CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 27 | SUMMER 2025

Maternal Critical Care in the UK

The Faculty of Intensive Care Medicine

In this issue

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WELCOME

Dr John Butler
Clinical Editor

Welcome to this bumper-sized summer edition of *Critical Eye*. We start this issue with some fantastic news and with an important event to add to our diaries.

The Faculty of Intensive Care Medicine can announce that 1 July 2026 is the date for the intended formation of the College of Intensive Care Medicine (CICM). This is a truly momentous landmark for our speciality. It is important that we acknowledge the considerable amount of effort required to get us to this point and we should be grateful for the determination of Dr Bryden, as Dean, and the other members of the Faculty Board for their massive collective endeavours.

There remains much work to be done but we will see many substantial advantages to attaining College status including developing our own sense of identity, creating our own unique strategic vision and developing stronger relationships with the governments of all nations. The Faculty is running several engagement events which will provide an opportunity for us to influence what the future College should look like and how it will succeed into the future. The Dean's report provides more detail on the various aspects of this development as well as other important political developments.

The much-anticipated GPICS v3 was circulated for consultation a few weeks ago. Hopefully everyone has had an opportunity to review the document in its current state and make further recommendations. In his article, Dr Gardiner provides an insight into the delicate balance required to put together this crucial piece of work. The final version should be available in our inboxes very soon.

It is clear that the speciality of Intensive Care Medicine in the UK continues to move forwards at a considerable pace. Now more than ever it is important that we represent the specialty with a college that can provide aspects of the necessary leadership and expertise. With this in mind I would strongly encourage our fellows and members to engage with the work of the Faculty as we move towards our future College status.

We welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

Message From The Dean

Dr Daniele Bryden
Dean

By now, I hope you will all have heard that 1 July 2026 marks the intended formation date of the College of ICM (CICM). As I write this we're approaching the one year anniversary of the general election and whilst we have greater clarity in some areas (there really is not enough money to spend on healthcare in any UK nation) we have considerably more upheaval and uncertainty.

The Government's three big shifts for the NHS to greater focus on disease prevention, more use of primary care/community services and greater use of digital solutions remain a challenge for ICM if we don't find ways of ensuring our activities align with those goals.

We must therefore bend with the winds and seek ways to consolidate and develop our opportunities for member and patient benefit and continue to raise the importance of ICM with external stakeholders. I remain surprised and a little depressed that even after the experiences of Covid, so many senior decision-makers and advisors at high levels of NHS leadership still don't quite understand what ICM is or comprehend the changes that have occurred since FICM was formed. In 2011, 87% of our members had some form of connection to the RCoA; that figure now stands at 52%. We are a distinct medical specialty which is why we need the independence of governance and financial decision making that we have started this journey to achieve. As a Faculty of another college we do not have that and I've spent much of the past two and a half years explaining those points to everyone I can. It's why the formation of a College of ICM rather than continuing as a Faculty of other colleges will go on to have such external significance in terms of how the specialty is eventually perceived and what we can therefore do directly for our fellows, members and patients.

Dialogue

Representing the interests of ICM is also different for each nation and there are particular risks in England as the announced dissolution of NHSE could leave clinical leadership for some areas e.g education, in a potential void. Now more than ever, it is important that we represent the specialty with a college that can provide aspects of that much needed leadership, expertise and memory when many appear to have forgotten.

As FICM we continue to provide leadership in professional education and training, professional standards for the specialty and advocacy as the professional voice for ICM. However, as CICM we must look wider e.g. towards providing more obvious support and advocacy for ICM research for patient benefit and developing as the place that represents our common sense of identity. Maintaining a clear dialogue with you as members will mean a new college is mapping its strategies to what's needed in a way that is agile and responsive.

If events in other colleges and organisations tell us anything, it is that we need to deliver what is realistic and what you want, recognising the clear difference between our functions and that of a trade union or membership society. The BMA and other trade unions represent your interests in contracts of employment and terms and conditions of service. When CICM is formed as a charitable company, our charitable objects will mean that we'll have a different role. As a charity, we'll be regulated by the Charity Commission (and its rules for public benefit), in addition to the obligations we already carry towards the GMC as the regulator for professional standards and education. There can be tensions between the perception of what colleges and trades unions should be doing and actually are legitimately engaged in, but with dialogue and a clear understanding of the views of all stakeholders, we should be able to navigate them. Colleges should always and do advocate for their members but must do so within a different set of constraints from trade unions where the representative voice is more direct than in charitable organisations.

But that doesn't mean we shouldn't actively involve members in decision-making and be responsive to your concerns. An important goal of this present period of engagement is to really understand what your grassroots sentiments and experiences are and try to find a way of reflecting them in the new structures and values of CICM. We need to start off on the right foot.

Changes

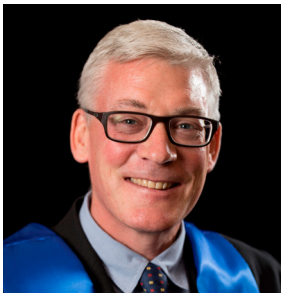
What else do we need to consider? In England the dissolution of NHSE and changes into new models of care is currently not fully delineated. Although there is a stated desire to professionalise medical leadership and management there is a concomitant significant reduction in headcount across NHSE. Work we have started on specific ICM leadership training, promoting courses like the "Consultant Intensivist in Transition' (CIT) course, will help raise awareness of the need for early years consultants to understand more about commissioning, project management, leading MDTs and making best use of NHS structures to influence delivery of ICM patient care. We are also already looking towards the needs of the new NHS in terms of embedding sustainable healthcare values in the curriculum.

We are working hard towards the date of 1 July 2026 to form the new College of ICM and hope to leverage this change over time for stronger working and advocacy relationships with the governments of each nation, some of which are not as direct as they could be. In the intervening period we are conducting a number of engagement events to hear what you would like from the future college. Board members are speaking at local meetings and events alongside discussing with external stakeholders and multiple organisations so we can get as full a picture as possible. It's clear at this stage that our diversity is a major strength and that many of you value the opportunities that come from being a relatively new medical specialty: we should not be afraid to consider fresh approaches to longstanding paradigms and not be afraid of the new whilst respecting the past.

Creating the college is very much a work in progress and one you can all play a part in shaping. Work will not stop after 1 July, but rather the focus must shift towards establishing independence of key functions such as exams delivery and growing into a robust organisation with a clear identity that represents the speciality today and in the future. Those of you with long memories will recollect how emergency medicine has already shown what is possible. Those of you at the start of your careers will hopefully develop a longstanding professional relationship with CICM and see this as a unique opportunity to shape the future.

Later this year I will finish my term as Dean. It has been the highlight of my career and an enormous privilege to lead FICM at this time and on this journey. I hope you will all see and experience benefits for the specialty from our combined work and feel a sense of ownership for the College you are helping to create. Thank you.

Dean-Elect update



Dr Jack Parry-Jones
FICM Dean-Elect

I am very proud to represent you as the incoming Dean of the Faculty of Intensive Care Medicine. I am enormously grateful to Dr Danny Bryden who will be a very hard act to follow. My aim is to provide the leadership and continuity I believe we need as our specialty continues to evolve and we move to College status in July 2026. I am also delighted to have Dr Matt Williams as the incoming Vice Dean.

The announcement that we are to transition from a Faculty to becoming a College of Intensive Care Medicine in July 2026 is a massive milestone for Intensive Care Medicine in the UK. Behind that announcement lies a lot of hard work to collectively get us to this point. There is still some way to go and some further work, but we have accelerated in the last 12 months.

I was also honoured to give the Fitzpatrick Lecture in April, on the historical influences on ICM at the Royal College of Physicians, on their College Day. This brought into perspective how long this journey to becoming a College has taken. It does feel like we have a much clearer destination and we now also know the speed at which we are travelling.

Engagement

One of the great things about Intensive Care Medicine is the multidisciplinary team. The move to becoming a College needs to encompass the whole MDT and I include in that our patients, their relatives and friends. Some of our patients sadly die and we also bear a responsibility to these people and their loved ones, as well as a responsibility to those that survive, some with new physical and mental disabilities. With this in mind, the Faculty team met with ICUSteps and the Donor Family Network looking to improve our engagement with the public and share learning between us. These two charities already have some wonderful resources and I highly recommend visiting their websites; links below. We will be looking to provide new educational material to our ICM residents and the wider MDT in collaboration with these charities.

Transition

The Consultant Intensivist in Transition Course (CiT course) came to Wales in May. It has been run in Edinburgh and prior to that was run in Oxford, having been brought to the UK by Dr James Day. Diolch yn fawr, thank you, James, and to Dr Sara Cook for all her hard work in making the two day course such a success.

Our ICM residents and those undertaking portfolio pathway training are better trained than they ever have been, but in common with other medical specialities, the step up to becoming a consultant is harder and is more than just knowledge and skills.

The experience of being a consultant intensivist and lessons learned often the hard way, can be gainfully shared and taught. There are pitfalls that can be avoided or at least mitigted. This can make senior resident's transition to becoming a consultant more enjoyable and less daunting. One of the Faculty team on the day said it is great to give something back to our residents and I echo that sentiment. The new College will be for residents in the years to come, as much as for those who are already ICM consultants.

The College of Intensive Care Medicine: Your feedback as part of our pathway to independence

Mr Stephen Williams
Strategic Lead for
FICM Independence

In July 2026, the Faculty of Intensive Care Medicine will become the College of Intensive Care Medicine. This transition represents the natural evolution of a specialty that has grown significantly since FICM's establishment 15 years ago. We now serve 4,735 members across diverse professional backgrounds, reflecting the maturity and breadth of Intensive Care Medicine. The transformation follows a carefully planned roadmap initiated in 2022, with member surveys, due diligence, and stakeholder engagement confirming our readiness for independence.

The transition will provide Intensive Care Medicine with enhanced visibility to strengthen our voice among peer colleges, benefit you as our members, and improve quality of care for patients and families. Independence means greater control over our governance and finances, enabling us to make decisions on how we can enhance member benefits and campaign more effectively for lifelong careers in Intensive Care Medicine.

Engagement

The transition to college status is built on extensive engagement across the intensive care community. From last year's Let's Talk event, our recent CICM Connection event, discussions with devolved nation groups, the ACCP Conference, your representatives through the Faculty's committees and sub-committees, and ongoing feedback from members, clear themes are emerging about what is important to members. June's CICM Connection event, chaired by Danny Bryden, formed a cornerstone of this engagement. Jack Parry Jones outlined the rationale for independence, timeline, and governance changes whilst gathering member feedback on values and priorities. The discussions brought together a range of perspectives from across ICM, capturing the diversity of our specialty.

Current membership reflects this diversity: Fellows comprise 53% of membership, Intensivists in Training 22%, and Advanced Critical Care Practitioners 9%. Recent CCT intention surveys reveal significant evolution in career pathways, with 33% pursuing single ICM, 42% dual training with anaesthesia, 14% dual with acute internal medicine or emergency medicine, and 11% triple training combinations.

Key themes in your feedback are:

Professional identity

A consistent theme has been the need for Intensive Care Medicine to be recognised as a distinct specialty rather than as a service provided. This sentiment reflects frustration with how intensive care is often positioned across the NHS. Discussions emphasised how college status would enhance professional credibility, supporting intensive care specialists to be recognised as experts in their field within their organisations. The transformation represents an opportunity to establish a clear professional identity that reflects the sophistication and specialisation of modern ICM.

This recognition extends beyond individual professional standing to encompass the specialty's position within the broader medical landscape. College status provides a platform for more effective advocacy and representation in professional forums, government discussions, and policy development.

Diversity and inclusion

Engagement across multiple groups has reinforced the importance of diversity extending beyond training backgrounds. Representation from devolved nations, different demographics, and robust support for locally employed doctors has been consistently emphasised. The evolution in training approaches reflects the specialty's growing appeal and maturity. Feedback has acknowledged that some Resident Doctors have felt less represented, highlighting the importance of inclusive approaches as the specialty develops. The college transition provides an opportunity to address these concerns whilst maintaining the strength that comes from diverse professional backgrounds. Gender representation continues to improve, whilst work-life balance preferences among residents and consultants continue to evolve. These demographic changes reflect broader shifts in medical careers and the specialty's adaptation to changing professional expectations.

Training and professional development

Training pathway discussions have generated significant interest. The potential for direct Intensive Care Medicine entry routes was raised at CICM Connection, while maintaining appreciation for the diversity of backgrounds that currently strengthens the specialty. This balance reflects future opportunities whilst building on established strengths. Questions were raised about developing core Intensive Care Medicine training programmes that incorporate elements from other specialties, balanced against maintaining the current diverse recruitment landscape. The emerging consensus suggests that whilst diverse backgrounds remain valuable, structured core programme development might be considered for the future, without forcing premature specialty commitment.

Enhanced advocacy

The potential for CICM to achieve equality with other medical colleges, particularly regarding workforce planning and government influence, has

> The new structure will maintain the three core committees … reporting to a future College Council, to which the current Faculty Board will transition. Independence is a journey: 1 July 2026 is not the end point, but it is a key milestone along the way.

emerged as a consistent theme. Becoming a College will enhance professional representation when engaging with healthcare policy professionals and governmental bodies, especially as the NHS in England looks to deliver on the commitments in the 10 Year Plan.

Continuity and stability

Questions about the curriculum and examinations have arisen consistently. Stability is extremely important as we transition to becoming a College; we will maintain the same curriculum, standards, and quality and exams will continue following established pathways. We will remain co-located with our host parent College the RCoA so that we can achieve economies of scale and the safe transition needed. For the next 2-3 years at least, we will move with the RCoA to its new London premises when it vacates Churchill House in July 2026. We have been discussing how we best engage and work with the devolved nations, and of course the same applies to all the English regions. We need to consider how best to strengthen national and regional involvement in the new College. Our aim is a College for all; most of the FICM Board work outside of London with representation from Scotland and Wales.

The governance transition involves moving from the current structure under the RCoA Board of Trustees to charity status. The new structure will maintain the three core committees (Training, Assessment and Quality; Careers, Recruitment and Workforce; Professional Affairs and Safety) and the Small and Specialist Units Advisory Group, reporting to a future College Council, to which the current Faculty Board will transition. Independence is a journey: 1 July 2026 is not the end point, but it is a key milestone along the way.

On 1 July 2026, CICM's legal status will be as a charitable arm, or subsidiary, of the RCoA. This interim position will allow a safe transition CICM to continue to benefit from RCoA's support while it grows its resources. At inception, however, we will act solely in the interests of our specialty with strategic oversight from a CICM Council and legal responsibility residing with a CICM Board of Trustees.

Future fees

The question of member fees arises a great deal and we are working through what this will look like. We want to hear from you in terms of the benefits that you value most so that we can consider the total cost as part of our long-term financial planning. With this in mind, we are starting to run surveys with resident doctors and Regional Advisors and will continue to engage with all members. It's important to recognise there is a cost to all our work and the decisions we need to make will inevitably involve trade-offs — which is also why it's important that we understand your views. Through the Faculty's membership of the Academy of Medical Royal Colleges, we are also engaging with our partners to assess fee levels and concessionary rates.

Next steps

The engagement programme continues through multiple channels including future CICM Connection meetings, ongoing devolved nation discussions, sub-committee consultations, regional advisor engagement, and direct member feedback opportunities.

While members have shown strong support for establishing the College, elevating the specialty's identity and profile and strengthening our advocacy capabilities, we know we have much work to do. For more about the independence project and how to get involved, see here. We are constantly updating the FAQs and have outlined the milestone path that will take us to 1 July 2026 and beyond.

Maternal Critical Care in the UK

Dr Penny Beddoes
Anaesthetics ST6

Dr Deborah Horner
Consultant in Critical Care and Anaesthesia

In the UK, maternal critical care admission is rare: a national maternity and perinatal audit published in 2019 found that just over 0.2% of women will require ICU or HDU admission during or in the weeks following a pregnancy[1]. This means that critical care units in hospitals with such patient a month. Recent MBRRACE reports indicate that with increasing medical complexity in the maternity population, maternal mortality rates are rising in the UK and concerningly, in the 2024 report, only 17% of the women who died were considered to have received "good" care[2]. The combination of low throughput with some specific requirements for good quality and safe management of these patients mean that unit and team preparedness are key.

Updated guidelines highlight the importance of system-based strategies to ensure that women's care needs, as well as those of their fetus or neonate can be safely met in an area that is often geographically remote from the obstetric and neonatal expertise available on the delivery suite.

Guidance

The draft guideline for the provision of intensive care services (GPICS V3)[3], includes an updated section on the care of the critically ill pregnant (or recently pregnant) person and defines both minimum standards and outlines recommendations for quality service for these women. Multispecialty expertise, readily available on delivery units should be maintained daily for maternal critical care patients. While on ICU, where gestation is over 20 weeks, daily review from an intensivist, obstetrician and midwife should be performed with input from a maternal medicine physician, obstetric anaesthetist or other related medical and surgical specialties where needed. At gestations before viability, patients may still benefit from reviews from the wider MDT. In admissions expected to last longer than 48hours, GPICS recommends the involvement of a clinician with regional expertise in maternal medicine and maternal critical care, through the maternal medicine networks.

