CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 19 | WINTER 2021

FICM10: Ten Years of the Faculty

The Faculty of Intensive Care Medicine

In this issue

The Faculty of Intensive Care Medicine

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WELCOME

Dr John Butler
Clinical Editor

Welcome to this physically bigger, and hopefully better, edition of *Critical Eye*. I want to start by paying tribute to the incredible levels of hard work, commitment and resilience shown by the NHS staff working within intensive care units up and down the land during this extremely difficult time.

The health service continues to battle against the ongoing challenges brought by the COVID-19 pandemic with UK hospitals facing a more acute crisis than during the first wave in the spring and many more patients being treated in hospital, despite the national lockdown.

Throughout the pandemic our NHS intensive care units have played a pivotal role in the response to the COVID-19 crisis. As a result, there are many patients who are alive today as a direct consequence of the expertise and devotion of the staff working within our specialty. Everyone's response to this challenge has been incredible.

As we are all aware, the NHS runs on the goodwill and dedication of its staff. Reports today, using data from June and July 2020, suggest that a high proportion of people working in ICM are reporting levels of distress. Clearly, looking after our own health and personal and psychological wellbeing is a priority. In addition to the resources available in the FICM wellbeing centre, this edition includes a couple of useful articles outlining the importance of providing psychological input and support to both staff, patients, and families at this particularly difficult time. I am sure this is an area that needs more development and investment in the future.

In 2020, the Faculty of Intensive Care Medicine celebrated its tenth anniversary from its humble beginnings as the IBTICM. We have been somewhat delayed by the pandemic, but we celebrate that milestone with our FICM10 pieces in this issue. An essential guiding influence on this successful journey, through those early years, to where we are now in 2021 came from Mr Daniel Waeland our previous Head of Faculty. Regrettably, Daniel left us in 2020 to pursue new opportunities but he remains an important part of our story as a Faculty. In this edition Daniel provides us with his personal insight through the first ten years of the FICM, highlighting the multiple achievements through the succession of four Deans and numerous board members. I would like to take this opportunity to thank Daniel for his dedication and wish him every success for the future. We also welcome his successor Mr James Goodwin, who many of you will know from his previous work with the Faculty and who returns to us after five years as the RCoA's Head of Research.

I hope you enjoy reading this edition and let us all hope for a better year in 2021. We welcome any ideas for future articles. Please send your comments to **contact@ficm.ac.uk.**

Message From The Dean

Dr Alison Pittard
Dean

Hello and welcome to the first edition of *Critical Eye* for 2021. At the time of writing there is a lull before, what will undoubtedly be, a storm. A storm whipped up by a relaxation of restrictions over Christmas, coordination of mass vaccination programmes and the usual winter pressures. By the time you read this there is no doubt that things will have been difficult for everybody. However, a new year brings with it an opportunity for new beginnings. This can take many forms, be they personal or professional, but for our specialty things will never be the same again.

There have been many challenges but, also opportunities to transform the way we deliver critical care in a very short space of time. The first wave highlighted the importance of investing in the multi-professional team and looking after our health and wellbeing. It also exposed the lack of expansion in capacity to meet an ever increasing demand over the years. Another thing we have learned is the importance of mutual aid and that the establishment of adequately resourced transport services for the critically ill will be warmly welcomed. Building flexibility into the system, in terms of space and staff, will be essential if we are to maintain resilience going forward.

Wellbeing

Our wellbeing centre launched a number of years ago now and has expanded to include a resilience hub. Much of our work involves collaboration and I was delighted when the Joint Fatigue Working Group, which involved the Faculty, Royal College of Anaesthetists and the Association of Anaesthetists, received the BMJ award for Workforce and Wellbeing team of the year.

The FICM are incredibly proud and pleased to be a part of the team contributing to this important work highlighting need to change the culture of fatigue in the healthcare profession. In particular the group's #FightFatigue social media campaign has been incredibly effective in raising awareness and the group have created many education and support resources to help units access proper rest facilities for the workforce.

