CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE ISSUE 20 | SUMMER 2021

Collaboration between Emergency and Critical Care

The Faculty of Intensive Care Medicine

In this issue

The Faculty of Intensive Care Medicine

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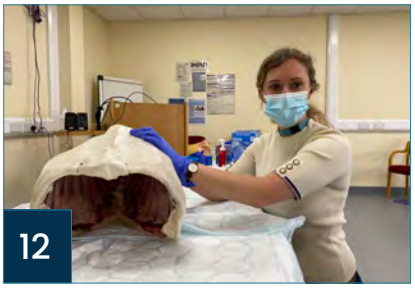

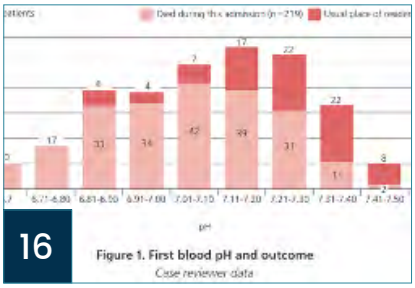

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WELCOME

Dr John Butler
Clinical Editor

Welcome to this summer edition of Critical Eye, I hope you have all had time for some rest and relaxation during the recent good weather. It's hard to believe, but this is the 20th issue of *Critical Eye* since its first publication in January 2012.

The ongoing success of the newsletter is down to the hard work and commitment of all the members of the FICM administration team, but in particular to Dawn Tillbrook-Evans who has worked tirelessly for many years to make sure this is an informative publication for Fellows and Members.

Despite the tremendous national efforts with the vaccination roll out, the critical care workload generated by the COVID-19 pandemic remains significant. The ICM specialty continues to rise to the challenge of this life-threatening infection in a truly remarkable way, which is widely recognised by our fellow professionals and the public at large.

Even under the burden of this increased demand, the work of the Faculty does not standstill. August 2021 will see the introduction of both the new ICM curriculum and the Lifelong Learning Platform (LLP). These developments will ultimately make the lives of both trainees and trainers easier with a reduced assessment burden and a reliance on High Level Learning Outcomes (HiLLOs), rather than competencies.

The eICM project progresses at pace with new content and exciting future plans. In addition, there are essential minor updates to the second edition of *GPICS* (2019) being undertaken with the aim to publish version 2.1 in 2022. In May the Faculty's mentoring scheme, FICMThrive, was launched which provides support to consultants in the first five years of their posts. The FICM is looking to appoint additional mentors so please consider volunteering for this rewarding role.

Notwithstanding our recent challenges, it is important to remember that our specialty remains very attractive to many doctors in training. The Regional Advisors' update comments on the unprecedented interest in ICM shown by the recent 203 national training appointments (a 100% fill rate) from a record 600 applicants. These newly appointed colleagues are warmly welcomed to our specialty, and I wish them every success in the future.

I hope you enjoy reading this edition, stay safe and thanks again for everyone's contributions.

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

Message From The Dean

Dr Alison Pittard
Dean

I cannot believe that I am entering my third and final year as Dean. The majority of my tenure has been under the cloud of COVID-19 but there are some silver linings. The profile of our specialty has been raised and hopefully we will see an investment in terms of capacity. The health and wellbeing of staff has always been a priority, but the consequences of the pandemic have highlighted the relevance of workplace wellbeing and the benefits of a good work/life balance.

Staff are our most valuable resource and it is vital that we look after ourselves and each other. Our collaboration with the College of Intensive Care Medicine, Australia and New Zealand, has workforce wellbeing at its heart and you will see some of the fruits of our endeavours in the coming months.

Collaborative working

At the peak of the first wave there were weekly meetings with the Chief Medical Officer and twice weekly meetings with NHS England. These were organised by the Academy of Medical Royal Colleges, of which FICM is a member. Apart from the content of the meetings it was a fantastic opportunity to collaborate, and I personally feel that I got to know other college leaders a lot better than I would have done otherwise. There are some who I have never met in person, and it will feel so strange when we do meet face to face for the first time. One thing I have learned during the pandemic is that together we are stronger and being united in our message makes us much more likely to be heard. Irrespective of what specialty we work in we face similar problems, they may just require different solutions and talking to each other helps us prioritise to ensure that patients remain the focus of our efforts.

'Long COVID' is a term that has entered the clinical arena and, although not necessarily related to ICU admission, has afforded us the opportunity to highlight the importance of the quality of life after critical illness, of which rehabilitation is a key component. Another big change is the rapid adoption of technology. The majority of our meetings now use a digital platform,

> "Leadership is not about being in charge. Leadership is about taking care of those in your charge" — Simon Sinek

as does a significant proportion of our patient and relative communications. Whilst much of this change is for the better I, for one, really miss the human contact and those chats over coffee. As the world emerges I think the way forward is a hybrid approach. A mix of face-to-face and virtual meetings will satisfy the personal needs of individuals but also reduce the impact that travel has on the environment. We have a backlog of fellowships and other awards to present and I am looking forward to resuming these in-person events to undertake some of the more enjoyable aspects of being Dean. I will have to ensure that I dress appropriately though, having only had to worry about my top half for almost two years!

New Curriculum & e-Portfolio

COVID-19 has changed so much but there have been unrelated developments that were going to occur anyway. Our new curriculum, which has been in the making for several years, will soon be implemented and will ultimately make the lives of both trainees and trainers easier. With a reduced assessment burden and a reliance on High Level Learning Outcomes (HiLLOs), it feels to me like a return to the good old days of just knowing when someone is good without having to unpick every aspect of their practice. We will also have a new e-portfolio to support this. As with anything new there will be teething troubles but the transition appears to be going well so far. A huge thanks to everyone who has helped make this happen.

We had some amazing applicants for the Women in ICM (WICM) Emerging Leadership programme and I had the pleasure of welcoming them to the FICM Board meeting in July. I am also delighted to have been selected by one of our candidates to be their mentor. I thoroughly enjoyed the experience with my first mentee and look forward to supporting the programme going forward.

Work/Life Balance

Finally, I hope you all manage to get some time over the summer to focus on yourselves and your family, whether that is at home, on holiday in the UK or perhaps further afield. Home working has become normal for many and whilst we cannot deliver critical care remotely, much of our non-clinical work can be done in this way. We have seen evening meetings being scheduled more frequently and this begins to encroach on our personal life. I have found it really difficult to separate work from my life at home, never putting my phone down for fear of missing out on a tweet or WhatsApp message. And I know if there are stressors at home this can mean there is no 'safe haven' for you to escape to for some respite. It is so important to look after yourself; if you don't, you may be less able to look after your patients. I have learned this the hard way and, having returned to work following time off, plan to focus on my work/life balance and factor in some device -free time; well perhaps that will be a new year resolution!

Leading the Way: FICM Annual Meeting 2021

Dr Sarah Marsh
Annual Meeting Lead

The Annual Meeting for 2020 was postponed due to the first wave of the COVID-19 pandemic. Last year, the FICM turned 10 years old and the theme of the meeting was planned to reflect the achievements over that decade and look at what the future holds for ICM in the UK. The messages from the original meeting remained important so we carried them over to 2021. The meeting was held virtually with over 70 speakers and attendees.

Alison Pittard opened the meeting with 'Leading Critical Care into the Future' — a review of the Faculty's achievements over the last 10 years, including the last 18 months, and looking at what the future holds for the specialty. Professor Colin Melville and Lt Col Andy Johnston gave us their perspectives on leadership with both agreeing that we should be developing our leadership skills in the same way we develop our clinical skills. Dr Liz Thomas spoke on mentoring and the Faculty's new mentoring scheme FICMThrive. Dr Tara Quasim, lead clinicians for the InS:PIRE programme, discussed how the service has improved the quality of life of critical care survivors by helping bridge the gap between primary and secondary care. Dr Paul Dean and Dr Charlotte Summers debated whether 'the way to improve intensive care unit care is by local quality improvement not research'. They concluded that a collaboration of both was needed. Professor Hugh Montgomery discussed whether people can and want to live forever. Dr Julie Highfield spoke about how leaders can keep themselves and their teams well. Lastly, Dr Polly Fitch discussed how we can communicate effectively with relatives, relaying useful tips on how to have difficult conversations, and emphasising the need for peer support to share the emotional load and allow reflection.

The overall messages throughout the day were to ensure that all staff were supported either by peers, mentors or with psychological assistance; that leadership skills are as important as clinical skills and that leaders should engage with their staff so they feel valued. I'd like to thank all of the speakers, the FICM team and the attendees for making this meeting possible. Look out updates of the 2022 meeting on the FICM website.

Attendee Feedback

> "Great to be able to access the session I missed live and also to be able to re-watch one of the best sessions.

> "I can't afford to go to London for all the events — making attendance digitally an option makes CPD more accessible for those of us not based in London or who can't afford the cost of travel.

Critical Futures: Life After Critical Illness

Ms Joanne McPeake
Nurse Consultant & LACIWP Member

Ms Helen Sanger
Physiotherapist & LACIWP Member

The COVID-19 pandemic has highlighted the challenges which survivors of critical care can experience. These physical, social and emotional issues commonly referred to as Post Intensive Care Syndrome (PICS), can be devastating for patients and their families. Yet, across the UK a lack of funding and established infrastructure has resulted in inequity of access to post ICU recovery services.

Life After Critical Illness (LACI) was commissioned as workstream 12 of the FICM Critical Futures Project. In November 2019, the Faculty founded the Life After Critical Illness Working Party, a group formed across multiple professions and organisations and professions throughout the UK, including patient led organisations. The overarching aim of the group was to provide clarity around the current service context as well as providing support for future implementation of recovery services.

Survey

To understand the current scope of critical illness recovery practice, a UK wide survey was undertaken. Led by Dr Bronwen Connolly, this survey received responses from nearly three quarters of UK NHS ICUs. This survey showed a considerable increase in the provision of outpatient rehabilitation services compared to the same survey undertaken in 2013. The granular results of this research are presented in detail in the LACI guidance, giving a clear picture of the precise structure and functioning of current services across the four nations, including the service models utilised and personnel required. What is clear is that there is motivation and a perceived need to provide these services, however, funding streams and infrastructure remain sporadic.

Implementation

A strength of this document is its focus on the practical implementation of services within the UK context. Service models, across the clinical continuum of care are described in detail alongside the logistical implications for services attempting to implement these innovations in practice. Combined with example business cases and a discussion of funding streams, the LACI guidance provides practical information for clinicians wishing to secure funding for the set-up or improvement of follow-up services in the NHS.

This document undoubtedly provides an important resource for clinicians and commissioners. However, there is still much work to be done. Deciding which outcomes are meaningful to both patients and healthcare organisations, and how these can be measured, remains a challenge. Moreover, how staff and services adapt to ensure that they have the correct skills to provide this care must also be considered fully in future consultations.