From a nursing perspective, even the most experienced critical care nurses will have had little exposure to maternal critical care patients, and most will not have had formal training in this area. The Critical Care National Network Nurse Leads Forum (CC3N) published a national adult critical

BTHFT Maternal Critical Care: Admission Checklist

>22 weeks pregnant / postpartum admission to critical care

On admission (within 1 hour)

	Completed	N/A
Display Critical Care Maternal Alert poster at patient's bedside	☐	☐
Inform on-call **obstetric consultant** of admission	☐	☐
Inform on-call **obstetric anaesthetist** of admission	☐	☐
Inform **midwife in charge** on labour ward of admission	☐	☐
If antenatal, ensure resuscitaire present on critical care + checked	☐	☐
If antenatal, consider presence/location of hysterotomy kit/guide and delivery pack	☐	☐
Ensure emergency obstetric medications available - including oxytocin, ergometrine, carboprost and misoprostol.	☐	☐
Complete maternal VTE assessment + prescribe appropriate LMWH dosing	☐	☐
Consider need for large bore IV access	☐	☐
Ensure valid group + save sample and clarify requirement for anti-D (NB Group and save sample only valid for 72 hours in pregnancy)	☐	☐
Clarify presence of any safeguarding alerts + actions required	☐	☐
If post-natal, clarify location + condition of the baby to update patient/family	☐	☐

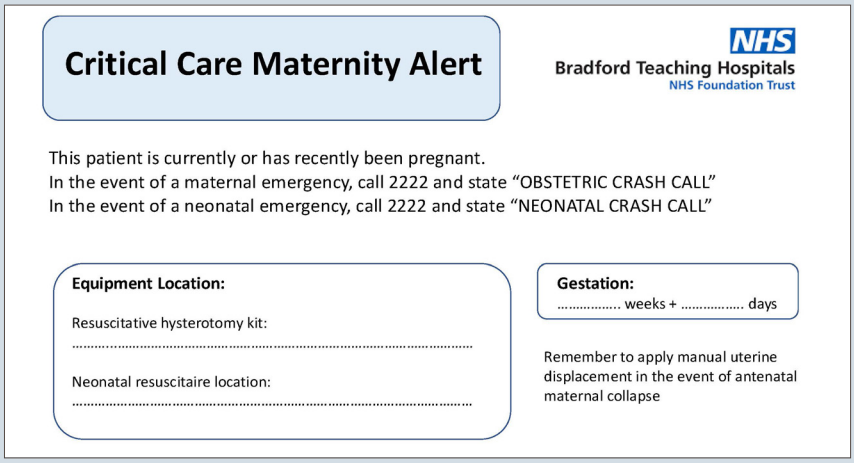
Clinical handover

	Completed	N/A
If antenatal - ensure emergency delivery plan clearly documented by MDT	☐	☐
Document target physiological parameters, including BP and urine output in pre-eclampsia	☐	☐
Detail any obstetric specific infusions (eg. oxytocin/magnesium/hydralazine) and ensure documented plan for these on EPR	☐	☐
Ensure aware of any obstetric procedures and post operative instructions	☐	☐
In PPH - ensure EBL and ongoing management plan documented, including any devices in situ	☐	☐

Within 12 hours of admission

	Completed	N/A
Document MDT review on EPR (to include consultants in ICM, obstetrics, obstetric anaesthesia, midwife +/- any other relevant medical/surgical specialists)	☐	☐
MDT review to include documented assessment of fetal compromise, need for fetal monitoring + risk of labour/delivery	☐	☐
If high risk of labour/delivery - ensure Neonatal team aware	☐	☐
Inform relevant medical / surgical teams of admission to critical care	☐	☐
Consider medication safety in pregnancy + need for critical care pharmacy review	☐	☐
Consider requirement for critical care dietician review +/- input	☐	☐
Perform urine dipstick for proteinuria +/- send PCR (protein:creatinine ratio)	☐	☐
If antenatal, discuss + document preferred feeding wishes	☐	☐
If postnatal, establish feeding wishes + contact infant feeding team (see over)	☐	☐
If postnatal, encourage (where appropriate) infant visiting, photos of newborn, clothing/muslin swaps	☐	☐

Figure 1: *Example admission checklist..*



Critical Care Maternity Alert

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

This patient is currently or has recently been pregnant.
In the event of a maternal emergency, call 2222 and state "OBSTETRIC CRASH CALL"
In the event of a neonatal emergency, call 2222 and state "NEONATAL CRASH CALL"

Equipment Location:

Resuscitative hysterotomy kit:
.....

Neonatal resuscitaire location:
.....

Gestation:
..... weeks + ... days

Remember to apply manual uterine displacement in the event of antenatal maternal collapse

Figure 2: *Example bedside alert.*

care maternal competency framework for registered nurses in 2024[4]. This provides a detailed curriculum for critical care nurses wishing to gain further accreditation in this area and some regions have begun developing training courses to help nurses to gain these competencies. Some units have identified experienced ICU nurses to act as champions through dissemination of learning, and be representatives in multidisciplinary groups with an interest in maternal deterioration, both in the critical care unit but also in the wider hospital. These inter-specialty and inter-disciplinary links are key to ensuring a collaborative approach to maternal deterioration promoting both high-quality individual care, as well as effective hospital systems to ensure treatment is responsive and streamlined.

Checklists

Both CC3N and GPICS encourage the use of checklists and bedside alerts to ensure that specific drugs and equipment that may be unfamiliar is checked and immediately available. This should include a prompt to make use of the new national maternal early warning score (MEWS) tool[5], appropriate for use in women of all gestations as well as those who are post-partum. Checklists should ensure the immediate availability of a resuscitaire as well as the drugs and equipment required in the event of an emergency, such as unexpected delivery, post-partum haemorrhage or maternal cardiac arrest.

Resuscitative hysterotomy is a procedure that carries significant technical and non-technical challenges but one that must be available immediately in the event of maternal cardiac arrest: local SOP's should consider proximity of critical care to labour ward and prepare intensive care clinicians to perform this in the absence of an obstetrician if the geography of their site requires this. An example of a bedside alert and admission checklist are shown in Figures 1 and 2.

In addition to the clinical management of maternal critical care patients, both GPICS and CC3N emphasise a holistic approach when caring for pregnant and post-partum women who are critically unwell. It is recognised that these patients are vulnerable to postnatal mental health problems which, together with physical separation around the time of birth can have a negative impact on bonding at this early stage. In this context, GPICS emphasises the importance of maintaining contact between mother and neonate. If the neonate is well, this could mean keeping them at the mother's bedside during her stay and allowing a birth partner or relative to remain with the mother to assist with care of the baby. This might require us to challenge existing dogma among staff on ICU around the presence of babies on the unit or allowing relatives to stay outside of visiting hours. Women in ICU should have equity where possible with women on postnatal wards in terms of contact with their baby. If a baby is unwell and needs to remain on a neonatal unit, video contact should be provided, and exchange of muslins between the mother's bed and the baby's cot can help mothers and babies retain familiarity with each other's scent. Establishing breastfeeding can be a difficult time for mothers, even in the context of a straightforward birth. Midwifery and infant feeding team expertise should be sought to facilitate breastfeeding, hand expressing or pumping of breast milk if the mother wishes to do so.

Support

Six percent of all women experience PTSD following childbirth[6] and those admitted to critical care are likely to be a vulnerable group. Follow up in intensive care clinics with a view to screening and onward referral to support services should be arranged for women admitted to intensive care during pregnancy or post-partum.

Most women who become unwell during pregnancy or post-delivery are not managed

How prepared is your unit for an acutely unwell maternity patient?
• Does your unit have a maternal critical care guideline or SOP • Does your unit have a lead intensivist for maternal critical care? • Does your unit have a bedside checklist for maternal critical care patients • Have any nurses completed or begun CC3N training competency framework • Is MEWS in use for all maternal critical care admissions? • Resuscitative hysterotomy/Perimortem section – who would perform this in your unit?

Questions to consider on unit preparedness.

within the footprint of the critical care unit: enhanced maternal care units allow for the delivery of a standard of care for women needing additional monitoring or physiological support within the delivery unit which allows for proximity to neonatal and obstetric expertise. By their nature, these patients are a group at risk of deterioration and their safe management outside of critical care should be underpinned by clear escalation routes to critical care and local guidelines which reflect the throughput and acuity of individual units.

The new MEWS tool prompts involvement of critical care outreach teams (CCOT) in the case of acute deterioration and may help to encourage early liaison between maternity and ICU to ensure safe and timely critical care transfer where needed. Where interhospital transfer is needed, clinicians should refer to the FICM and ICM Guidance on The Transfer of the Critically Ill Adult, Version 5 awaiting publication, which will include a chapter addressing the specific challenges for maternal critical care patients in this area.

Conclusion

In conclusion, maternal critical care admission is a rare event. These patients need a spread of clinical expertise, with the right equipment, drugs and guidelines to manage both day to day care and emergencies. This requires individual and unit preparedness through education and training, accessible guidelines and SOP's and kit lists for equipment and drugs. These patients require holistic care with a focus on maternal and infant bonding, feeding support and follow up after their critical care admission. Multidisciplinary collaboration across the hospital can help ensure effective systems for the detection and management of maternal deterioration with a view to ensuring that all women who become unwell while pregnant or following delivery receive "good" care.

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Bringing simulation to the intensive care team

Lina Grauslyte
Locum consultant in Intensive Care Medicine

Even though in situ simulation (ISS) in Intensive Care Medicine is relatively new, it has become increasingly popular[1]. ISS is a team-based simulation strategy involving multidisciplinary healthcare team members training and solving high-stakes scenarios in their work environment on the intensive care/high dependency unit[2].

ISS can come in many 'different shapes and sizes', so it is easy to adapt to various environments, learning needs, team structure variations, and available resources.

Why should you do in situ simulation?

In an ISS programme, the scenarios mimic realistic clinical situations in a real-life environment, with the team working together daily. As a result, there are a variety of benefits that come from using it:

- Identification of latent safety issues/errors. Conducting ISS in the clinical unit allows the team to find any hidden system vulnerabilities, equipment faults, or gaps in protocols without exposing patients to them[3]. Occasionally, it can be as simple as an inconveniently placed difficult airway trolley or as complex as faulty alarm systems.
- Systems testing. In case of a new environment (new hospital, new unit, new theatre block, etc.), ISS can act as a systems testing tool before

real clinical work with patients is commenced, reducing the risk of situations leading to patient harm[4]. The same applies to testing new local protocols and procedures (e.g., new haemorrhage call testing, new medical emergency team call testing).

- Improved clinical competence. Regular ISS training allows the ICU team to practice managing high-risk situations in a realistic environment, improving clinicians' proficiency through repeated practice[5].
- Team building and enhanced team performance. ISS allows the team to practice dealing with high-risk situations in a controlled way. There is ample opportunity to work on communication, role allocation, shared mental models, and team cohesion with colleagues that everyone works with regularly[5]. This aspect of ISS is essential considering the increasing turnover of staff among all healthcare professional groups in the ICU.
- Positive impact on patient outcomes. Studies have demonstrated that ISS can significantly improve patient outcomes, including reductions in morbidity and mortality rates. By fostering a continuous learning and safety culture, ISS contributes to better clinical practices and patient care[5].

How to start planning in situ simulation?

As with any systems-wide educational intervention, a clear structure and plan will allow for fewer issues arising along the way. Key aspects to consider while planning/implementing an ISS programme:

- Leadership engagement. Considering that ISS happens in a busy environment with ongoing patient care around it, careful planning is required to ensure ongoing commitment to it. With support from clinical leads, the matron, and senior nursing staff, it is much more likely that time and space are secured for the ISS to take place.
- Establish a team. A team of regular staff (an ICU consultant, an education fellow, practice development nurses or simulation champions, etc) allows for both continuity and regularity of ISS.
- Establish aims. ISS can be used for a variety of purposes (systems testing, latent error identification, etc.). Identifying the aims and what topics/scenarios are most appropriate for specific ICUs is a crucial step while planning ISS.
- Consider metrics. The team should establish ISS's aims clearly. Early identification of aims will allow the planning of possible metrics to be measured and data to be collected once the ISS programme becomes regular. Reports of identified latent safety issues should be collected alongside action plans and reviews in local quality and safety meetings. Collectively, all the metrics track ISS's positive impact on patient care.
- Consider available resources. Aside from human resources mentioned in the text, the resources that must be considered are space, time and equipment. An increasing number of new intensive care units include a bedspace in their unit layout specifically dedicated to ISS. That is, however, a luxury, rather than a necessity. ISS can be done in any available bedspace in the intensive care unit. Time is a more contentious resource. Timing the simulations to make the whole multidisciplinary team available requires teamwork and flexibility from everyone involved. In ISS, equipment plays an important yet not vital role. A manikin ensures a higher fidelity of the simulation; however, running a low-fidelity simulation without a manikin is possible only using some monitoring equipment. In ISS, the focus should be moved more towards the environment and the team, rather than external equipment and educational gadgets.
- Safe and structured debriefing. Most of the learning in any simulation activity comes from a facilitated debrief following the simulation activity. Debriefing high-stress scenarios requires someone trained in the activity to ensure both a constructive and a psychologically safe conversation. Considering that ISS involves staff who have to continue working together after training, the debriefer has to ensure that there are no residual unresolved issues following simulation activities and that the lessons learnt are clear and shared among the team.
- Feedback and review. Collecting regular feedback from staff allows an ongoing evaluation of the ISS programme's effectiveness. Combined with other metrics

used to track the impact of ISS, it serves to drive and add direction to the ISS programme.

Possible barriers to consider

- Resources and logistics. Intensive care units are busy, dynamic places. Staffing levels and experience vary, as do available space, equipment, and time allocation. While it is essential to ensure that ISS does not in any way impact the quality of care and patient safety, persistence in maintaining regular ISS is one of the key tools in establishing a culture that allows for working around most logistical and resource-related issues.
- Changes in the team. Resident doctors frequently rotate in and out of intensive care units, and while they should be included in the simulations, the ISS programme should not rely on them to be sustained. Team members who will be part of the team for longer periods of time should show initiative to develop the programme, ensure that the simulations are regularly run, and review the scenarios/measurable outcomes at fixed intervals.

Conclusion

Running regular in situ simulations in the intensive care unit is challenging. However, it is an immensely beneficial individual and systems training tool with relatively few resources required. Bringing the training into the unit automatically becomes more high fidelity and multidisciplinary than in any other setting. It also allows the team to challenge itself with realistic scenarios, encourage realistic team building, and test the system for latent safety issues in realistic conditions. With key stakeholders on board, an enthusiastic team and some patients, and a well-established and regularly reviewed ISS programme can substantially benefit the unit and the patients.

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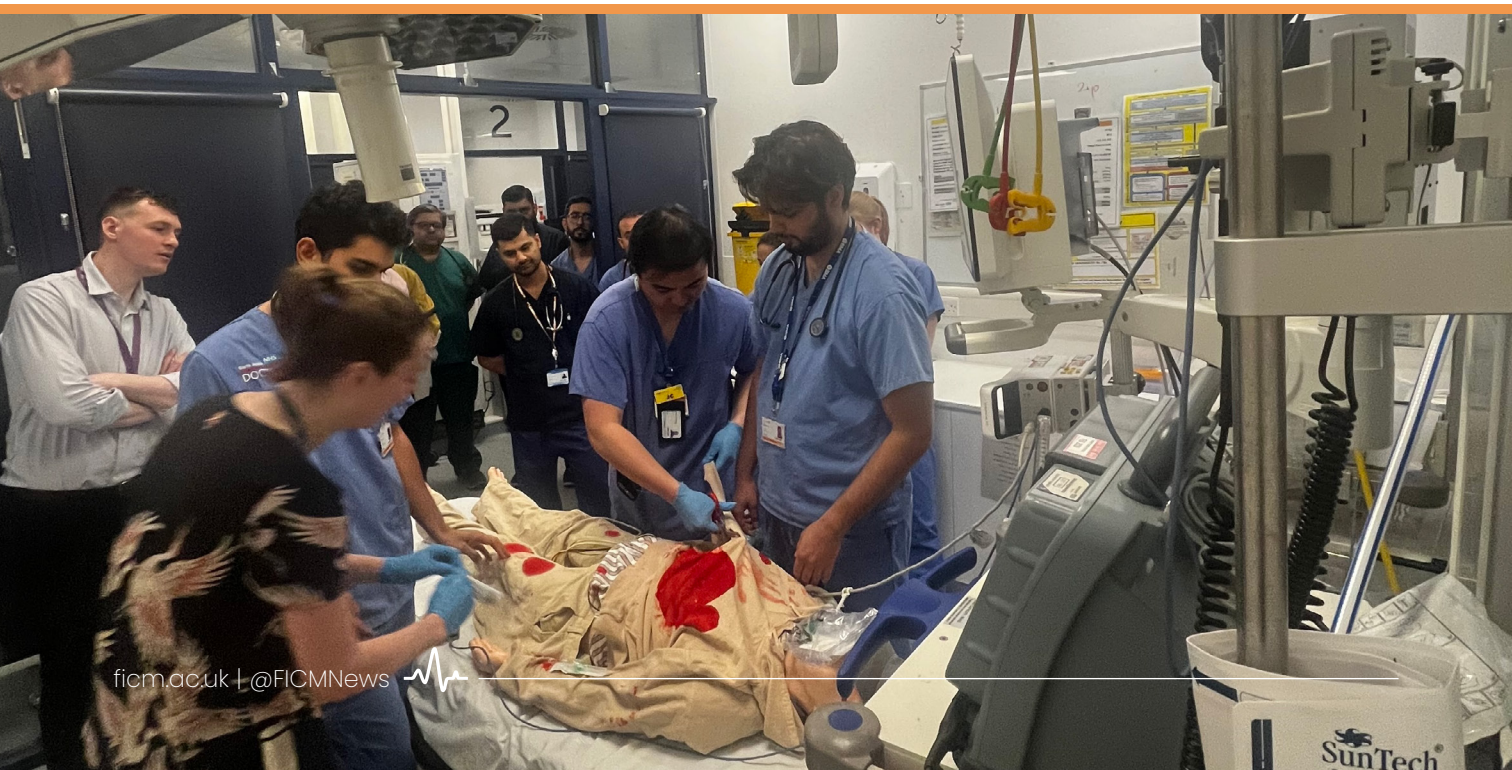
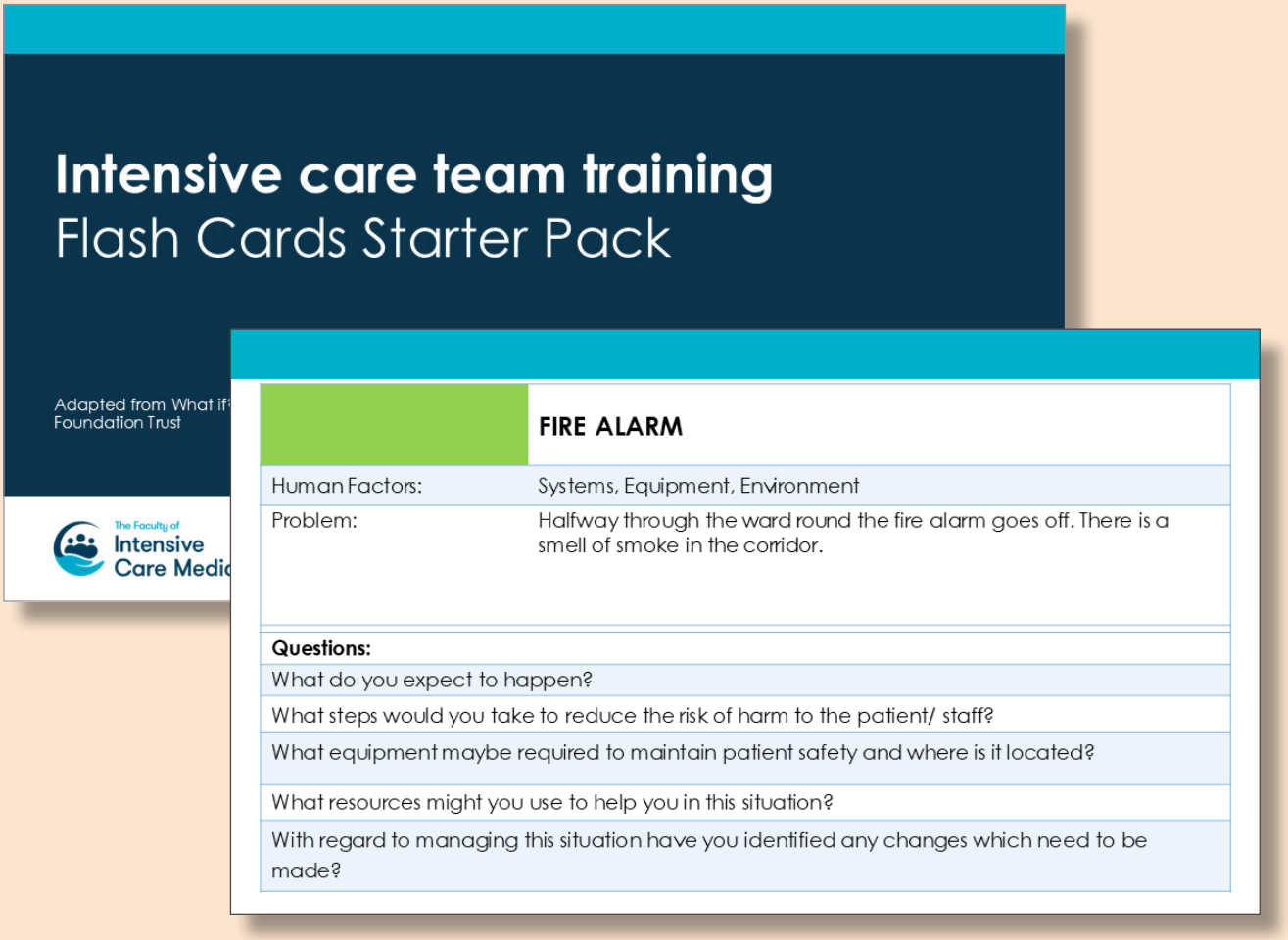




