The Faculty of
Intensive Care Medicine

Quality Management of Training Report 2016

KEY MESSAGES

1. More trainees completed the FICM Trainee Survey this year but the number is still below 100% completion.

2. Our survey provides very different data from the GMC survey. The post-level data has already enabled Regional Advisors and Faculty Tutors to make changes directly to their programmes.

3. Placements within the critical care environment received the highest ratings from trainees.

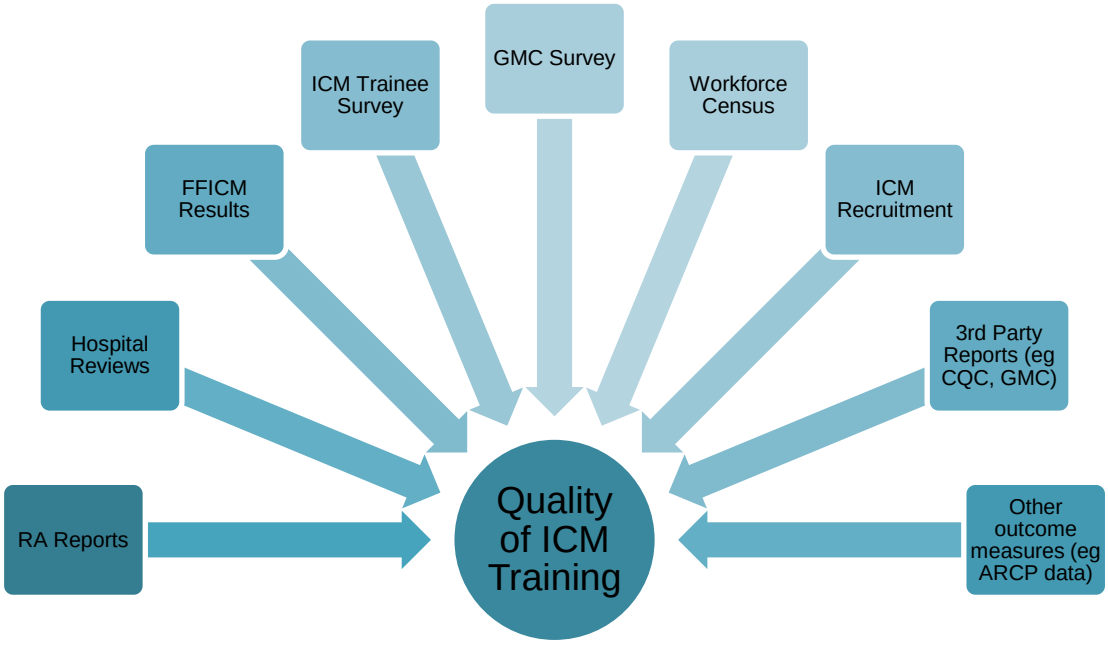
4. There has been an improvement in ratings of medicine placements.

5. No long-term issues have currently been found (i.e. through longitudinal analysis), potentially demonstrating that issues are being dealt with proactively through the year by year data.

SECTION 1: INTRODUCTION
Chris Thorpe QA Chair

Welcome to the second Quality Management of Training Report from the Faculty of Intensive Care Medicine. The Quality, Recruitment and Careers Sub-Committee (QRC) oversees the collection of data that allows the FICM to quality manage its training programme. As a relatively young specialty we are continually looking at how we can best develop our specialists of the future. Linking training to the obvious outcomes of consultant performance is difficult at the best of times, but even more so as our new training programme has yet to produce many consultants.

The QRC uses information from a number of sources – the 'Quality Nexus' – to increase the validity and reliability of information.



SECTION 2: FICM TRAINEE SURVEY 2016
Chris Thorpe

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.

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. This allows the RA to make immediate changes to the training programme.

2.1 OVERVIEW OF 2016 RESULTS

We received 140 replies, up from 111 in 2015. This is still substantially below the number of trainees asked to complete the questionnaire.

