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Report of RCEM Accreditation of ACCS Training in Iceland

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Approved by RCEM Training Standards Committee
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Accreditation Visit Iceland June 2019

Objective

Accreditation of an ACCS training programme for Emergency Medicine trainees across all three ACCS training years, CT1-CT3.

Delegation

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Landspitali Hospital representatives

Chief Medical Officer – Dr Ólafur Baldursson

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ACCS Anaesthesia TPD - Dr Gunnar Thorarensen

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References for Accreditation

- Gold Guide January 2019 (Conference of Postgraduate Medical Deans - COPMeD
- Icelandic Healthcare System Gold Guide, May 2016
- ARCP externality documents RCEM 2018 / RCoA 2019

Introduction

Emergency Medicine is an established speciality in Iceland. The first Emergency Medicine Physician took up post at Landspitali Hospital in 1991, having been trained in the United States. The service and speciality has evolved since that time, to a current compliment of medical staff within the Emergency Department of

24 Consultants (representing 18 WTE). Training to Consultant level in Emergency Medicine occurs outside of Iceland, principally in the Nordic states, UK or USA.

Medical Care in Iceland is delivered across two Hospitals, Landspitali located in Reykjavik (the capital) and the other in Akureyri (north island location). Clinical care is also provided across the island by primary care practitioners and a number of private clinics. A pre-hospital air and land ambulance service transports those needing acute medical care to Reykjavik, with Landspitali being the acute receiving Hospital. The Emergency Department at Landspitali is located within the main hospital, and provides clinical care across all levels of acuity, to both adults and paediatric patients. Landspitali and Akureyri Hospitals both have Emergency Departments, though trainees currently only rotate through an ACCS programme at the Landspitali site. The Landspitali Emergency Department sees 70,000 patients per year; 10,000 of these attendances are paediatric patients. The Hospital is supported by Neurology, Neurosurgery, General Surgery, Intensive Care, Anaesthesia, Acute Medicine and Speciality Medicine including Respiratory and Gastroenterology. Further acute Paediatric, Obstetric & Gynaecology, specialist Cardiology and Mental Health services are located at a second site within the capital some two miles away from the Emergency Department. A new hospital build is underway at this second site so as to co-locate all services. This second site currently has no Emergency Department.

The Emergency Department at Landspitali has 45 beds, including a 4 bed resuscitation room, clinical high acuity and ambulatory care areas, plus a separate but co-located minors area. Diagnostic services include ED point of care ultrasound, radiology and co-located CT scanning. There is also access to MRI 9-5 each day. The Hospital has laboratory services, mortuary, operating theatres, Critical Care facility and the other infrastructure required to run an acute hospital. The Emergency Department has a hanger type area in front of the main Emergency Department entrance used for Major Incident management.

The Emergency Department in Reykjavik is recognised by the Australasian College of Emergency Medicine as a training site for the Emergency Medicine Certificate and the Emergency Medicine Diploma.

ACCS training in Iceland

ACCS training prior to 2015 did not exist in Iceland. There is no current higher Emergency Medicine training programme in Iceland. Clinical service is provided by Consultant level Physicians who had trained outside Iceland, gaining accreditation for training principally from Nordic countries, the USA and UK. Consultants from further afield are also employed within the Icelandic healthcare system, including Emergency Medicine Consultants from Australia and New Zealand. Following a partnership with the Royal College of Physicians of London (RCP) and the RCP accreditation of Core Medical Training in Iceland in 2016, the Royal College of Emergency Medicine was invited to visit in 2016. A delegation including the Deputy Chief Executive, Dean of the College and Curriculum Lead were invited to support the introduction of the 2015 clinical curriculum, with specific focus on ACCS training. This introduction of a curriculum for Emergency Medicine based trainees in ACCS was mirrored by recruitment of Acute Medicine and Anaesthesia based trainees into programme. A Royal College of Physicians of London (RCP) educational supervision training package with supplemental training days added further impetus to establish the core elements of an ACCS programme. This Royal College of Physicians' training programme was attended by 150 Consultants.