Wider impact

As we move forward with the ambitious agenda of providing the correct support during recovery, we must not lose sight of the wider impact that providing rehabilitation can have. By listening to our patients following critical illness, service providers can improve their in-CU care. Additionally, by understanding patient outcomes and 'closing the loop' of care which follow-up provides, staff morale may improve, and we can provide a mechanism for reducing staff burnout- an important consideration as we hopefully emerge from almost 18 months of pandemic care.

Collaborative Working between Emergency Medicine and ICM

Dr Liza Keating
Working Group Chair

July 2021 saw the launch of the jointly authored *Better Together: Collaborative Working Between Emergency Medicine and Critical Care*. Described as a framework for improved working between specialties, this document represents an important collaboration between the Royal College of Emergency Medicine (RCEM) and Faculty of Intensive Care Medicine (FICM).

This work was instigated by the then president of RCEM Dr Taj Hassan and our former Dean Dr Carl Waldmann and followed on from their joint position statement published in December 2018. The overall aim is to improve the care of the critically ill patient in the resuscitation area while clearly focussing on high quality patient experience, adequate staffing, wider system engagement and excellent system leadership. The arrival of this document is timely as emergency departments across the UK are seeing their highest attendances ever recorded.

Writing Group

The document was written by a group of dual trained emergency physicians working across the UK, with representation from both large and smaller trusts including major trauma centres as well as trauma units. Importantly, the views of a patient focus group were also sought early on in the process and their feedback has been incorporated into the document. The patient focus group recognised that the demands of caring for these patients can be great for all staff groups. They were particularly keen to stress the need to ensure adequate support for the entire team working in this environment. References to available well-being resources from the RCN, RCEM and FICM have been highlighted.

Thank you

Many thanks to all FICM and RCEM members who have taken the time to respond during the consultation period. Your feedback has been invaluable and the comments received were thoroughly discussed by the group.

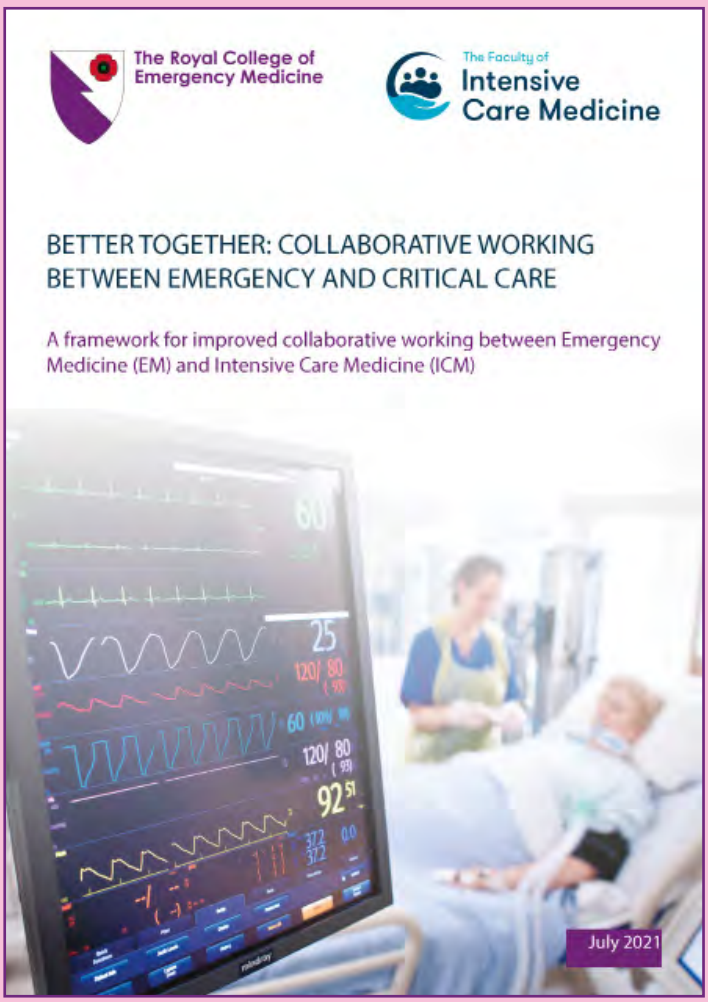
Additionally, a wide range of stakeholders have been involved in the publication of this document. Their feedback has also been essential to the usability of the document. Particular thanks go to Dr Sue Crossland from the Society for Acute Medicine, the Intensive Care Society, the team at Resuscitation Council UK and Anna Crossley from the Royal College of Nursing for their input.

Transfers

Since the launch of this framework, there has been important work around transfers and the recommendations

included are reflective of national guidance from the FICM and ICS. Additionally, whilst historically a number of organisations have made recommendations around nursing workforce numbers in ED, we have been able to incorporate long awaited standards recently issued from a collaboration between RCEM and the RCN. Published in 2020, the guidance entitled *Nursing Standards for a Type One Emergency Department* clarifies that there will be a minimum of one Registered Nurse to each patient in the resuscitation area. It goes on to define that this ratio will be at least two Registered Nurses to one patient during the resuscitative phase of illness or injury, such as cardiac arrest and the initial assessment of major trauma.

The greatest challenge is perhaps yet to come: the implementation of the recommendations.



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BEST PRACTICE STANDARDS AND RECOMMENDATIONS

The *Better Together* document has been divided into three sections:

- Processes
- Staffing
- Training and equipment

Each section has highlighted relevant standards and best practice recommendations in keeping with previous critical care guidelines.

Standards are the essential elements of care that must be used to identify key priorities for the resuscitation area.

Recommendations are statements that should be routine practice in the UK. Both standards and recommendations are endorsed by the key stakeholders including RCEM and FICM.

For every emergency department in the UK there will be aspects of this framework that are not currently met, and it is hoped that these gaps will be used as a driver and focus for areas of development with the ultimate aim of improving patient outcomes.

Developing Chest Drain Training in ICU

Dr Emma Searle
Anaesthetic Trainee
Chesterfield Royal Hospital

During a difficult night shift, a patient undergoing treatment for COVID-19 became markedly unwell, having developed bilateral tension pneumothoraces. Additional stresses in this scenario included a lack of clinical equipment available, reduced staff experience, and significant numbers of redeployed nurses in an unfamiliar environment.

The added intrusion of PPE meant that communication, teamwork, and situational awareness were of paramount importance.

COVID-19 has seen huge and varied challenges to intensive care and anaesthetic departments; often support by staff who have limited skills in our specialty.

There has been a large increase in the use of chest drains in these patients particularly post intubation, often for a pneumothorax. Multiple training opportunities were highlighted and it was considered that alterations of practice within critical care and theatres could be developed and adopted.

Training Method

All anaesthetics and critical care staff were invited to attend targeted training sessions. Training included indications for insertion of a chest drain, theory for safe insertion, followed by practical simulation of Seldinger and surgical chest drain insertion using an animal thorax.

Nursing staff gained additional practical information about setting up for chest drain procedure, maintenance and care of a patient with a chest drain, identifying abnormal signs, when to escalate and how to remove a drain.

Teaching materials

Handouts and an educational video were developed to consolidate the teaching. These compiled both medical and nursing sessions and were widely distributed throughout the trust. This also allowed for those unable to attend opportunity to enhance their knowledge.

Procedural equipment checklists were developed with images and text subtitles highlighting the equipment required.

These have been placed on procedure trolleys and in clinical areas where all staff can access and familiarise themselves prior to use. These can be easily used, wipeable for movement between areas and indication of what equipment is required or for restocking of clinical stores.

A checklist, adapted from FICM, has improved documentation of insertion of chest drains. It provides the framework used for a stop moment pre- and post-drain insertion. It will also provide safer information at hand over between staff.

Results

Nursing staff showed greater confidence with caring and setting up equipment for chest drains. 41% stated pre-teaching that they would feel comfortable setting up a drain, this increased to 97% post teaching.

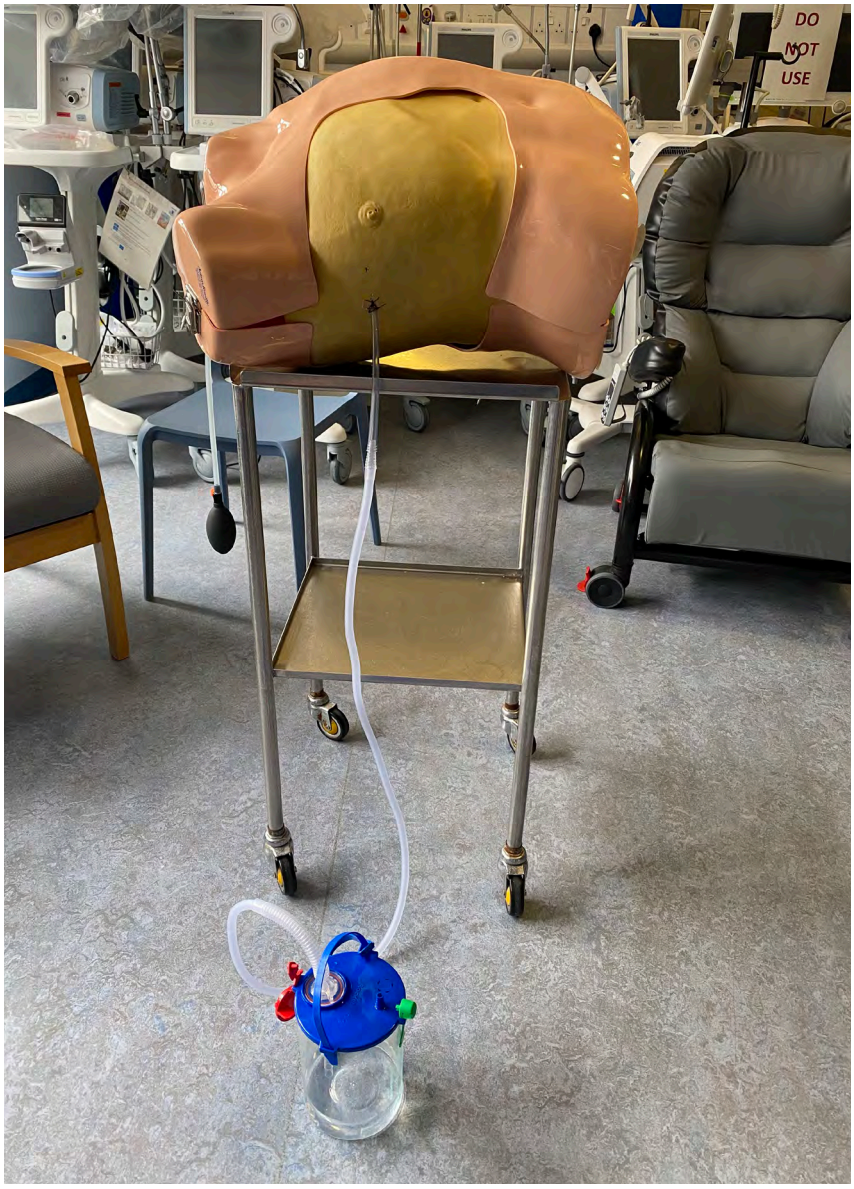
The implementation of the new equipment checklists improved confidence from 41.3% to 100% of nurses understanding the equipment required.
Pre and post teaching surveys showed significant improvement of doctors' confidence levels (1 = least, and 10 = expert) when inserting a surgical chest drain.