ICU Liberty Singers

A less formal approach to improving mental health, and a different take on voices from the frontline, saw 144 ICU staff of all professions join the virtual ICU Liberty Singers. This was instigated by an approach from Kari Olsen-Porthouse, a freelance choir director based in Nottingham, who wanted to contribute something to the NHS.

> **"Another thing we have learned is the importance of mutual aid and that the establishment of adequately resourced transport services for the critically ill will be warmly welcomed. Building flexibility into the system, in terms of space and staff, will be essential if we are to maintain resilience going forward.**

Kari offered four free virtual singing sessions and, before we knew it, this snowballed into Sony granting us permission to record our version of '*Every Breath You Take*' and releasing the single to raise money to support the health and wellbeing of ICU staff. This was an amazing achievement; we even had Dr Rob Bevan join from New Zealand. Singing has a positive effect on happiness and wellbeing as do our social connections, of which we have been starved during 2020.

The positivity that emanates from this group suggests that similar benefits can be obtained virtually. Kari helps workplaces create and maintain harmony through group singing and offers packages ranging from online singing workshops to ice breaking sessions at conferences and events. If you are interested in exploring this, either for your workplace or on a personal level, check out Kari's website at https://libertysinger.com/services.

Curriculum approval

Our new curriculum was approved by the GMC in December; the amount of work that went in to achieving this cannot be underestimated and a huge thanks goes to Dr Tom Gallagher, Dr Chris Thorpe, Miss Natalie Bell and all members of the Training, Assessment & Quality Committee.

National Recruitment

As we have to plan our activities well in advance, both the 2021 recruitment round and the first sitting of the FFICM exam will, once again, be online. Dr Sarah Marsh plans to deliver the prep course to mirror this. I very much hope that our October exam will be face to face and it should also soon be clearer as to when we will be able to resume our meetings in person. I'm sure that will feel a bit strange to start with but we will get used to it very quickly.

FICM10

Our birthday plans were put on hold last year but we will be sharing our tenth anniversary celebrations, albeit belatedly, throughout 2021. We did manage to undertake some of them, including the ICM Trainer Award, with Dr Andrew Campbell from the Wrexham Maelor Hospital being a worthy winner, and the inaugural Timothy Evans Essay Prize.

Tim was the Faculty's founding Vice-Dean and we wanted to pay tribute to the immense contribution he made to the specialty. The essay categories were based upon his interests and views of the role played by all members of the ICU team in delivering patient care. There was a prize for the winner of each category and the overall winner was Dr Sarah Shuker who put forward a strong case for why every foundation programme in the UK should have an Intensive Care Medicine post as an essential component.

Thank You!

Thank you all for everything you and your colleagues do, especially during COVID, and please pass on my thanks to those who do not normally work in intensive care, without whom we would not have been able to deliver the care that we did. I hope you enjoy reading this edition of *Critical Eye* and I look forward to whatever 2021 brings.

FICM10: The Faculty of Intensive Care Medicine: The First Ten Years

Mr Daniel Waeland
Former Head of FICM
and Honorary Fellow

When the opportunity to write a piece for our FICM10 edition came up, it seemed logical for me to write it. Partly as I was appointed to help create the Faculty back in the summer of 2010, and partly as by the time this is published I will have left the Faculty after ten happy years and will therefore be part of its past.

It will be impossible to mention all the projects, work streams and activities that the FICM has birthed, supported or contributed to, nor the people (clinical and administrative) who have made that possible. Our FICM10 webpages help summarise some big milestones. I have attempted below only to give a flavour of what the first ten years has included.

Foundations

The Faculty is ultimately a successor body to JACIT (the Joint Advisory Committee for Intensive Therapy, 1992-1996) and then IBTICM (Intercollegiate Board for Training in Intensive Care Medicine, 1996-2010) and exists in no small way due to the successes of all those who led and contributed to those earlier phases. We were fortunate to have Julian Bion and Tim Evans elected as our founding Dean and Vice-Dean.

