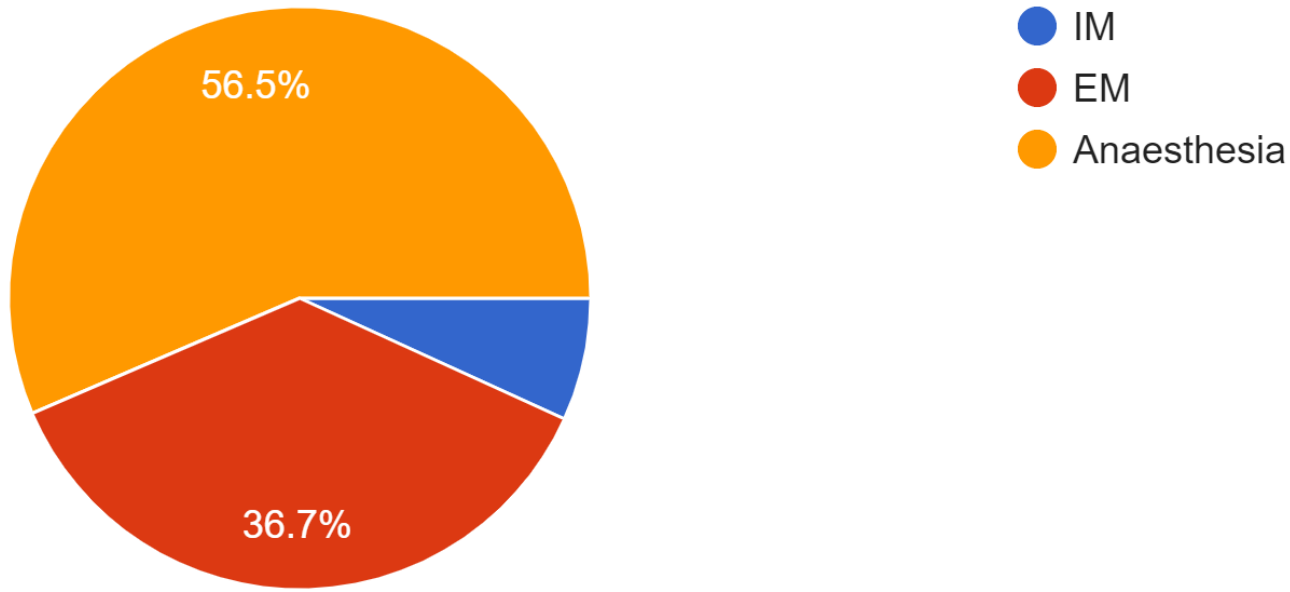
ACCS Trainees Survey: Effects of COVID on training

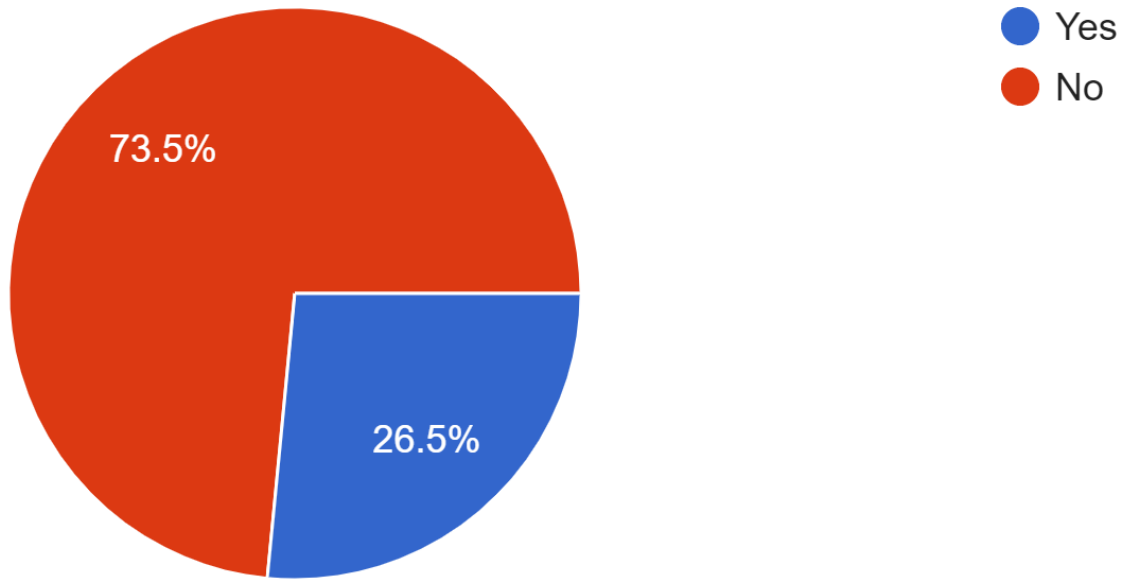
What is your ACCS parent specialty:

147 responses



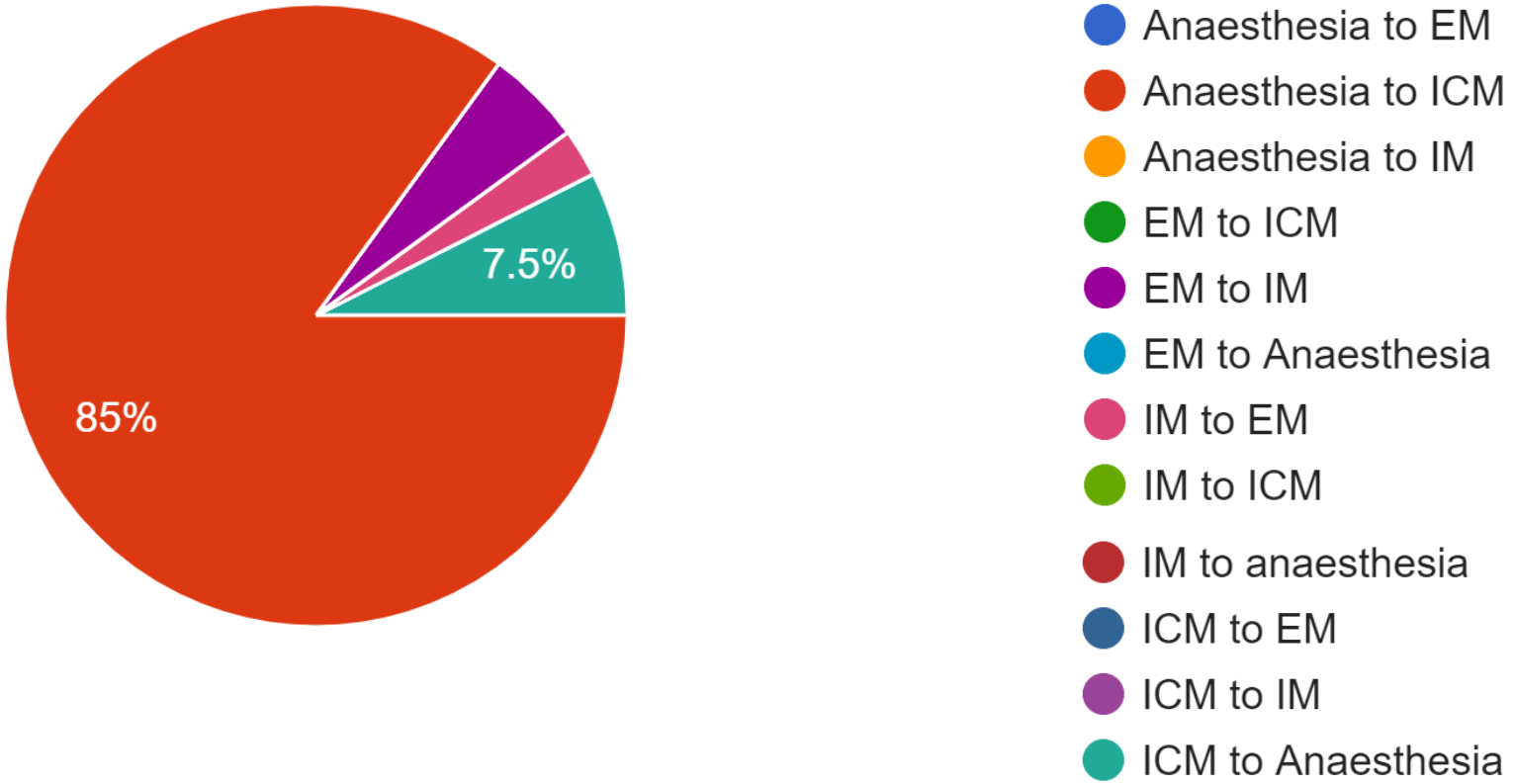
Have you at any time been (or are you due to be) re-deployed to a different specialty?