The pre-teaching average was 1.1 with an increase to 5.8 post teaching, with the highest post session score being increased to nine.

Feedback

Anonymous feedback from the teaching day was overwhelmingly positive with nursing comments such as *"I feel much more confident with setting up and looking after chest drains"*, and *"Extremely useful as I have never had any teaching on chest drains before"*.

The doctors' teaching sessions were also extensively positive. *"This was brilliant teaching. A really good review and the ability to practice. Good concise handout to then reflect upon. I've never used/seen a Seldinger drain kit before, but having used it in the simulation I would have no hesitation using it in an emergency scenario."*



Conclusion

The patient who inspired this project has been discharged home following a long stay on the ICU. The development of dedicated training, a more robust clinical process, and a more confident staff cohort, have allowed for improved management of patients requiring chest drain insertion.

Get Involved in your Faculty

FICM Board

The FICM Board currently has three vacancies (2 will commence in January and 1 in July 2022). The election will be held on **19 October 2021**. Those who are eligible to stand will be notified via email during the **week commencing 2 August**.

Information on eligibility, application requirements and key dates can be found on the FICM website.

Appointment Advisory Committee (AAC) Assessor

One of the roles of the College is to nominate assessors to sit on Advisory Appointments Committees (AACs) this is regarded as an important part of the maintenance and improvement of standards of practice in FICM.

AAC Assessors needed!

We have a shortage of AAC Assessors in Intensive Care Medicine and Paediatric Intensive Care Medicine sub-speciality. We are keen to find assessors suitable to attend these AAC panels.

AAC assessors are asked to volunteer to attend panels throughout the year and there is no limit on the number you can attend. All new assessors must complete our online training and update this training every 3 years.

How do I get involved?

The RCoA is currently recruiting AAC Assessors for England Wales and Northern Ireland across all specialties.

For more information, visit: Advisory Appointment Committee (AAC) Assessor Information and Application Form or contact: **aac@rcoa.ac.uk**

FICM Education Sub-Committee: Podcast Lead

The FICM Education Sub-Committee (ESC) are seeking a podcast lead. The ESC are a group who support each other in new projects and have a real passion for education, whilst experience of podcasting will be of benefit, this is not a requirement. We are looking for individuals who are energetic and passionate to learn with the support of the Faculty!

The ESC coordinates and oversees the Faculty's focus in the areas of:

- Overall education strategy
- Events, study days and conferences
- e-ICM: the NHS e-learning resource for critical care
- The FICM's wider e-learning resource, FICMLearning.

If you have any questions, please do get in touch with us: contact@ficm.ac.uk

The job description, application and details of how to apply can be found here

Application Deadline: 10 September 2021

Time Matters: A report on the in hospital care of out of hospital cardiac arrest

Dr Simon McPherson
NCEPOD Clinical Coordinator

60,000 out of hospital cardiac arrests (OHCAs) occur annually in the UK, with a 9% rate of survival to hospital discharge, and considerable regional variation (2.2–12%).

The 2021 report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviewed the care of OHCA patients from 2018 who achieved a sustained return of spontaneous circulation (ROSC) for at least 20 minutes. Organisational questionnaires (182), clinical care questionnaires (699) and case notes (416) were reviewed. The report makes 13 recommendations to improve the care of OHCA and was supported by data from the Out of Hospital Cardiac Arrest Outcomes Registry at Warwick University.

Presented here are recommendations and key findings most relevant to critical care.

Figure 1 shows the data for pH and survival, a similar pattern was seen for lactate and time to ROSC.

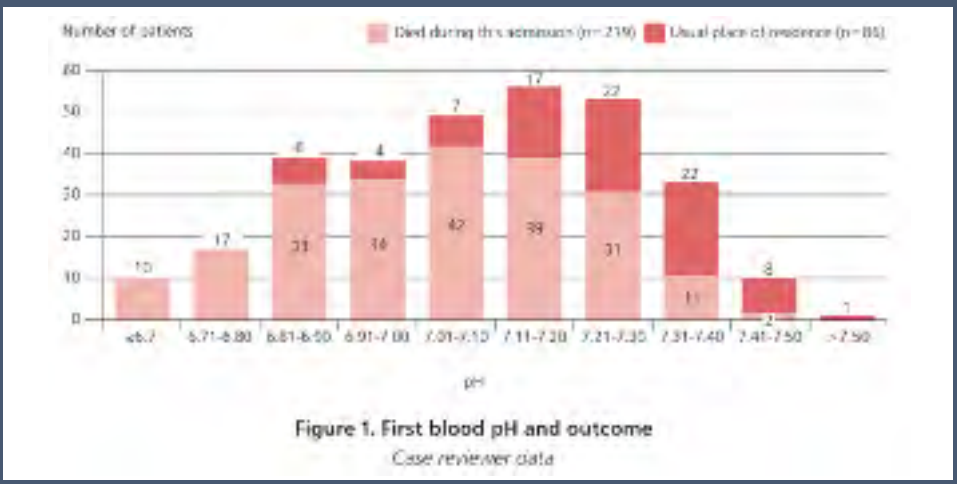


Figure 1. First blood pH and outcome
Case reviewer data

Implement effective systems to share existing advanced care directives (ACDs) between primary care, ambulance trusts and hospitals.

- 3.2% (21/661) of patients were resuscitated contrary to an existing ACD.

No single factor (including time to ROSC, lactate or pH) on admission accurately predicts survival after OHCA. Do not use such factors to make decisions about critical care organ support or interventions.

- The highest admission lactate in a survivor was 19.8 mmol/l
- 9.6% (10/104) of survivors had an initial pH ≤ 7.0
- 39 minutes was the longest interval between OHCA and sustained ROSC

On admission after an OHCA, prioritise percutaneous coronary intervention (PCI), because a primary cardiac cause for OHCA is likely.

- 25.3% (47/186) of patients with ECG changes, suggestive of myocardial infarction or ischaemia, were not discussed with a cardiologist
- PCI was on-site at 88/182 (48.4%) hospitals, with a 24/7 service in 53
- 4.4% (31/698) of patients were admitted directly to the cardiac catheterisation laboratory
- 26.9% (111/412) of patients had catheter coronary angiography; in a quarter this was inappropriately delayed

See Figure 1 for data for pH and survival.

Use active targeted temperature management (TTM) during the first 72 hours in ICU to prevent fever (temperature over 37.5°C) in unconscious patients after OHCA

- 77.8% (130/167) of hospitals had a TTM policy
- 41.4% (104/253) of patients within 24 hours of ROSC did not receive TTM when it was indicated, and it was rated as poor or unacceptable for 57.5% (126/219)

In unconscious patients reliable neurological prognostication requires:

1. **At least 2 of - clinical assessment, imaging, EEG and biomarkers**
2. **Sufficient time for the effects of sedation and TTM to be excluded**
3. **The final neurological prognosis occurs at least 72 hours post ROSC**
4. **Repeat the assessment if any doubt**

- Formal neurological prognostication occurred in 48% (134/279) of patients where indicated
- 19.4% (26/132) of patients had a single modality used
- 19.8% (26/131) of patients had inappropriately timed neuro-prognostication and 46 patients had treatment withdrawn without neurological prognostication.

Identify all survivors of OHCA who would benefit from physical, cardiac, neurological and psychological rehabilitation before hospital discharge and ensure this is offered to them.

- 71.1% (133/187) of survivors were offered physical rehabilitation;
- 29.4% (55/187) neurological rehabilitation
- 59.0% (72/122) cardiac rehabilitation (where applicable) and
- 20.0% (21/105) psychological review

Overall 50% (208/416) of OHCA patients in the study received a rating of good care by the case reviewers. In the remaining patients, room for improvement in clinical care (36.5%) and/or organisation (15.6%) was identified. International exemplar healthcare systems report survival rates of up to 25%. Improving NHS performance to these levels, would add 3250 survivors annually.

Dr Stephen Cole
President SICS

Dr Barbara Miles
Secretary &
President Elect SICS

CRITICAL EYE *Spotlight:* The Scottish Intensive Care Society (SICS)

The Scottish Intensive Care Society (SICS) was formed in January 1991 by representatives from the existent intensive care units in Glasgow, Edinburgh, Aberdeen and Dundee following a meeting in Perth to coordinate and promote the specialty.

Prior to the Society's formation there had been a few regional and national educational meetings but there was no overarching Scotland wide group. The early aims of the Society were to promote and disseminate intensive care education, audit and research.

Representation

The Society was formed with the explicit aim of achieving wide geographical and national representation across Scotland, not just from the urban population centres. The initial constitution of the Society divided Scotland into three regions and ensured representation from the North (Inverness, Aberdeen and Dundee), the East (Fife, Lothian, Forth Valley and the Borders) and the West (Greater Glasgow and Clyde, Forth Valley, Dumfries & Galloway, Ayrshire and Lanarkshire). Regional representatives are elected by the regional membership and serve a term of two years that can then be extended into a second term. We also have representation from nurses, AHPs and doctors in training and aim to represent all staff groups working in critical care.

The first President of the Society was Dr A.B.M. Telfer of Glasgow Royal Infirmary who had previously served as the president of the UK Intensive Care Society. The term of the president is two years with a preceding year as president elect and subsequent year as the immediate past president.

In the early days, the main focus was the Annual Scientific Meeting which expanded over the years from an initial half day meeting held at the Station Hotel in Perth, into a two day meeting at Stirling University, then to various "Hydro" type hotels within central Scotland. In recent years we have held two-day meetings at one of the large golf hotels in St Andrews. These residential meetings have always been aimed at the entire multidisciplinary team working in intensive/critical care with a strong academic element and a great social programme. As these meetings are generally held in January, they have often coincided with the annual Burns Night celebrations and a Ceilidh giving the meetings a traditional Scottish flavour.

Scottish Intensive Care Audit Group (SICSAG)

The Society was, from its inception,

heavily involved with investigating ICU data to allow outcomes audit, quality improvement and more recently process audit. The Scottish Intensive Care Society Audit Group (SICSAG) was formed as a sub-group of the main council and the chair of SICSAG is co-opted onto council. The initial funding for SICSAG came from the Scottish Office for development of an electronic ICU bed availability tool and grew into an internationally respected audit.

After detailed discussions in 2006, SICSAG formally entered into a partnership with the Scottish Government and became one of the stable of health care audits coordinated by ISD (the Information and Services Division of the Scottish Government). This collaboration resulted in the provision of a statistician together with resource to support local audit facilitators and an annual publication on outcomes audit and infection surveillance.

The promotion of transparency and continuous improvement has always been at the forefront of SICSAG's ideals and it reports unit identifiable outcomes to two standard deviations from the national mean. There is a robust governance process to investigate any potential outliers.