Trainees are satisfied overall with their training in their various attachments (Table 1). Notably, trainees undertaking placement within critical care report the most positive ratings.

		Inappropriate	Appropriate	Excellent
Stage 1	**ICM**	**6 (10%)**	**27 (44%)**	**28 (45%)**
	Medicine	**3 (12%)**	**18 (72%)**	**6 (24%)**
	Anaesthesia	**7 (15%)**	**16 (36%)**	**22 (49%)**
Stage 2	**Cardiothoracic ICM**	**3 (18%)**	**11 (65%)**	**3 (18%)**
	Paediatric ICM	**1 (5%)**	**10 (52%)**	**8 (42%)**
	Neuro ICM	**1 (5%)**	**11 (50%)**	**10 (45%)**
	General ICM	**0**	**6 (46%)**	**7 (53%)**
Stage 3	**Stage 3**			**3 (100%)**

Table 1: How would you rate the standard of training in this attachment?

Free comments once again were extremely illuminating and trainees took the opportunity to express their views in detail: two contrasting replies from different attachments are shown below. It can be seen how this sort of information would prove helpful for the RAs in Quality management of their training programme. It also demonstrates the benefit of longitudinal analysis of the surveys to track both (a) where quality issues are related to the individual rather than the post and (b) that improvements are taking place.

"This was one of the best training experiences that I have ever had. The Acute Physicians (two in particular) were incredibly supportive and inspiring in helping me to develop my clinical and non-clinical skills. They have been very approachable and have made me feel like an asset to their team. There is a fantastically supportive culture towards their trainees of all

grades and the level of opportunistic teaching is very good. If I could nominate them for a training award I would!"

"Not enough opportunistic teaching, service provision took far too much priority over training due to shortages on the rota. Most consultants were well supportive of trainees. Average quality training experience overall due to exposure to lots of cases. Consultants were not good at completing WBPAs and then we are criticised at sign off for not having enough. Some agree to meet and complete them then are often repeatedly unavailable or do the assessment and say to email the form then simply do not complete it."

2.1.1 Stage 1

ICM attachments continue to perform well at stage 1. Input into ARCP has improved and this reflects familiarity with the process by both trainees and trainers. Informal teaching is well regarded but formal teaching less so with 14% of respondents rating it as poor.

Improvements this year have been seen in medical attachments during stage 1, where responses have improved in many areas including training ethos, training support and appropriate level of responsibility. An example can be seen in table 2. This could possibly be because medical trainers are becoming more familiar with the requirements of ICM trainees.

How well were you supported by your trainers in your attachment?			
	Not well supported	**Supported**	**Well supported**
2015	**42%**	**8%**	**50%**
2016	**4%**	**46%**	**50%**

Table 2: Medicine attachments 2015 vs. 2016

2.1.2 Stage 2

Trainees are now entering stage 2 in some numbers and we can see overall that the blocks are performing well in the most part. Cardiothoracic training appears to be the worst of the specialist blocks, and compared with paediatric and Neuro ICM struggles in formal teaching, training ethos and ARCP input in addition to the more global rating of standard of training.

2.2 FUTURE AREAS OF WORK

The FICM trainee survey provides useful detailed information. Comments on specific blocks have been very helpful once again in identifying areas of excellence or areas where improvement is needed. Plans for the 2017 survey include:

1. Further review on increasing completion rates will be discussed by the QAC. Some RAs are keen to make it compulsory but there are negatives as well as positives in this approach.
2. Continuing the 'traffic light' system that highlights outliers, both good and bad. Next year will have 3 year's longitudinal data and those units with 3 consecutive outliers will be contacted.
3. Stage 2 needs to be subdivided so we can ascertain whether there is a difference between those trainees undergoing specialist blocks in ICM and those undertaking them in Anaesthetics.