147 responses



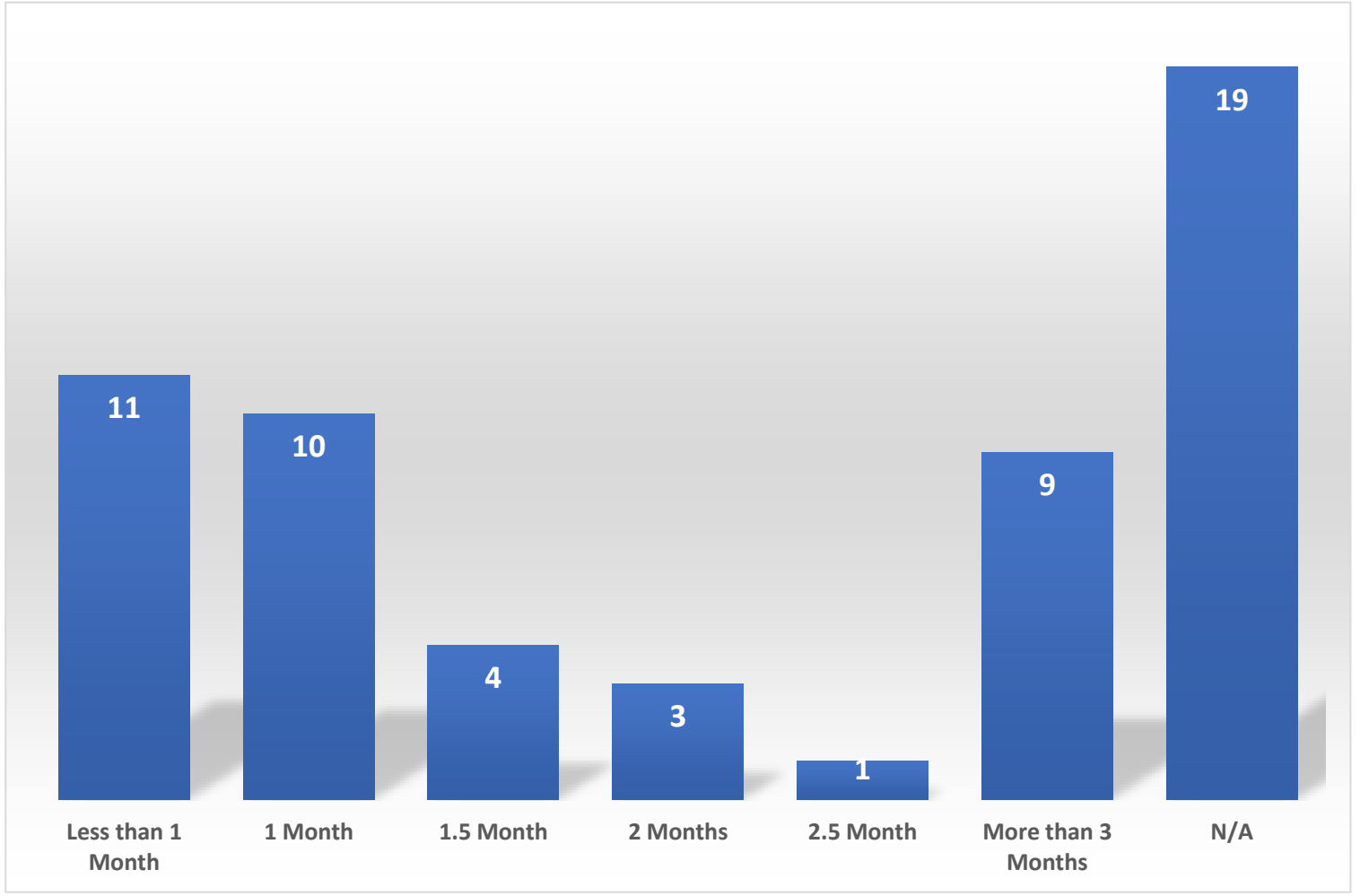
a) If so, from which to which?

40 responses



b) For how long were you re-deployed?

57 responses



c) Do you feel this has/will adversely affected your training? If yes, how? - 1/2

56 responses – 1/2

- No. The issues I had were multiple cancelled lists prior to this.
- Yes. The Anaesthetics rotation is so precious for ED trainees as it’s our only opportunity to gain these skills. Not only has it been cut short by a month but main theatres has been closed also for the first month of our rotation, leaving us all in day surgery. This has been useful in lots of ways but has also limited learning and we will ultimately take longer to gain the required skills but have less time to practice them. I would love the opportunity to spend more time in anaesthetics to gain more confidence in these skills.
- Mildly yes
- Whilst we were not technically "re-deployed", our rotations were delayed by 1 month. Therefore 1 month of Emergency Medicine was replaced with 1 month of Internal Medicine due to extension of the Acute Internal Medicine Placement. I feel that in the grand scheme of things it has unlikely adversely affected my overall training as an intensivist/anaesthestist. However I do feel that it has detracted from the ACCS experience which is meant to provide a broad experience of complementary specialities such as Acute Medicine and Emergency Medicine.
- Yes, massively reduced anaesthetic exposure. Less teaching. Less mentoring and not part of the department.
- It gives less time for my IAC but hoping it will still be manageable
- Has reduced number of anaesthetic lists I've done, and my time on obstetrics
- Less exposure to elective anaesthetic lists
- Yes - I feel I have the skills required but didn’t get as much out of my ITU rotation as I would have given the interruptions and starting without any induction (especially as we were on a different rota pattern and mostly covering out of hours)
- Yes, for the month we did not have any anaesthesia training and we’re covering post-op HDU. However, there has since then been every effort made by consultants to help prioritise us for lists, but these aren’t the usual “ACCS” style theatre lists.

c) Do you feel this has/will adversely affected your training? If yes, how?

56 responses – 2/2

- Less time spent in anaesthetics, no elective work occurring. Harder to do projects.
- Yes. Limited time post IAC/ Yes, less time practicing in anaesthesia.
- Yes - lack of time and available elective surgery lists for modular training.
- In some ways it has because I have not done as many Anaesthetics as I would have expected or got the range of specialities. But in other ways I was exposed to a lot of very acute emergencies and gained a lot from this.
- Reduced number of anaesthetic cases
- lack of time/experience in theatre, delivering anaesthesia, reduced caseload, less confidence in theatre. Extra time in ICM not being rewarded and not counting for anything as ICM module was signed off in ACCS 2 year.
- Yes. In my first 12 months of anaesthesia training I had only 4 months of theatre time which was fragmented throughout the year and therefore I found it difficult to build up skills and experience. This meant by the end of ACCS CT2 I did not feel confident delivering an anaesthetic.
- Lack of training opportunities due to covid - procedures exposure heavily impacted
- Yes, so have been given an extension to training (6 months) to make up for time lost
- Yes, with regards to portfolio it has meant one less month to be able to gain competencies required in A&E

d) Do you feel this has had/will have any advantages? If yes, specify?