Critical Care Delivery Group (CCDG)

The Critical Care Delivery Group (CCDG) was developed to provide assurance to health boards and service providers on the safe provision of intensive care and high dependency care at hospital and health board level. Like SICSAG, the CCDG was formed by working closely with the Scottish government. The chair of the CCDG is also a co-opted member of SICS council, along with Chairs from the Research, Education and Trainee sub-groups.

The Society is also permanently represented on the multidisciplinary Donation and Transplant Group which advises the Cabinet Secretary of Health and the Scottish government on donation and transplantation matters.

Future Plans

The future has, in common with many others, been shaped by the COVID-19 pandemic and we had to move to a virtual (eASM) meeting in 2021. We had a fantastic response with over 500 delegates registered. One challenge for the future is, if, how or when do we move back to an in person annual scientific meeting.

We currently have over 500 members and clearly recognise that building a sustainable future for our specialty rests with enthusing our multidisciplinary team and showing potential critical care staff that ICM is both stimulating and highly rewarding.

Welcome from Australia and New Zealand

Dr Rob Bevan
Vice President
CICM Australia & New Zealand

As 2020 began, our organisations aimed to focus on a '2020-Vision': to develop opportunities, promote wellbeing and equity, advocate for our patients, trainees, and specialists in areas of commonality, whilst learning lessons from where we each took different paths. We noted that "*This should be invaluable as we negotiate the uncertainties ahead.*" At the time of writing that, nobody had heard of COVID.

Many of us in Australia and New Zealand have family and friends in the UK and felt frustrated and helpless as you faced unprecedented demands. Down here in ANZ, we have not emerged unscathed; local outbreaks, uncertainty, lockdowns, border closures, vaccine supply concerns and an inability to travel still weigh heavily on our daily lives.

Our organisations have had to rapidly innovate to support our trainees, Fellows and staff so that training and our organisations could function. Adapting training and assessment to the uncertain and constrained post-COVID environment has at times been all-consuming. Notwithstanding, we have witnessed survival, heroism, adaptability and triumph through collaboration and these experiences have been truly humbling. We are immensely proud of the global ICM community. Despite our geographical separation, the last year reinforces more than ever the benefits of working and learning together.

Moving forward together

Back to the vision. At the end of 2020, representatives of the Faculty and College agreed to focus on a few projects (under four domains) which should bring meaningful benefits:

Training

Look into ways we might streamline the accreditation of training time between our countries to promote consistency and flexibility for trainees who wish to gain international experience.

Assessment

Explore the opportunities that our enhanced familiarity with virtual platforms brings e.g. sharing access to our community of learning, examination preparation and meetings.

Wellbeing and culture

Each of our organisations (in conjunction with our respective Societies) are devoting considerable effort to understand the specific challenges we face that impact our own wellbeing. Linking our respective groups, sharing knowledge and resources whilst collaborating on new ventures will be prioritised.

Equity

We will aim to quantify and understand the inequity which exists within our specialty. We will promote dialogue between our respective groups including CICM Indigenous Health/BAME initiatives as well as WICM/WIN representatives.

Advocate for patients

We are delighted to collaborate with the Faculty, the challenges of 20/21 have only increased the need to advocate for critically ill patients and those that care for them, whilst learning lessons from where we each took different paths.

We look forward even more to being closer.

When Staffing is Critical

Dr Daniele Bryden
FICM Vice Dean

Dr Jack Parry Jones
FICMCRW Chair

Staffing, staffing, staffing. The most serious concern about meeting the demands placed on critical care by COVID-19 was never about ventilator numbers. Critical Care's response was always about staffing expanded units, staffing to meet patients' care needs and staffing to best uphold the expected high standards of care set by our specialty.

The *Critical Staffing* series predates COVID. We always hoped this series would provide a way forward for critical care teams across the UK to examine their staffing requirements and make appropriate plans; even more so now following two COVID waves. We know critical care staff are our most precious resource, and we know retention is as important as recruitment. *Critical Staffing* is not just for critical care management teams, but also wider hospital management structures planning short, medium and long term staffing responses, and COVID recovery.

Staff Wellbeing

Critical Staffing 2 looks to address staff wellbeing to help units maintain staff. We know how mentally and physically exhausting, but also how rewarding it can be working in such an environment. We need to ensure rewards outweigh penalties, and where people struggle, there are support structures readily available. We also need to ensure critical care can be a lifetime career; not one prematurely curtailed by exhaustion and burnout. This requires job plans that acknowledge age, not ignore it, and place real value on experience.

Many *GPICS* standards have been tested during the past 18 months. A crisis response so reliant on pulling staff from their usual work is not resilient or sustainable. How do you manage a recovery plan for elective services when their staff are working, or will potentially have to work, in the critical care arena? One part of the solution is more staffed critical care capacity as seen in most European countries. Another is the Faculty's work on Enhanced Care; acknowledged by NHS England as one way of developing a different, more flexible and efficient pathway to support some aspects of a necessary expansion beyond standard ward level care.

The one-off 100 additional ICM training posts Health Education England gave to English regions to ICM in 2020 was very welcome. However, we need to find a way of moving from pockets of excellence, to a future where we universally offer the same highly regarded ICM service, staffed by a team of ICM trained multi-disciplinary professionals that the public has seen over the last 18 months and expects.

ICM National Recruitment

Dr Tim Meekings
Recruitment Lead

The recently completed national ICM recruitment round for 2021 proved to be challenging due to the difficulties imposed by the pandemic. Once again, we were unable to carry out a face-to-face process for interviewing and had to rely upon the portfolio self-assessment to rank applicants from across the UK.

Ideally, we would have liked to have supplemented this with an online interview process, to help identify the applicants with the necessary experience and aptitude to join the ICM training programme. Unfortunately, the timing of the interview process would have meant that the window for online interviews would have coincided with the second peak of the pandemic surge in critical care and we simply did not have the time and the consultant intensivists available to deliver this during such an unprecedented time of peak clinical activity.

The only alternative

This left us with the only alternative of relying upon the portfolio self-assessment scores, with an additional process of score verification to provide a degree of quality assurance. The verification process was undertaken by a team of consultant intensivists with previous experience in the interview process and training provided by the Faculty, to ensure the process was as fair and equitable as possible.

Once the verified applicants' scores were released, there was an opportunity for applicants to appeal and have their self-assessment scores reviewed by a second consultant intensivist and marked up or down (or kept the same), depending upon their judgment — with whichever was the higher of the two scores taken forward as the final score.

Recruitment numbers

For the 2021 recruitment round, there were a total of 595 applicants, of which 573 met the longlisting criteria. After verification of the self-assessment scores, 493 applicants were deemed to be appointable and were then placed in rank order. Through a matching process, these applicants were then offered training posts according to their preference and their ranking in their preferred area of training. A total of 203 ICM training posts across England, Scotland, Wales and Northern Ireland were available; and this year there was a 100% fill rate for these posts.

Next year

Looking ahead to 2022, there remains a degree of uncertainty as to how we will deliver the interview process for ICM recruitment. If a full face-to-face process is not possible, the hope is that we can offer a combination of self-assessment portfolio scoring with verification by trained assessors, in addition to an online interview process.

Depending upon the resources available, the online interview process will either be a panel of two interviewers or a multiple online station interview with two or three pairs of interviewers. This is very much still in the planning stage and more information will be released as soon as it is available. Whichever process is used, the aim remains the same — to recruit a broad-based and high quality workforce to work in ICM, both now and into the future.

Careers, Recruitment and Workforce (FICMCRW)

Dr Jack Parry-Jones
FICMCRW Chair

"The best way to predict the future is to create it."

For 10 years ICM has existed as a standalone General Medical Council registered specialty. A future, where all critical care is directed by trained intensivists is not yet realised, even in normal times. In a pandemic we were sadly short and consequently reliant on colleagues from other specialties, particularly anaesthesia and medicine.

The time taken to reach a point where all ICM care is led by trained intensivists, and where we are less reliant on help from other specialties is dependent on several factors.

Recruitment

Firstly, recruitment and the number of ICM national training numbers (NTNs). In 2021 we saw more than two applicants for every ICM NTN. Many applicants to ICM were disappointed despite a very good argument for sustained increases in ICM NTNs. Any increase in critical care capacity requires more NTNs and we know UK ICM capacity is well short of the European average.

Careers

Secondly careers. Some ICM consultants prematurely retire from ICM into, most commonly, anaesthesia. This removes those best placed to shape the specialty's future into one where older intensivists still play an important role. Older intensivists' future should not be Orwell's horse from Animal Farm — "I will work harder" (burnout) or be put out to green pasture (premature retirement) or Boxer's sticky end, sold for glue (death in service). Job plans need to be flexible and cognisant of age. With a retirement age of 67 we risk losing 12 years from a career in ICM if 55 years old is seen as past it.

Workforce

Pre-pandemic, Arora and Abbey conducted a survey of ICM consultant advertisements to ascertain desirable and essential shortlisting criteria. Of 104 advertisements, most posts — 97 (93.2%) were advertised with the option of a second specialty, 73 in anaesthesia (70.1%). 32 (30.7%) posts, mainly in units with more than 25 beds, were open to applicants with a single CCT in ICM. An ICM CCT, or equivalent was listed as essential in 47 (45%) posts, but only desirable for most others.

Larger units (greater than 13 beds) were more likely to list an ICM CCT or equivalent as essential.

Despite *GPICS*, the majority of advertisements did not require an ICM CCT. If care for all critically ill patients is to be directed by trained intensivists, then advertisements need to reflect this. As more trained intensivists are either single CCT, or dual trained with a specialty that isn't anaesthesia, advertisements for consultant anaesthetists will increasingly miss intensivists with a non-anaesthetic CCT. This risks a situation of excess ICM consultants in larger hospitals and no ICM consultants in smaller ones.

Crossroads

We stand at a crossroads. In one direction lies a future with a medical workforce of consultant intensivists, with or without a second specialty, who remain within it for a whole career. We need to create that future with more ICM NTNs, supported by flexible job plans for older intensivists, and backed by a broader recognition of ICM in its own right to equalise access to ICM trained consultants.

Women in Intensive Care Medicine (WICM)

Dr Liz Thomas
WICM Chair

The Women in ICM (WICM) Sub-committee have continued to meet regularly, developing projects and I am delighted to report we have made excellent progress despite the pressures and demands of the ongoing pandemic. The Faculty believe that all ICM doctors would benefit from having access to a mentor and in May we launched the Faculty's mentoring scheme – FICM Thrive.

Although Thrive is being hosted by the WICM committee, we are keen to promote that the mentoring programme is for doctors of all genders. The scheme will initially provide mentoring to consultants in the first five years of their consultant post. To be a mentor you need to complete a one-hour e-learning module, and we are particularly looking for volunteers to become mentors. The application form is on the FICM website. Being a mentor is a rewarding process, which can promote wellbeing and self-development and is invaluable to the people being mentored.