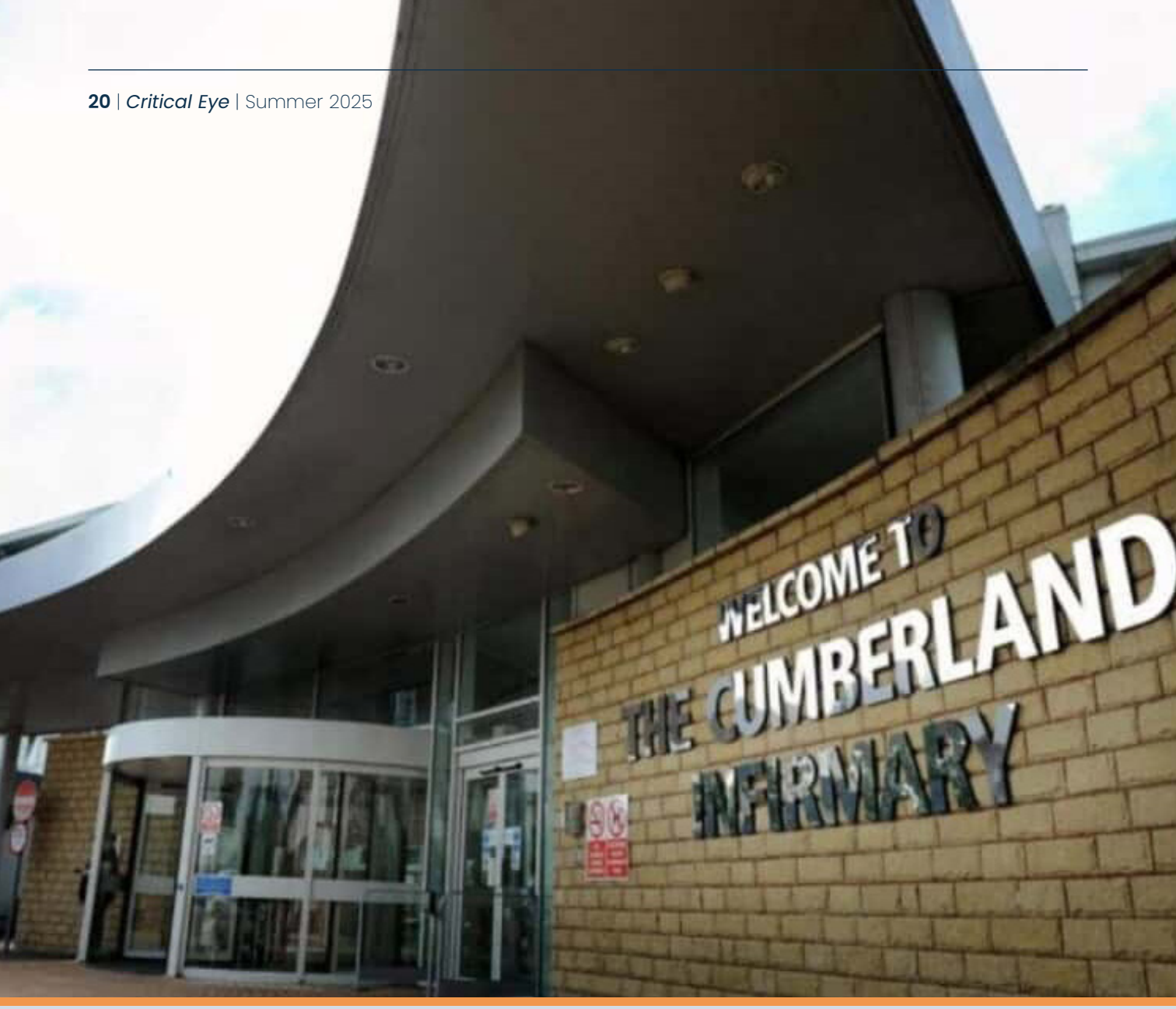
ICU Flash Card Starter Pack:

A New Resource for Critical Care Teams

We are pleased to publish this Flash Card Starter Pack for Intensive Care. Adapted from the EKHUFT model, this pack includes:

- A set of ready-to-use flash card scenarios relevant to intensive care practice
- A customisable flash card template for creating localised training content
- An implementation guide with practical tips to support uptake in your unit
- This resource is designed to be used flexibly—during handovers, downtime, or debriefs—and to engage the entire critical care team, including doctors, nurses, AHPs, and support staff.

[Click here to access the starter pack and demonstration video on the FICM website.]



Advanced Training in a Smaller ICU: Our perspective as trainers

Stage 3 ICM training follows successful completion of Stage 2 and passing the FFICM examination, with a year designed to equip Intensivists in Training with the ability to work independently as a consultant in ICM. We report our experience in playing a part in Stage 3 training in a small remote UK intensive care unit. North Cumbria has two of the most remote ICUs in England: comprising general ICUs of nine and six beds in Carlisle and Whitehaven Hospitals serving a population of circa a quarter of a million.

Dr Jon Sturman

Consultant ICM,
Northern rep SSUAG

Dr Maddie Wood

Consultant and FICM
Tutor NCIC

Dr Tom Sams

Consultant and Clinical
Director ICM

While the nearest tertiary care in Newcastle Hospitals is at least 60 miles from the closest site, the two trust acute sites themselves are 38 miles apart. Services such as vascular surgery and interventional cardiology are offered locally to provide timely acute and chronic interventions in hospitals of size not commonly associated with such specialties. The nature of challenges faced by remote working are well described by the Small and Specialist Units Group on the FICM website and can be mapped to a number of areas of ICM training.

Approximately three years ago, on agreement with the Northern Deanery, we began a programme of (optional) Stage 3 training modules in ICM at Cumberland Infirmary. This represented a new focus in a unit which hitherto derived Intensivists in Training (IiT) from the Foundation programme, ACCS Year 2 and residents on three month rotation from various stages of training in Anaesthesia — in other words a significantly more senior resident position than previously encountered. The challenges were to deliver a favourable training experience at an appropriate level of clinical independence, delivery of educational supervision, a fiscal case for the trust, participation in out of hours working and making all of this work in a rota slot that was unpredictable in allocation and timing.

Dr Tom Sams, Clinical Director

Having previously rotated as a Stage 3 IiT in the region I had a balanced view of the educational opportunities in North Cumbria. Coincidentally post pandemic we faced a consultant staffing crisis with retirements and consultants returning to their home countries and a team of seven was working on a nominal one in nine rota. Equally there is always pressure to balance spending on service versus delivery of training capacity. The solution in fact worked neatly all round. The nine bedded unit is staffed by two consultants in hours and one out of hours. The Stage 3 IiT replaces one of the daytime consultants approximately, on average, three days per week and therefore allowed such colleagues time in theatres (most of the department are dual Anaesthesia and ICM).

Effectively the Stage 3 IiT would liberate approximately 7.5 DCC per week to the department. Nights and weekends on call were on a one in eight basis for the Stage 3 IiT, in a supranumerary basis, with a consultant allocated for advice and attendance where necessary. As such the whole process became at least cost neutral for the trust and colleagues were able to deliver DCCs in their non-ICM components of their job plan.

Recruitment for us — like many ICUs — faces challenges, but I'm pleased to say we have recruited two consultant colleagues in the last three

years who have rotated as Stage 3 IiT and all agree that this rotation played a part in their career choice.

Dr Maddie Wood, Consultant and FICM Tutor

I was the 'prototype' IiT and spent my module approximately six months before CCT. I'd previously worked in a more junior grade on rotation in the trust, so how I would fit in was not entirely unknown. I was pleased that after a short orientation I was treated as if I were a consultant colleague, leading ward rounds and being given the headspace to formulate plans over a number of days. I was able to, before and after ward rounds, discuss strategies with the consultant of the week and get feedback. Although a small unit, the casemix is very varied and balancing work inside and outside the unit gave me confidence in supervision of IiTs and ACCPs of varying experience whilst keeping a general oversight.

Bed management for two small units can be a very fluid process and I learned efficiencies in this area with a wider appreciation of staff numbers and skills in general. Whilst some other units in the deanery offer opportunities to work on the consultant rota in a supernumerary capacity , Carlisle's decision to take one of the consultants off the unit to make space for a Stage 3 IiT was unique. It gave me more opportunity to take on the responsibilities of a consultant whilst retaining the necessary support and supervision as I worked alongside the second consultant. On a managerial level I had opportunities to gain experience in non-clinical areas by spending time and meetings with consultants who have interests in management, safety and risk — the sort of areas that are sometimes less well polished when starting a consultant post!

There's no doubt that the rotation gave me greater confidence when I transitioned to being a consultant, as well as being a 'try before you buy' exercise in weighing up where to settle in my career. I subsequently became FICM Faculty Tutor and it has been very satisfying to guide more IiTs through the same rotation, of which to date we now number seven. The feedback from Stage 3 IiTs is universally positive; mainly around the ability to act up in the consultant role, and the access to opportunities as the trust only accepts one Stage 3 IiT at a time — a luxury of a smaller unit.

Dr Jon Sturman, Northern representative for SSUAG

Recruitment is a frequent topic for the Small and Specialist Units Advisory Group. Factors such as casemix, unit size, rota composition and non ICM duties (in and out of hours) are professional factors which have bearing on recruitment. Geography and family factors play an equal part. Additionally, working patterns in the last few years of training may play a part in shaping career choices: it is important that IiTs see a balanced perspective of working in smaller and larger units during this crucial time. Equally the onus is on small and remote units to come up with valuable training opportunities. Over and above the general process of training and maturity, these can be thought of in two ways.

Firstly, what can be done with more time and headspace than a bigger unit? We would propose that consultant level leadership practice can be delivered in such units in a 1:1 supported way with a consultant. More subtly, IiTs can develop the resourcefulness to deal with situations where not all specialties are on site and weighing management of patients locally or for tertiary referral. Ultimately this benefits IiTs whether they choose a consultant job in a small or larger ICU in the networked approach recommended in GPICS with an understanding of each other's perspectives.

Secondly, what portfolio opportunities can be delivered? In our experience, exposure to the non-clinical aspects of consultant life can be delivered — in other words exposure to what awaits as Supporting Professional Activities work as a consultant. Examples include attendance at management and risk meetings, governance and bed management — common to all rotations of course, but perhaps less daunting in a smaller organisation.

Conclusion

In summary, we have shown that Stage 3 training in a small remote unit is feasible and with creative rota management can deliver valuable experience to intensive care doctors in preparation for consultant life.

Regional Advisors

Dr Andrew Sharman

Lead ICM Regional Advisor

Time flies: this will be my last report as lead regional advisor as my three-year term comes to an end in October. Since I last wrote, a lot has happened, incuding our first round of dual recruitment into ICM specialty training, which was a great success. Residents can now accept two training offers in the one round, something that has been long requested by Intensivists in Training. There are many other positives in the recent news.

These include: an FFICM exam with a 68.7% overall pass rate. Publication of the Rotational Training document, exampling good practice and advice to reduce rotational burden for residents but recognising the value to moving through hospitals in a region — it is well worth a read. The completion of the ICM sustainability project, ready for submission to the GMC. Our curriculum will be the first to implement these considerations when approved. In addition, we have published an electronic version of the Multi-Consultant Report Form, to allow easier feedback from colleagues for the residents. My thanks to Dr Nicolas Plummer for his support with this.

TLAM

The Training Leadership Annual Meeting (TLAM) for the educators occurred in May and was a great success. Thanks to Drs Jack Parry Jones, Sarah Clarke and Victoria Robson for their interesting and insightful talks. The afternoon session was given over to Laura Harding from the GMC, who delivered a session on Fairer Feedback conversations for residents. The learning point is in the title; it's all about real conversations, a two-way communication exercise. Being inclusive and supportive is so important for our residents (and our colleagues) but this appears to be a struggle. In the recent resident survey, 30% still report undermining and bullying behaviours. We must all work harder to acknowledge and eradicate these behaviours, often cloaked as microaggressions. I direct you to read the Training Quality report just published, which summarises the results of both the residents and Regional Advisors survey. There is so much positive in this report, which trainers should be proud of.

Moving on

I am reminded very much of a quote Dr Bryden uses that "we are only caretakers in our roles". I have thoroughly enjoyed my 'caretaker' role as Regional Advisor for the East Midlands where I have seen 47 residents becomes consultants, with some becoming Faculty Tutors and one about to be the next Regional Advisor. Being elected to 'caretake' the Lead Regional Advisor role for the last three years, has been particularly enjoyable. I have enjoyed the diversity of work, the challenges and the ability to actually make changes for the better. I have had the pleasure to represent over 30 Regional Advisors and oversee 250+ Faculty Tutors in those three years. I approve the appointments and work with them. I know how talented, dedicated and committed these trainers are. They are often financially under recognised by their trusts and at national awards, but their role is essential for the future of Intensive Care Medicine.

Without trainers, we cannot train residents. I want to acknowledge the important role you play. Your commitment has not gone unrecognised or unnoticed by me or the Faculty. Farewell and best wishes as I leave you in the very capable hands of Tom Williams.

Education Subcommittee

Dr Sarah Marsh
Chair FICMESC

FICM's Education Subcommittee (ESC) is responsible for the educational output published across FICMLearning. We are a committee of consultants, resident doctors and co-opted ACCP and pharmacist members. The content we generate is free to access in bite-size portions and covers CPD requirements for senior clinicians through to new resident doctors, as well as resources that can be used for exam preparation too.

If you haven't come across FICMLearning yet, do have a look — there are podcasts, case studies, blogs and a simulation section covering how to get started, debriefing and a whole host of ready-made simulation scenarios for you to use.

After the success of the Fire Safety learning bundle in 2024, we have developed another 'burst' of education for this summer on Maternal Critical Care. We have created an education archive discussing MCC including a case study, a blog written by a patient, and a podcast with Dr Katie Cranfield. Additionally, there are simulations relating to the critically ill mother and e-learning (e-ICM) sessions collated on this subject to engage learners. Find it in the FICMLearning section of the website as well as our piece in this edition of *Critical Eye*.

Multidisciplinary team training is essential for safe, effective care in the ICU and is reflected in national initiatives such as Health Education England's Patient Safety Syllabus and the GPICS V2. Taking inspiration from the flash card set published by the RCoA based on the work done at East Kent Hospitals NHS Foundation Trust, this spring we launched our Flash Card Starter Pack, designed to encourage team working by reviewing a number of clinical and non-clinical scenarios during the busy working day on the ICU.

The cards are designed to be used on the go so at the end of a ward round, during teaching or as part of an induction process for example. We have recorded a short video to show the flash cards in use to help you on your way and you can find this within the FICMLearning webpages along with the flash card set. There is a template included too so that you can create your own bespoke cards, and we'd love to hear about them if you do. We pass our thanks to the RCoA and EKH NHS FT for permission to do this.

We have a simulation group within the ESC and we are keen to know more about what activity is being delivered within critical care across the country. To that effect we have created two surveys; the first aimed at clinical fellows in simulation and the second for trainers involved in simulation, to tell us about the provision of simulation, training and support available. By understanding the current level of provision of this important resource we can hopefully build on the work being done, so please complete the survey sent to you by email or find the links in the Dean's Digest .

This year's Spring Education Meeting was held virtually in April. The programme was diverse and topical with presentations including assisted dying, frailty and the new code of practice for diagnosing death using neurological criteria. A huge thank you to all the presenters and the ESC members who organised and ran the meeting.

FICMLearning

@FICMNews

www.ficm.ac.uk/ficmlearning

FICMLearning is a free and open access educational material (#FOAMed) hub for FICM.

e-ICM

A joint venture between the Faculty and e-Learning for Healthcare (e-LfH). Nine modules of resources, free to all NHS staff members and students.

Case of the Month

Whilst primarily written for trainees preparing for the FFICM examination, these short articles can be used as 'quick CPD' by anyone.

Simulation

Supporting development of basic or more advanced technical skills and capabilities at all levels of experience, in both individual and team-based practice.

Podcasts

The FICM podcast is available on the FICM website as well as via Apple Podcasts (iTunes) and Spotify.

Blogs

Blogs are released every month in rotation with WICM and cover all apects of ICM. Blogs are written by subject matter experts.

Are you taking advantage of FICMLearning yet? Visit the website for regular updates.

Training, Assessment and Quality (FICMTAQ)

Dr Sarah Clarke
Chair FICMTAQ

As we move forward in our preparations to become a College, it is important to point out that the work of the Faculty's Training, Assessment and Quality continues unabated, 'business as usual'. From previous reports you will have noted just how many activities and areas TAQ is involved in, and it is core business: that of ensuring high quality training and assessment, and maintenance of transparent and robust standards.

Rotational training

The publication of the guidance document on Rotational Training is welcomed by IiTs and trainers, and is the result of a collaborative approach, to share good practice already in existence in some regions. In it, there are examples and suggestions to support lead trainers and residents where some difficulties may lie in their patches: Lead Employer models, whole stage Educational Supervision, creative LTFT working and rotation patterns, personalised Stage 3 placements are just a few of the ideas which form a welcome and creative guidance document. I hope you find it useful.

Quality

Many of TAQ's activities in recent years have been guided by the results of the RA and IiT annual surveys, and this year is no different. With very welcome and constructive collaboration with RAs and IiT Lead Representatives, the newly formatted Training Quality Report 2025 has just been published. The design of the two surveys were deliberately dovetailed to complement each other, incorporating questions around issues raised in the 2023 survey report, to gain greater

Action Plan arising from IiT Survey

For FICM's Training, Assessment and Quality Committee (FICMTAQ)

- Rotational Training & Maximising Training Opportunities Working guidance has been published
- Best practice statements, particularly for:
  - Stage 1 Medicine
  - Keeping in Touch (KIT) Days and maintaining skills during partner and sub-specialty placements
  - Recognition of airway capabilities for all residents in Stages 2 and 3
  - Opportunities for Stage 3 learning and experiences
- Address provision of curricular teaching, nationally and regionally
- Training Capacity Assessment guidance to support Units, existing workforce, and any proposed expansion.
- Working with Partner Colleges to enhance understanding of Dual/Triple programmes, and competence of all ICM IiTs in Stage 2
- Reduce discrimination of IiTs from different training backgrounds
- Hard line on bullying
- Submission to GMC for clarification of HiLLO6 Learning Outcomes

For the FFICM Examinations Subcommittee (which reports into FICMTAQ via the FFICM Chair of Examiners and sits under the overarching Examinations Committee for the FRCA, FFICM, and FFPMRCA).

