Royal College of Physicians | IQILS

How can trainees get involved?

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Why get involved?

- JAG - Joint Advisory Group on Gastrointestinal Endoscopy established in 1994
- Initially to standardise endoscopy training
- Has since evolved to meet its current role in quality assuring all aspects of endoscopy in the UK
- To provide high quality, patient centred care
- It is now an expectation that a trust has JAG accreditation

- In a similar way…
- IQILS is a programme designed to support improvement in liver services in the UK
- In order for a trust to be accredited there needs to be a demonstration of good training

- In summary – good for patient care, good for our training…

Good training

- Registrar timetable uploaded
- Trainee feedback
- Teaching, audit, research
- Supportive environment – induction, policies, SOPS, know who to go to with issues

	Enh level 1	Level 2
TRUST NAME		
WTE Hepatologist	Minimum 1 defined hepatologist	Minimum 2 preferably minimum 3
HCV ODN treatment Hub	At least sub hub	✓
24 hr UGI bleed rota	✓	✓
TIPSS on site		Shared care pathway if not
TJ biopsy/HVPG		✓
Hepatology CNS team		✓
Alcohol liaison service	✓	✓
Hepatology specific clinics	✓	✓
Hepatology GP pathways	✓	✓
Liver transplant assessment	Links with centre	✓□ (minimum partial work up)
Liver transplant outreach clinic		✓□ (and/or self run clinic)
HPB SMDT	Minimum local MDT	✓
HCC resection		Shared care pathway if not
HCC embolisation/RFA		Shared care pathway if not
Liver histopathology MDT	R/v within HPB/gastro MDT	✓□ (minimum review within HPB/gastro MDT)
Liver radiology	R/v within	
MDT	HPB/gastro MDT	✓□ (minimum review within HPB/gastro MDT)
Dedicated liver SpR	Assigned to hepatology clinics	✓
Formal liver education programme with trainee feedback	✓	✓
Study leave to attend BASL schools of Hepatology / BASL meeting	✓	✓
Variceal screening endoscopy list		✓

Why get involved

- Understanding of the service in which you work
- Being part of the team
- We are the consultants of the future and may wish to pursue accreditation in our future trusts
- Overlap with our curriculum (Generic Capabilities in Practice - CiPs)

Overlap with curriculum

JRCPTB
Joint Royal Colleges of Physicians Training Board

- Generic Capabilities in Practice (CiPs)
  - 1. Able to function successfully within NHS organisational and management systems
    - Leadership certificate.pdf
  - 2. Able to deal with ethical and legal issues related to clinical practice
    - CbD (HST) 17 Nov 2020 Ashley Bond, Consultant Gastroenterologist (Gastroenterology)
  - 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
  - 4. Is focussed on patient safety and delivers effective quality improvement in patient care

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How did I/how can you get involved

- One of the aims of this event is to raise awareness and encourage/empower trainees to participate more
- Member of the trust for 3 years so know the service well. Regular contact with patients and all different members of the MDT
- Attended preparation meetings for the assessment process
- Looked through the website at the 6 standards
- Interviewed as part of the assessment progress
- Celebratory lunch!