51 responses – 1/2

- Got another month in anaesthesia which helped increase number of cases (which were reduced due to covid). However delayed my start in ICM which has seriously negatively affected learning opportunities
- Yes with some intense icu experience
- None! Had completed 6 months icm prior to the pandemic. Resulted in a huge loss in anaesthetic experience.
- Being able to be of use in the pandemic was pretty special.
- I would like to dual specialise in ICU down the line, so it has benefitted in increasing my skill level.
- Greater exposure to emergency anaesthetics
- More confidence with sick ICU patients
- Yes, I really enjoyed the challenge of working in ITU and feel that I was very well looked after in anaesthetics and prioritised to have access to as many cases as possible. There were innovations in terms of designing our own rota and teaching each other.
- I think it allowed us to settle in and get to know some of the anaesthetic consultants. But otherwise for training time away from anaesthetics was a large disadvantage.
- Not Applicable
- It has encouraged me to think about a different exit specialism
- Yes , gaining airway competencies before working in ICU
- Still able to sign off some anaesthetic compentencies; nice being back after more airway training
- A lot of emergencies and experiences that would never have happened in that number prior to COVID

d) Do you feel this has had/will have any advantages? If yes, specify?

51 responses – 2/2

- More ITU experience.
- More experienced in ICM and managing COVID patients/multi organ failure but as module signed off in ACCS 2 year not able to get any credit. Service provision on ITU.
- More ICM experience which is useful but not a substitute for theatre time, case numbers, development of airway skills, etc.
- Possibly greater exposure to ventilators but otherwise no benefit
- Yes - proning was an essential skill to learn
- More ICU experience
- Yes, having done an extra month of acute medicine particularly during COVID has given me further skills of how to manage a medical patient from clerking to ward stay to discharge.
- Great experience with opportunity to step up.
- the acute med covid rota was acute med clerking people rather than gastro ward

e) Have you had your duties changed within a specialty placement (e.g. covering different wards, seeing only COVID/non-COVID patients etc.)? If yes please specify how

105 responses - 1/4

- ICM block coincided with first wave of pandemic. As a result, >90% patients were covid patients
- Working on Covid only ITU for 2 months.
- Seeing only covid patients in ICU
- More covid patients
- No, Internal Medicine duties remained the same.
- Yes covering icu during anaesthetic oncalls.
- Yes- covering on calls and ICU
- Just a lot more workload on ICM placement. Good for training and learning, but felt a lot more workload than expected normally.
- Yes - Covering ICU
- Almost entire medical block dedicated to COVID patients
- All my acute med time was on a non-covid admissions pathway - thus saw next to no resp, less sepsis as all with cough/SOB/temps were admitted under red pathway. Now on ITU & majority so far has been covid, less of the “usual” ITU although that is changing.
- Additional ICU experience in Anaesthetics
- Yes, on ICU I spent 3 months working on COVID ITU seeing only COVID patients.
- During Acute Med Rotation, had sometimes covered normal general medical wards to fill rota gaps
- Whist on AM I was on the COVID respiratory ward and only saw COVID patient, significantly narrowing my exposure to general acute medical patients. Additionally my experiences have been dramatically change by having to self isolate/being unwell with COVID for a total of five weeks during my AM block meaning that my total time in the specialty was significantly decreased.
- On my Medicine placement I exclusively covered respiratory high care

e) Have you had your duties changed within a specialty placement (e.g. covering different wards, seeing only COVID/non-COVID patients etc.)? If yes please specify how

105 responses - 2/4

- Yes - didn’t have any anaesthetic on calls!
- Yes - from covering acute medical unit to general medical cover
- Vast part of Anaesthetic placement had little/no surgery taking place and was asked to assist on ICU. I was not formally redeployed.
- More work on COVID ITU
- ICU disaster rota - a lot more nights
- Yes, I have been covering COVID AMU as part of my AMU placement.
- For the first month duties were ICM based not anaesthesia covering only post-hdu.
- ICU placement - second half became COVID only patients
- Yes - moved to suspected COVID medical ward for a few months then moved back to Acute Medicine
- Yes - moved to respiratory ward for period rather than AMU
- Covering outlier covid wards on ITU
- Only seeing non- covid pts
- In Medicine, stayed on AMU instead of rotating to Respiratory. In ITU, patients different, so all General ITU patients were only Covid, and eg trauma was sent to different ITU.
- 3 months of seeing almost only covid patients on ICU - still had lots of teaching, procedural opportunities and ED/ward reviews
- Not particularly changed.
- No emergency theatre anaesthetic duties out of hours, covered by consultants while we did ITU.
- Variation of both

e) Have you had your duties changed within a specialty placement (e.g. covering different wards, seeing only COVID/non-COVID patients etc.)? If yes please specify how

105 responses - 3/4

- Spent significant time during AM placement covering covid assessment unit. This made it difficult to get assessments done for presentations other than breathlessness
- On ITU would be covering COVID or non COVID ITU. Obviously fewer non COVID patients and generally a lot more time looking after COVID patients
- A&E -> seeing many/mostly covid patients during peak of COVID wave
- Yes - seeing only COVID patients on ITU for the majority of the time.
- During our anaesthetic on calls we covered theatre recovery which was turned into a HDU. That was the only minor disruption to our placement. I really commend the anaesthetic consultants at BSUH for undertaking a ICU nights rota to help protect our training
- 3 months on Covid Assessment Ward during AMU placement
- Often (but not exclusively) whilst on ITU covering only covid patients.
- Yes, ITU role as opposed to anaesthetics. Furthermore less theatre experience due to covid measures.
- Yes, last year during my Acute Med placement I mainly was seeing COVID patients. While in ITU, since February until now, there would be days when I would see only COVID patients as well
- Patients streamed away from emergency department so often seeing only Covid patients.
- On respiratory having majority covid patients for period of time. Otherwise on AMU less opportunity to do ascitic drains in SDEC
- I was unable to see any potential COVID patients as I am slightly immunosuppressed.
- Some shifts in ED and on AAU have been in the "red" areas, seeing only Covid or suspected Covid, but this is balanced with time in non-Covid areas.
- 1st month of ICU block was exclusively COVID - but this didn't negatively affect training, if anything it enhanced it