SECTION 3: GMC TRAINEE SURVEY 2016
Chris Thorpe

3.1 THE ROLE OF THE GMC

The GMC sets the educational standards for UK doctors through both undergraduate and postgraduate training. Under the umbrella of **promoting excellence** they have produced standards that form the basis of medical education. These came into effect in January 2016.

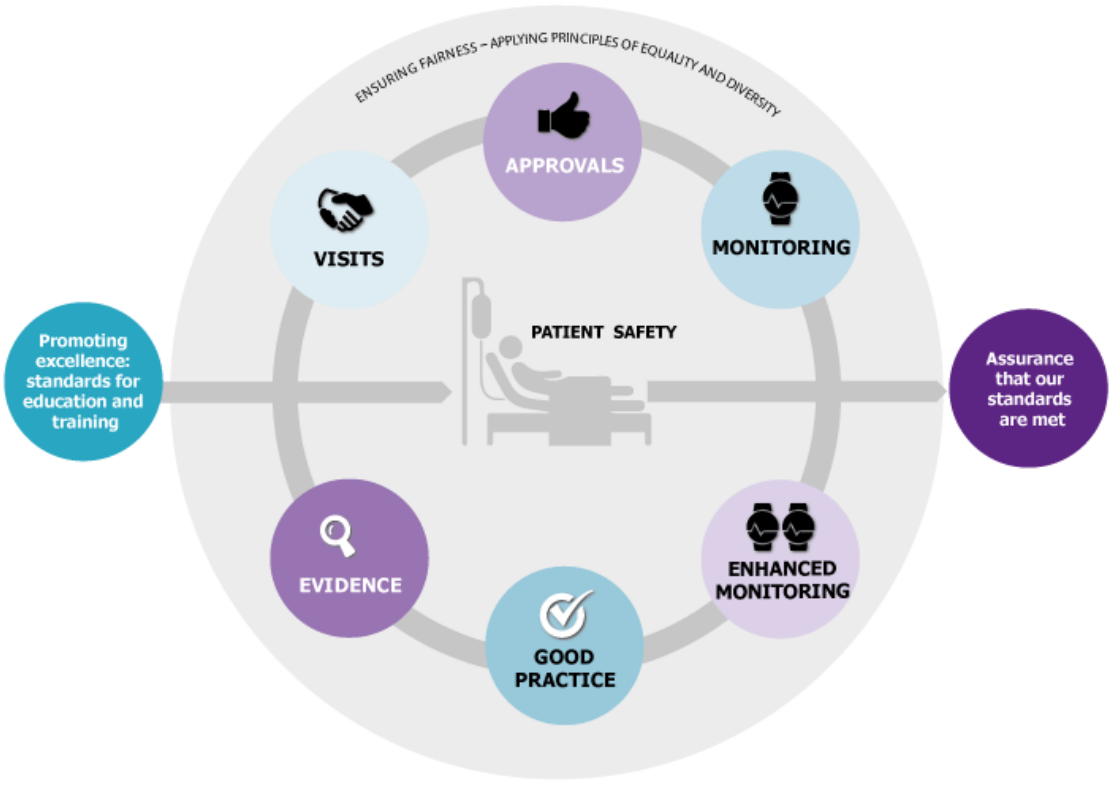
Promoting Excellence: GMC standards for medical education and training

Patient safety is the first priority: refer to Good Medical Practice

Theme 1 Learning environment and culture
Theme 2 Educational governance and leadership
Theme 3 Supporting learners
Theme 4 Supporting educators
Theme 5 Developing and implementing curricula and assessments

The GMC is responsible for ensuring these standards are secure and does this though the Quality assurance framework, which is summarised below:

The Quality Assurance Framework (from the GMC)



3.2 GMC SURVEY IN 2016

The GMC survey provides 3 sets of information:

- Firstly generic answers are obtained from all trainees undertaking an attachment in ICM irrespective of their base specialty. This gives a rough overview of how a unit or deanery is performing when all trainees are taken into account. It is a very blunt tool however incorporating trainees at different stages, and as most are not FICM trainees the answers mix disinterested trainees with career Intensivists.