1. Leadership and operational delivery

Standard	Guidance	Evidence	Level
1. Leadership and operational delivery			
1.1 The service has an operating plan which is reviewed annually.	This must include: • measurable objectives and key performance indicators for the service for that year • organisational chart for the service • roles and responsibilities for staff members involved in the service • summary of staffing cover, including at weekends and overnight • statement on improvement, innovation and transformation • plans for service development depending on local need • plans for disease prevention across the clinical pathway • training and workforce development plan which includes succession planning to meet the needs of the service • detailed pathways outlining how referrals are managed across different specialities and across other liver centres (both to and from).	• Annual operating plan. • Minutes of service management meetings where this is discussed. • Evidence of how key parts of the plan are shared with the wider team.	Level 1
1.2 There is a comprehensive service description available on the organisation's website.	The service description should help patients/carers and referrers better understand what the service provides. The webpage must describe: • overall scope of the service provided (including who the service aims to provide treatment/care for, range of services offered and whether research or training is undertaken). • service organisation including the team members involved in delivering the service, frequency of clinics, location(s) including satellite services and how to contact the service for help and advice, including out of hours. • facilities available, including access for service users with specific needs. • any links with other clinical services/ stakeholders, including managing pathways across organisations. • how patient involvement is incorporated into the running of the service. The external-facing information should be agreed in advance with patients/carers.	• A website link outlining the service description. • Evidence of regular review.	Level 1
1.3 The service has a leadership team that is visible, approachable and communicates regularly with all staff members.	• The roles and responsibilities of individuals in the leadership team should be clearly defined and should include a lead liver doctor, lead nurse and manager. • The leadership team holds regular (at least quarterly) meetings to discuss service management issues. • Communication should include face-to-face methods (for example, huddles/debriefs). • Communication to staff should include highlighting important changes to the delivery of the service, new statutory information impacting the service and updates on quality, safety and clinical governance. • Communication about any changes to the delivery of the service may also be important to share with other teams (eg diagnostics, companion specialties, referrers, GPs etc). • The service should have feedback systems in place to ensure leaders are effective (eg 360 tools or equivalent).	• Minutes of regular service meetings. • Evidence of requesting and collating feedback about the effectiveness of the liver leadership team from staff members. • Examples of notices, bulletins or other communications to staff. • Where applicable, examples of communication to stakeholders outside of the clinical service, where there have been changes to service delivery.	Level 1
1.4 The service works collaboratively across health and social care boundaries.		• Evidence of presentations/teaching for GPs and companion specialities. • Evidence of communicating inappropriate referrals to referrers.	Level 2

> Attendance at hepatology team meetings – Registrar representative

> Teaching GPs/AE – AE SHOS BASL decompensated liver disease bundle

2. Person centred care

2. Person Centred Care			
2.1 The service embeds principles of shared decision-making with patients.	• Staff have a responsibility to involve patients (and carers/family as appropriate) in making decisions about their care and should make clear what options are available and the relevant risks/benefits of the options.	• Evidence of patients being involved in decision-making in their care (for example a sample of anonymised clinic letters or leaflets showing the options available). • Evidence of comprehensive written/online material available to support patient learning and evidence of providing this information to patients/carers. • Evidence of signposting to local/national support groups (for example posters in clinical area or anonymised patient letters, highlighting this).	Level 1
2.2 Patients/carers are encouraged to feedback on their experience.	• An annual formal survey, specifically for liver patients, must include, as a minimum: o quality and safety of care provided o involvement/shared decision making in their care o quality and clarity of information provided o dignity, respect and compassion o feedback on facilities and the environment. • Patients/carers should be encouraged to make comments on improvements to the service in ways that are readily available and accessible. • Staff members should be notified of feedback from service users, carers or representatives.	• Examples of different methods of encouraging patients/carers to feedback (eg posters in clinic with clear signage or leaflets readily accessible to patients etc). • Complaints log for the last year and how the service responded to these (anonymised). • Where applicable, samples of feedback from Patient Advice and Liaison Service (PALS). • Patient/carer survey responses and other feedback (Friend and Family Test, comments box etc), and actions taken. • Annual survey results.	Level 1
2.3 The service strives to improve as a result of feedback,	• The service should capture and investigate and act on concerns and complaints.	• Evidence of improvements made to the service as a result of patient/carer feedback.	Level 2