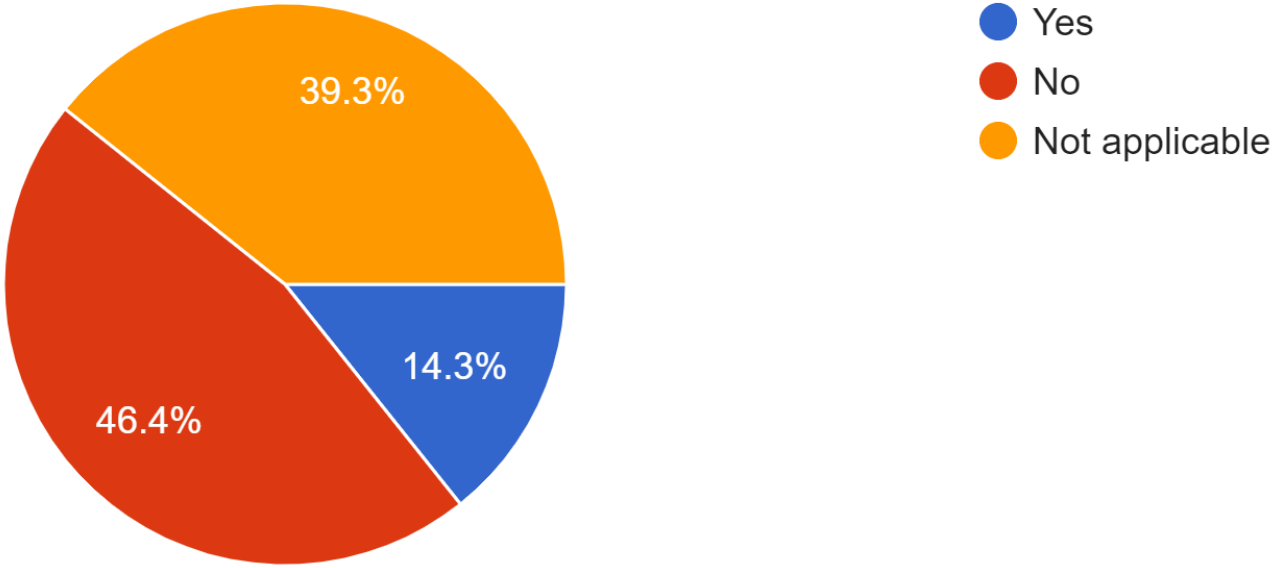
e) Have you had your duties changed within a specialty placement (e.g. covering different wards, seeing only COVID/non-COVID patients etc.)? If yes please specify how

105 responses - 4/4

- Whilst working in medicine I had a mix of covid and non covid ward shifts. Neither excessive and provided good case mix.
- 1st on calls became ICU support rather than theatres overnight and on weekend days.
- ICM - seeing only covid patients for 2 months
- Cover covid wards/admissions
- Quite a lot of time of seeing only covid patients or looking after covid only patients for at least a week a month for my acute medicine placement
- Reduced scope of practice and numbers of patients seen during Anaesthesia placement
- Only seeing patients in one unit
- The high dependency area became the covid positive escalation area so saw majority covid positive patients.
- Seeing only COVID patients for a period on ICU
- Yes, night shifts providing additional ICU cover during anaesthetics block.

If you have (or were due to have) an Anaesthetics placement this year, have you been (or do you anticipate being) unable to gain the IAC sign-off before August 2021?

140 responses



ACCS Training Leads Survey: Effects of COVID on training

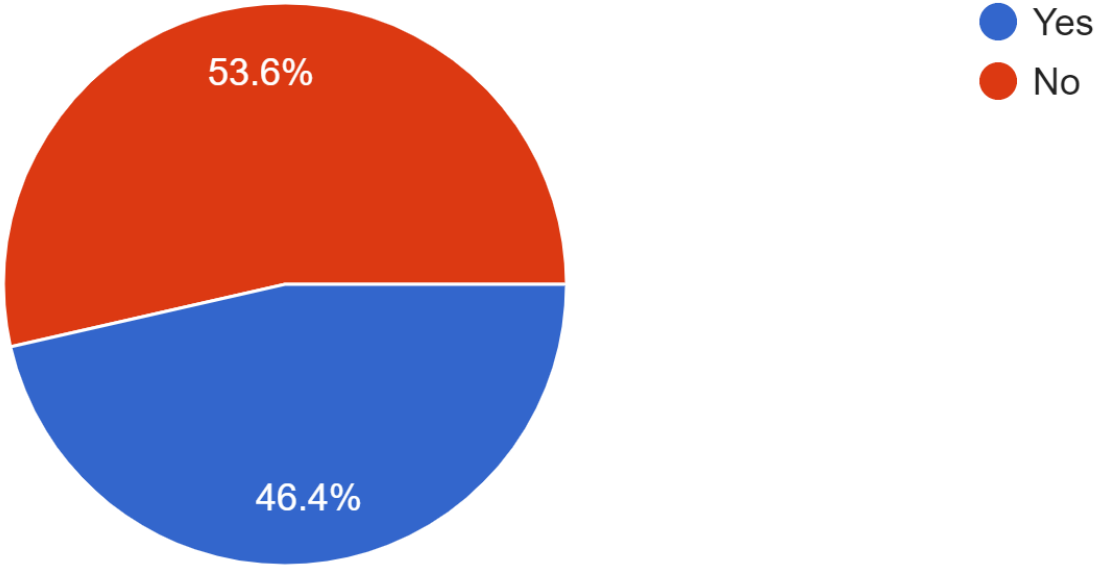
a) Please specify your School/Deanery and specialty