Striking the Balance

We are delighted to be able to run our annual meeting this year – Striking the Balance. This will be held on 30 November 2021 and we have a day of excellent talks booked. To keep safe and avoid the risk of cancellation, we are holding this meeting online, so you don't have to brave the winter weather and can join from the comfort of your own home. Booking is now open for this event with a special Early Bird disocunt ticket price if you book before 6 September.

As always, everyone is welcome at the meeting so click here to see the programme and book your place. Look out for the booking form and programme, again, everyone is welcome at the meeting even though it is being hosted by WICM.

Women in ICM Wider Group

I am pleased to announce we have redeveloped and welcomed almost 90 new members into our Women in ICM wider group (WWG). We are hoping to use this wealth of experience and enthusiasm to good effect in our social media outputs, Thrive mentoring, general promotion of ICM as a career for all and to create working parties to help the WICM Sub-committee members in our projects. If you are a woman and would like to be involved there is still time; please email us on wicm@ficm.ac.uk to get involved.

WICMEL

Following on from the successful completion of the first cohort, we have appointed our next four WICMEL (Women in ICM Emerging Leadership) fellows who will start the programme in July. Look out for blog and social media posts from the fellows who have completed the programme about what they have got out of it.

A career for all

Our final major workstream is working to engage medical students and promote ICM as a career for all. This project is in the early stages of development, but we are always keen to hear from anyone who may wish to be involved in this and any other areas of work.

You can contact us via social media: Twitter @WomenICM or via email wicm@ficm.ac.uk.

Critical Care Pharmacists

Mr Greg Barton
FICMPSC Chair

I find it hard to believe that the Pharmacy Sub-Committee (FICMPSC) is already a year old, and what a year it has been! No sooner had our members been chosen and our first major workstreams defined than COVID waves came crashing upon us. This hasn't particularly slowed us though; underpinning the work we want to develop around education and training, credentialling and mentoring is a revamp of the syllabus and curriculum.

These were first developed by the United Kingdom Clinical Pharmacy Association (UKCPA) and later adopted by the Royal Pharmaceutical Society (RPS) Faculty. Rather than re-inventing the wheel, the opportunity arose to apply to be one of two "pioneer" specialty groups and work with the RPS to develop a Specialist Pharmacist Advanced Practice Framework. Sitting alongside the Core Advanced Practice Framework and sandwiched between Early Years and Consultant Frameworks, this will eventually create a career pathway for pharmacists in all sectors. Along with Mental Health, the UKCPA/FICM Critical Care Pharmacist application was successfully awarded the opportunity to develop their specialist framework.

Assessment and support

This is great news; by working together the FICM, UKCPA and RPS have ensured that this project has progressed at a great pace, with the final document due for release this September. On the back of this work, the FICMPSC will be able to progress with developing a sustainable method of assessment, support and mentorship that will be available to all pharmacist members of FICM.

Workforce Survey

Richard Bourne and I, along with Mark Borthwick (Consultant Critical Care Pharmacist, John Radcliffe Hospital Oxford) have completed the data collection and analysis of the 2020 workforce survey and aim to publish soon in a peer reviewed journal. We had a fantastic response rate of greater than 97% and just like the first survey in 2015, it shows a beautifully detailed picture of pharmacy services to critical care across the UK.

Once published, with the support of the wider FICM community, we hope to use the data to highlight the strengths and weaknesses of the current workforce in the national media, and develop and bolster the service where it is currently falling short of *GPICS* standards. Watch this space!

Get involved

The FICMPSC aims to greater engage the pharmacy members with the rest of the FICM and its workstreams. To that end, Alan Timmins – Critical Care Pharmacist, Fife, Scotland – is supporting the FICM with the production of the *Safety Bulletins*, adding expert support and detail to the medicine's alerts. The FICMPSC encourages current pharmacy members to get in touch if they wish to get more involved at contact@ficm.ac.uk.

Advanced Critical Care Practitioners (ACCPs)

Dr Simon Gardner
ACCPSC Co-Chair

Since 2009 and the inception of ACCP training, it would be fair to say that most critical care units have struggled to secure significant recurring funding to assist in the training and education of ACCPs. The university tuition fees, the ACCP salary whilst in training and supernumerary, and the consultant time for teaching, education and supervision etc, all had to be funded solely by the employer.

This remains a significant financial burden and, in many cases, has precluded the possibility of units embarking upon ACCP training. Over the last couple of years, in certain areas of England, this situation has improved dramatically. There are now two potential mechanisms by which ACCP training centres can gain vital assistance with funding for education.

Funding Options

Firstly, with the national standardisation and rollout of Advanced Clinical Practice (ACP) training schemes across the UK (covering all areas of healthcare, both primary and secondary), Health Education England (HEE) has, in certain regions, started to offer sizeable training grants for employers that are designed to be used specifically and solely for the training and education of ACPs. In many instances, ACCP training can be recognised as satisfying the criteria for an HEE approved ACP course.

It is important to understand that ACP training (per se) is not ACCP training. For any ACCP training site, the rigorous content of the FICM National ACCP Training Curriculum must be strictly adhered to. This is essential for any trainee hoping to gain FICM ACCP Membership. Adherence to the FICM curriculum mandates the delivery of regular, formal critical care education throughout years one and two of training, with specifically allocated modules in critical care spanning the first two years. Nonetheless, several established ACCP training centres in the UK have successfully negotiated the application process in conjunction with their Higher Education Institution and obtained HEE ACP training grants.

The award of an HEE ACP training grant is at the discretion of the local/regional HEE Faculty of Advanced Practice. At present, the precise monetary value and availability of this training grant can vary from region to region, but the intention going forwards is to standardise this award. Inquiries and applications should be directed to the relevant HEE regional office in the first instance, but if any interested parties require more information please contact me via the FICM contact e-mail address: contact@ficm.ac.uk. The training grant itself has several restrictions placed upon what the money can be utilised for – it cannot be utilised for the trainee's salary for example, but it can be utilised to pay for dedicated educational sessions and educational supervision by consultants, lecturers etc. as well as external courses and other educational activities/resources.

The second funding mechanism available for ACCP training follows on from the ACP pathway above and utilises the Apprenticeship Levy. Any employer with a pay bill in excess of £3,000,000 is required to pay 0.5% of their total wage bill into a dedicated digital account. This money can only be utilised to pay for approved apprenticeship training. ACP courses, including

ACCP training as detailed above, may now be eligible for apprenticeship funding. These monies can be used to pay for the HEI tuition fees up to a maximum of £12,000 over three years. Again, advice on apprenticeship funding and the application process can usually be sought from within the employing organisation and/or HEE.

In combination, the HEE ACP training grant and the apprenticeship levy funding can amount to up to £42,000 per trainee over the three year training cycle, which in many cases can transform the financial viability of ACCP training for any given critical care unit.

Expanding and developing

The ACCP Sub-Committee has now been in existence for approximately seven years. During this time the make-up and remit of the committee has expanded and developed significantly, in order to mirror the expansion of ACCP numbers in the UK. The committee chairs and members have taken on substantial programmes of work over recent years, including the development of the National ACCP training curriculum, the National ACCP CPD and Appraisal pathway, seven national ACCP conferences, and in depth and ongoing liaison with new career developments such as ACP and Medical Associate Professionals.

This work continues to this day with the ACCP career development programme, additional advanced ACCP education and training modules (e.g. Optional Skill Frameworks (OSFs)), FICM HEI accreditation process and FICM ACCP membership applications.

All members of the Sub-Committee conduct this work within their own time and without remuneration. We have been extremely fortunate in being able to recruit knowledgeable, committed and forward thinking consultants and ACCPs. It is almost inevitable that within the context of trying to safely and effectively develop an entirely new and advanced level clinical practitioners, with all the attendant governance, legal, resource, logistical and infrastructure requirements, that challenges and differences of opinion will occur along the way. The FICM and the ACCP Sub-Committee have always sought to address and overcome these challenges head-on by discussion, engagement and communication with both the growing ACCP membership but also other parties within FICM and the wider NHS.

Supportive and positive

It is impossible for there to be unanimous agreement at every juncture, but on the whole, I believe the committee has managed to safely negotiate most of the these obstacles in an equitable and logical manner, particularly taking on board the majority views of the ACCP membership. When there is disagreement, we would encourage a supportive and positive approach to engaging in healthy debate; giving the individual or organisation the benefit of the doubt that they have tried to operate in the best interests of the ACCP community.

ACCP Conference — June 2021

Helen Singh | Event Lead

The ACCP Sub-committee organised its first ever online conference on the 4 June. With the year we have just had, there was an obvious choice of theme for the event- lessons learned from the COVID-19 pandemic.

The conference was fortunate to secure talented speakers from all over the UK. The Dean of the Faculty, Dr Pittard opened the conference for us with a personal reflection on the impact of COVID. Afterwards Annemarie Docherty and Kenny Baillie talked us through their research findings. In addition, the use of ECMO, the Psychological Impact of COVID and the development of the Nightingale Hospitals were other topics at the conference. The final speaker of the conference really brought patient focussed care into perspective. Professor Grant McIntyre talked about his experience of being in hospital with COVID for 128 days, including a period of 42 days spent on ECMO.

The ACCP Sub-committee are extremely grateful to all of the speakers for giving up their time, and also to Lucy Rowan and the Faculty team for ensuring our first online conference ran smoothly.

Training, Assessment and Quality (FICMTAQ)

Dr Chris Thorpe
FICMTAQ Chair

Over the last few months TAQ has been setting up the new curriculum and new ePortfolio, the Lifelong Learning Platform (LLP). Since the last Critical Eye, a sheaf of documents marshalled by Matt Williams along with help from Sarah Clark, Andrew Sharman and the Faculty team have emerged into the daylight. Change is always difficult, and it is unfortunate that this has happened at the same time as COVID.

The new LLP comes into play alongside the new curriculum in August, and doctors in training and trainers will need to ensure that the appropriate documentation is transferred from the old to the new portfolio. Details on this are available on the FICM website, but there are a few points that are worthwhile emphasising.

Lifelong Learning Platform

Firstly we do not need all of the data to be transferred from the old ePortfolio into the LLP, rather that it is very much directed at documents that encapsulate the progress to date. From this it can be worked out exactly what needs to be done over the coming months. The timescale for completion of the work is December 2021, however this is best done earlier rather than later. It should be noted that there is a limited amount of training time, and there is no way that trainers will be able to do all of this at the last minute for all of the trainees needing to transfer. It is therefore imperative that you sit down early, preferably as early as possible, to work out completion of the transfer of your documentation.

The new curriculum

The new curriculum will be an improvement over the old one. It is outcome focused, with samples of evidence to back up the delivered outcome. The two main groups that are entering into the new curriculum are newly appointed doctors in training, bringing their core training into the programme from their differing pathways and secondly those who are already on the ICM programme that will need to transfer summary documents across from the old curriculum. Guidance on both of these aspects has been produced and is available on the FICM website.