- Secondly generic answers are presented from all ICM specialty trainees. The problem here is that the trainees can be in any of the components of training e.g. Anaesthetics or stage 2 paediatrics and there is no way of separating them out.

- Thirdly there is the opportunity to ask specialty specific questions. These are developed with the FICM and are targeted at areas we think may be helpful.

3.3 OVERALL RESULTS FROM THE GMC SURVEY 2016

Scores are out of 100, the higher the better. **Note that the two columns are comparing different things**: Column one has trainees from all specialties within an ICM attachment at the time of the survey; column two has FICM trainees only but these could be in other attachments such as Medicine or Anaesthesia at the time of the survey.

	All trainees in an ICM attachment (mean / 100)	FICM specialty trainees (mean /100)
Overall satisfaction	87	84
Local teaching	66	66
Regional teaching	65	65
OOH supervision	92	93
Clinical supervision	93	93
Reporting systems	78	77
Handover	80	74
Induction	88	87
Adequate experience	88	84
Supportive environment	80	79
Workload	48	47
Educational supervision	91	93
Feedback	75	78
Study leave	69	73

Table 3: GMC survey data 2016

3.4 INTERPRETATION

The one thing that stands out for both FICM specialty trainees and trainees undergoing a limited time attachment is the workload. An element of this comes with the specialty but there is no doubt that trainees feel the workload is high. We are not alone however and this is also seen with a number of other specialties.

It is encouraging to see high marks in clinical and OOH supervision, implying that although trainees are busy they are not left alone to cope.
Other indicators are broadly in line with other specialties. It would be good to up our game when it comes to local and regional teaching.

The Quality, Recruitment & Careers Committee (QRC) has met with the GMC to tailor specialty specific questions over the past two years but unfortunately the nature of the ICM programme makes it impossible at present to obtain the detailed information we need, There is the additional problem that the survey does not report any feedback if numbers total less than three.

For 2017 we have made the decision to use the specialty specific questions to focus on career intentions and the factors that influence this.

Whilst the GMC survey remains useful for general issues at a regional level, only the FICM survey provides the post-level data that allows us to affect active changes.

SECTION 4: REGIONAL ADVISOR REPORTS
Danny Bryden Lead RA

This year the RA reports were conducted through the survey monkey online platform.

4.1 EDUCATIONAL ENVIRONMENT FOR TRAINERS

Most responses indicated there was a bundling of the FT role within existing SPA and the increasing demands of educational supervision/portfolio completion were impacting on colleagues' willingness to take on additional roles. So far we have seen no impact on the quality of FT applications but this will need monitoring in future along with ensuring that trainees are getting appropriate educational supervision during their ICM training.

19 regions were happy that FICM Tutors were engaged in appraisal and educational governance.

4.2 TRAINING SUCCESSES

A variety of successes over the last year were commented on by the RAs. Teaching, pass rate in exams and improved training posts were frequently noted, along with echo training and local ICM course development. There were encouraging reports on trainee and trainer engagement and the provision of local training committees. Fill rates at trainee level, and successful consultant appointments were also mentioned along with the growth of academic ICM training. Web presence has also been developed successfully in some regions.

4.3 TRAINING CONCERNS

Comments on a need for expansion of the programme and increased funding to allow this, delays in training affecting progression including exam failure and inadequate funding of trainer time came up from several sources. Concerns with recruitment included the timescale being too late to fill vacancies, and the geographical restriction implicit in the system. There have also been some trainees who have withdrawn from the programme.