26 responses

Stoke School of Anaesthesia/West Midlands	Yorkshire and Humber
London North Central ACCS & Core Anaesthetics	North West
KSS emergency medicine	Henw
Severn	Royal Shrewsbury Hospital/West Midlands/Emergency Medicine
wales	North Western, Anaesthesia
Royal college emergency medicine/West midlands deanery	KSS
East Midlands	KSS
Mersey	West Midlands
Acute School/Health Education North East. TPD for anaesthesia/ICM	HENW (Mersey)
HEENE	Emergency Medicine, Health Education North East
Kss anesthetics	Northern - Emergency Medicine
West Midlands Warwickshire School Anaesthetics	Bristol School - Anaesthesia
Severn ACCS (I am replying for AM, EM and anaesthetics)	HENW ACCS/EM

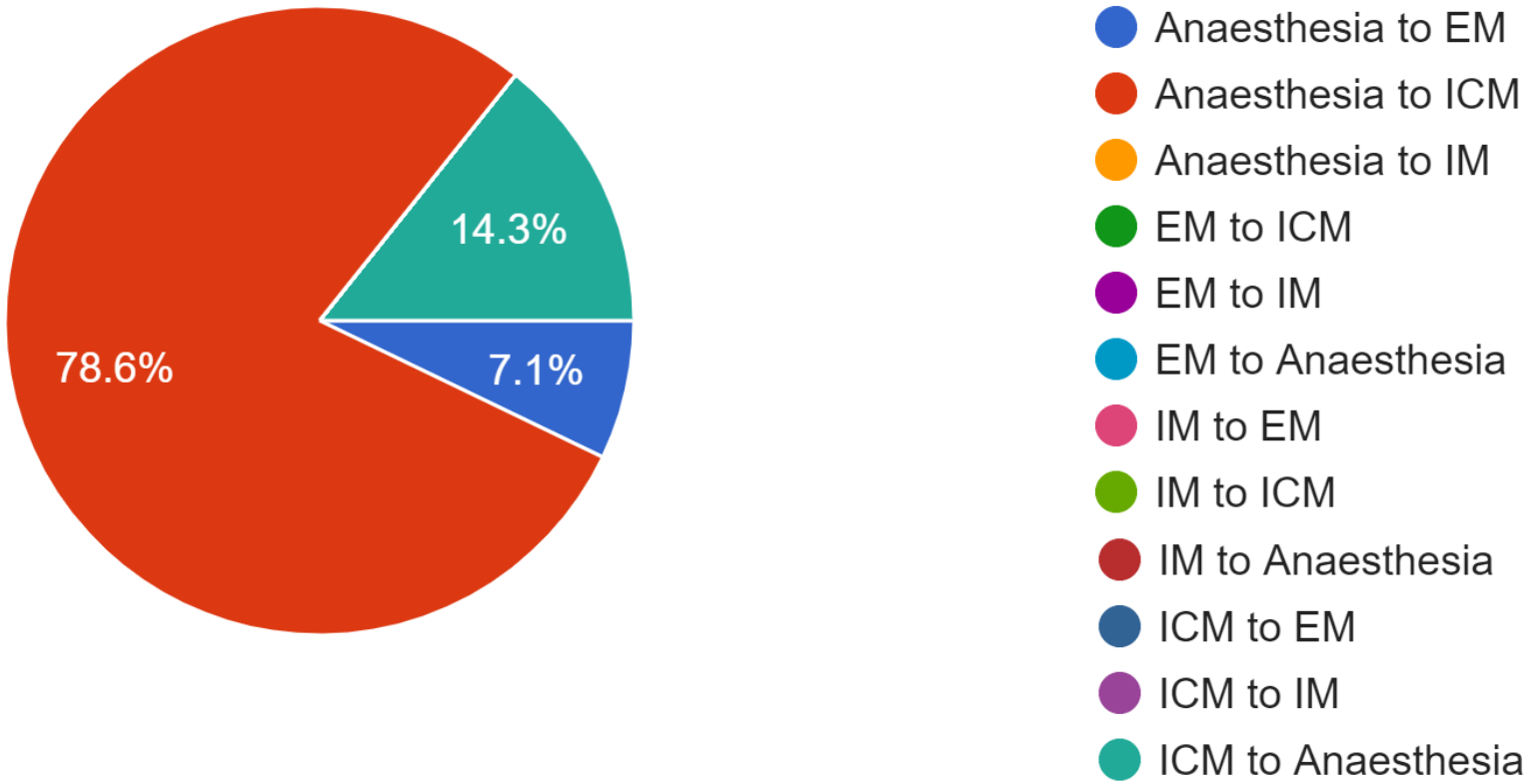
Have any trainees that you oversee been redeployed to a different specialty placement (as a result of COVID), such that their training has been significantly affected?