Standard	Guidance	Evidence	Level
complaints and concerns.	• Any action taken and improvements made in response to service users' views should be shared with users who provided feedback or raised concerns.	• Examples of how issues arising from feedback have been addressed and shared with patients (for example, 'you said/we did' poster). • Evidence of communicating to staff about feedback from patients/carers.	
2.4 The service supports person-centred care.		• Document to facilitate advanced care planning for suitable patients. • Evidence of using a prognostic scoring tool to identify patients suitable for palliative care.	Level 2
2.5 The service has a documented procedure for patient scheduling.	This includes day case and outpatient bookings. The service should reflect national and local recommended patient centred booking practices, booking opportunities should be equitable.	• Trust access policy. • Booking/scheduling procedure specific to liver, including sections on pre-assessment practice and escalation process.	Level 2
2.6 The service reviews and acts on did not attend (DNA) rates.		• DNA management policy for the service. • Evidence of reviewing DNA rates at regular service meetings. • Examples of actions taken to improve DNA rates.	Level 2
2.7 The service has a procedure for managing patients being transferred in/out from other services.	This includes patients being transferred to/from tertiary centres and, where applicable, between paediatric-adults. There should be clear pathways for common conditions including the investigation of abnormal liver function, the management of stable cirrhosis (NICE guidance), HCV, NAFLD (NICE guidance) and HCC.	• Procedure explaining how transfers to/from other services or regions are managed.	Level 2

> Demonstration of involving patients in decisions in documentation/letters

> Giving advice/access to written/online material/support groups

2. Person centred care

> Encourage patient feedback:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
My permanence in the ward was pleasant						
The staff was protecting my privacy and dignity at all time						
I was seen every day by a doctor						
I know roughly when my scans and/or procedure were happening						
I felt involved in decisions about my care and treatment						
I was able to ask the questions I wanted to						
The department was clean and tidy						
I was given the right amount of information about my condition						
If applicable, test results were explained to me adequately						
I understood what the doctor/nurse/ other healthcare professional told me						
I now clearly understand my diagnosis						
I was told how/where to get further support/information						
I know what to do if my condition changes						
I felt comfortable discussing my health with the liver team						
I was treated with respect and compassion						
My doctor/nurse was up to date with my medical history						
I feel confident about my liver						

...

team's knowledge of my condition						
I was happy with the quality of care I received						
I know how to contact the liver team on discharge						
Please provide us with any feedback on your experience and how we can improve our service						

How do you rate our service overall?	*	**	***	****	*****

2. Person centred care

3. Risk and patient safety

- Proactive incident reporting
- Significant investigation/root cause analysis
- Morbidity and mortality meetings

3. Risk and patient safety			
3.1 The service sets and monitors safety improvement targets.	• For example, these may be MRSA rates, re-admissions, falls etc. • The service should share how they are performing against these measures and engage in the team in improving on these areas.	• Examples of safety improvement targets. • Evidence of engaging the team with improving against the measures.	Level 1

Standard	Guidance	Evidence	Level
3.2 The service has a procedure and reporting system for recording and investigating incidents, adverse events or near misses.		• Incident reporting procedure, including how staff/patients/carers are notified about incidents affecting them. • Copies of meeting minutes where incidents and issues are discussed with a multidisciplinary group involved in the liver service (medical, nursing and management as a minimum). • Evidence of root cause analysis, where applicable. • Evidence of disseminating key information about incidents and change in practice to the wider team/Trust, where applicable. • Evidence of proactive communication to staff, encouraging them to report incidents and near-misses.	Level 1
3.3 The service uses incidents, adverse events and near misses to improve care.		• Evidence of sharing lessons learnt with staff. • Evidence of making service improvements as a result of feedback from incidents. • Evidence of sharing learning from incidents and near misses in mortality and morbidity meetings and with other departments/teams, where appropriate.	Level 2
3.4 The service has a risk management policy and communicates this to staff members.	It is expected that there is a named individual in the liver service who is responsible for risk management and all team members should know who this is and what their role entails.	• Risk management policy. • Named individual in the liver service who is responsible for risk management. • Risk register and evidence of discussion at management/clinical governance meetings. • Evidence of cascading information about risks to all team members.	Level 2