- Enhanced IiT representation on future Exam Development projects – representation is already in place via FICM's lead Intensivist in Training representative. The representative will feed back any planned development projects to the Intensivists in Training Sub-Committee as required.

For FICM's Careers, Recruitment and Workforce Committee (FICMCRW) and others

- The development of guidance on ACCP scope of practice, with evaluations of training capacities
- Career planning and resources for Single CCT, Dual and Triple CCT IiTs
- EDI projects with enhanced IiT representation
- Continue to highlight to government the increasing Less Than Full Time workforce

insight into experiences in training and keep track of important matters raised. Once again, I am very gratefully to all the Regional Advisors who contributed their time and efforts into submitting their data, and to our IiTs who responded. It is great to see that every region and combination of CCT programmes were represented. I shan't go into detail, but the key messages from the report are reproduced here. Whilst there are many positive to take from the key messages, there remain aspects which TAQ, the Examination Subcommittee and CRW will take forward in action plans.

Positives! 	• The ICM training programme continues to evolve with increasing representation of IiTs from diverse backgrounds, though this is not yet reflected in the current ICM consultant workforce • IiTs and trainers are highly engaged in training • IiTs appreciate and feel supported by their Trainers • The majority of IiTs are receiving programme inductions, regional teaching and some degree of EDT. There are improving reports of access to rest facilities, hot food and car parking arrangements • Support for the Faculty to progress toward becoming an independent College
Training challenges 	• Stage 2 training continues to be challenging, with pressure of examinations, multiple placements and LLP requirements especially for those balancing dual and triple CCT commitments • Increasing numbers of IiTs are training Less Than Full Time • Unacceptable episodes of bullying, discrimination and undermining are reported in both surveys • Trainers reported ongoing struggles to be recognised at a management level for their roles. Greater institutional recognition for educational roles is necessary
Job planning 	• Most IiTs plan to take up ICM consultant posts on achieving CCT, though remain concerned regarding job availability, particularly for Single CCT IiTs and those undertaking the dual/triple ICM CCTs with a medical specialty • A minority of regions reported difficulties appointing dual-trained IiTs in emergency medicine and medicine to consultant posts, due to traditional preferences and competition with anaesthesia/ICM consultants

Tolerance

I make no apology in repeating TAQ's stance that the differential treatment of our residents, either in or outwith the CCT programme, through protected characteristics, country of graduation, or core training programme must not be tolerated, and I urge all colleagues to take responsibility and call it out.

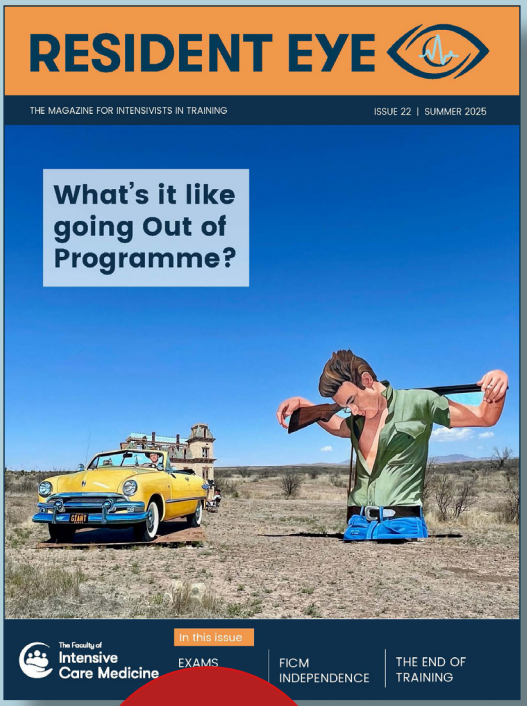
In other areas of TAQ, we have overseen the second hugely successful Consultant Intensivist in Transition Course. My thanks to Sara Cook and the Cardiff team for organising a fabulous two-day course, aimed at Stage 3 trainees, senior residents, SAS, senior LEDs and those recently completed training, to address the non-curricular aspects of becoming Consultants. Watch out for the next course in Manchester.

The work of the Education Subcommittee continues to produce excellent resources through FICMLearning and the FFICM prep course. I draw attention to the recent publication of the ICU Flash Card Starter Pack published is a very welcome and simple-to-implement educational aid. My thanks to the Sarah Marsh and her often understated, productive team.

Training capacity

Moving forward, the 'business as usual' model continues, and TAQ remains committed to its remit. The Portfolio Pathway route to the Specialist Register has plans for further resources and webinars, and the differential attainment and EDI work. We look forward to supporting the second Future Intensivists Conference in November, and the recent publication of the Training Capacity Assessment guidance, to support Faculty Tutors and units in evaluating their current educational provision, and supporting resources for consideration of expansion of such.

As always, my sincere thanks to the whole committee who contribute to TAQ. The four nation representation, resources and energy is humbling, as is the support of the Faculty secretariat who nudge, remind and help keep TAQ on track!



RESIDENT EYE

Our magazine for Intensivists in Training has a new name! In the latest issue:

- Navigating the end of training
- Spotlight on the Special Skills Year
- Applying for consultant jobs
- Career planning for single specialty training
- NHS Fellowship in Clinical Artificial Intelligence
- Updated training resources for IiTs

www.ficm.ac.uk/residenteye

FFICM Exam Calendar

	FFICM OSCE/SOE	FFICM MCQ	FFICM OSCE/SOE
Applications and fees not accepted before	23 June 2025	22 September 2025	08 December 2025
Closing date for exam applications	4 August 2025	20 November 2025	06 February 2026
Examination date	**29 Sept- 3 Oct 2025**	**14 January 2026**	**16-19 March 2026**
Examination fees	Both – £735 OSCE – £410 SOE – £365	£595	Both – £735 OSCE – £410 SOE – £365
Results released	28 October 2025	04 February 2026	14 April 2026

FFICM Examinations

Dr Victoria Robson
Chair of Examiners

The twenty-fourth sitting of FFICM took place in Spring 2025. The online multiple choice was in January, when 197 candidates entered the exam, with 160 (81%) passing. The pass mark was 64% of the available marks. The oral components were in March in London. One hundred and ninety-five candidates were examined.

Eighty-four (72.8%) of 115 candidates passed the Structured Oral Examination (SOE) and 145 (81%) of the 170 candidates passed the Objective Structured Clinical Examination (OSCE). Overall 144 candidates (68.7%) passed the orals components and are to be congratulated on achieving FFICM. This is higher than last year when the overall pass mark was 56.6% in March and October 56.6% in. Particular congratulations go to Drs David Swetman, Michael Tonkins and Nicolas Rey de Castro who were jointly awarded the FFICM exam prize for 2024-5.

Overall pass rates in the oral components for candidates who are on the ICM CCT training programme at the time of application were significantly higher than for those who are not on the ICM training programme, both in individual components and overall. These candidates in non-training posts have a wide variety of training and prior examination experiences, many including non-UK experience. Some do not have the breadth of UK experience which the training programme provides (including medicine, anaesthesia, and the Stage 2 specialty ICM areas) and may be in posts which do not have the same expertise in training and supervision which posts on the training programme provide. Thay also may not have access to the same formal teaching programmes. Those whose examination experience has been abroad, may have experienced examinations which are heavily knowledge-based, unlike UK higher postgraduate examinations which emphasise such skills as critical thinking, decision making, professionalism and may use simulation.

New format

Plans for the new FFICM Assessment of Clinical Reasoning oral examination (ACRE) are progressing well, although the details have not yet been finalised. This will replace the current oral components, and will consist of a circuit of stations, each with a clinical theme. The stations will reflect the clinical encounters an ICM doctor might expect in daily practice, such as a referral of a patient from the Emergency Department, a ward round patient review, dealing with a clinical problem in critical care, a discussion with a patient, relative or health professional. In depth discussion to assess understanding and reasoning behind decisions as well as the relevant applied basic sciences will also be included. The exam standard will remain that of the end of Stage 2 training. Further details and sample questions will be uploaded onto the FICM website when available, at least one year before the first sitting of the new oral exam, which will not start before 2027.

Thank you

I have reached the end of my term as Chair of Examiners. Dr Stephanie Strachan succeeding me from June 2025. I am confident that under Stephanie's guidance the exam will continue to flourish and attaining the FFICM will remain a badge of honour in the intensive care world. My thanks go to the FFICM examiners, who are all volunteers, for the work they undertake examining candidates as well as writing and revising exam questions and standard setting. My thanks also go to the RCoA exams department staff, who administer this exam.

Intensivists in Training

Dr Rosemary Worrall
FICM Lead IiT Representative

Since taking over the role of Chair of the Intensivists in Training (IiT) Subcommittee in January, my focus has been on strengthening the representation of IiTs on the other FICM committees. Between us, Taqua Dahab (Deputy Chair) and I attend the Careers, Recruitment and Workforce Committee, Training Assessment and Quality Committee, Exams Development and Assurance Group and the recently formed Equality, Diversity and Inclusion Subcommittee.

In addition, other members of the IiT Subcommittee attend the Professional Affairs and Safety Committee, Education Subcommittee and the Smaller and Specialist Units Advisory Group. We have also been working closely with the FICM Independence Strategy team to think about what IiTs want from the new College of Intensive Care Medicine and how IiT representation is evolving.

For me, independence is an opportunity for us to demonstrate Intensive Care Medicine is a modern and diverse specialty. Over the last decade the makeup of our workforce has changed, and although dual ICM/anaesthesia remains the largest stream within our training programme, this group are now outnumbered by those from dual/triple medical/ICM, dual EM/ICM and single ICM CCT IiTs. As our workforce, patient population and NHS change, we too must evolve. Independence will give us the opportunity to really advocate for ICM on a national level, to represent the views of our whole membership and to demonstrate that ICM is a specialty not a service. Whilst independence will bring some changes, I would like to reassure all IiTs that the day to day running of things such as LLP and exams will in the short term remain unchanged, and longterm, disruptions will be kept to a minimum.

Workstreams

This year has already seen publications of several documents with which the IiT Subcommittee have had significant involvement. The Rotational Training guidance document addresses the burden of excessive rotation during ICM training. Whilst it is acknowledged that there are benefits with some rotation, this document recognises that the ICM curriculum is designed to be flexible and offers pragmatic guidance with real life examples. We are working on several best practice statements which will further build on this document, but which are arranged to address the common issues that arise in each stage and stream of training.

The results of the 2024 Intensivists in Training Survey are reportd in the Training Quality Report 2025 , alongside the data from the Regional Advisor Survey. The 2024 questions focused on the experiences of IiTs undertaking the ICM curriculum and the practicalities associated with each stage. There were 380 reportable responses representing approximately 33% of IiTs. Whilst we received feedback from all four nations and from all training regions, the individual regional response rate ranged from 26—60%. The results of the 2024 cohort demonstrated that increasing numbers of IiTs are choosing to apply for LTFT training (27%) but that there is still more work to be done with regards to wellbeing, and stamping out discrimination

> Independence will give us the opportunity to really advocate for ICM on a national level, to represent the views of our whole membership and to demonstrate that ICM is a specialty not a service.

between those from different training backgrounds or with protected characteristics.

Overall, IiTs in each stage reported a positive training experience and many shared their appreciation for their trainers, Faculty Tutors, TPDs and RAs. In summary IiTs in Stage 1 enjoyed learning new skills, but found the medical year, portfolio burden and maintaining skills in partner specialties challenging. Those in Stage 2 again commented on the wide scope of practice and variety of learning experiences but reported it to be tough with the short rotations and exam burden. Finally, many Stage 3 IiTs stated they felt ready to become consultants and have increasing opportunities to practice autonomously or "act up" but still found expectations of the last few months including the job application process, unclear and daunting. In the 2024 survey, we also included a large number of free text responses and asked for IiTs to give their suggestions for curriculum improvement. Many of these comments were requests to clarify training requirements/HiLLO signoffs and improve resources, which we have built into workstreams for the 2025 year and hope will be addressed in the upcoming best practice statements.

The 2025 Training Survey will be released in the coming weeks. This year we are further scrutinising the inequalities in training highlighted by previous surveys and in particular are focussing on the non-clinical aspects of training that affect IiT experiences. Whilst not all these issues directly fall under the remit of FICM, it is clear from listening to the feedback from our IiTs, that Equality and Wellbeing are issues they feel strongly about and areas that the new College of Intensive Care Medicine should be advocating for.

Stage 3 Resources

Many thanks to Taqua and the CRW team who have continued the work building further resources for Stage 3 training and have created a Resource Hub where you will find advice on how to get the most out of the Stage 3 year, as well as example job plans and career stories. In addition to supporting the Intensivist Consultant in Transition Course, we will be holding a dedicated interview skills workshop at the 2025 Intensivists in Training Conference.

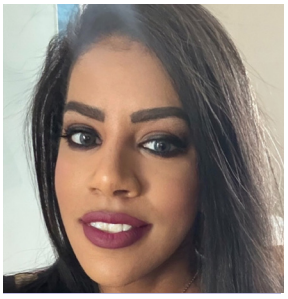
Conference

After the success of the inaugural 2024 Intensivist in Training Conference held at the Royal College of Anaesthetists, this year we are hosting the 2nd Intensivists in Training Conference at the Queen Elizabeth Hospital Birmingham. Join us on Monday 10 November for an exciting agenda, which again features two parallel streams with a full day speaker programme and options to book onto face to face workshops (Research Opportunities, Consultant Interview Workshop, Point of Care Ultrasound and Chest Drain Workshop/Open Chest Resuscitation Skills).

Whilst in person places will be limited to Intensivists in Training or those undertaking the Portfolio Pathway, there will be an opportunity for other resident doctors to attend by entering the abstract competition. Bookings are open on the FICM website and those in an ICM training programme will be covered by their Study Leave budget.

Finally I would like to thank all of those IiTs who are dedicated to improving training in ICM, in particular those involved in the Regional Representative Network and who contribute to the Intensivists in Training Subcommittee. In the coming months several subcommittee members will be demitting, please do keep an eye out for the adverts and consider applying!

Intensivists In Training Census Report



Dr Taqua Dahab
FICM Deputy Lead IiT Representative

Dr Richard Porter
FICM Census Lead

This report presents the findings from the 2024 census of Intensivists in Training (IiTs), which involved a total of 917 responders, including 228 IiTs. Due to a negligible response rate from Locally Employed Doctors (less than 1%), this cohort was excluded from further analysis.

The goal of this census was to assess the current state of IiTs, their job satisfaction, career intentions, and the sustainability of their working patterns.

General data

- Almost 20% of IiTs have responded to this census report, with North West England, London, and Scotland being the most responsive. Highlighting diverse representations across various locations.
- One-third of all Intensivists in Training are currently working less than full-time (LTFT). Indicating a shift in work patterns that may reflect broader changes in the field of ICM.

Enjoyment of ICM job and sustainability of current working pattern

- Three-quarters of IiTs report that their enjoyment of ICM jobs has either increased or remained unchanged.
- However, there is concern about the sustainability of the existing working pattern, as 37% of respondents expressed that their current arrangements are unsustainable.
- 25% of IiTs reported taking time off due to unexpected illness in 2024 for a few days (less than a week), which may correlate with the pressures faced in their jobs.

Career intentions and future outlook

- A striking 85% of IiTs are contemplating a long-term career in Intensive Care Medicine, a figure that has remained stable since the pre-COVID-19 pandemic census report. This consistency in career intentions reflects a strong commitment to the field despite the challenges faced during training and practice.

Key themes in improving job satisfaction

The census responses highlighted several key themes that could enhance job satisfaction among IiTs:

IT Systems

Respondents indicated that improvements in IT systems could significantly enhance their overall job satisfaction. A streamlined and efficient IT infrastructure is essential for optimising workflows and reducing administrative burdens.

Remuneration for additional roles

Many IiTs undertake additional roles outside their scheduled hours. It is imperative that these

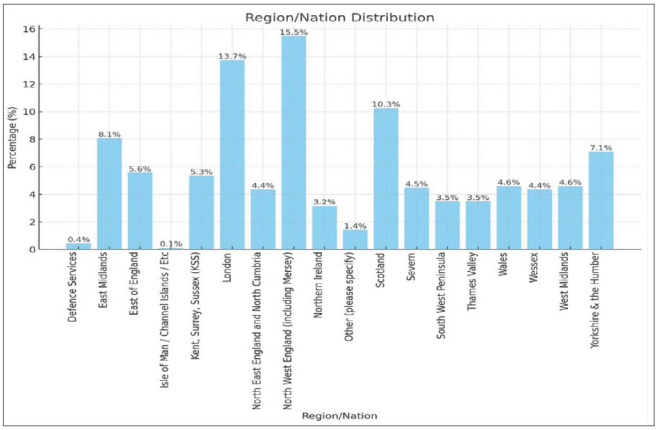


Figure 1: *Regional distribution of the responders*

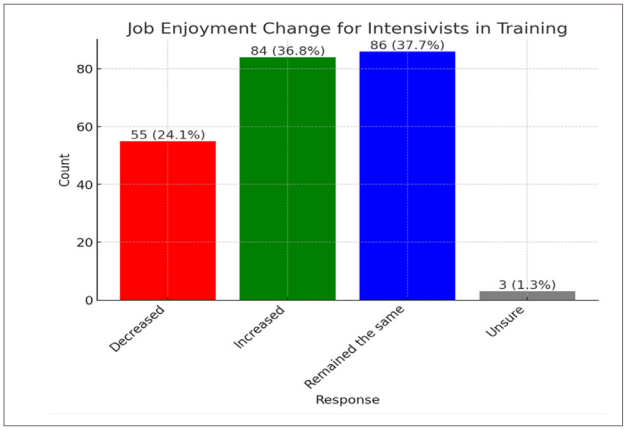


Figure 2: *Parentages of IiTs enjoyment for their jobs*

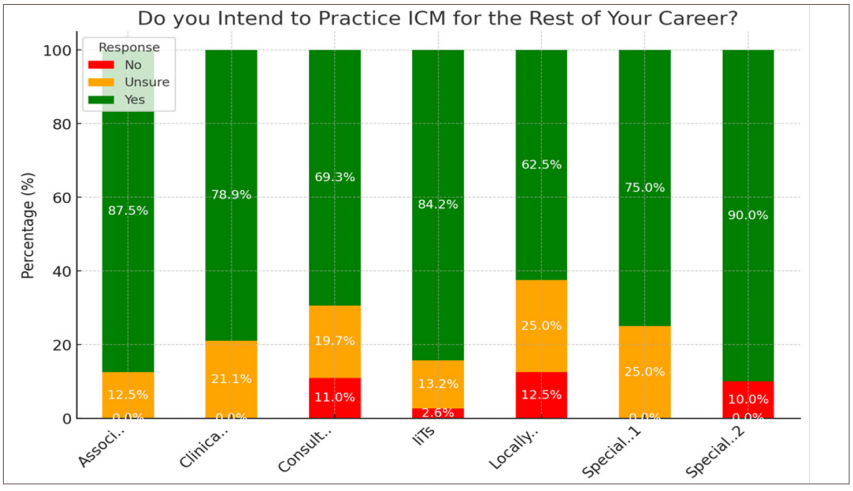


Figure 3: *Career intentions for IiTs*

contributions be acknowledged and adequately compensated, thereby fostering a sense of value and recognition among them.