28 responses



a) If yes, from which specialty to which specialty?

14 responses



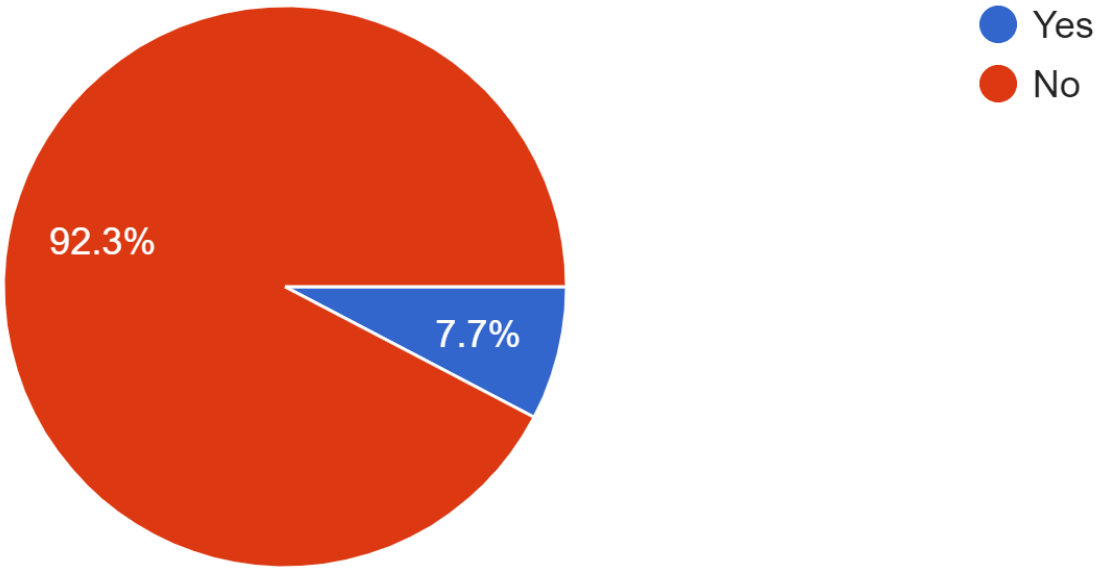
b) Roughly how many trainees (out of how many total) has this affected?

19 responses

22/ 80 got an ARCP outcome 10. Mostly minimum impact on training; all achieved their IAC by the end of placement.
4 out of 11
0
Aug-13
8
1
0
0
1 of 6
None
0
1 out of 46 at CT2 all themes
Me
only a few trainees and they have spent just a few extra weeks in ICM
10 out of 74
one out of 30

Do you anticipate any trainees being unable to gain their IAC before August 2021?

26 responses



a) Approximately how many (out of how many total)?

11 responses

all trainees should get their IAC	**9 answers**
Trainees being unable to gain their IAC before August 2021	**2 answers** (total number of trainees affected is 12 (8+4))

b) What are the main reasons for this

8 responses

- Lack of catch up training capacity in anaesthetics
- 0
- no theatres open?
- lack of elective training lists restarting and reduced amount of GA being given
- None in my hospital
- n/a
- Have prioritised ACCS EM trainees to allow them back into anaesthetics first to ensure they can get their IAC completed but have also been able to send back most of the ACCS anaesthetic trainees as well now
- Trainees were redeployed from anaesthetics to ITU but for relatively short periods compared to the first Covid wave. No trainees have had their training significantly affected ie. training has been affected but not significantly

What do you perceive to be the main effects of COVID on ACCS training? (both positive and negative)?

24 responses – 1/3

- Reduced exposure to anaesthesia hence lacking in confidence in managing anaesthetic cases
- Significant reduction in time spent doing anaesthesia. Burnout fatigue. Few positives
- Trainees have been at the front line of the pandemic as ACCS is all acute specialties. Lots of ITU experience of pneumonias. Teaching sessions by zoom are easier to get to. Cancelled exams, courses, teaching etc has been a challenge. Trainees have suffered from PTSD, gruelling rotas, work pressures/ stress. More trainees requesting support, OOP or LTFT as a result.
- trainees in their ANA blocks: all should obtain IAC , but their numbers of anesthetics cases are down (often less than 100 for their 6/12 block). we are looking at how we can continue catch up days for these trainees as they move into their ST3 year in EM. Trainees in their AM blocks have been moved to cover COVID wards. regional teaching has continued on line, what we have missed out on is the regional practical days, we have asked for trusts to provide this as much as possible in house. in house teaching has been lost in some trusts but the new curriculum being started in august has had a positive shake up on teaching and e portfolio time for trainees. Missed chatting to trainees face to face as i have in the past picked up problems that are others difficult to uncover. ARCPs easier on line but miss seeing the trainees
- positive- a better sense of community negative-stress and burnout risk
- nil
- too much ITU and not enough anaesthetics
- lack of range of airway experience, redeployment of the group
- Remote teaching working well for lecture format. Missing skills teaching face to face.
- Reduction in exposure to the full range of presentations, particularly in critical care

What do you perceive to be the main effects of COVID on ACCS training? (both positive and negative)?