4. Clinical effectiveness

Standard	Guidance	Evidence	Level
4.1 The service monitors clinical performance.	**For all liver services:** • Antibiotic prescription in acute variceal bleeding 24 hrs either side of the procedure (Draft NICE guidance). • Ascitic tap in emergency admissions with ascites. • Albumin and Antibiotic prescription in patients diagnosed with SBP within 12 hours of diagnosis. • % of acute admissions with decompensated liver disease seen by a gastroenterologist/Hepatologist within 24 hours of admission. • % of outpatient paracenteses carried out in ambulatory care. **For services that offer liver transplantation** • 90 day, 1 yr, 5yr and 10yr mortality for 1st transplants. • Time from referral to assessment. • Percentage of patients with chronic kidney disease at 1 yr. • Quality metrics (these should align with NICE guidance on cirrhosis and HCV ODN metrics).	• Audit in the last 12 months against these measures. • Evidence of sharing audit data with the wider team.	Level 1
4.2 The service has a quality improvement plan based on the clinical metrics.	The improvement plan can benchmark against other services and should have defined objectives and timescales for completion. Where the improvement plan objectives have not been achieved, add non-conformance to the risk register (if appropriate).	• Improvement plan showing performance against metrics and priority action areas for improvement.	Level 1
4.3 The service has a research register.	The register should record all research undertaken in the service, including ethics approval, where relevant.	• Register of research activities. • Evidence of reviewing and acting on participation rates in research projects.	Level 1
4.4 The service participates in local and national audit programmes.		• Evidence of audits. • Evidence of service improvement as a result of audit data.	Level 2

> TORCH
> BASL decompensated liver disease bundle
> Research
> NIHR associate PI scheme

5. Workforce

> Induction pack

> Teaching opportunities
- specialist nurses
- junior doctors

> Journal club

Standard	Guidance	Evidence	Level
5. Workforce			
5.1 A workforce skillmix review is undertaken a minimum of once a year, or whenever there is a significant change in the service.		• Evidence of workforce review, including clinical and administrative workforce. • Meeting minutes or action plans that show how deficits in service provision will be addressed.	Level 1
5.2 The service has an appraisal process for staff members.		• A policy that describes the appraisals process and managing and supporting performance. • Log of appraisal dates for the team.	Level 1
5.3 The service has training plans and development opportunities in place for staff.	Team members should receive mandatory training to safeguard patients in line with organisational requirements and the health and safety of staff members.	• Evidence of identifying learning needs across team and plans for resourcing/support this. • Mandatory training schedule and staff log showing compliance (85% compliance, or explanation of any non-compliance and plan to rectify). • Evidence of teaching and other developmental opportunities for learning (such as grand rounds, journal club, attendance at conferences etc).	Level 1
5.4 There is a service-specific orientation and induction programme.		• Induction pack(s) for staff including medical, nursing and administrative team members. • Evidence of gathering feedback from staff about the induction process and what, if any, improvements were made.	Level 2

6. Systems to support clinical service delivery

6. Systems to support clinical service delivery			
6.1 The service assesses its facilities and equipment.	A formal assessment must take place at least annually and include: • shortfalls of existing facilities and equipment • planned replacement of existing facilities and equipment planned purchase of facilities and equipment • meeting accessibility requirements	• Evidence of regular assessment of facilities and equipment. • Evidence of environmental reviews.	Level 1

Standard	Guidance	Evidence	Level
	• review of the facilities where patients are seen and treated, ensuring that the facilities meet the needs of the clinical team and patients • review of the facilities to ensure privacy, dignity and confidentiality of patients is maintained, including restricted areas. • Regular environmental spotchecks and review, at intervals determined locally.		
6.2 There is a process for document management and control.	• The process for the control of documents requires that: o documents are made available to the document users in a user-friendly format o documents are kept up to date, secure and, where necessary, confidential. • Information that is obsolete is removed from use and archived.	• Process of document management and control in the service.	Level 2

> Ensures facilities provide privacy, dignity and confidentiality of patients and raise concern if not the case

Summary

- An IQILS accredited unit demonstrates a unit that strives for improvement
- Working in such a unit instils pride and job satisfaction
- Registrars are an important part of the team and we have a lot to offer
- As demonstrated going through the standards you will see as registrars we are already doing a lot of wat is required but formally getting involved with accreditation can provide clarity and focus
- Getting involved can provide skills essential as future consultants and leaders