4.4 STAGE 2 TRAINING

The stage 2 year came up multiple times in RA discussion Comments that the year is a burden for dual anaesthetic trainees who have to complete a lot of their portfolio in this year as well as sit the exam. The administrative burden and apparent rigidity of stage 2 was commented on and RAs would like more flexibility. A lack of equity of training requirements across the specialties was also noted. This was discussed at length at the RA meeting and work is being taken forward by Mark Carpenter to identify what RAs feel could be done to improve the stage 2 training particularly around the curriculum and burden of assessments in that stage.

4.5 LETB/DEANERY ENGAGEMENT

Most RAs link in through anaesthesia. Most of work is being done by the TPDs and RAs for ICM and is very dependent on good interpersonal relationships. A sense came through that many Deaneries/LETBs hadn't still quite got to grips with the operation of ICM training

4.6 FICE/CUSIC TRAINING

This was one of the main topics of discussion at the recent RA meeting. Overall the view was that we are managing to support those trainees who wish to train at present but there was a strong view that introduction of FICE into the curriculum at present would NOT be supported by the RAs/FTs. The view was that we should encourage trainees who wish to develop this as an additional skill and with time there may be sufficient demand from the ground for its introduction into the curriculum. At present the feeling on a 'top down' imposition of training was that it would have a negative effect on trainers and trainees.

Current barriers include lack of mentors and job planned time, although this seems a much bigger issue for CUSIC than FICE. Support is needed for clearer mentor definition, job planning time for mentorship/training, more training courses and mentors in a region so as not to overwhelm individuals currently delivering the training, and also there needs to be a convincing case that FICE/CUSIC will affect delivery of patient care - RAs were not convinced about this. Concerns were also raised about where it sits in training and the training burden on trainees at a time when we are looking to try to reduce this.

4.7 ADDITIONAL ANAESTHESIA TRAINING

Some regions note that individual trainees are asking for extra time, refresher training later but other RAs did not feel this was an issue so almost certainly specific at present to one region. It has been questioned that we may have an issue with clearly identifying what the purpose of anaesthesia training is for non-anaesthetists: what skills they maintain and how they go about this. Subsequent discussion took place with the FICMTAC about how non-anaesthetists keep up their airway skills and the 10 intubations/year suggested as part of this updating and the need for all trainees completing the anaesthetic year to obtain the IAC certificate regardless of background.

SECTION 5: EXAMINATION DATA
Andy Cohen Chair FICM Examiners

Success in the FFICM Final examination is required for ICM trainees to progress into stage 3 training. Current exam regulations, including requirements for eligibility to take the exam, can be found on the Faculty website.

The final FFICM exam is designed to assess knowledge, skills and attitudes. It comprises of two components, a written paper and an oral exam. Each component of the exam must be able to show that it is valid, reliable and set to an appropriate standard. These aims are achieved by using groups of experienced examiners to write, update and standard-set questions.

The written paper is a machine marked test which is currently a mix of single best answer and multiple true false questions. The question bank has been created, and is maintained by, a core group of FFICM examiners. The final set of questions for any exam is selected by the core group who then use a modified Angoff referencing technique to set the pass mark and thus the standard for the exam. The pass mark is adjusted by the Standard Error of Measurement (SEM) to allow for borderline candidates.

In January 2016, 83 candidates sat the written exam, of whom 74 passed (89.15%). The pass mark was 68.81%. Exam reliability was 0.77 calculated using KR20. In July 2016, 72 candidates sat the exam, of whom 60 passed (83.33%). The pass mark was 64.52% and the reliability was 0.69.

Not all candidates take the oral exam that immediately follows the written paper. Candidates have up to 3 years to take the oral component of the exam once they have passed the written paper.

The oral exam comprises of a Structured Oral Exam (SOE) and an Objective Structured Clinical Exam (OSCE). The SOE allows testing of depth and understanding of the topic whereas the OSCE allows a range of skills to be tested such as clinical examination, communication and data interpretation. The two components of the exam have to be taken together on the first occasion but if one is failed candidates are able to carry forward their pass in the other component for up to two years. Thus in each cohort of candidates taking the oral exam some will be sitting both the SOE and OSCE and others will be sitting just one component.