In 2018 delegates from the Royal College of Emergency Medicine and the Royal College of Anaesthetists attended the first ARCP held within Iceland, providing externality review,

report and feedback to both parent Colleges. Recommendations were made, however overall the feedback was positive and supportive for the quality of review undertaken. In 2019 further externality and report from the Royal College of Anaesthetists has shown consistency in the ARCP process and development of the programme.

The Icelandic ACCS training programme has established essential elements necessary to develop, sustain and enhance an ACCS programme.

1. Recruitment

The recruitment process follows that undertaken by the Royal College of Physicians, which is essentially the same process undertaken by the UK ACCS programme. Trainees make an application, all are longlisted and interviewed. At interview, each candidate rotates through stations; each station has two panel members that use a scoring domain to objectively evaluate the candidate. The stations include clinical, ethical and curriculum vitae review. The process is managed and run in collaboration with the Landspitali Human Resources Department. Panel members are Emergency Medicine Consultants from Landspitali and have undertaken hospital based equality and diversity training. Trainees are appointed to post.

All themes are recruited through the same process. In 2017 there were 4 Emergency Medicine, 4 Acute Medicine and 4 Anaesthesia theme trainees recruited to CT1. In 2018 there were 18 trainees recruited to CT1 (6 in each theme), whilst in 2019 there were 10 trainees recruited (3 Emergency Medicine, 3 Acute Medicine and 4 Anaesthesia). The current EM theme compliment of trainees in CT1 is 7, CT2 only 1 and CT3 a total of 3 trainees. The numbers vary due to progress and attrition factors that are the same factors noted in the UK, namely poor progress, health, resignation and less than full time training.

2. Induction

Induction is undertaken for all ACCS trainees on starting the programme. This includes a hospital induction that is wide ranging and includes topics on fire safety, infection control, quality improvement, violence and aggression, the trainee as a teacher, wellbeing, access to health support services, less than full time training opportunity. A third day of induction then occurs that is for all ACCS trainees and includes details of the programme, teaching opportunity, supervision and rotations. A final fourth day of induction is given to EM trainees with specific focus on the Emergency Department including kit and equipment orientation, departmental layout, role and responsibility.

As trainees rotate into their second year, additional unit induction is delivered over four weeks in the Anaesthesia Department covering role and responsibility, the programme, departmental layout, kit and equipment orientation.

Induction materials are given to each trainee for reference.

3. Programme rotation and placements

The Icelandic ACCS programme follows the same 6 month placement rotation as in the UK. In CT1 this is 6 months in Emergency Medicine and 6 months in Acute Medicine. For CT2 the rotation is a more blended rotation with Anaesthetics and ICM being a combined specialty in Iceland. During this rotation trainees undertake a week of full time ICM every 5 weeks during the daytime but for on call hours, during evenings, overnights and weekends, trainees are covering both Anaesthetics and ICM. This reflects how the service is delivered in Iceland, with Anaesthesia Consultants providing care to the Critical Care Unit on a rotational basis.

The CT3 Emergency Medicine year has a strong focus on Paediatric Emergency Medicine. Trainees in this year spend a minimum of 3 months at the second site hospital in the acute Paediatric Department that has 10,000 paediatric attendances per year. As this department only sees sick children, trainees are not exposed to any injured children during this rotation as they are all managed in the main Emergency Department. During the remaining CT3 time back at Landspitali Emergency Department the trainees undertake the same rota as the CT1 trainees but in the CT3 role there is an increased emphasis on training in managing injured children. This is the first year (2018/19) that a CT3 trainee has been in post in the programme.

The Emergency Department has already been described. Trainees work a band 1 equivalent rota, working 8-10 hour shifts, up to 20 shifts per month that includes 3-5 night shifts every month and 1:3 weekends. All shifts have Emergency Medicine Consultant clinical supervision 24 hours per day, seven days per week. All of the patients managed by the trainee must be discussed with a Consultant, though the CT3 trainee has independence in managing the Minors stream of patients. 50% of the Consultant tier are trained as Educational Supervisors. There are an additional 18 residents that support the clinical service in delivering patient care.