Rota management

There is a clear demand for enhanced rota management practices. Respondents suggested the implementation of self-restoring rotas and advanced rota writing prior to rotation commencement. Additionally, there is a need to distribute long shifts more evenly throughout placements. Many asked for recognition of Self Development Time (SDT) and Keep In Touch (KIT) days by local trainers.

Burden of rotations

Flexibility in rotations is crucial to reducing the administrative burdens and errors associated with payment changes. The adoption of a Lead Employer model could alleviate some of these challenges, leading to improved efficiency in rotational management.

Burden of assessments

The costs associated with FFICM exams are cited as a significant burden, given the lack of reimbursement by the national study budget. This is particularly problematic if there are multiple exams attempts.

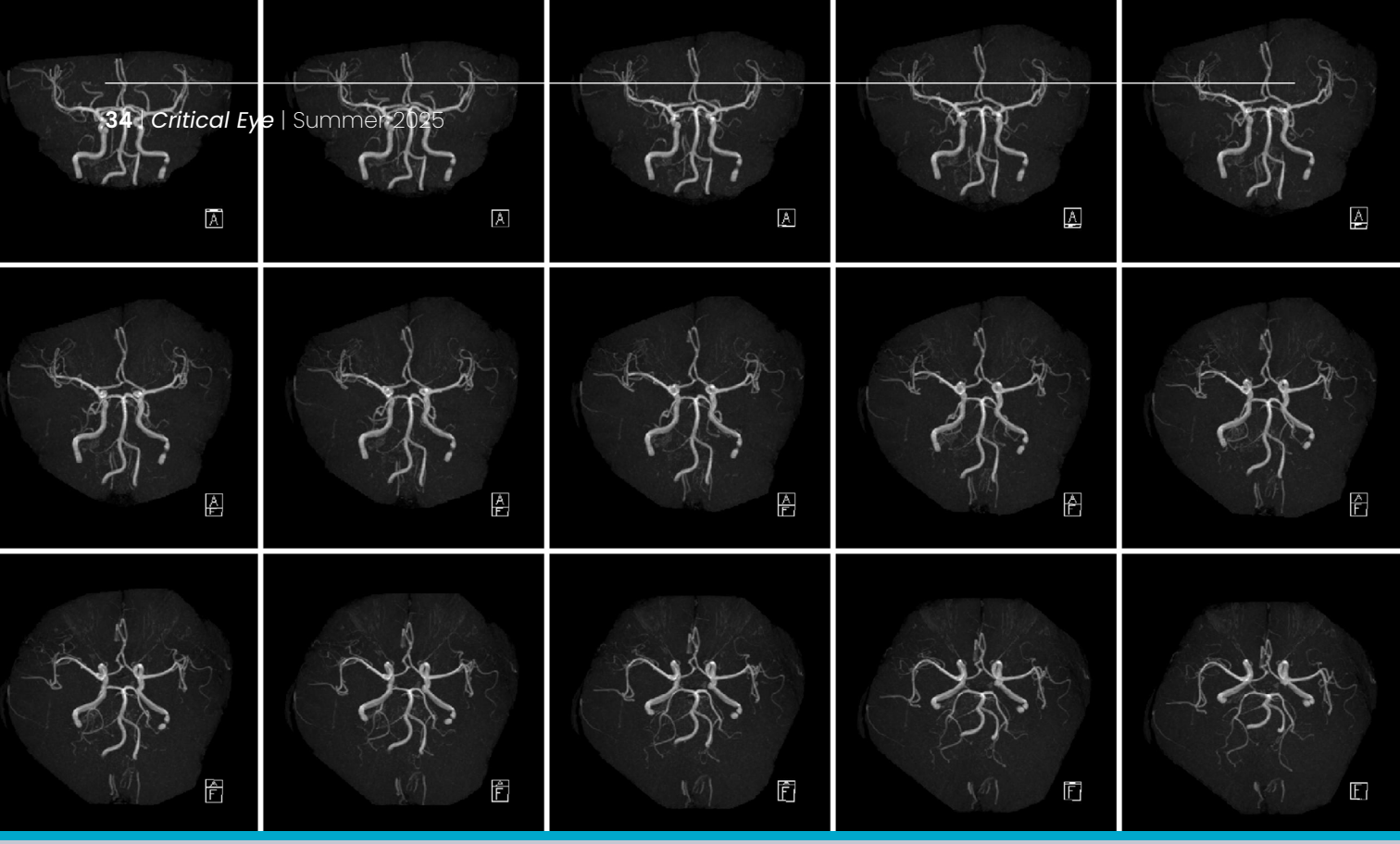
Portfolio formative assessment, such as Supervised Learning Event forms, should be re-evaluated for conciseness and practicality, as the current version requires duplicated information and lots of writing.

Wellbeing

The wellbeing of IiTs remains an ongoing challenge. Enhancements in the availability of rest facilities, such as restrooms, hot food, lockers, and access to a care park, could substantially improve job satisfaction and overall wellbeing.

Conclusion

In conclusion, the findings from the 2024 Intensivist In Training Census provide valuable insights into the current landscape of ICM training. While the majority of IiTs express satisfaction with their roles, significant concerns regarding the sustainability of working patterns and overall wellbeing necessitate attention and action from relevant stakeholders. Addressing these issues is essential to ensure the continued engagement and development of future intensivists.



Developing a protocol for administration of intra-venous contrast for imaging via vascular access devices other than peripheral cannulae

Dr Joanna Dixon
Consultant Radiologist

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ST6 Anaesthetics

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Consultant in Anaesthesia and ICM

Ms Sharon Iles
CT Superintendent Radiographer

We work in a multi-site trust which each year delivers 70,000 CT scans with contrast. Administering the contrast necessary for a scan can be challenging in both critically ill and less acute patients with controversies around type and location of vascular access device (VAD). Through collaboration between our vascular access service (VAS), anaesthetics, critical care and radiology we have developed a Trust-wide protocol for the use of central venous catheter (CVC), midlines, peripherally inserted central catheters (PICCs) and extended dwell cannula (EDCs) for the administration of IV contrast for patients both in and outside critical care.

To better understand how this outcome was achieved we have outlined the considerations from two main viewpoints and detailed the agreements we have included in our protocol.

The VAS, anaesthetics and critical care perspective

Reliable peripheral IV access can be challenging in many patients, particularly the critically ill. Contributing factors include long hospital stay, peripheral oedema, multiple previous VADs or repeated blood sampling. Consequently, many patients require insertion of more specialist VADs than a peripheral cannula and gaining extra peripheral IV access for a scan adds delay, creates potentially unnecessary workload, risks additional line related infection and certainly involves further patient discomfort.

Safe VAD positioning is achieved using ultrasound guidance (as recommended in the soon to be updated AAGBI Safe Vascular Access guideline1) and a combination of other relevant safety checks (e.g. transduction, ECG, CXR, imaging). As a result, when compared to a peripheral cannula, these VADs should have more catheter length in vessels with larger lumen and greater wall thickness - all reducing the likelihood of contrast extravasation.

Ongoing concerns about VAD-related incidents produced a drive to better understand the risks of our equipment, ensure best practice, deliver quality training and improve VAD identification. This has resulted in standardising VADs used in adults across all teams in the Trust with a well-received knock-on effect of reducing costs. All cannulae, EDCs, midlines, PICCs and CVCs inserted in any location should be familiar to trained members of staff. It also means that line characteristics (flow and pressure ratings) obtained from the manufacturers could be shared with radiology to agree a pragmatic approach to contrast delivery through a range of VADs, similar to that described for CVCs in the 2022 ICS guidance[2].

The radiology perspective

As described above reliable vascular assess is essential for the safe delivery of intra-venous contrast. In addition, the flow rates and pressures delivered by Power-injector devices to achieve these flow rates must be considered for two reasons. Firstly, there is a concern that exposing a vascular access device to excessive pressures may damage the device and secondly that impaired flow rates may result in sub-optimal imaging.

In our Trust midlines and PICCs inserted are clearly marked with maximum pressure and flow ratings: Generally, 325 psi and 5 ml/sec. Our routinely used Vygon standard multi-lumen CVCs are not marked with pressure and flow ratings but following discussion with the manufacturer the distal lumen has been agreed to be rated at 150psi and a flow rate of at least 2.0ml/s.

Different scan protocols require different contrast flow rates, for example an abdominal angiogram requires a flow rate of 4-5 ml/s, whereas a portal venous abdominal CT requires a lower flow rate of 3ml/s. The flow rates are similar

> In our experience, implementing the routine use of VADs, rather than insisting on peripheral access is not known to have had any detrimental impact on the overall diagnostic quality of scans.

to those used with peripheral cannulae. As midlines, PICCs and CVCs are longer, often with smaller luminal diameter, small adjustments in pressure and flow rate can be made by the performing radiographer depending on the VAD being used and individual patient factors to optimise image quality. Standard imaging, for example CT abdomen with contrast, is possible using all our Trust standard midlines, PICCs and CVCs. However, the flow requirements for angiographic imaging are too great for these standardised CVCs.

Considering the increased time taken for contrast to reach the end of a longer VAD: generally, protocol timings do not need to be adjusted as the more time-critical phases (angiograms) are planned using bolus tracking techniques. The volume of contrast used also does not require adjustment, as this is generally based on patient weight rather than access route. In our experience, implementing the routine use of VADs, rather than insisting on peripheral access is not known to have had any detrimental impact on the overall diagnostic quality of scans.

Setting up the protocol involved education and training of all appropriate radiographic staff in identifying various VADs and connecting injector pumps safely. Training regarding aseptic no-touch technique (ANTT) is provided routinely as part of Trust mandatory training. Further training regarding accessing and flushing PICC and midlines was initially provided by the VAS and cascade training then passed down via the CT Superintendent. All of the radiographers involved in accessing the VADs are required to read the Trust's CVC, PICC and midline policies and complete face-to-face training and competency assessment using a mannequin.

At the time of scan booking, enquiries are made with the ward staff regarding vascular access. If a CVC, midline or PICC is to be used they check that it was inserted within our local Trust and which lumen, if any, is being used for parenteral nutrition so this can be avoided. VADs inserted outside of the trust require further investigation to enable safe usage. Final safety questions are also included on the checklist completed by the radiographer at the time of the scan.

An open line of communication

Arriving at a trust wide protocol has required and continues to rely upon excellent communication between the major stakeholders. Better understanding the requirements and concerns of these parties has helped craft a protocol which places optimal patient care at its heart.

Communication on an individual patient and scan basis is essential so that both radiology and home teams can understand what vascular access devices are present and the contrast requirements of that scan. In the case of critically unwell patients, this conversation is now held prior to the patient leaving the safely of critical care and avoids unnecessary delays in the CT scanner.

References

1. Association of Anaesthetists of Great Britain and Ireland. Safe vascular access 2016. Anaesthesia 2016; 71: 573-585.
2. Intensive Care Society. Guidance for: The use of central venous catheters for the administration of radiological contrast media in critically ill adults. 2022.

Figure 3: *Royal Devon University Healthcare NHS Foundation Trust*

Intensive Care Medicine Consultant Jobs: Looking for jobs and looking for colleagues

As a resident doctor, as you head into the latter part of your training you will start to think (and perhaps even worry) about consultant jobs. Thoughts may include: "will there be a job for me?", "what type of consultant job do I want?", "should I stay locally or move elsewhere?" and '"hat are the on-call requirements?". Meanwhile, consultants, especially if you are the Clinical Lead (CL) or the Clinical Director (CD) preparing to advertise positions wonder "will there be any applicants suitably qualified?", "how can we attract the right person to this job?" and "what exactly do we want them to do?"

Dr Zoe Brummell
FICMCRW committee member

Dr Alice Carter
ICM Regional Advisor

Dr Matt Williams
FICMCRW Chair

Dr Liz Thomas
Recruitment Lead

Figure 3. Royal Devon University Healthcare NHS Foundation Trust

In England and Wales, these respective parties often find each other through NHS Jobs or via independent online recruitment services[1]. Significant work is undertaken by Intensive Care Medicine (ICM) departments to write jobs descriptions, person specifications and prospective job plans as well as negotiate with the senior leadership and/ or the finance director. Multiple different guidance exists about how the appointment of NHS consultants is best achieved, including legal and regulatory requirements for NHS employers' and 'best practice' approaches[2-10]. Royal Colleges and Faculties, in our case FICM, approve prospective job descriptions to provide quality assurance for consultant posts. For ICM resident doctors, trying to interpret what these job descriptions and person specifications mean in practice can be difficult.

In view of this, we decided to review the information being given in ICM consultant job adverts on NHS Jobs. Our aim was to establish job availability for both single specialty and dual-trained Intensivists, identify other job variations, and also to help guide departments on how to provide crucial information for potential applicants. We used current FICM, Royal College of Anaesthetist (RCoA), Academy of Medical Royal Colleges (AoMRC) and NHS Employers guidance in determining what data should be collected.

Methodology

The NHS jobs website was reviewed on a weekly basis by one ICM consultant (for consistency) between 17 March 2024 and 22 August 2024. ICM consultant jobs were searched for using the word: 'Intensive' in the 'What?' box, filtering with 'consultant' and sorting by date posted (newest). A second search was undertaken using the word: 'critical' in the 'What?' box, filtering with 'consultant' and sorting by date posted (newest). All jobs matched through these search criteria were manually reviewed. Jobs related to paediatric, psychiatric, neonatal intensive care or other non-ICM specialties were excluded from data collection. Data was extracted into an excel spreadsheet under the headings: closing date of job, NHS trust, number of posts, single and/or dual, if dual which partner specialty, permanent or locum, split site job, Direct Clinical Care Sessions (DCCs) in ICM, DCCs in another specialty, Supporting Professional Activities Sessions (SPAs) (Figure 1), ICM on call (1st on) frequency, Total Programmed Activities (PAs), need for Fellowship of the Faculty of Intensive Care Medicine (FFICM), requirement for GMC Specialist Registration (CCT or equivalent) in ICM, any financial incentive. Once all the data was collected, quantitative analysis was undertaken using descriptive statistics. Qualitative content analysis was used to describe and quantify patterns in the data.11 The data and analysis was then reviewed by a second ICM consultant for sense checking[2-6].

Direct Clinical Care (DCC)	Sessions (4 hours for 1 session) spent directly interacting with patients to deliver clinical services. For ICM this generally means time spent covering the Intensive Care Unit
Supporting Professional Activities (SPAs)	Sessions (again 4 hours for 1 session) spent undertaking non-direct clinical care, such as undertaking work or tasks to support the functioning of the Intensive Care and/or the wider hospital and/or undertaking continuing professional development

Figure 1: *Understanding DCC and SPAs*

Findings

116 job adverts meeting the search criteria were found during the 23-week review period. The geographical location of the jobs advertised was across England and Wales (Figure 2). In the vast majority of cases only one job was being advertised (1 = 102 adverts (88%), >1 = 14 adverts (12%)). In one advert, seven jobs were advertised across two hospitals (United Lincolnshire Hospitals NHS Trust: Lincoln or Boston).

Several ICM departments re-advertised the same (or very similar job) in this review period

- University College London Hospitals NHS Foundation Trust (National Hospital for Neurology and Neurosurgery)
- East Kent Hospitals University NHS Foundation Trust (Canterbury)
- University Hospitals Sussex NHS Foundation Trust (St Richards - Chichester)
- Isle of Wight NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- Betsi Cadwaladr University Health Board: Glan Clwyd Hospital
- East Suffolk and North Essex NHS Foundation Trust (Ipswich)

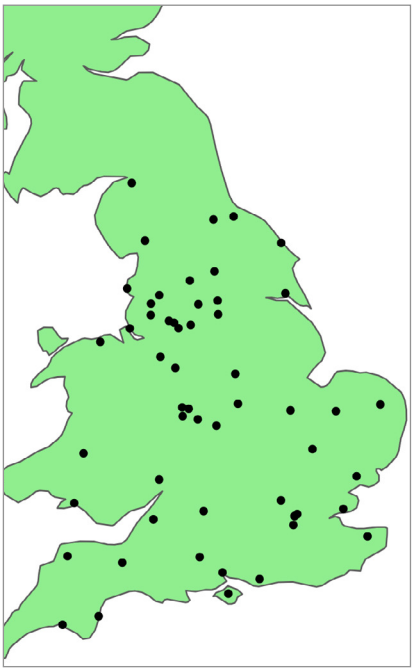

Figure 2: *Location of hospitals in England and Wales advertising an ICM Consultant job during the review period*

- Mid and South Essex NHS Foundation Trust (Basildon)
- Mid and South Essex NHS Foundation Trust (Southend)
- The Royal Wolverhampton NHS Trust (New Cross Hospital)
- Imperial College Healthcare NHS Trust (Hammersmith)

A small number of departments were looking for single specialty ICM consultants (11% of the adverts) in contrast with the largest number of departments (47%) who would consider either single or dual trained consultants (depending on individual applicants, second specialty and/or preference). Forty-one percent of departments were looking for dual specialty trained consultants, the majority of which (again 41%) were looking for individuals dual trained in anaesthesia. 8% of adverts stated preference for anaesthesia but would consider other specialties. A significant proportion (38%) were looking for any of the dual trained specialties (or did not specify a specialty). None of the adverts stated that they were looking for someone to work across more than two specialties (triple accredited).

72% of departments were recruiting to permanent (substantive) consultant positions. A small number were advertising for both locum and permanent consultants. It is of note that for substantive ICM consultant posts, prior approval of job descriptions should have been provided by a FICM regional advisor (as part of good practice). The majority of jobs were based on one hospital site (56%). However, several adverts noted that they would require the applicant to work across hospital sites, with one advert commenting that "The appointment is to the Trust, not to specific hospitals".

The number of DCCs in ICM ranged from two to nine. It was not possible to calculate the interquartile range for this as many adverts gave a range for their job. In many cases (24%) the number of DCCs in ICM was either not clear or negotiable. The number of DCCs in second specialty ranged from 0 – 6.25. Again, it was not possible to calculate the interquartile range and in many cases the number of DCCs in a second specialty was not clear or appeared to be negotiable. Where the stated number of second specialty DCCs was four or greater the second specialty was always Anaesthesia.

The range in SPA time was 1 – 3. The vast majority of adverts had SPAs of 2 or less. 7% of adverts either did not state or didn't make clear the number of SPAs, for some of these jobs a proposed job plan was provided, but there was a lack of clarity of SPA value for a 10 PA job. There were two employers giving 3 SPAs, both based in Wales (where 3 SPAs is expected as part of their Consultant contract)[12]:

- Swansea Bay University Health Board
- Betsi Cadwaladr University Health Board: Glan Clwyd Hospital

The on-call frequency advised in the job adverts was highly variable (Table 1), with a few adverts advising that the on-call rota was shared with anaesthetics. One dual job with anaesthetics (Scarborough and York) advised that the on-call work will involve overnight Consultant cover of the Intensive Care Unit and weekend daytime cover of the Acute theatres and obstetrics. Several trusts (16%) either did not state or did not make clear what the on-call frequency was.