24 responses – 2/3

- no negative effects during the AM/EM year. Reduced anaesthetic case numbers is definitely an issue, and willingness to allow trainees to do solo anaesthetics in these high risk groups. However much more consultant presence during covid.
- unable to do novice training in anaesthetics.
- Less exposures to minors as covered by Orthopedics But positive get to know how we procede to pandemics. What changes could be done
- More disruption to acute medicine working as bed numbers under acute medicine rose from 38 to 75 beds at peak. This diluted consultant and junior staffing time over many beds and took away from education to enable service provision on this scale. Plenty of clinical exposure gained, but at the cost of more educational ward rounds and post take clinical discussions.
- Negative: loss of face to face teaching and courses, loss of opportunities for trainees to meet each other at teaching events and share experiences. Negative: impact on anaesthetic experience, fewer lists and more regional techniques but numbers now increasing again Negative: general impact on well being for some trainees and for those shielding Positive: opportunities to gain unique experience in aspects of intensive care medicine
- 1. Increased burden on supervisors 2. Reduced opportunity for development of practical skills in medicine eg pleural procedures, especially during first wave. 3. High pressured clinical areas 4. Psychological impacts - both clinical and quality of life for trainees outside of work 5. Increased trainee anxiety around lack of training opportunities (regional courses etc) and delay to examinations.
- Accs does not translated well on lllp. Getting wpba on lllp by non anesthetists is a nightmare. Covid has made this situationuch much worse. Remaining on itu instead of moving to anesthetics for iac is unsatisfactory, but although covid has lessened, surgeries arent happening so experience gained is not adequate.

What do you perceive to be the main effects of COVID on ACCS training? (both positive and negative)?

24 responses – 3/3

- greater ICM exposure and more confidence in dealing with sick patients,less anaesthetic time,less face to face teaching but as online teaching has improved more resources here,more anxiety with trainees concerned about accessing some of the modules due to lack of elective work in some hospitals.Affect on trainees mental health.
- Trainees are in the acute specialties which have been at the forefront of managing the Covid pandemic. They have rotated from one acute specialty to another which does not give them any rest or meaningful recovery time - I feel that this has great potential to adversely affect their well being and potentially expose them to moral injury. Due to the reconfiguration of services eg Paediatrics or minor injuries being re directed from the Emergency Department this has the potential to reduce the trainee exposure to these groups. Like wise with the burden of presentations to AMU or ITU being predominantly Covid related this may reduce the trainee exposure to the more usual presentations.
- Adversely affected: anaesthetic training, trauma experience, access to resus courses, reduced F2F/simulation training. However, there are certain benefits to remote learning which we can take forwards even if in person teaching resumes (e.g. remote speakers)
- Reduced availability of educational courses to supplement shop floor training
- Increased intensity of workload with possible narrowing of focus, ie not exposed to the usual breadth and diversity of clinical cases, especially in critical care. Positive effects - realisation of value of work they are doing and the specialties that they work in.
- Burnout. We are seeing some trainees off in sick leave and others opting for LTFT training
- Changes to rota patterns. Senior heavy - should be good for WPBA's but may impact on obtaining own experience and autonomy. Remote learning does not allow for peer face-to-face discussion/reflection and support.

We are aware that there is plenty of excellent and innovative practice taking place. Are there any strategies that you have adopted to maintain training during the pandemic, which could be shared with other regions?

19 responses – 1/2

- Some essential novice courses continue to be face to face with Covid modifications. SWAPIT https://www.swapithub.co.uk/ now a fantastic on-line resource for anaesthetics.
- see above
- Frequency of teaching sessions has decreased drastically locally.More teaching sessions should be conducted
- virtual training sessions have taken off in a big way with much better attendance for sessions
- ensuring training is protected and making the most of every training opportunity
- online training
- prioritised new starters over specialty trainees, using consultants to cover daytime escalation areas releasing trainees to get to theatres,
- COVID safe sim training reduced capacity, closed numbers and PPE mandated
- zoom/teams tutorials
- No just tried to keep heads above water, 2 consultant colleagues went off with burnout, so we failed in this. However we did mange to protect other clinical specialists by taking such a large increase in bed numbers! Our trainees suffered alongside the consultants of the department.

We are aware that there is plenty of excellent and innovative practice taking place. Are there any strategies that you have adopted to maintain training during the pandemic, which could be shared with other regions?

19 responses – 2/2

- On line teaching; hybrid approach to new starter course in anaesthesia with small group sim and on line sessions
- I dont think any strategies have been successful
- started face to face paediatric anaesthetic sim training to help achieve some of the paediatric anaesthetic competencies,online OSCE and SOE practice,still able to do face to face failed intubation drill assessments
- Ensuring that monthly regional ACCS teaching continues virtually. Some departments have rostered trainees to the Paediatric assessment unit or minor injury to ensure continued (although much less) exposure to these patient groups. Anaesthetic Departments have been very proactive in ensuring that trainees obtain their IAC.
- It has really been about mitigating the negative impact on training as much as possible and making the most of remote teaching and e-learning.
- Most teaching has moved online to Teams
- Our main strategy was to continue to train and (like many others) continue training online using MS Teams etc, this had linked effects to morale and a feeeling of worth.
- no
- Difficult to say