The Acute Medicine Department consists of an admitting ward for acute medical emergencies. This is a 20 bedded ward where the CT1 trainee works, seeing all adult unselected acute take. Consultant presence is 0800 – 2300 each day, whereupon the Consultant is on call from home and contactable for consultation. Consultant out of hours on call is provided by General Internal Physicians. If immediate medical care support is required for very sick patients, trainees can contact and gain support from the Emergency Medicine Consultant who is resident; both departments are in proximity to each other. Agreement has been made that overnight, sick patients preferentially stay in the ED under ED care. There is no 4 hour target. Trainees work a band 1 equivalent rota, with 3-4 night shifts worked every 8 weeks and 1:5 weekends. The majority of their shifts are day shifts to maximise Consultant contact time. 3 months are spent in the Acute Medicine Unit. The other 3 months are spent in the Cardiology Department located at the other hospital site. Trainees are again supervised by a Consultant Cardiologist from 0800 – 2200, with on call for consultation thereafter. Trainees undertake rotations through the PCI unit, ambulatory chest pain unit, and acute admission wards that have a total of 40 beds. Further clinical experience is gained in Out-Patients with arrhythmia and heart failure clinics. The rota includes daily work from 0800-1600 with extended days from 0800-2100 once or twice per week. Overnights are done every night for one week, every 8 weeks.

The Anaesthesia Department provides services to theatre suites of 10 operating theatres in one location and 9 in the other location of Landspitali in Reykjavik, covering all surgical specialities. Trainees undertake a 4 week induction period, and then gain competency towards their initial assessment of competency in Anaesthesia (IAC). Most trainees attain this at 3-4 months, and are then allowed to deliver an anaesthetic with semi-autonomous practice. The trainee is then also on call. Work patterns include daily work from 0730-1530 with 16 hour overnight shifts every 5th night. The Anaesthesia service always has a Consultant on site 24 hours per day providing supervision to trainees. Every 5 weeks trainees also undertake one week of full time intensive care medicine. There is an Intensive Care Unit (ICU) on both hospital campuses, with 6 and 7 beds that both have senior Consultant presence 24 hours per day. Trainees undertake competency attainment on this rotational basis, being on call for Anaesthesia and ICU at the same time as providing medical emergencies cover to the hospital. The on-call rota is combined with Anaesthetics.

Trainees have named Educational Supervisors in each post, daily Clinical Supervision as well as thematic overarching Educational Supervision for mentorship and support across all years of programme. For example, when out of EM, the CT2 trainee gets an additional mid and end of term review with their overarching EM educational supervisor.

4. Supervision

An Internal Medicine programme has already been accredited by the Royal College of Physicians of London (RCP) since 2017. As part of this programme development, an educational supervision training package was delivered by the RCP. Emergency Medicine, Anaesthesia and Acute Medicine Consultants were also trained, giving a compliment of 150 Consultants trained at the Landspitali Hospital site that includes 50% of the ED Consultant tier.

The hospital service is predominantly a Consultant delivered service, with supporting clinical care given by Resident Staff. Trainees therefore are in a position of almost constant Consultant supervision within their clinical environment.

The training faculty that were interviewed all put a priority on developing a culture of learning. This is not unique to ACCS, as Landspitali is the University Hospital that teaches and trains Undergraduate Medicine. Patient safety is also seen as a priority. The hospital has an electronic incident reporting system, whilst the Emergency Department undertakes a case review process that supports an evolving clinical governance system. Within the ED there is also a staff reporting box that allows all staff, including trainees, the opportunity to anonymously raise concerns or challenge practice, behaviours or training issues.

Educational Supervision is undertaken by those Consultants who wish to perform this role. They are expected to complete ARCP and educational supervision training. Consultants do not undertake annual appraisal, but have an annual review which covers role and responsibility. Payments are made for additional roles undertaken, including those aligned to educational activity; an option to take time back as annual leave is also provided. Performance review is undertaken on such additional roles on an annualised basis.