Some adverts advised a current on call frequency, with the aim that this will reduce (for example from 1 in 8 to 1 in 12) over-time. Some other adverts advised that the rota is currently 1 in 8 but will change (increase in frequency) to 1 in 6. Trusts with the lowest on call frequency were Liverpool University Hospitals NHS Foundation Trust (Aintree) – 1 in 16, University Hospitals of Leicester NHS Trust (Leicester Royal Infirmary) – 1 in 16 and East Lancashire Hospitals NHS Trust (Blackburn) – 1 in 18. Several of the job adverts gave examples of the rota relevant to the role, however in some instances only limited versions were given (such as four weeks). Where only four weeks was given, it was very difficult to ascertain the full work pattern of these jobs. Most jobs (84%)

On call frequency	Number of adverts	Percentage of adverts
1 in 4 to 1 in 6	1	1%
1 in 4.5 weekends, 1 in 8 weekdays	1	1%
1 in 4.5 weekends, 1 in 9 weekdays	2	2%
1 in 5	2	2%
1 in 5 weekends, 1 in 10 weekdays	3	3%
1 in 6	6	5%
1 in 6 to 1 in 8	3	3%
1 in 6 weekends, 1 in 8 weekdays	2	2%
1 in 6 weekends, 1 in 12 weekdays	1	1%
1 in 6 weekends, 1 in 14 weekdays	1	1%
1 in 6 weekends, 1 in 18 weekdays	1	1%
1 in 6.5 weekends, 1 in 13 weekdays	1	1%
1 in 7	2	2%
1 in 7 to 1 in 8	1	1%
1 in 8	21	18%
1 in 8 to 1 in 9	1	1%
1 in 9	12	10%
1 in 10	9	8%
1 in 10 weekdays, 1 in 12 weekends	3	3%
1 in 10 weekends, 1 in 20 weekdays	1	1%
1 in 11	2	2%
1 in 12	13	11%
1 in 13 to 1 in 18	9	8%
Unclear or not stated	18	16%

Table 1: *ICM on-call frequency according to job adverts*

advertised exactly 10 PAs. Several jobs were slightly above 10 PAs (for example 10.2 or 10.4 PAs). Some jobs advertised the possibility of increasing the number of PAs for example, 10 (+2 additional PAs). Some jobs advertised a range for example 9 – 11 PAs.

FFICM (or equivalent) was an essential requirement in 59% of the job adverts and was desirable in 22%. In the other adverts, three advised appropriate royal college membership was required. Some jobs (those for dual positions with anaesthesia) required FRCA. In one case the need for any royal college/faculty examination was not stated. The need for a CCT or equivalent in ICM was essential in 67% of cases and desirable in 16%. Four adverts stated that the applicant needed to be on the GMC register, but did not specify the specialty. In the rest either ICM and/or anaesthesia was essential, except for in three adverts where it was not clear. FICM recommend that ICM consultants are appropriately trained and on the GMC register.

The vast majority of trusts (79%) did not offer any financial incentive for taking up an ICM consultant role. One trust however was offering a relocation package of £7k with an additional £20k lump sum and 1.5 additional SPA time for the first 24 months (East Suffolk and North Essex NHS Foundation Trust: Ipswich). A different trust was offering £10k welcome premium and removal expenses, with an additional 1 SPA for the first year (Airedale NHS Trust). The others trusts who were offering financial incentives were offering this as part of relocation expenses. Some trusts also offered temporary accommodation.

For several adverts, there was very little information about the job work pattern to give applicants an informed choice. In one case there was no job description available at all (perhaps the advert was written with a specific candidate in mind). It was noted that many of the information packs contained redundant information which could be off putting to applicants. However, some adverts had made a real effort to better understand what it was about their location that might encourage people to move there, whether this was city living, transport links, cultural activities, schooling or stunning scenery (Figure 3).

Discussion

The findings from this study demonstrate the changing landscape of ICM training and consultant posts across England and Wales. It is of significance that very few jobs appear to meet current AoMRC recommendations, for example: that new consultant posts should include 2.5 SPAs[3]. FICM recommends that the minimum number of core SPAs in ICM is 1.5. It is also of note that many jobs do not meet FICM recommendations, for example: that the minimum criteria for a person specification for a post

with ICM includes as essential:[5]

- Eligible to be included on the Specialist Register or within six months of achieving CCT at the time of interview.
- Must have completed intermediate or Step 1 training in ICM or equivalent
- And as desirable: CCT in ICM as described by the Faculty of Intensive Care Medicine (or evidence of equivalent levels of experience/training).
- FFICM or other professional or higher qualification in ICM

FICM also recommends for job descriptions that there is "A description of the clinical workload and work pattern in intensive care (and linked specialities as appropriate), and an indication of the new post's relationship to existing posts."[5] This study has also brought up questions of fairness. Is it okay if a job is advertised with a specific person in mind? As per NHS Jobs Terms and Conditions: "You must ensure that your use of the service promotes fair and open competition and that equal opportunities for all job seekers is practiced at all times".[13]

Limitations

The authors acknowledge that due to time constraints this analysis is limited to only jobs advertised on the NHS Jobs website in England and Wales and does not include ICM consultant adverts in Scotland and/or Northern Ireland[14,15].

Conclusion

At present there are lots of ICM consultant jobs (both dual and to a lesser degree single specialty) available to applicants. This study suggests that there are currently more jobs than applicants.

Therefore, if you are struggling to appoint to an ICM consultant job, consideration should be given to what other ICU departments are doing to encourage recruitment: ensuring the posts are open to ICM trained doctors from all backgrounds to apply to (for example single ICM CCT, dual CCT with emergency medicine, or dual/triple physician CCT), higher SPA time, financial incentives and promoting your department or location.

Recommendations

As a starting point to improve both the likelihood of applicants finding positions they would be interested in pursuing and ICU departments identifying suitable candidates we recommend:

- CD/CLs should review current FICM guidance on approval of job descriptions
- Resident doctors should become familiar with consultant job plans and how they are constructed. The British Medical Association (BMA) provide a simple overview of this in their 'overview of job planning'[16].

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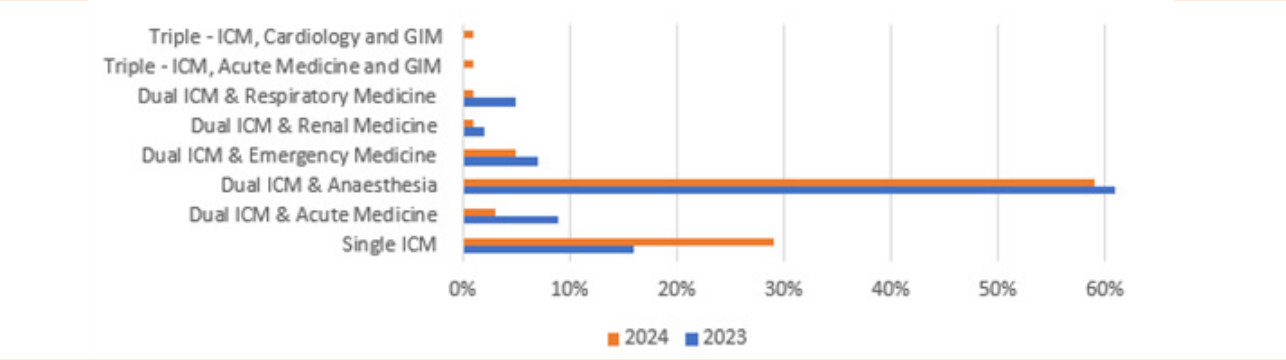
Careers, Recruitment and Workforce (FICMCRW)

Dr Matt Williams
FICMCRW Chair

As we approach the summer holiday season, I hope readers are able to get some respite and time away with those close to them. May the workload hopefully lessen, whilst not being in the "winter pressures" period, and the non-clinical communications and meetings ease off a little, at least for a moment!

At the time of writing, we have just held our June meeting. The agenda was packed. I extend my thanks to committee members for the huge amount of work being undertaken and the healthy discussions held. Here are a few headlines.



ICM CCT completion by specialty in 2023 and 2024

Recruitment

Thanks are due to Liz Thomas (lead), Bob Docking (deputy lead) and their team who have worked with the National Recruitment Office team to recently complete a smooth recruitment round. Thanks also to the consultants and senior IiTs who provided their valuable time to conduct the online interview process in March. Whilst FICM are not yet able to confirm the position following this round, initial reports are very encouraging. We look forward to welcoming our new Intensivists in Training joining their programmes in August. It appears that simultaneous recruitment has run successfully too. This was somethng long requested by candidates for ICM and long campaigned for by FICM.

We are delighted to be publishing a recruitment report which provides information on the recruitment to ICM training and the output of those achieving ICM CCTs since 2008 (congratulations to 123 doctors who achieved CCT in 2023, and the 142 in 2024). It also provides details on the backgrounds of doctors entering ICM training, with less coming from the anaesthetic core training pathway over recent years, and the CCTs doctors achieved in 2023 and 2024 (see table above). This is important information for ICUs to understand as they consider future recruitment of consultant colleagues.

Workforce

The committee is preparing reports to detail the information gleaned in the 2023 census of clinical leads and the 2024 census of doctor members. Richard Porter has provided some data from the former in recent editions of *Critical Eye*.

Careers

Thanks to Andy Martin and Taqua Dahab (Deputy Lead IiT representative), further resources have been added to the website section including example job plans such as single ICM, ICM with respiratory medicine and ICM with emergency medicine. They have also been preparing for a further careers workshop at the IiT conference in November; this will concentrate on the preparation for consultant appointments including interview considerations.

I was privileged to join FICM colleagues at a joint RCEM/ FICM careers day to discuss the career pathways for physicians in Intensive Care Medicine with Emergency Medicine. This was a very positive, informative, sold-out event showing the interest in this career path. Credit must go to Drs Fraser Waterson, Andrew Charlton and Liza Keating for organizing it.

Elsewhere in this edition, Zoe Brummell reports on the findings of a 6-month review of consultant jobs advertised via NHS Jobs last year. It will make interesting reading for prospective employers and applicants, particularly in increasingly constrained fiscal times. Partly prompted by the findings, CRW are now revising information on recommended ICM consultant job plans and the processes to approve them. Regional Advisors can provide valuable support to write high quality job plans that maximise the chances of successful recruitment to consultant intensivist posts with the best applicants. Additionally, Appointment and Advisory Committee (AAC) assessors play an important role to appoint the most suitable candidates to the role. John Berridge, recently elected Board member, is leading work to ensure FICM has enough trained AAC assessors to support this work.

Finally, the Diversity, Equality and Inclusion Subcommittee held its first meeting this month. Their work as the 'critical friend' for the Faculty as it evolves into a college around all aspects of inequity and inequalities will be so important.

ICM ST3 National Recruitment

Dr Liz Thomas
Recruitment Lead

At the time of writing this update the recruitment team have just released an in-depth report on the 2024 ICM ST3 national recruitment round. The 2025 ST3 recruitment round has also completed and we are starting to think of next year's process. We are delighted to report that overall the 2025 round has gone well. Congratulations to all the applicants who have secured posts.

Currently the fill rate is embargoed by MDRS, but we had 181 posts over the four nations. The process involves the applicant reading all the information from ICMRO and checking they meet the minimum criteria to apply. Then the candidates apply via Oriel, provide information so that they can give a self assessment score, which is independently verified by a consultant volunteer. Once this is done, the candidates who have scored sufficiently (18 points this year) are invited to interview. Due to an increased number of applicants this year we successfully increased our interview slots by almost 20% to 384. I personally love the interview stage — every year I am heartened and inspired by the high level of skill, communication and achievement in the doctors who apply to be trained in our specialty.

Gratitude

The process could not run without a significant number of key people. The NHS England staff at ICMRO work tirelessly (and quite rightly received excellent feedback in the post-application questionnaire sent out to applicants) and make my role easier. I am assisted by Dr Robert Docking from Glasgow, as deputy clinical lead, and Dr Aoife Quinn from Cambridge is medical lead for ICM ST3 interview questions. Also, we have had approximately 220 kind senior IiT and consultant volunteers who have given their time for self-assessment verification and interviewing. We have two senior doctors interviewing and scoring at each station and we try to have an observer as well, this means that interviewers can rotate and there is another person involved in the process which increased resilience and helps maintain fairness and standardisation. Thank you to all the kind people who give up their time to help this process. I am very grateful, as are the candidates.

Simultaenous recruitment

This year we have had a major change, which the doctors applying have been requesting for many years. Candidates can be appointed to two training programmes in one cycle — ICM and a GMC-approved second specialty, as long as they are in the same region. Changes can always turn up unexpected consequences, despite our efforts to think every situation through. I am delighted to report that up to this point the process seems to have gone well, with a significant number of doctors accepting two job offers. Of course, this is only the start of the process and we may find complications that we have not predicted at time of commencing work, but we are positive and optimistic that this big change has rolled out without major complication and significantly enhances the experience for our doctors.

Webinar

There will be an online information and question event for doctors applying for ICM ST3 training posts in the 2026 cycle at 7pm on Monday 3 November 2025. I will be running this alongside Dr Docking and we will discuss the process and answer questions from candidates applying.

Diversity, Equity & Inclusion Subcommittee

Dr Som Sarkar
DEISC Chair

As I sit to write this summer update, I reflect on the progress we have made in making the foundations for our DEI Subcommittee, as a meaningful and sustainable support mechanism for the Faculty. We have incorporated the Women in Intenisve Care Medicine (WICM) group, and I am pleased to have the continued support and wisdom of Dr Cath Roberts as our Deputy Lead, as well as support from Dr Matt Williams as CRW chair and the Faculty secretariat.

We had our inaugural meeting in June, with a number of key stakeholders, setting the scene and highlighting where our focus needs to be. Being aware of the work our partner colleges are involved with in this arena has highlighted the need for our journey be complementary but focused on certain aspects unique to critical care. Our main function will be to support and guide the Faculty's business from clinical stakeholders as 'critical friends', to be collaborative, trying to eliminate blind spots, and improve inequity and inequalities in our ventures.

We have set some key points that our role will be advisory, not investigative, or disciplinary, and would recommend for local NHS/Deanery escalation through existing processes to be followed, nor would we offer case-by-case advice. That said, we would ask to encourage engagement with surveys as they come through to guide our strategy and change as needed to progress. We ask you all, especially leads, trainers, ESs and Faculty Tutors, to encourage those working in your departments to fill these surveys. Without the data, we continue to struggle to evidence many of the issues which bubble under the surface and are often diluted in non-specific surveys. You might not think this affects you directly, but we all have a responsibility to advocate for each other.

Some of the data from the last census has highlighted the increasing awareness of adult caring duties. There have been improvements in work life balance being fostered by Schools and Employers generally to accommodate LTFT employees, but workforce planning will ultimately be guided by capacity and demand of trained clinicians coming through, who are 'sandwiched' caring for both children and elderly parents. We hope to continue to use these data to guide our views on workforce and training.

Our initial work will be around how we can improve our offer across the Faculty around mentorship and leadership CPD with what is uniquely required by our membership. We are also looking to increase our subcommittee membership; if you are interested, please get in touch. Thank you all for your continued support and look forward to your engagement.

Small and Specialist Units Advisory Group

Dr Jack Parry Jones
SSUAG Chair

"Our unit is Gilbert Bain Hospital, Shetland, 351 km from the nearest ICU." There is small and remote, and then there is Shetland. But as John Donne said: "No man is an island, entire of itself" — the same can be said of all critical care units, none of which should exist in isolation. This is especially true of small, remote, and small and remote units.

Even within large units we are often reliant on our internal network of support within the hospital — haematologists, cardiologists, neurologists, respiratory physicians, microbiologists etc who we reach out to when we need them. This sort of internal support, even if not at hand 24/7 in large units, just isn't possible in the same way in small and remote units. That does not mean however that it can't be available remotely.

A theme that continues to emerge when we survey small and remote units is that their isolation needs to be reduced by improving connections both virtually and physically. The latest Faculty survey results from May 2025 are being analysed — thank you to those clinical directors and lead clinicians who responded. Critical care transfer services are improving across the UK but they are not universal or equal. The same with critical care network services; more formal structures and processes could be usefully formed to support individuals working in small and remote units.

Training and maintenance of skill sets across the multidisciplinary team also remains a major issue. This is especially true of nursing, when for example renal replacement is not regularly performed, but also across the MDT smaller units simply cannot afford to have dedicated AHPs, pharmacists and psychologists. They may not exist at all or are shared across multiple areas in the hospital. Better maintenance of critical care skill sets and training within either network arrangements or between large and small units need to be developed and strengthened. The increasing number of ICM residents completing their ICM CCT, or those with the portfolio pathway equivalent, bring their up to date knowledge and experience of central connections and networks. Seriously considering a consultant post in these small and remote hospitals requires flexibility but the first step is to bear it in mind.

Configurations of services are an issue in some areas of the UK, but small and remote units remain essential in many places as without these critical care services these hospitals simply would not exist in the same form. If you are in a remote part of the country, either on holiday or even more for those living there, and the "bell tolls for thee", you will be grateful these services exist and for their staff's efforts.

Critical Care Pharmacists

Greg Barton
PSC Chair

The PSC has wasted no time in putting the new subcommittee members to good use. Following on from our first meeting we've sub-divided into two main workstreams: 'Coaching' and 'Portfolio guidance'.

Coaching

The PSC has run coaching sessions within the group to identify suitable tools and structure. The next steps with be to support FICM volunteer coaches in the delivery of a consistent model. Initially the offer out to pharmacist members is likely to be two 1 hour coaching sessions three months apart with either another pharmacist or a medical practitioner. Once we are ready to go all pharmacist members will be notified.

Portfolio guidance

A number of subcommittee members have experience (both positive and negative) of completing Royal Pharmaceutical Society (RPS) Advanced Practice and Consultant ePortfolios. With the support of the RPS we are going to provide some examples of what makes a god/bad entry and run a short webinar along side these. This will happen early summer.

Job plans and descriptions

Plans to develop generic Advanced and Consultant pharmacist Job Descriptions and Job Plans are moving forward slowly but at least moving forward! Job Planning in pharmacy is a relatively new concept and not many examples have come to light even though they are a fundamental part of an application for consultant post approval. What JPs/JDs exist can vary greatly depending on where, when and with what focus they were developed. The aim is still to produce examples of these documents that can be developed locally

Survey

PSC carried out a survey in the spring trying to identify the areas of the curriculum which pharmacists felt the most needed support. Overall it was all pillars except clinical practice with no individual area standing out. We will share results in a pharmacist newsletter and are currently working on identifying content for a series of short webinars.

Helping to shape CICM

Stephen Williams, Strategic Lead for FICM independence, attended our most recent PSC meeting to present the vision, the journey and the key milestones for the transition from Faculty to College. PSC are actively engaging with Mr Williams and the Board discussing how and where pharmacist input can be strengthened.

Advanced Critical Care Practitioners

Natalie Gardner
ASC Co-Chair

Gregor McNeil
ASC Co-Chair

The past year has been busy and productive for the Advanced Critical Care Practitioner (ACCP) Subcommittee (ASC). The Faculty remains committed to enhancing the ACCP role across the UK, reinforcing their critical position within intensive care teams nationwide, especially as the Faculty moves towards college status.

Building on previous initiatives, the ASC broadened national representation significantly this year, welcoming six new members from previously underrepresented regions. We anticipate valuable contributions from these new members, further enriching our subcommittee's discussions and decisions.