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 2016, 85 candidates sat the SOE. Of the 85, 66 (77.64%) passed the SOE component. 11 candidates sat the SOE with a previous pass in the OSCE. 8 from 11 passed giving a 72.72% pass rate for SOE only applicants.

In October 2016, 71 candidates sat the SOE. Of the 71, 53 (74.65%) passed the SOE component. 10 candidates sat the SOE with a previous pass in the OSCE. 7 from 10 passed giving a 70.00% 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 2016, 78 candidates sat the OSCE. Of the 78, 57 (73%) passed this component. 4 candidates sat the OSCE with a previous pass in the SOE. 3 candidates passed, giving a 75% pass rate for OSCE only candidates. In October 2016, 72 candidates sat the OSCE. Of the 72, 46 (63.88%) passed this component. 11 candidates sat the OSCE with a previous pass in the SOE. 6 candidates passed, giving a 54.54% pass rate for OSCE only candidates.

Overall

In April 2016, 55 candidates from 89 (61.80%) passed the exam overall compared with 49 candidates from 82 (59.76%) in October 2016.

SECTION 6 QA REPORT FROM ICM NATIONAL RECRUITMENT 2016
Jonathan Goodall Careers Lead

6.1 QA PROCESS

This was the second year that the FICM recruitment process was quality assured. The process had matured significantly since 2015 and alterations include a specific briefing form given to QA assessors (QAAs) as part of the introduction to the process and an alteration to the day to allow QA briefings at both the start and the end of each day, and to ensure that each QAA was able to attend both the plenary briefing, and importantly the station specific briefing for the station they were due to QA

6.2 OUTLINE OF THE DAY FOR QA ASSESSORS

1. Attend generic briefing session with all other interviewers
2. QA assessors attend the station specific briefing session with other interviewers for that station
3. After the station specific briefing QA assessors return to plenary room for QA briefing with QA lead for the day
4. QA assessment for the first 4 cohorts of interviews
5. QA assessors return to plenary room during the 5th cycle of interviews.
   This time will be used to:
   a. Review the day with other QA assessors
   b. Ensure that forms are completed as appropriate
   c. Produce a summary of the QA experience

An individual timetable was provided for each QA assessor, detailing timings and location for each interview session, which provided clarity for each assessor and was well received by those involved in the process.

QAAs were provided with comprehensive information and paperwork for each a station, including scoring matrices (i.e. they were given the same documentation provided for the assessors allocated to each station).

6.3 KEY PRINCIPLES 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; with the single (notable) exception that one interviewer had not received any training, and had not read the briefing.

6.4 QA ASSESSMENTS CONDUCTED

The reflective practice and task prioritisation stations were double marked as in 2015. This process was enhanced in 2016 as a random selection of the questions were marked for a third time by the recruitment QA lead. The scores on all questions were checked by an independent marked to ensure that total marks warded were correct.
Individual comments made during the QA process were noted and discussed by the QRC committee in September 2016 to inform the process for subsequent years.
Recommendations for 2017

6.5 INTERVIEW PROCESS

The process works very well and needs little change. QAAs were impressed with both the quality of the material, the questions and the conduct of the interviews.
The quality of clinical materials needs to be improved (particularly the chest x rays)
The order of questions in the scoring matrix for assessors in the portfolio station should match the order of questions in the self-scoring matrix.
The QA of written stations will be improved by ensuring that a minimum of 10% are re-scored by a third independent QAA.

6.6 SUMMARY

The Recruitment QA process works well and has become an integral part of ICM National recruitment. It appears to have been improved by the changes introduced for 2016. The attendance of QAAs at briefings and provision of ‘paperwork’ appropriate to their station is essential. It also seems that the QAA process benefits from providing assessors with individual timetables, which ensures smooth running of the day.

It is recommended that this process continues for subsequent rounds of ICM recruitment.

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