**8**	**11%**	11%	5%
Intensive Care stage 2	Excellent	**25**	**46%**	44%	53%
	Appropriate	**27**	**50%**	49%	46%
	Inappropriate	**2**	**4%**	7%	0%
Special skills year stage 2	Excellent	**7**	**44%**	46%	
	Appropriate	**9**	**56%**	43%	
	Inappropriate	**0**	**0%**	10%	
Intensive Care stage 3	Excellent	**7**	**70%**	54%	100%
	Appropriate	**3**	**30%**	46%	0%
	Inappropriate	**0**	**0%**	0%	0%

SECTION 3: GMC TRAINEE SURVEY 2018
Chris Thorpe Quality Lead

3.1 THE ROLE OF THE GMC

The GMC is responsible for ensuring both undergraduate and postgraduate training standards are upheld and does this though the Quality Assurance Framework, which is summarised below:

The Quality Assurance Framework (from the GMC)



3.2 OVERALL RESULTS FROM THE GMC SURVEY 2018

Scores are out of 100. Results are from all higher ICM trainees.

Indicator	2012	2013	2014	2015	2016	2017	2018
Overall Satisfaction	87.37	81.05	84.35	82.1	83.71	81.02	**80.79**
Clinical Supervision	95.4	92.53	93.59	93.1	93.11	94.67	**94.91**
Clinical Supervision out of hours				92.37	93.26	93.64	**92.77**
Reporting systems					76.96	78.01	**78.79**
Work Load	42.61	45.58	45.5	49.7	47.05	51.08	**51.17**
Teamwork						73.8	**74.27**
Handover	78.25	74.11	73.44	75.35	73.76	73.59	**67.83**
Supportive environment				78.13	78.87	76.09	**75.74**
Induction	87.35	85.43	87.9	88.7	87.37	83.02	**81.36**
Adequate Experience	89.61	80.96	83.8	81.77	84.51	80.13	**78.68**
Curriculum Coverage						76.98	**75.66**
Educational Governance						76.35	**76.37**
Educational Supervision	82.35	80.24	87.04	86.36	92.69	89.64	**86.94**
Feedback	75.71	71.24	73.77	75.77	77.47	71.3	**71.55**
Local Teaching	62.88	63.41	65.67	64.63	66.32	63.53	**73.54**
Regional Teaching	67.09	68.03	66.26	65.92	65.4	66.54	**68.63**
Study Leave	72.14	66.84	68.19	71.84	73.04	64.49	**64.26**
Rota Design							**65.64**

Overall most responses to the GMC survey from ICM trainees remain similar to 2017. Of note, local teaching has improved considerably compared to previous years, a tribute to the hard work put in by tutors and all members of the team involved with their programmes. We continue to score very well in clinical supervision, both in and out of hours. In a complex acute specialty this is a notable achievement.

In 2018 there were no outliers in the overall figures so we were comparable with other schemes.

SECTION 4: REGIONAL ADVISOR REPORTS
Mark Carpenter Lead RA

This year the RA reports were conducted through the survey monkey online platform. 29 out of 32 RAs submitted reports.

4.1 EDUCATIONAL ENVIRONMENT FOR TRAINERS

From the 2017 report this was improved with the majority of FTs having time within their job plans to discharge their duties.

4.2 TRAINING SUCCESSES

Significant numbers of training successes highlighted by RAs throughout the 4 nations. The Northwest School of ICM presented their success with their own medical posts that can be allocated by the ICM TPD. Other schools presented flexible routes by which they allocate medicine and anaesthesia posts as required.

4.3 TRAINING CONCERNS

Post numbers and allocation remains a problem in a number of regions. Those regions struggling to be able to recruit sufficient trainees have been in discussion with postgraduate deans. Several regions have taken the opportunity to use the Faculty engagement events to promote the need to support further recruitment which has been useful.

Comments about competency and e-portfolio burden continue, but with the acknowledgement that the new curriculum is likely to reduce this burden. The work by the trainee reps and TAQ to look at ways to reduce this burden have been recirculated to trainers in the regions.

4.4 FICE/CUSIC TRAINING

FICE is clearly becoming more established across the country with only a few regions unable to provide coverage.

4.5 MORALE

The continuing issue of morale was mentioned in a number of reports with a variety of ways of improving morale being listed under training successes in many regions with wellbeing days and events throughout the country. Evidence from attrition rates would suggest that ICM as a specialty with low morale or high burn-out is largely “Fake News” and the faculty committees are working to recognise and publicise a positive message of ICM as an interesting a varied specialty with a good work-life balance.

SECTION 5: EXAMINATION DATA
Andy Cohen Chair FICM Examiners

The FFICM exam is organised and managed by the College exams department. The department provides a bridge between multiple interested parties such as examiners, candidates, the Faculty and GMC. It also supports the FFICM Examinations Committee and the subgroups representing each component of the exam.