Maintaining high standards remains crucial, and the ASC is collaborating closely with other FICM groups to develop guidance around ACCP Scope of Practice. This resource aims to guide Intensive Care Medicine consultants in defining their local scope of practice for ACCPs, ensuring clear governance and structured expansion where appropriate. Additionally, the Sustainable Careers for ACCPs document underwent extensive review, receiving approval from FICM Careers, Recruitment, and Workforce Committee, providing detailed guidance on job structures and supervisor job planning.

ACCP Membership application process

The past year has seen significant improvements in the ACCP FICM membership application process. The ASC has transitioned from individual remote reviews to twice-monthly online review meetings. This change has markedly enhanced efficiency, accelerated approval times, and allowed experienced committee members to mentor newer members through the review process. We extend our thanks to the FICM administrative team for supporting these changes.

ACCP training accreditation

The ASC continues to undertake accreditation of Higher Education Institution (HEI) ACCP training programmes, and we are currently completing the accreditation of our third HEI course. Each accreditation process involves a thorough review of submitted evidence, an in-person visit to the institution, and detailed discussions with trainees, qualified ACCPs, and local Intensive Care Medicine consultant educational supervisors. Accreditation significantly strengthens the national network of FICM-accredited programmes, ensuring consistent adherence to rigorous clinical and educational standards.

To further enhance quality assurance, we have integrated digital data

> **Looking forward, the ACCPSC remains dedicated to representing and advancing the ACCP profession.**

collection points throughout the five-year accreditation cycle, facilitating continuous monitoring and improvement. Additionally, a structured online event is planned to support HEIs interested in accreditation, fostering transparency, collaboration, and shared learning. We continue to receive expressions of interest from other HEIs and anticipate commencing the next accreditation process by the end of 2025.

Advanced Skills Frameworks

Over recent years the ACCPSC have developed a number of specific Optional Skills Frameworks (OSFs) covering diagnosis of death in organ donation, advanced airway and transfer. Going forward these documents have been renamed Additional Advanced Skills Frameworks (AASFs). We have undertaken this name change to emphasise these documents remain the FICM standard for those ACCPs who wish to expand their scope of practice to incorporate these skills. While the diagnosis of death AASF has recently been updated, we are currently undertaking a review of the advanced airway document and plan to review the Transfer AASF from next year.

Equivalence

The Equivalence Pathway is being revised to offer clearer guidance to ACCPs and educational supervisors navigating the equivalence application process and is expected to be available to ACCP members in the coming months.

Regional engagement

Proactive engagement with Scotland, Wales, and Northern Ireland continues. Northern Ireland marked the completion of its first ACCP cohort and secured funding for future training. Scotland will host its annual ACCP conference in November, while Wales monitors HEI developments closely to safeguard training standards.

A comprehensive website review is underway to clarify public listings of accredited training sites, enhancing transparency and accessibility for all stakeholders.

Conference

The 2025 ACCP National Conference was successfully hosted online in June, attracting strong participation and facilitating meaningful professional exchange. Feedback from attendees is currently being collected and analysed to inform improvements and enhancements for next year's in-person event planned for 2026.

Preparations are already underway to deliver a dynamic and engaging programme that continues to foster community interaction and professional development.

Future

Looking forward, the ASC remains dedicated to representing and advancing the ACCP profession, championing clarity in scope of practice, supporting advanced education, and ensuring career sustainability. We extend our gratitude to all ACCPs, committee members, and colleagues whose unwavering commitment continues to enhance intensive care delivery across the UK.

Flourish from the start: supporting international doctors new to UK ICM practice

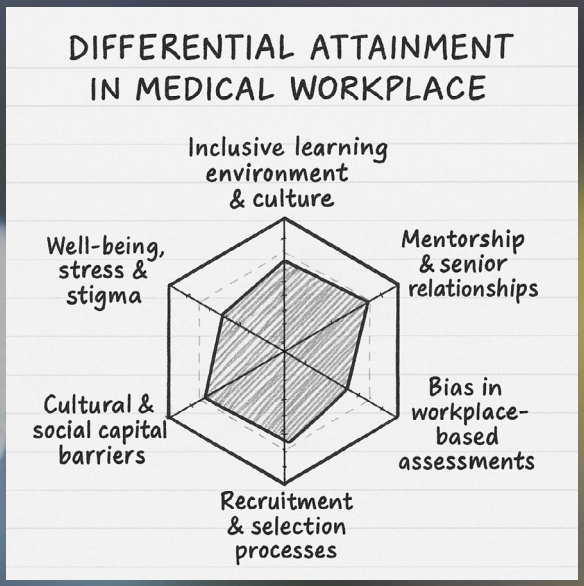
Dr Taqua Dahab
FICM IMGs Rep and Deputy Lead IiT Representative

With almost a third of the NHS workforce comprising international medical graduates (IMGs), a proportion of these work within the Intensive Care Medicine environment. Mixed skills and background, without a doubt, bring strength to our systems. However, it's essential that an inclusive culture, which celebrates this diversity, is embraced to fully recognise and invest in our workforce.

International doctors arriving in the UK are often high achievers with excellent portfolios. Nonetheless, as they endeavour to adapt to their new lives, they encounter numerous challenges.

Cultural differences emerge, necessitating that international doctors take time to grasp the new interpersonal skills required to integrate into a different community. The absence of their established psychological support network can lead to feelings of isolation, as they leave behind family and friends for a fresh start. Moreover, navigating the increasingly complex visa and immigration process adds to their stress. Adjusting to the colder, darker climate, decoding local slang, and figuring out how to register their children for school—wondering if those little ones will make friends in time for their upcoming birthdays—are additional hurdles. All of these factors, external to their work, can significantly impact their performance in the workplace.

At the medical workplace, international doctors often find themselves in an unfamiliar 'community of practice'.
At the onset of their journey, they may struggle to 'fit in' due to a lack of insider knowledge on how to navigate the system the 'UK way'. This can lead to a decline in confidence, leaving them vulnerable with only limited access to mentorship or support. Trainers supervising these doctors may not necessarily understand the challenges they face, both inside and outside of work, nor do they possess clear resources to help this group during their transitional period effectively. Consequently, a gap can form between supervisors'



expectations and the actual performance of international doctors, leading to a 'deficit narrative' or a perception that IMGs need to 'catch up'. This reflects a systemic problem known as Differential Attainment.

Differential attainment

Differential Attainment (DA) among IMGs is a well-researched and documented phenomenon in the medical education literature over the past decade. This phenomenon suggests that doctors from specific backgrounds, such as international medical graduates (IMGs), tend to perform less effectively at work, experience lower job satisfaction, and have fewer opportunities for career progression. This is due to socio-cultural factors rooted in the learning environment we discussed above.

A question has been raised in the medical education literature about whether 'subconscious biases' affect the assessment of international doctors when compared to others, simply because their background reveals that they have not trained here or are not as fluent in communication as others. The evidence suggests this, unfortunately, could happen[1,2].

DA is a complex problem! There is no single solution that could help to prevent it, nor is there a proven, evidence-based formula to tackle it all. The key is to acknowledge the data, quantify the gap, and work to narrow it.

FICM support

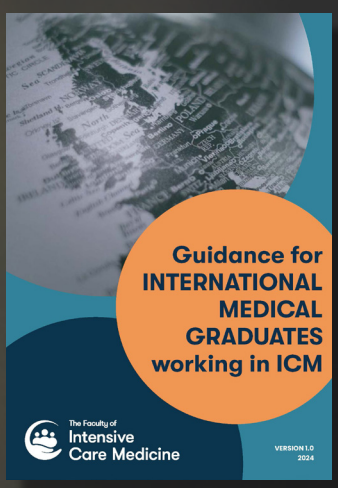
FICM (the soon-to-be CICM) is committed to supporting a positive experience for our international doctors new to the UK Intensive Care Medicine practice. We celebrate the diverse experiences they could bring to the specialty. We are collaborating with IMGs and their supervisors to address differential attainment during this transitional phase through a systematic approach.

We have launched new resources aimed at assisting IMG colleagues in adjusting to their first 12 months of UK ICM practice. This resource includes practical information to aid their pre-arrival preparations, such as guidance on opening a bank account, registering with a GP, applying for school for their children, completing immigration paperwork, and understanding tax codes. These small yet significant signposts can be invaluable in helping a doctor establish themselves in a new country.

For educators supervising Locally Employed Doctors (LEDs) who are IMGs, we have published structured guidance, the 'Initial Assessment of Competencies in ICM'. This framework outlines various procedures and Supervised Learning Events that can be signed off, encompassing four key components: practical procedures, equipment, common presentations, and resuscitation. Upon completion, educational supervisors can generate a certificate for practice with distant supervision. This structured method of competency assessment acknowledges the prior experience an IMG may bring from abroad, contextualising it within the UK framework.

Such an approach facilitates setting measurable targets, monitoring progress, and checking milestones, thereby mitigating anxiety for both IMGs and their supervisors regarding expectations during the initial placement in ICM.

These resources are available at the FICM website, under Careers & Workforce.



Professional Affairs and Safety (FICMPAS)

Dr Dale Gardiner
Chair FICMPAS

My thanks go to Dr Mike Spivey who is demitting from the Committee. Mike has been FICMPAS's Revalidation Lead and served three terms. We've also said goodbye to Dr Angela Lim, our Intensivist in Training Representative. Thank you, Mike and Angela. I know your time on FICMPAS was disrupted during COVID, but we appreciate all that you managed to achieve.

Other membership changes that have occurred in FICMPAS since the last *Critical Eye* are:

- Dr Alex Maidwell-Smith and Dr Gemma Talling have joined as representatives from the Intensivists in Training Subcommittee (IiT Subcommittee).
- Dr Anthony Smith has joined as a representative from the Smaller & Specialist Units Advisory Group (SSUAG)
- Mr Richard Faulkner has joined as a representative from the ACCP Subcommittee.

I am very pleased with this expansion of representation and how it helps reduce the risk of siloed actions and discussion.

Safety

Dr Peter Hersey and team produced more excellent *Safety Bulletins* in February and June 2025. The *Safety Bulletin* remains our main vehicle for sharing safety news, highlighting relevant incidents, and increasing awareness of prevention of future death reports. A recent example from the February *Safety Bulletin* concerned the risks of 'Just to let you know' calls. Please ensure you have read and stay up-to-date with the Safety Bulletins. All are available at: www.ficm.ac.uk/safety-bulletin.

GPICS v3

The GPICS v3 consultation will have closed by the time you read this edition of *Critical Eye*. I am hoping you had a look and made comment if you so wished. My co-lead editor, Dr Paul Dean (ICS), the Editorial Board and I are especially keen to hear your thoughts, particularly on the style changes we have made:

- Standards are now defined as minimum standards. A minimum standard, are must statements, expected to be met by all ICUs or to record on a risk register if unmet.
- Recommendations are now defined as recommendations to provide a quality service. They are hallmarks of what a high-quality intensive care service should look like. Good ICUs, forward-thinking ICUs, should be achieving many of them.

- Background is now defined as background and explanation. As a deliberate choice in GPICS v3, only one sentence, and only one 'must' or 'should' respectively, is allowed in each minimum standard and recommendation to provide a quality service. This stylistic decision was made to aid auditability and readability.

There will inevitably be chapters in GPICS V3 that provoke strong opinions — looking at you Workforce chapters — but GPICS must balance three competing tensions (in this order, I'd argue):

1. Providing safe and effective intensive care services across all UK ICUs.
2. Promoting the specialty of intensive care medicine and intensive care in general.
3. Complying with external regulations (e.g., General Medical Council, contract law).

I look forward to reading your consultation responses and discovering how well (or not) you think we have balanced these tensions.

CPD Matrix

On behalf of FICMPAS and with the support of FICM Board, Dr Peter Hersey has led an update to the CPD Matrix. The previous version was dated and we were aware of a misconception that every specialty topic needed to be completed during each revalidation cycle. However, there is benefit in having a structure for individuals, if they so wish, to describe which areas of intensive care medicine match the CPD activities they have undertaken. There is no obligation to use the updated CPD matrix. It is not something to 'complete' over a revalidation cycle. Instead it is a helpful framework provided for those who wish to use it.

The updated CPD matrix has two levels:

- Level 1 maps ICU activities to the GMC's generic professional capabilities framework.
- Level 2 mirrors the HiLLOs (higher level learning outcomes) from our training curriculum. The rationale being that the HiLLOs describe the scope of our specialty. Reference to HiLLOs also encourages a career-long spiral learning approach.

You can learn more and, if you so wish, download a Google Sheets or a Word Version of a CPD logbook here.

Diagnosing death using neurological criteria

The updated 2025 Academy of Medical Royal College Code of Practice for the Diagnosis and Confirmation of Death has been in place since January 1, along with the updated testing forms available from the FICM website.

The adoption of the updated testing form has generally gone very smoothly. Thank you. FICMPAS does not underestimate the challenge change can bring. Verbally, I have received many positive comments regarding the clarity of the testing form including the updated apnoea test and the change in timing the diagnosis of death to the end of the second set of tests.

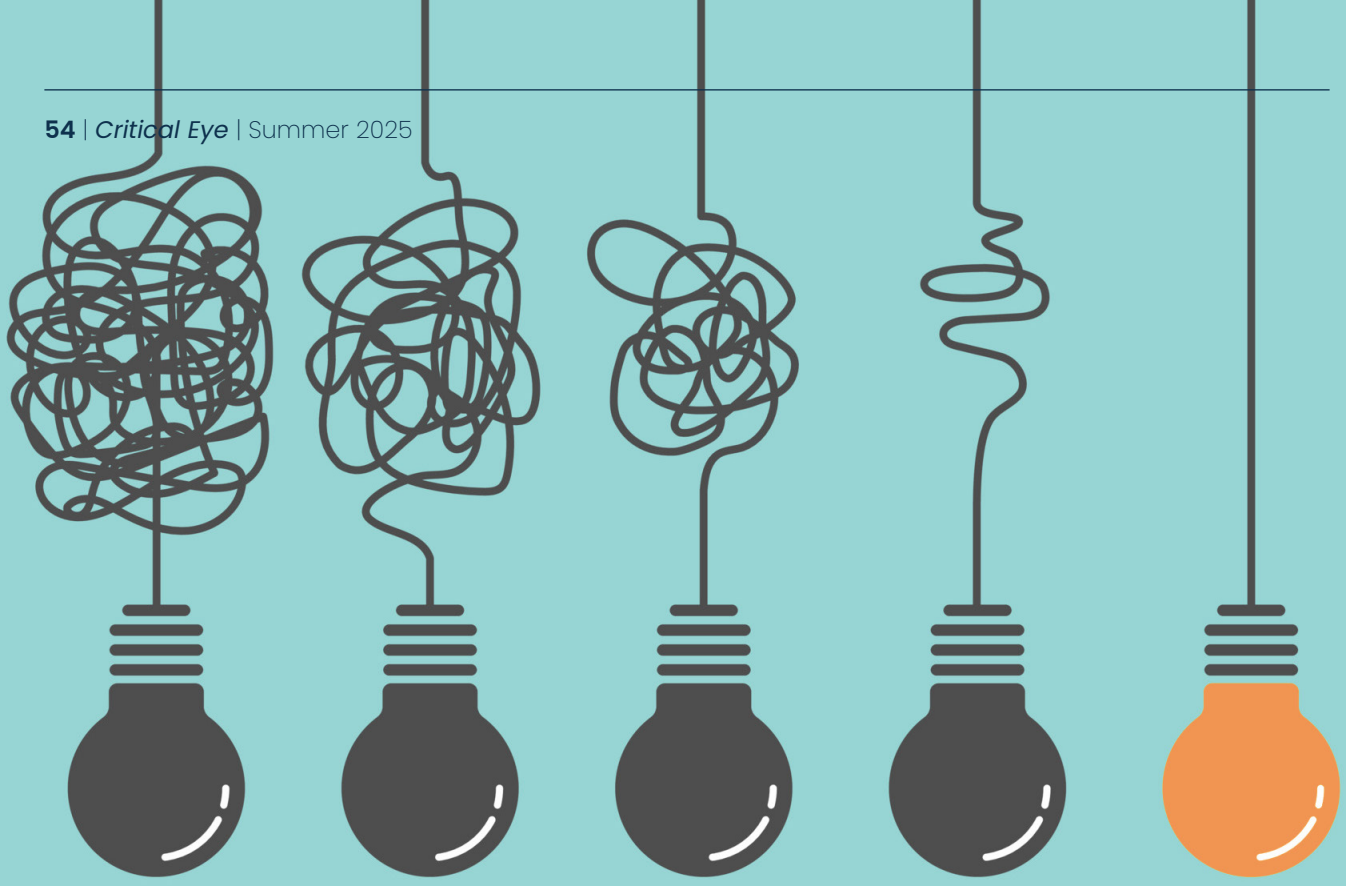
However, the neurological death testing rate in the UK fell from 87% of potential testable cases in 2019/20 to 72% in 2024/25. Since January, and the start of the updated 2025 Code, the testing rate has continued this downward trend and fallen further to 67%.

A deeper dive into the data, collected by NHS Blood and Transplant as part of the Potential Donor Audit, suggests that between January and March, 21 Trusts/Health Boards had the potential to test more than six patients (approx. teo per month). The testing rate in these hospitals varied from 33%-100%. Given the even smaller numbers for the other Trusts/Health Boards it is difficult to provide a percentage range at the current time.

Qualitative exploration of the non-tested cases across the UK (not just the largest hospitals mentioned above) suggests that there might be a benefit for the creation of a stabilisation aide memoire. There were multiple cases of ICUs trying to manage cardiovascular instability with peripheral metaraminol. Or a reluctance to administer DDAVP or start vasopressin in cases of Diabetes Insipidus.

Similarly, the stricter requirements in the 2025 Code regarding hypothermia were not always recognised until late. FICMPAS is in the process of drafting a stabilisation aide memoire, based on the ones that some units are already using across the UK. Hopefully more on this clinically helpful initiative in the next *Critical Eye*.

While not exclusively our own part of the FICM website, most of FICMPAS's activities and outputs can be found on the website. Check it out.



Quality Improvement Improvement? Applying QI to healthcare

Matthew Needham
FICMPAS Quality Improvement Lead

Quality Improvement is a systematic and continuous methodology for analysing and adapting processes to achieve better outcomes. Despite the impressive track record of the discipline in maximising the output of privately owned industrial concerns, the benefit seen from its introduction into healthcare has been more muted.

This may represent the limitations of applying such production focused improvement tools to a service industry, but also the specific, well documented difficulties of undertaking QI in the NHS[1]. Fully realising the potential of improvement science to drive better outcomes is a key challenge for all those who work in healthcare and one in which FICM must take the lead. Much has already been achieved and by better understanding the barriers to widespread implementation of QI we can begin to create solutions to some of these challenges.

QI challenges

For a typical intensive care unit these impediments can be broken down

into those relating to personnel, departmental infrastructure, the internal context of the hospital and the external context of the wider NHS. Summarised in a fishbone diagram (Figure 1) they can be used as a basis to consider the ways that FICM can help facilitate more impactful QI.

Currently, QI in intensive care is largely left to resident doctors who have little formal QI training, rotate through different departments frequently and must be balanced against the competing time pressures of a busy clinical workload and extensive ARCP requirements. This often leads resident doctors to view QI as another box to be ticked with the minimum of effort, and with a few notable exceptions can unfortunately result in a myriad of low-impact projects which rarely address problems in a systematic way.