There is no formal Training the Trainer development programme, though hospital based training in the use of the e-portfolio, ARCP panel member development, educational supervision, equality and diversity and quality improvement planning supports the faculty in maintaining and enhancing their educational trainer needs.

The trainers interviewed were aware of the support structures within the hospital, including occupational health services, Psychiatric services for Doctors, the role of the TPD and supervisor.

5. Rotas

The rotas have been described for all three years of training. Within the Emergency Department an emphasis is made on self-rostering, with trainees managing the ACCS rota. The CT3 EM trainee 'runs' the ACCS EM trainee rota, including all aspects of leave. All other rotas are band 1 compliant.

6. Progress reviews

Progress reviews are part of the ACCS programme. There are established review points and supervisor meetings both when in ACCS placement and across all parts of the

training programme with an Emergency Medicine parent specialty supervisor. Different evidence is used to inform feedback and progress review, including Multi Source Feedback - hospital 360, Faculty Education Governance statement, ARCP outcomes, direct shop floor feedback and debrief. Further, TPDs are part of a wider Medical Training Committee in the Landspitali Hospital that provides opportunity to share information, progress concerns and opportunity to direct and support trainees within the ACCS programme, since the programme is principally at one base site and the size of the programme is relatively small.

The Emergency Medicine trainees reported a strong culture of formative feedback, supported progress review and directional support. They have opportunity and access to their Educational Supervisor and also to gain supportive and directive feedback within the clinical environment.

7. Teaching and training / additional training opportunity

In addition to materials used for induction, an established teaching programme exists across all themes of the ACCS programme. Trainees undertake and complete all adult life support courses including neonatal life support. Simulation training is used as part of the Emergency Medicine placement using in situ simulation (training is ASPiH accredited – the Association for Simulated Practice in Healthcare), such as the beyond BASIC airway management course.

There is a formal programme of education for trainees in Intensive Care and Anaesthesia to attain their initial assessment of competency in Anaesthesia. An Emergency Medicine teaching and training programme is open to ACCS trainees; this covers clinical topics aligned to the training programme and is part of a syllabus that is annualised and accessible to all trainees. Teaching occurs every Wednesday and the time is protected for trainees to attend these sessions. These sessions on average last 3 hours and include teaching topics as well as simulation.

Further training opportunities exist for EM trainees including Mass Casualty Management training days, Wilderness Medicine, Pre Hospital Emergency Medical experience with the Helicopter Ambulance Service and land based EMS service.

Trainees are expected to engage with the ultrasound curriculum from CT1, undertaking classroom learning, supervised scanning, log book development and sign off. This is aligned to those assessments undertaken within the UK RCEM Ultrasound Curriculum.

After CT1, trainees are given an annualised budget to travel for conference abroad with all costs covered e.g. ACEP Conference in the USA.

8. Support services and remediation

Trainees and Trainers are aware of access to support services. The TPD is a main focus for both parties to gain direction and signposting. Landspitali Hospital has a Chaplain, Hospital Psychiatrist for staff, Occupational Health and Human Resources service. Doctors can self-refer to services or have recommendation for referral made by their TPD.

There is no specific return to work support service or formalised programme to manage trainees with differing needs. The EM TPD is the main focus on managing trainees with poor progress or other factors affecting differential attainment.

9. ARCP

Reports have been made both by RCEM and RCoA in relation to externality and the Icelandic ACCS ARCP in 2018 and 2019.

10. TPD

There are three ACCS Training Programme Directors, one each in Emergency Medicine, Acute Medicine and Anaesthesia / Intensive Care Medicine. These three TPDs are the main focus of the ACCS programme, developing curricula, supervision, teaching and training programmes and a support network for trainees. Each of the ACCS TPDs is a member of the Hospital Medical Committee which is a forum used to network, feedback, develop and progress all training within the Landspitali site.

The TPDs have very limited administrative support, such that most administration tasks for recruitment, placement, communication with supervisors, ARCP and remediation is undertaken by them.