The website also contains information on dual CCTs with Anaesthesia and Emergency Medicine. There is still ongoing discussion about the new triple CCT with the medicine specialties, and once this is ironed out guidance for these trainees will be issued. Other documents include ARCP guidance, detail on the assessment strategy, assessment tools and documents explaining implementation of the curriculum.

In other news

In other news, there has been a particular concern for dual trainees about implementation of the new pay increment at ST6, and potential variations in how it could be interpreted. We have released an explanatory statement that has been taken forward by the BMA. Essentially once a trainee has started training in their first specialty, that should be the start of the ST labelling, and the years progress linearly from that point irrespective of which specialty the trainee happens to be in. For example, a trainee may enter at ST3 in the old curriculum. The terms and conditions of employment contracts are outside of our remit at FICM, but detail on how the years are labelled should help frame discussions appropriately.

Trainee Update

Dr Guy Parsons
FICM Trainee Representative

These are interesting times. I write this in a local park where the temperature has somehow topped 30 degrees and a procession of shirtless men migrate past like overgrown salmon. The bizarrely named 'Freedom Day' has come and gone, marked by the PM going into isolation and coronavirus cases once again skyrocketing. We have a new Health Secretary, a BMA workforce report suggesting that up to 1 in 5 doctors will leave the NHS post-pandemic, a regulator once again chastised for racial discrimination, another pay award that is a real-terms pay cut, and poor France — oh how I miss France — has become "amber-plus" (garnet perhaps, or rust?), squashing many holiday plans.

Far from sitting back as idle spectators watching these ludicrous scenes, the Faculty has been a hive of activity. Many, many hours of work have gone into the development and release of the new ICM e-Portfolio which is now available. Exams and ARCPs have received considerable focus, the WICM Emerging Leadership Programme has begun, new guidance has been issued on collaborating more effectively with our Emergency Medicine colleagues, and much, much more. A particular focus of mine recently has been the clarification of the 'training year' for doctors in training and the consequent entitlement to enhanced nodal pay — this is hopefully being sorted out now. So, it's been a very busy year so far, but a productive one, and I am continuing to push to improve our training and conditions as far as I can on your behalf. Of course, we are also all busy with our clinical work as sadly our units have come under pressure once more and I send you all the best of luck for the time ahead.

Dr Cat Felderhof
FICM Deputy Trainee Representative

The first six months of my rep term has been an unusual introduction to FICM with virtual meetings in the midst of the second wave of covid, online recruitment and the preparations for the launch of the new ICM curriculum in August. Challenging beginnings but one I have found fascinating, nonetheless.

Congratulations to all the new StRs who will be joining ICM training this year, you have managed to be appointed to extremely competitive training posts whilst working in some of the toughest conditions both inside and outside of work. There is much to be proud of and we look forward to having you on board. Your appointments coincide with the introduction of the 2021 curriculum which aims to move ICM training further away from a 'tick box' culture and reduce the paperwork burden, a very positive step which will hopefully make ICM specialist training more gratifying and less arduous.

To facilitate further positive changes to ICM training we would like to have a stronger StR communication network across the four nations, which would allow us to understand the positives and negatives of training throughout the UK and enable us to utilise the 'collective brain'. We are attempting to achieve this by having contact with all regional reps and so if you are a rep and you are not already linked up with us then please do get in touch at **cat.felderhof@ggc.scot.nhs.uk**.

Lifelong Learning Platform

Natalie Bell
FICM Board & Training Projects Manager

The new FICM Lifelong Learning Platform (LLP) is now live, coinciding with the launch of the new FICM curriculum. If you are an ICM Supervisor or a doctor currently in an ICM training programme, you should have received an email with your login details. If you are an existing user of the LLP, you should have been given access to the FICM side of the platform in your account.

We had to issue accounts/access in a phased approach so as not to destabilise the platform. The phases were as follows:

Phase 1 started on 13 July – issued logins/access to all of our existing doctors in Stages 1 and 2 of the ICM CCT Training Programme.

Phase 2 started on 26 July - issued logins/access for all of our ICM Supervisors.

Phase 3 is now complete – issued logins/access for all other roles/ users.

Phase 4 started on 4 August – started issuing logins/access for our 2021 cohort of doctors entering the ICM CCT Training Programme that we have received completed registration forms for. **We will not be able to issue logins/ access for these doctors until we have received a completed registration form.**

We were not able to issue users with logins/access as early as we would have liked and for that we sincerely apologise. The development process took longer than expected due to the complex nature of integrating the functionality required for our users with the existing functionality and structure of the platform. This required us to deploy our developments in phased releases to ensure the platform remained stable and usable for everyone.

We understand it is a difficult and busy time for you all. We will continue to make updates to the platform as it rolls out. Please bear with us during this time as we work hard behind the scenes to deliver this new system for you.

Key Points

1. The User Guide for FICM Learners can be found here. Please read this to help you navigate the new system and to answer any immediate questions you might have. The User Guides for Supervisors are currently in development and will be published in due course. We also have video demonstrations of the new LLP for Learners and Supervisors on the website.

2. To access the LLP you will need to login via the RCoA's domain page here: https://lifelong.rcoa.ac.uk/login - once you have logged in you will then see the FICM branding to know that you are on the right site for ICM training.

3. For all those with existing LLP accounts, you will not have received an email with login details to access the FICM side of the platform. **You will be able to use your existing account details to login.** The FICM Secretariat have added the respective FICM Learner/ Supervisor roles to your existing LLP account, so you should be able to see and access the FICM/Supervising ICM tabs now. This is easier to spot if you access the system from your computer as it displays all your respective tabs on one

screen. If you check the LLP via your phone, you will have to navigate to your FICM tab via the menu button in the top right-hand corner. For dual LLP users the default branding is the RCoA's, you will know when you navigate to the FICM side of the platform as the branding should change to display the FICM logo etc. If you cannot see the FICM Learner/ICM Supervising tabs appearing in your account, please do not hesitate to contact us (llp@ficm.ac.uk).

4. All FICM Learners should now be able to create placements in their accounts as we have completed uploading all of the ICM Educational Supervisors onto the system. It is mandatory requirement to add an Educational Supervisor to a placement before it can be saved so you would not have been able to do this previously. You should have received an update regarding this in the LLP.

5. **Placements for Dual Learners (e.g. RCoA and FICM)**: A default message will always appear on both dashboards asking you to create a 'current' placement but this is just a reminder making you aware that placements need to be created before evidence gathering. The way the system has been designed is that only 1 placement can be active at any one time. This is crucial for its functionality and to ensure no data gets corrupted when pulling through into ESSRs and other forms in the platform. If a placement has been created on the RCoA side of the LLP you cannot create/ duplicate the same placement dates in the FICM LLP (and vice versa). However, if you wish to transfer evidence from RCoA to FICM (or vice versa) to link to specific outcomes/capabilities in the curricula you will need to download from one side and then upload to the other as a Personal Activity and link it to the appropriate outcomes/ capabilities. We hope to implement an improvement in a future development that will hopefully negate you having to do this, enabling you to create Personal Activities, Personal Reflections and Supervised Learning Events and attach them to both curricula at the point of creation but we have to focus on ensuring any urgent issues that may arise during the launch are addressed first.

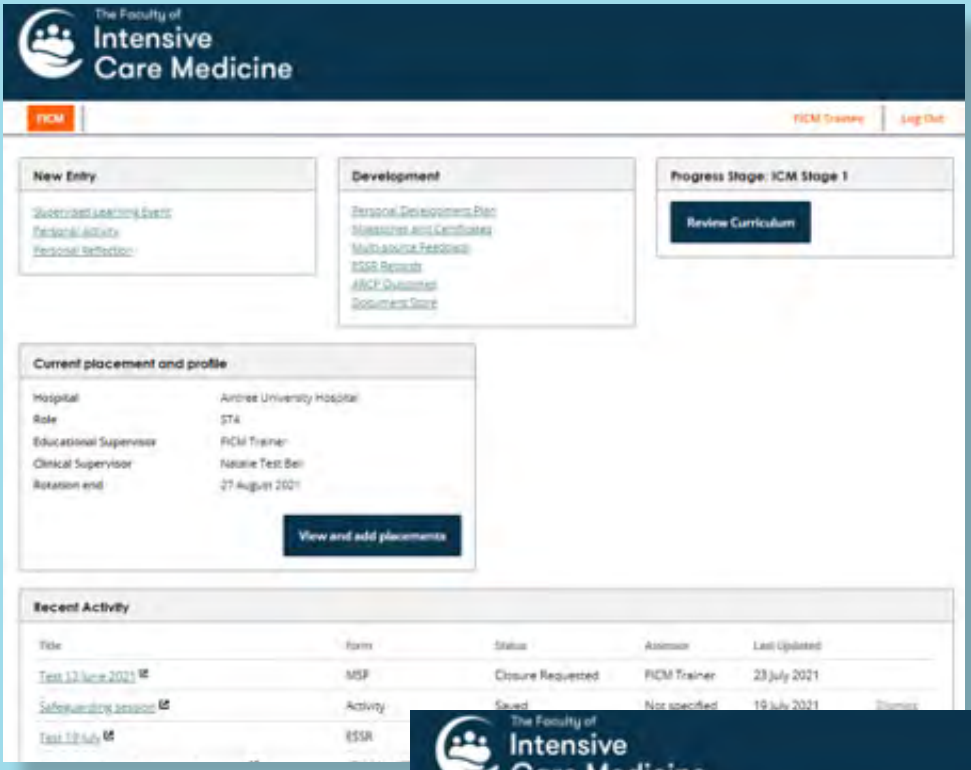
6. **Tabs for Dual Supervisors (i.e. RCoA and FICM):** All of the ICM and Anaesthetic assessments you are sent to approve from doctors in training and any ARCPs you have been invited to attend should all appear in the 'For your review' and 'Next ARCP' boxes in your 'Assessing' tab. When FICM Learners have added you to their ICM placements as an Educational/Clinical Supervisor you will then see a list of the ICM doctors you are supervisor for in your 'Supervising ICM' tab. We are currently working on a fix to ensure that supervisors can view their dual learners' (ie RCoA and FICM) accounts even though they may not have an active placement in that specialty.

7. We have produced detailed guidance about how to download your data from the NES portfolio. Remember you have until the **31 December 2021** to do this. Also see our transition guidance for what evidence from the NES portfolio you will need to upload to the LLP.

8. Any doctors in training that will CCT by 31 August 2022 should contact us if they want to move to the LLP, as we have assumed you will be remaining on the NES platform unless we are informed otherwise.
9. The platform is still in development and will be continuously reviewed and improved while you are using it. For example, we know that one of the tables in the Special Skills Modules in Stage 2 of the curriculum is displaying erroneous rows and we are going to be correcting this in due course.

We hope this helps clarify, but in the meantime, should you have any queries or do not believe something is working for you in the LLP, please do not hesitate to contact us: llp@ficm.ac.uk.