At the level of the Intensive Care Department other barriers exist, typically a dearth of resources to support change, variable training in leading and supervising QI, prioritisation of other activities such as medical education and research and the siloing of QI projects by job role. At the wider hospital level accessing data vital for measuring change can be difficult and it is uncommon for there to be a strongly led central improvement department. As all the previously mentioned challenges are replicated across clinical specialties there are relatively few projects being completed at sufficient scale to result in lasting clinically meaningful improvement.

Considering the wider context of the NHS, chronic underfunding, undermanagement and organisational upheaval have not produced fertile ground for improvement sciences to take root. Notable efforts have been made to facilitate the introduction of QI with experts in the field creating numerous high quality resources and frameworks[2] but this is fragmented across Royal Colleges, NHS trusts and not-for-profit organisations. Engaging healthcare professionals has been difficult and a lack of opportunities to present and publish QI or an established career pathway for improvement science experts has also held back wider adoption.

Easy wins

Evidently not all these limiting factors have simple solutions and many are beyond the scope of FICM, but we believe that there are several things we can do in the short term to improve our QI offering and generate momentum for future initiatives.

Very soon we will be launching an update to the QI section of the FICM website. This will provide a synopsis of the QI process along with templates, tools and a checklist that we hope will make conducting a QI project less daunting even for novices. Making use of these resources should facilitate high quality projects that are more likely to address systems and create sustainable change. For those wishing to expand their understanding of QI methodology there will be links to educational material and external resources that will allow a deeper exploration of core themes within Quality Science.

Inspired by the success of the FICM *Safety Bulletin*, and with the aim of promoting spread and scale of successful QI work, we will soon be launching a QI-themed newsletter. This will showcase impactful projects completed in UK intensive care units, provide inspiration and methodologies that others can adopt and we hope raise the profile of improvement science in our specialty.

Finally, we recognise that improvements cannot be imposed from above and we really want to hear from all healthcare providers who work in intensive care about the barriers they face and what we as a faculty can do to make QI work better. Later in the year with the intention of better understanding our current state we will be conducting a survey of residents, ACCPs, consultants and QI leads to inform our further work. In the meantime if you have any suggestions or wish to feedback on your experiences of Quality Improvement in Intensive Care then please get in touch via contact@ficm.ac.uk.

Major projects

The more formidable challenges to implementing QI methodologies outlined above still exist and cannot be ignored. FICM will not be able to solve all these alone but has the capacity and responsibility to contribute to potential solutions. We would soon like to begin hosting regular QI meetings to raise the profile of improvement science and give an opportunity for the presentation of projects. Such a forum will allow recognition of the hard work done by those striving to make intensive care better for our patients as well

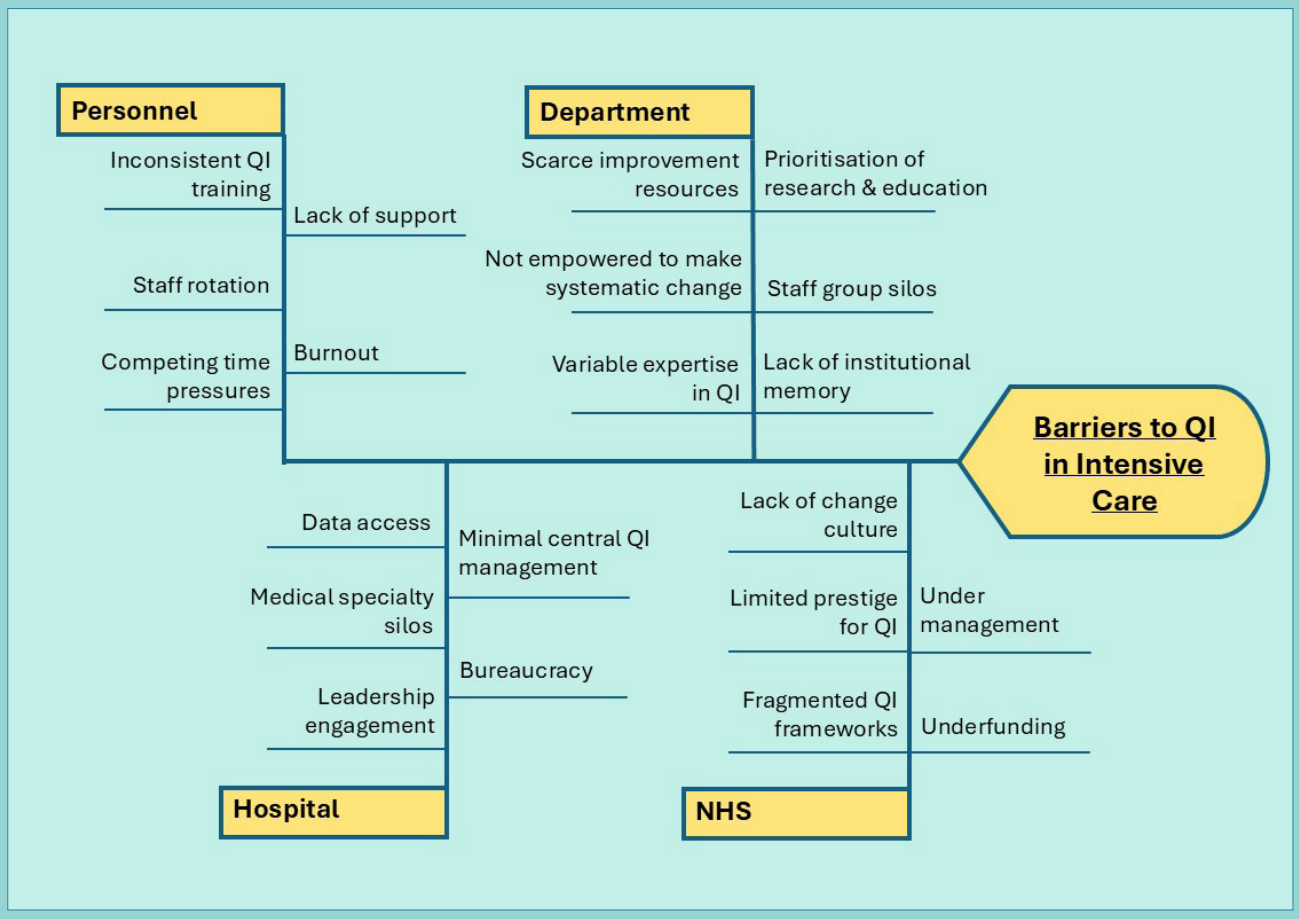


Figure 1: *A fishbone diagram outlining some of the barriers to more successful QI in Intensive Care*

as disseminating outstanding practice more widely.

To better support departments across the country we would like to explore how best we can create a network of QI leads. By engaging local leadership this approach would allow for the rapid sharing of successes, resources and expertise. It could also create opportunities to collaborate on larger scale projects that would enable systematic improvement efforts to reach more patients.

Given the importance of working across disciplines we continue to attend sessions of the RCOA QI working group and are an independent member of the Royal Colleges Improvement Network. This is a recent effort to develop standardised resources, competencies and approaches that maximise the capability of the NHS to conduct QI. It promises to be an invaluable opportunity to learn from other colleges and showcase our own commitment to QI.

Conclusion

QI is a powerful tool to drive improvements for patients and healthcare practitioners and provides opportunities for all healthcare professionals to become more engaged with the management of local services.

There are numerous ongoing challenges and limitations that continue to hold back the widespread adoption of QI in the NHS and many are not easily solved. Nevertheless we are working hard to make QI more accessible to those working in our specialty, and as we transition to becoming an independent college it is vital that we are able to expand our QI offering to match those ambitions.

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Legal & Ethical Policy Unit

Dr Monika Beatty
LEPU Chair

In April 2025, the UK supreme court (UKSC) published the judgment in Abbasi and Haastrup [2025] UKSC 15. FICM had intervened in this case, which was heard in April 2024, alongside but independently to, other stakeholders including the BMA, RCN, and the RCPCH and the PCCS (who produced a combined intervention). The case concerned anonymity for healthcare workers involved two paediatric serious medical treatment cases.

Whilst concluding that the law did not support indefinite anonymity for healthcare workers (HCWs) in this situation, the UKSC highlighted three avenues whereby HCWs could be awarded anonymity during court proceedings:

1. As the Court's duty is to act in the best interests of the child, preserving HCW anonymity during acute proceedings would fall under the remit of Parens Patriae (the inherent power of the courts to act as a parent to protect the well-being of a child) i.e., to allow HCWs to focus on providing care to the child and to avoid disclosure of the child's identity via jigsaw identification.
2. Application of the Broadmoor principle whereby preserving HCW anonymity during acute proceedings will allow the Trust or Health Board to continue to provide adequate care to other patients (i.e., to avoid disruption of services by protestors etc).
3. HCWs can make their own application under tort law i.e., prevention of defamation. The Court has suggested that it would be reasonable for HCWs to consider this at the outset and make a conjoined application with the Trust, if they felt likely to be named and that this disclosure would place them at risk.

Routes one and two would apply during court proceedings and extend to a cooling off period determined by the relevant court.

Route three would be the only way for HCWs to apply for an extended period of anonymity. This would only be granted in exceptional circumstances and HCWs would have to make a very clear case regarding why they believed that this was necessary, specific to the case in question (i.e., referring to previous cases where staff harassment occurred, would be insufficient grounds). Whilst the UKSC judgment involved two paediatric cases, it is likely to apply to adult serious medical treatment cases i.e., those involving the Court of Protection in England and Wales and equivalent courts in Northern Ireland and Scotland.

This judgment is obviously concerning to FICM and its fellows and members and has implications for all HCWs who practice in ICM. The potential ramifications were clearly stated in FICM's intervention, which complemented those produced by the other medical organisations who intervened. The UKSC judgment is final and will be applied in future cases (other than in the exceptional circumstance that the UK parliament changes the law). FICM LEPU is collaborating with the RCPCH Ethical and Legal Advisory group and representatives from the RCN and PCCS, to determine how best to support HCWs who may be involved in similar cases. We will also work with other stakeholders and aim to ensure that appropriate processes are in place, should any HCW need to explore option three above. We will keep you updated regarding our progress and further information will be issued in due course.

FICM LEPU is expanding its membership and will be advertising for new members in the near future: I urge all interested to apply.

Artificial Intelligence and Data-Driven Technologies in Critical Care

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The rapid expansion of data-driven health technologies, particularly those involving artificial intelligence (AI), has the potential to transform the way we deliver care. For a specialty as data-rich as intensive care, the possibilities are significant; however, we should not see these benefits as being guaranteed. It is imperative that we navigate the advent of AI-enabled healthcare with the same rigour and caution applied to any new clinical intervention.

The Faculty of Intensive Care Medicine's (FICM) recent position statement on medical AI highlights that whilst AI is a transformative technology, a degree of caution is necessary before adopting these tools into practice[1].

This article seeks to explore that essential tension: the great promise of AI in the ICU, and the profound ethical and practical hurdles we must overcome to realise it safely and equitably.

The regulatory context of AI in medicine

For clinicians to engage safely with these technologies, it is crucial that we understand how they fit into regulatory frameworks. Put simply: most AI used in healthcare will qualify as a medical device[2]. The Medicines and Healthcare products Regulatory Agency (MHRA) is the UK's medical device regulator, with responsibility for overseeing tools which qualify as Software as a Medical Device (SaMD) and AI as a Medical Device (AIaMD). For a tool to be compliant with the UK's medical device regulations, its manufacturer must demonstrate safety and efficacy for its intended purpose.

Understanding this classification is vital, as it highlights our professional responsibility to ensure that any AI tools we use are compliant with regulations intended to preserve patient safety.

Key AI capabilities for critical care practice

The potential applications of AI in the ICU are wide-ranging. As of 2025, several key capabilities are already widely present in AI tools available for patient care.

- Medical image analysis algorithms enable the automated interpretation of radiological and pathological images (usually with a radiologist reviewing the reports for errors).
- Clinical Decision Support (CDS) systems, frequently embedded within the Electronic Health Record (EHR), can analyse myriad data streams far faster and in greater detail than human clinicians, providing clinical prompts or risk estimations.
- Ambient Voice Technology (AVT) systems are an emerging area of interest for many clinicians. As detailed in recent NHS England guidance[3], these tools can automatically produce clinical documentation from spoken conversations, promising a much-needed reduction in administrative burden. Whilst the appeal of reallocating time to direct patient care is powerful, the NHSE guidance rightly highlights the significant data governance, privacy, accuracy and safety challenges that must first be addressed.

Algorithmic bias and health inequity

Like any health intervention, AI carries both benefits and risks; its clinical value must be proven through robust evaluation. However, a significant body of evidence reveals a persistent and central challenge: algorithmic bias. Systematic reviews consistently show that health datasets used to train AI models often lack diversity, transparency, and traceability[4,5]. A recent review of mammography datasets, for instance, found that most originated from a limited number of high-income countries, with inconsistent and poor reporting of individuals' demographic attributes such as race or ethnicity[6].

This is not merely a theoretical problem. When an AI model is trained on data that fails to reflect the diversity of the population on which it will be used, it is likely to underperform for underrepresented groups[7]. The consequence is the creation and amplification of health inequity. A growing literature demonstrates the propensity of algorithms to underperform for certain groups of patients based on their sex, gender, race, ethnicity and other characteristics, causing misdiagnosis, inappropriate treatment recommendations, and real-world harm[8-10].

One perspective is to view biased algorithms not merely as a technical deficit, but as an informative artefact[11]. Put simply: health inequity and societal disadvantage was around long before the development of artificial intelligence. Biased algorithms developed using skewed data can illuminate the underlying societal and health system inequities that created them. The discovery of bias in an algorithm, therefore, becomes more than a technical problem to be fixed; it presents an opportunity to identify and address the root causes of inequity in our health systems and society at large.

Further considerations for safe AI implementation

Beyond the central issue of bias, a host of other challenges demand our attention.

> The potential applications of AI in the ICU are wide ranging. As of 2025, several key capabilities are already widely present in AI tools available for patient care.

- Consent and Data Governance: How do we ensure patients understand how their data is being used to train and run these systems, and what happens to their privacy in the process?
- Automation Bias: How do we guard against over-reliance on an algorithm's output, leading to errors where an algorithm's recommendation is followed without question?
- Misuse and Scope Creep: How do we ensure a tool deployed for one specific purpose is not used "off-label" for another, where its performance is unknown?
- Business Failure and Cybersecurity: What happens to patient care if the vendor of a critical AI tool goes out of business, or if the system is compromised by a cyberattack?

The opportunity ahead: a call for clinician leadership

Notwithstanding these profound challenges, the potential for AI to enhance critical care remains significant. If implemented with care, these technologies could help us detect patient deterioration earlier, optimise treatments with greater precision, and free up our time to focus on the essential human aspects of patient care.

The path forward, therefore, must be one of cautious optimism, underpinned by collaborative, clinician-led governance. We must not be passive recipients of technology designed without our input.

As intensivists, we are accustomed to interpreting complex data, managing uncertainty, and leading multidisciplinary teams. These are precisely the skills required to guide the safe and ethical integration of AI into our practice. By working with our patients, and with experts in data science, ethics, and regulation, we can ensure these powerful tools are harnessed not just for innovation's sake, but for the fundamental purpose of providing safer, more effective, and more equitable care for all our patients.

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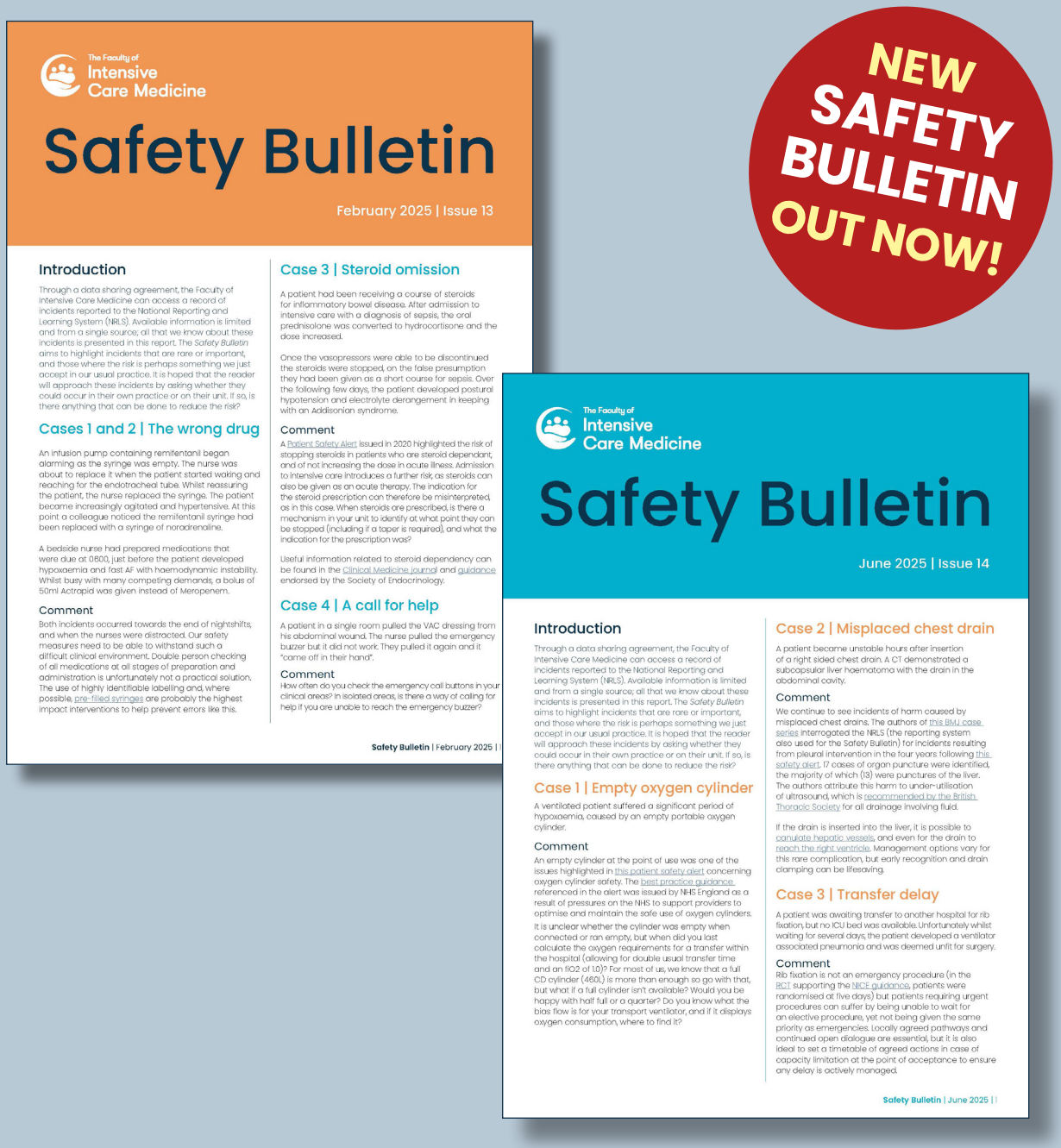

The 13th and 14th issues of the *Safety Bulletin* are out now, summarising NHSE/I-sourced data on critical care incidents classified as moderate or severe in patients above the age of two in a more digestible and readily available form for doctors, nurses and AHPs working in critical care.

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