Quality Assurance of programme and Educational Governance

1. Government Health Board

The Minister for Welfare is appointed as a Government official who has overall responsibility for all aspects of healthcare in Iceland, including the training of medical practitioners.

2. Postgraduate Medical Education Committee

The Landspitali Hospital Postgraduate Medical Education Committee consists of a Chair, representative Training Programme Directors for each of the training programmes, Quality Lead for the hospital, trainee representation, senior administrators from the hospital, Human Resource and Academic / University representation. The committee is responsible for all aspects of educational governance at the Landspitali Hospital site and reports to the Chief Medical Officer. This committee meets every month and produces an annual report for the hospital that is distributed to the Minister for Welfare.

3. Accreditation Committee

An accreditation committee exists that is accountable to the Directorate of Health and the Minister of Welfare. This committee consist of three representatives whose role includes evaluation of training programmes and educational facility. In 2019 this Accreditation Committee approved the Landspitali site to develop Higher Emergency Medicine training, over a three year programme, leading to accreditation and completion of training recommendation by the Directorate of Healthcare.

4. Training Programme Directors and Educational Supervision

Training Programme Directors and Educational Supervisors are hospital appointed positions, where Consultants have annual reviews of performance and posts are remunerated. Training has already been described, and includes use of the e-portfolio, ARCP panel member development, educational supervision, equality and diversity and quality improvement planning.

The TPD is part of a larger ACCS group that has developed links, attended meetings and trainer events as part of the Inter Collegiate ACCS training Board at the RCoA.

There is no formal annual appraisal undertaken equivalent to that in the UK. There is no formal Training the Trainer events for faculty in Iceland but TPDs from the program have attended Training the Trainer events by the ICACCST in London.

Faculty do meet either at Departmental meetings or with TPDs at the Hospital Postgraduate Medical Education Committee.

5. Reporting systems and patient safety

The Landspitali Hospital has an electronic incident reporting system. This generates a report and process for investigation of clinical incident. The report is formulated and submitted to the Chief Medical Officer.

The Emergency Department has developed a clinical incident review forum where cases are evaluated by presentation at departmental meetings. This allows reflection and feedback. A report of cases and actions is generated and forwarded to the Chief Medical Officer.

A staff reporting box is within the Emergency Department allows staff to anonymously report issues and concern to the Head of Department.

There is no longitudinal reporting process that can highlight repeated concerns over clinical practice, or the effects of any intervention or remediation. Likewise any individual trainee concerns with training issues, health and wellbeing are not triangulated between Educational Supervisor, TPD and this reporting system.

6. QI

Quality Improvement is now at the forefront of clinical care at Landspitali Hospital. There is a hospital appointed Quality Lead who has been trained and practiced in this role in the UK.

Quality improvement forms part of the ACCS trainee's role, with projects being allocated and developed in post from CT1. Trainees are actively encouraged to enhance clinical practice within the ACCS programme e.g. developing a morning team brief / self-rostering on rotas.

Additional observations

A number of other observations were made during the visit and are of note:

- Early adoption and implementation of QIP
- Integrating the use of ultrasound in clinical practice in the ACCS programme
- Advanced airway training and use of clinical skills within the Emergency Department
- Pre Hospital Medicine programme and a Wilderness course is used to enhance team bonding and team building
- A wellness room has been refurbished within the Emergency Department to allow down time and reflection. This has comfy chairs, mood lighting and music
- A committed and cohesive core of ACCS trainers are delivering ACCS training that has rapidly developed a sustainable programme

- Links with the University are strong and will allow the potential development of medical education
- Trainees were on the whole very happy, felt empowered and were engaged with their programme.
- TPDs are fully committed and are driving all aspects of the ACCS programme
- ACCS interviewing and recruitment is unique in that this is not replicated for other programmes apart from Internal Medicine
- ARCP process is established, has had externality that has shown a high standard for a new programme
- 24 hour clinical supervision by Consultants is the norm
- Year 4 medical students are used within the Emergency Department to help fill gaps in the summer; this provides opportunity for future recruitment. They also gain additional experience by acting as interpreters for overseas and new to Iceland Consultants