New Screenshots

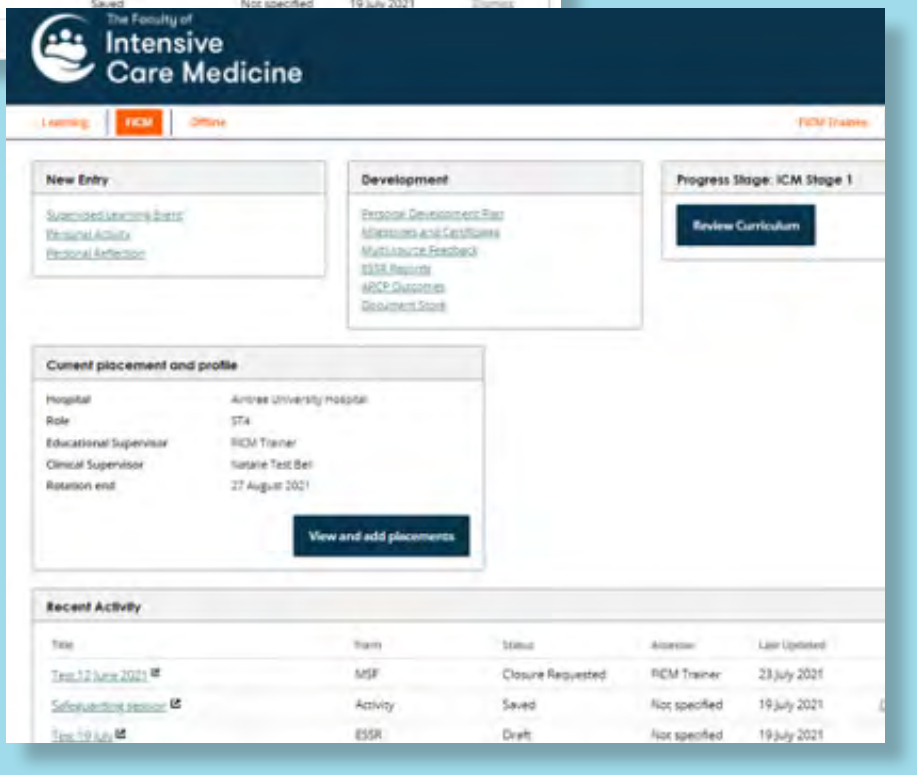


Single FICM Learners

When you login you will be presented with the following FICM dashboard.

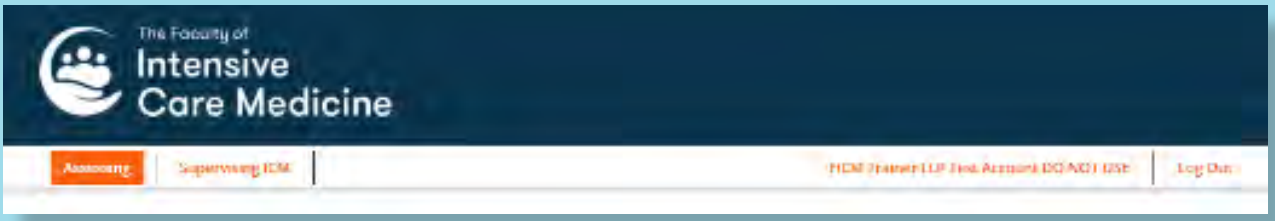
Dual Learners ICM/ Anaesthesia

When you log into your existing RCoA LLP account you will come across a main screen which will have two tabs along the top titled 'Learning' and 'FICM'. Please click on FICM and you will see the following dashboard.



ICM Supervisors (e.g. new user with no Anaesthetic roles/existing LLP account)

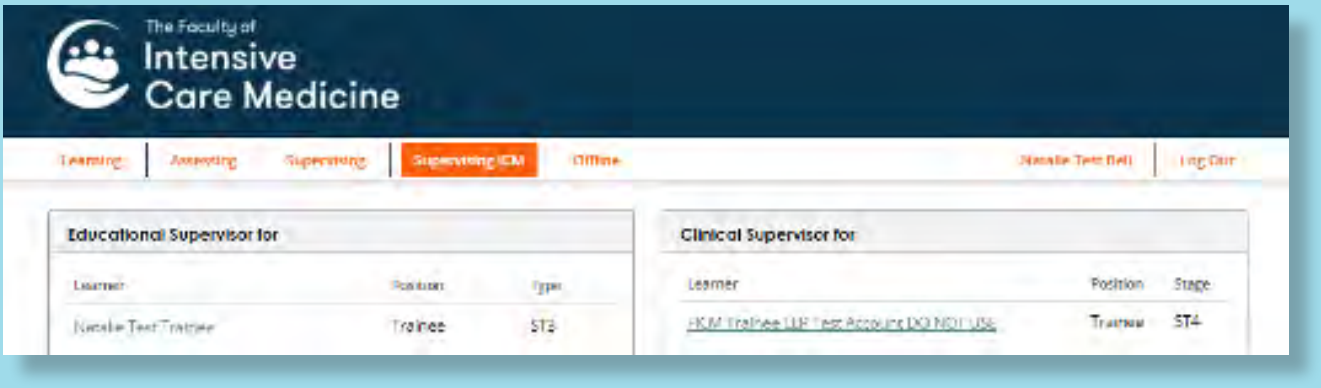
When you log in you will see the following dashboard with two tabs labelled 'Assessing' and 'Supervising ICM'.



When ICM doctors have added you to their placements as an Educational Supervisor you will see a list of the ICM doctors you are supervising in your 'Supervising ICM' tab. The same principle applies if the ICM doctor has added you as an ICM Clinical Supervisor. The learners' names will populate in the 'Clinical Supervisor for' box in the 'Supervising ICM' tab. Any assessments you have been sent to review/approve from FICM Learners and any ARCPs you have been invited to attend will appear in your 'Assessing' tab.

Dual Supervisors (e.g. RCoA and FICM)

When we have added the ICM Educational Supervisor role to your existing LLP account, you will see an additional tab appear titled 'Supervising ICM'. When ICM doctors have added you to their placements as an Educational/Clinical Supervisor you will then see a list of the ICM doctors you are supervising in your 'Supervising ICM' tab. Your new tab should appear like this:



Regional Advisor Update

Dr Matthew Williams
Lead RA

I previously referred to an ever-lengthening tunnel in regards to how many of us might have felt we were viewing life during the pandemic, but as the beneficial impact from UK's vaccination programme is seen, and the hope that is derived from much of the last restrictions being lifted in July, let us hope that we start to see the light appearing more clearly.

After a very busy clinical period in the first 3-4 months dealing with the effects of the huge second wave of the pandemic, I hope there has been some time for all of you to at least draw breath and rest. The effects of the pandemic will be long lasting for all of us, in so many different ways. But, there are many positives to take from this difficult period and many things to be proud of, for those in our specialty.

Training

Alongside their clinical day-to-day activities in hugely pressed times, the RAs have continued to deliver their educational and training responsibilities with commitment and reliability, for which I would like to extend my gratitude. Their work with the Faculty Tutors and Training Programme Directors (TPDs), continues to ensure the specialty is well placed to meet the challenges of training the next generation of intensivists.

Much of the last six months has been spent preparing for the transition to the new 2021 curriculum. Regular updates have been circulated; there is an ever-growing set of source and guidance documents on the website to help, including how the ICM curriculum is to dovetail with partner specialties' curriculum changes. The RAs will be key to help smooth this process in August and beyond.

Recruitment

There was an early, but understandable, decision made to run this year's recruitment round solely as a portfolio verification process. The case continues to be made for a further sustained expansion in the number of training posts in the future, and a return to more of a face-to-face process.

The good news is that there was unprecedented interest in ICM training, with almost 200 new posts being appointed from a record nearly 600 applicants. We welcome these new colleagues to the ICM CCT programme from August. There is now the possibility of having prior training and experience count towards their CCT programme, via the CESR-CP route. RAs will be key to reviewing whether individual doctors can incorporate these posts into their CCT programme.

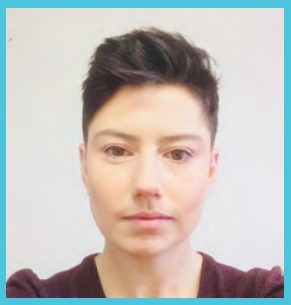
Other RA activities include reviewing job descriptions and person specifications for proposed new ICM consultant posts. I would urge any unit considering new posts to seek the input of their RA; more often than not, a job description is improved by the RA. This will help with maintaining the standards of future consultant posts, and therefore future services and training of subsequent Intensivists.

Thank you

In closing, I'd like to say thank you to the 25 other RAs, Andrew Sharman (Deputy Lead RA), the FICM secretariat, and FICMTAQ for their support to me as Lead RA.

As always, we are keen to hear about any issues relating to training and education in ICM. Do get in touch, with your own RA or the Lead RAs directly – details are on the Faculty website.

eICM



Dr Sonya Stone
eICM Clinical Lead

An extraordinary amount of progress has been made with eICM since our last update all the way back in the summer of 2019, despite the exceptional circumstances we've all faced. I am pleased to be able to share with you just some of those developments here, and some plans for the future of eICM.

I took over as Clinical Lead earlier this year and could like to thank both Dr Pete Hersey and Dr Jim Buckley for their leadership. It is a great privilege to take on the Clinical Lead role and to have received such a warm welcome from the FICM Education Sub-Committee. I look forward to developing the project and to continuing the expansion of our user demographic.

User engagement

The COVID-19 pandemic saw unprecedented activity in our ICUs and with it a huge effort from our colleagues in other specialties joining us to help. The eICM project saw our biggest increase in numbers over this period with engagement at an all-time high. High quality educational resources, that are quick to access and user friendly, were invaluable in providing evidence-based online training to those new to, or returning to, ICM.

Since the beginning of the COVID-19 pandemic, we have seen a 39% increase in launches of eICM sessions, and a 24% increase in the number of active users on the platform. We now have nearly 12,500 active users from professional backgrounds including nursing, physiotherapy, occupational therapy and medicine, and have recorded more than 230,000 launches since the project's inception. This is excellent news and is testament to the high-quality sessions written by our contributors from the ICM community.

In our previous update, we asked for your help in sharing details of eICM with the wider multi-disciplinary team. Since then, we have developed a learning pathway specifically for our ICU nursing colleagues mapped to the Step Competency Framework Levels 1-3 which is now live on the platform and continues to gain momentum.

New and future content

We are very pleased to have added two new sessions in recent weeks: *Induction of Anaesthesia in the critical care unit: Part 1* and *Rheumatological Emergencies*. We also have sessions nearing completion that we hope to make live very soon, and we are working on a new Learning Path mapped to the ACCP curriculum so please keep a look out for those and share details widely.

Finally, thank you to all that have been involved with eICM over the last couple of years, and to the many authors and editors that have contributed to the project. We welcome suggestions for future content and if you would like to get involved with writing sessions then please do get in touch.

Please share

Please share details of the eICM project with your colleagues, trainees, or anyone else you think may be interested. You can also engage with the project on Twitter using #eICM. Look out for tweets from @FICMNews and @HEE_TEL for information and links to new sessions as they go live.