At its meeting in October 2018 the FFICM Examinations Committee Sub Group agreed to formalise the process for standard setting in the exam and asked the current lead, Dr Cockings, to implement this. It is envisaged that a small number of interested examiners would join Dr Cockings and work with the exams department professional statisticians to examine methods of standard setting in the exam, the marking scheme used and advise on data collection. It is hoped that this will allow continued exam development; increase feedback of information to examiners about their own performance; assist with examiner training and inform the appraisal process.

At the last exam sitting 6 new examiners were welcomed to the FFICM. All new examiners have experience of training and assessment but in addition were invited to attend a new examiner training day before the exam. New examiners are paired with experienced examiners when they start examining and are appraised after they have taken part in two exams. Appraisals are also offered to established examiners. It has been agreed to admit a further 7 examiners in summer 2019.

The FFICM machine marked test is currently under review. The GMC has expressed the view that it would like this part of the exam to change over time from the current format of 60 multiple true false questions and 30 single best answer questions to all single best answer. It has been suggested that the current guidance on writing single best answer questions should change from all options offered to the candidate being correct, with the candidate selecting the best possible answer, to all options being feasible. Permitting incorrect options to be offered allows a wider range of questions to be asked and removes subjectivity about what is acceptable. This would bring the Faculty in line with a number of other colleges.

In January 2018, 111 candidates sat the exam, of whom 97 passed (87%). The pass mark was 68% and the reliability was 0.7254. In July 2018, 59 candidates sat the written exam, of whom 39 passed (67%). The pass mark was 66%. Exam reliability was 0.571 calculated using KR20. Candidates are free to sit the oral exam immediately following the machine marked test or up to 3 years after. Once the oral exam is attempted, if one component is failed candidates are permitted to take the single pass forward for a further two years. Thus the cohort of candidates taking the oral exam cannot be compared to those that sat the previous machine marked test.

The Borderline Regression (BR) and Hofstee methods are used in the standard setting of the SOEs, with Hofstee being used to cross reference the result achieved from the BR method.

In April 2018, 105 candidates sat the SOE. Of the 105, 78 (74%) passed the SOE component. 10 candidates sat the SOE with a previous pass in the OSCE. 7 from 10 passed giving a 70% pass rate for SOE only applicants.

In October 2018, 73 candidates sat the SOE. Of the 73, 53 (73%) passed the SOE component. 12 candidates sat the SOE with a previous pass in the OSCE. 10 from 12 passed giving a 83% pass rate for SOE only applicants.

OSCE Standard setting is performed using modified Angoff referencing by the OSCE working party prior to the exam being taken and a cumulative pass mark for each paper agreed. In April 2018, 104 candidates sat the OSCE. Of the 104, 68 (65%) passed this component. 9 candidates sat the OSCE with a previous pass in the SOE. 3 candidates passed, giving a 33% pass rate for OSCE only candidates.

SECTION 6: RECRUITMENT
Jonathan Goodall FICM CRW Careers Lead

QA Process

The QA process is now embedded as an integral part of the FICM recruitment process. It is fully supported by both the CRW and the interviewers and recognised as beneficial by the lay representatives reviewing the recruitment process.

Changes to process for 2018

1. There were no structural changes to the recruitment process this year. Panel members were required for the four face to face stations, along with a Quality Assurance lead for each day.

2. The process for Quality Assurance Assessors (QAA) followed the now established pattern developed in 2016. QAAs attended plenary briefing, station specific briefing for the station they were due to QA along with QA briefings at both the start and the end of each day.

3. Clear guidance and a 'QA specific' timetable were provided for each QAA, along with appropriate documentation in an 'Assessors Pack' prepared in advance of each day by administrative staff.

4. A revised assessment form was used for 2017.

Key Principle of ICM Interviews

In line with established processes, interviews were conducted using the following key principles:

- Interviews adhered to the format in interview guidance
- Was appropriate supporting paperwork for interviewers available?
- Appropriate training available for all interviewers
- Had interviewers received equality and diversity training within the previous 3 years?
- Were there candidates with special requirements?
- Candidates were treated with fairness, politeness and respect
- Was there discussion around calibration and scoring before the interviews started?
- Appropriateness of scoring
- Published criteria followed
- Interview panel provided feedback on suitability of questions
- Mechanisms for highlighting probity issues in place

Adherence to these was assessed by the QAA in each station. In 100% of interviews observed during this process, all the above key principles were adhered to.

The introduction of electronic scoring was widely welcomed by the interviewers. This made a significant impact on the QA process too, removing the requirement to recheck calculations and transcription for errors.

Recommendations for 2019 Interview Process

- The process continues to work well and needs minor refinements only. As in previous years, QAAs were impressed with both the quality of the material, the questions and the conduct of the interviews.

- The person leading the briefing needs to have written guidance as to what needs to be included: it was found to be very different at the same station on consecutive days in 2018.

- The person leading the briefing session should check that all interviewers for that station are present before starting the briefing process.

QA Process

- The QA process works well and was improved by the changes made since 2016.

- The attendance of QAAs at the briefings (plenary and station specific) is essential, as is providing QAAs with station information (including scoring matrices and a tailored timetable).

- The shortened QA questionnaire was felt to be an improvement by QAAs.

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