Challenges and requirements

This ACCS programme has had a rapid period of development, the time and investment to provide an excellent training opportunity in Emergency Medicine (as well as the additional two other ACCS programme themes). The programme does however have challenges that we would recommend are addressed, namely:

- A formal link to incident reporting, critical clinical event, the trainee and remediation / reflection is necessary. These elements are integrated into the UK programme, and are seen as pillars necessary for strong clinical and educational governance, as well as patient safety. A longitudinal process to evaluate such reports against trainees in programme is also necessary so as to identify trends of concern with knowledge, skills, attitudes and behaviours. This must be in place by the **next ARCP 2020**.
- Structured training reports are mandatory for all trainees at ARCP, which must be in place for **ARCP 2020**. If this is not present at ARCP, then if in isolation, this is an outcome 5 and must be provided within 2 weeks.
- Formal adult and paediatric safeguarding training are essential parts of the ACCS curriculum. This would initially require face to face training and then updates via electronic training packages. This must be in place by the **next ARCP 2020**.
- The trainees questioned the value of some of the Cardiology placement, especially elements of ward cover and certain clinics e.g. heart failure clinics. It has been UK experience that the Acute Medicine posting should be in Acute Medicine alone with supervision by those clinical supervisors who understand the role of the ACCS trainee and the elements of their training programme and e-portfolio. One option is to evaluate sending a pair of ACCS trainees to Akureyri to undertake Acute Medicine. Clinical supervision and communication between two training sites does require careful consideration so that trainees are not managed in isolation and have full access to their TPD and support networks. One option already being considered is the ES / CS buddying system. This could also be extended to trainees, where a more senior trainee in programme is buddied up with a more junior CT1. Review of changes will inform programme assessment by planned trainer / trainee survey and outputs at ARCP.
- There are plans already underway to develop and distribute a trainee and trainer survey which must be in place by the **next ARCP 2020.**
- Formal ACCS rather than generic hospital train the trainer events will allow more specific ACCS related training topics to be covered and will also allow the ACCS training faculty to network.

- The ACCS CT3 EM is the first year of such posting in the ACCS programme. There are new tools to be conversant with, such as the ELSE. Review of outputs will inform development of this aspect of programme and need specific focus at **ARCP 2020**.
- Succession planning for TPDs is necessary, as the whole programme is dependent on their intimate involvement.
- Administration support is **essential** for any programme, to allow TPDs to focus on those elements necessary to develop and manage programme, rather than administrative task.

Outcomes of the GMC themes for accreditation of programme:

- Theme 1: Learning Environment and Culture

Standard 1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, cares and families. **Standard met.**

Standard 2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum. **Standard met.**

- Theme 2: Educational Governance and Leadership

Standard 3: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met. **Standard partially met.**

Standard 4: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training. **Standard partially met.**

Standard 5: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity. **Standard met.**

- Theme 3: Supporting Learners

Standard 6: Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum. **Standard met.**

- Theme 4: Supporting Educators

Standard 7: Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities. **Standard met.**

Standard 8: Educators receive the support, resources and time to meet this education and training responsibilities. **Standard met.**

- Theme 5: Developing and implementing curricula and assessments

Standard 10: Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum. **Standard met.**

Summary

It is clear that great progress has been made establishing the ACCS training programme in Iceland since 2016. Previous guidance and recommendations have been implemented and the team strive to continually improve all areas of training. Special recognition must be made of the dedication and enthusiasm of Dr Hjalti Már Björnsson, who as EM TPD has led the delivery of the EM ACCS training pathway.

It is the recommendation of the Accrediting Delegation to the RCEM Training Standards Committee that the College accredits the EM ACCS Programme for years CT1 and CT2 in Iceland for a period of three years from September 2019, subject to the requirements stipulated above being completed by the ARCPs in 2020. The accreditation of the CT3 year will be reviewed in 2020/21.

Ends