Smaller and Specialist Units Advisory Group (SSUAG)

Dr Chris Thorpe
SSUAG Chair

The Smaller and Specialist Units Advisory Group (SSUAG) recently met up again for the first time since September 2020. COVID-19 has affected all of us in large and small hospitals, and one of the plus points has been an improvement in network relations with our larger colleagues. As we move away from COVID-19 however, some of the old issues continue to arise.

One of the roles of SSUAG is to provide a point of contact for discussion and advice for issues relating to smaller, remote and rural units, and we get to see the variety of issues that crop up. We also have a repository of evidence, articles and blogs on the SSUAG section of the FICM website which provide useful, easily accessible resources for Trusts, hospitals, networks and units.

Every unit is different

It is very difficult for us to provide blanket recommendations for all units, and so individual discussion can be very helpful. Every unit and indeed every hospital has different structures, different staffing, and different patient populations, and the location can vary from extremely isolated to relatively close support.

While we can suggest potential solutions, in the end it is the responsibility of the organisation on the ground to provide the clinical governance required.

Increasing Training Numbers

One of the main issues is still the availability of trained intensivists. The presence of trained intensivists guiding a team, which may include other specialists, usually anaesthetists at present in the UK, to provide the care is integral to the sustainability of the unit. The FICM has been pushing hard, through the Careers, Recruitment and Workforce committee (CRW), to get an increase in training numbers but we are competing against other specialties for a limited pot of money.

Other options for increasing training numbers are being explored; supporting CESR-CP and CESR routes is one area that could be improved. This would seem to be a useful strategy as trainees increasingly want to incorporate flexibility into their training, a fact recognised by HEE and the GMC. Examples include the introduction of Out of Programme Pause (OOPP), which offers the chance to step outside of the normal rotation for a year, but still to have capabilities potentially counted, and opening up less than full time (LTFT) training for any trainee.

Varied Training

Certainly, increasing exposure within training to all types of units and in varying locations is integral to getting consultants. A spell in a rural or remote hospital can open eyes and hearts to the type of job and lifestyle that is very different to a big urban hospital.

During COVID-19 restrictions, it brought home how it can be a great blessing to live in the countryside, where we have time to stand beneath the boughs and stare at sheep or cows. I suspect there will be an uptick in doctors looking for a life that has more greenery and sky, and giving them a taste of what is out there can only be helpful for smaller units.

Diagnosing Death using Neurological Criteria

Dr Dale Gardiner
Clinical Lead

In 2021 in the UK, a diagnosis of death using neurological criteria, had to be reversed. The case concerned bilateral therapeutic decompressive craniectomy as a treatment for severe traumatic brain injury.

With representation from ICM clinicians across the UK and colleagues from paediatric critical care, an expert group reviewed the case and made recommendations which have been accepted by the FICM and the ICS.

The expert group would like to acknowledge and thank the openness and transparency of the clinicians involved in this case and their commitment to patient safety and advancing medical practice.

Recommendations

The main recommendation was that 'Therapeutic decompressive craniectomy' should be added as a **red flag** to the nationally endorsed testing forms. It was noted by the expert group that when the Code was published in 2008 therapeutic decompressive craniectomies were very rare in UK clinical practice. Since then, it has become an established procedure in refractory intracranial hypertension.

During the review the expert group used the opportunity to improve the nationally endorsed testing forms by:

- Giving more prominence to the **red flags** to ensure they are seen and accounted for.
- Specifically, advising that clinicians should consider the need to delay testing and/or perform ancillary investigations if a **red flag** is identified.
- Enhancing clarity and emphasis. This included removing symbols for greater or lesser than in the testing form questions.

Regular review

It was noted, during the review, that the Academy Code is now 13 years old. Good practice would suggest that regular reviews and updates of the Code are appropriate, and we will explore this further with the AoMRC.

Update your paperwork

The diagnosis of death using neurological criteria is an important diagnosis made almost exclusively in the UK by intensive care doctors. We would ask that you update older versions of the nationally endorsed forms with updated versions from the FICM website.

Professional Affairs and Safety (FICMPAS)

Dr Peter Macnaughton
FICMPAS Chair

The Committee has continued to function virtually, and we hope to have our first face to face meeting in over two years next March, although with how the pandemic has progressed to date, I'm not holding my breath!

The optional skills framework module for advanced airway competencies for ACCPs is nearing completion. Training qualified ACCPs in Advanced Airway management will allow them to provide immediate resident ICU advanced airway support as defined in *GPICS* v2 (Medical staffing standards 2.5:5), provide added safety during ACCP led intra and inter-hospital patient transfers and facilitate airway procedures in a busy critical care department. The structure of training will involve an initial three-month full time (or equivalent part time) attachment within the Anaesthetic/Theatre environment. This is followed by a period of supervised advanced airway management in the critical care environment to complete work-based and simulation based OSCE assessments, with final sign off by two ICM consultants.

ACCPs completing this module will have airway skills that are equivalent to the Core Airway Skills in the Anaesthetics curriculum with some additional skills relevant to critical care practice. ACCPs are now firmly established in many units where they are essential and highly valued members of the critical care workforce. The development of this module and other advanced skills such as focussed ultrasound can only enhance the role of ACCPs.

Safety Bulletin

The collaboration with NHS Improvement has resulted in the publication of two editions of our safety bulletin *Safety Incidents in Critical Care* with the third currently in preparation. These bulletins highlight lessons from analysis of all the safety incidents involving critical care reported on the National Reporting and Learning System (NRLS) database. We have tried to group the incidents into themes and provided some recommendations to improve practice.

GPICS

A roadmap to the next edition of *Guidelines for the Provision of Intensive Care Services* (*GPICS*) has been agreed with our partner, the Intensive Care Society. Essential minor updates to the second edition, which was published in 2019, are being undertaken with the aim to publish as version 2.1 in 2022. Work will begin on the next major update (version 3) later next year.

Current standards for staffing of critical care will not change in v2.1. Although staffing structures during the surge response for the pandemic may not have matched current *GPICS* guidance, there is a strong view within the specialty that the existing guidance should still be the standard as we (hopefully) return to more normal working. Prior to embarking on the third edition, a national assessment of compliance with existing standards and recommendations is planned using the audit tool that was developed pre-COVID and has just been released via the FICM website.

Legal and Ethical Policy Unit

Dr Sonya Daniel
LEPU Member

There has been a high level of public interest in cases concerning disputes about end-of-life care decision making in intensive care in recent years. Treating clinicians in some high-profile cases have been subjected to intimidating behaviour and death threats after mainstream media coverage.

Applications were made recently by the parents of two children who were the subjects of end-of-life proceedings in the high court before they both sadly died. The parents sought to be released from Reporting Restriction Orders (RROs), granted to provide anonymity to treating clinicians including after death, so that they could speak in public about their experiences and identify NHS staff who had cared for their children. The Legal Ethical Policy Unit (LEPU) was asked to provide a statement in support of continuation of the RROs by the solicitors acting for the trust named in the case.

Drafting a Response

I was tasked with drafting a response to this request. I have been a member of LEPU since 2019 and this was my first submission to the courts. I relished the challenge, although felt some trepidation at the prospect. I was reassured by the fact I had clinicians experienced in writing submissions and our fantastic members with a legal background to support me. After researching the subject, I constructed an initial draft. This was circulated to members of LEPU who made comments on the arguments and I gratefully received help with the proper construction of a legal document. After being approved by the FICM board it was then submitted to the solicitors.

Judgement

Sir Andrew MacFarlane, President of the Family Division, in considering the competing rights of the parents under the European Convention on Human Rights to free speech, and clinicians to a private life, held that continuing the RROs was necessary and proportionate: "Why should the law tolerate and support a situation in which conscientious and caring professionals, who have not found to be at fault in any manner, are at risk of harassment and vilification simply for doing their job?". He refused the applications for discharge of the RROs stating, "the potential for individuals to become vulnerable to physical attacks and to suffer adversely in terms of their mental health and wellbeing requires to be taken seriously".

The full judgement can be found here.

FICM Safety Incident

Risk of retention of component of tracheostomy insertion kit

Situation

A percutaneous tracheostomy was performed. The procedure appeared to proceed straightforwardly. However, during bronchoscopy after the procedure, a foreign body was noted in the lower airway.

Assessment

The tracheostomy insertion kit used was the Tracoe Experc Dilation Set with a Tracoe Twist. The tracheostomy comes preloaded on an inserter that includes a silicone sleeve to smooth insertion.

When the tracheostomy has been appropriately sited, the inserter should be removed. The tip of the silicone sleeve inverts and is removed with the inserter.

The manufacturer's Instructions for Use highlight that a check must take place to ensure that the silicone sleeve is still located on the inserter after it has been removed.

Look out for the 3rd issue of *Safety Incidents in Critical Care* due out in August 2021!

Background

On further inspection, the foreign body was a portion of the tracheostomy introducer equipment. The foreign body could not be removed bronchoscopically via the tracheostomy.

The patient was therefore reintubated orally and the foreign body removed successfully. The tracheostomy was then resited, and the oral endotracheal tube removed.

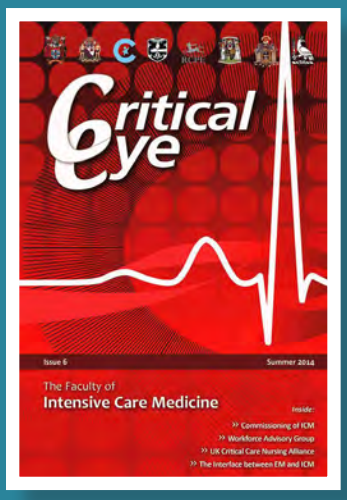
Recommendations

A similar incident has been reported in the literature and it is highlighted in the manufacturer's Instructions for use. It highlights the risk of retention of foreign bodies following invasive procedures.

Local checklists will be amended to reflect this incident. The incident has been reported to the MHRA and the manufacturer.

The fault is thought to be extremely rare and no obvious cause was found for the tip of the sleeve to break off.

You can find Issue 1 and Issue 2 here.



20 ISSUES
and
10 YEARS
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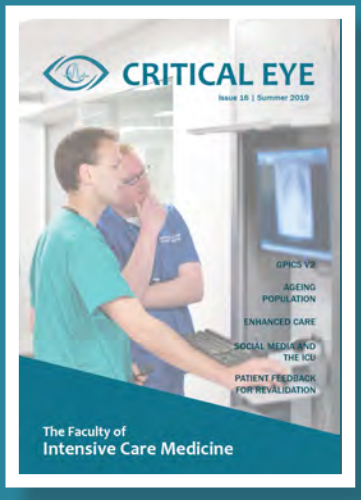

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Intensive
Care Medicine

www.ficm.ac.uk

@FICMNews

Churchill House | 35 Red Lion Square | London WC1R 4SG
tel 020 7092 1688 | *email* contact@ficm.ac.uk