When the Faculty was founded at the first ever Board meeting in 2010, it came into being following the careful liaison between seven parent Colleges (eventually expanding to eight) and with the support of the wider community. It should have been a measured first year of preparation and development. Instead, the Postgraduate Medical Education Training Board (PMETB), now fully subsumed into the GMC, presented us with an interesting foundation present. The Joint CCT was no longer considered acceptable under their statute and we had less than 18 months to create a single CCT curriculum, pioneer transferable competencies with five partner specialties, transform the Diploma into the FFICM Examination, and set up a national recruitment process.

In a way, this has set the form for how the Faculty has worked ever since — punching above its weight and delivering more for its members than might be expected of its size and resources. We have now published the first full review of that curriculum, which led the way in moving from competency to outcome-based curricula. The exam now has an international standing. National recruitment grew from 72 posts in 2012 (and a 72% fill rate) to 289 in the last recruitment (and a 97% fill rate) following lots of successful lobbying.

Julian's Deanship saw the Faculty develop its existence, its gravitas and its standing. During this period, we created a solid foundation on which to build in future years.

Further growth

Under the second Dean, Anna Batchelor, we saw further important milestones, including the Faculty becoming the professional home for ACCPs, the Faculty joining the Academy of Medical Royal Colleges, the first annual workforce census, and the publication of *GPICS*. We now have an ACCP curriculum, a pioneering appraisal pathway, run the ACCP national conference and have undertaken a national evaluation of the role, among many other areas. We have led important national projects for the Academy, including the current Sepsis Collaborative.

The workforce census led to regional and national workforce engagements, a national data bank and, with the work of others, a national critical care review in Wales. *GPICS* began life as a short proposal that Carl Waldmann and I put together in 2012, Tim Evans then developed into a full project and finally Julian Bion transformed into the wider concept working with the ICS and stakeholder organisations across the multiprofessional team. It now underpins Care Quality Commission standards and is the key standard for critical care services.

Anna's Deanship saw the Faculty expand and grow, reaching a new national audience and widening its responsibility more clearly beyond doctors.

Critical Futures

The third Dean, Carl Waldmann, saw the birth of e-ICM, a national e-learning resource for the specialty, Critical Futures and the launch of Women in ICM (WICM). e-ICM now has thousands of hits each month from across the world and FICMLearning has launched to develop e-learning further. Critical Futures has led to the *Care at the End of Life* report, the Enhanced Care work and the birth of the Life After Critical Illness national project on rehabilitation and recovery in the autumn of 2019.

WICM now has an active Twitter and blog, has reviewed all of our recruitment materials, started an annual networking meeting and an Emerging Leadership Scheme.

Carl's Deanship saw the Faculty build upon its previous developments and introduce projects that addressed clear gaps in provision in the community and look clearly towards the future.

COVID and the Faculty

Our fourth Dean, Alison Pittard, was only recently in post when COVID hit. In her and Vice-Dean Danny Bryden's first seven months, the Faculty had to manage the significant amount of attention that has turned to critical care — the biggest in the Faculty's history. We have managed huge amounts of media messaging, senior NHS and political briefings, lots of quick turnaround pandemic standards and guidance, reorganisation of training progression, and provision guidance for rehabilitation and recovery.

Alongside this, existing Faculty business like Enhanced Care and the curriculum rewrite has continued to its normal high standard. The Faculty has strengthened professional links with the critical care pharmacy community is another significant milestone for the Faculty and for critical care as a whole.

Looking forward

With a new Dean and Vice-Dean only just entering their second year, new blood coming in at the senior management level, and excellent clinical and administrative teams underneath them, I look forward to watching from the outside as the Faculty continues to grow, develop and succeed. I would particularly like to thank the administrative team across both of the Faculties I looked after — none of this would be possible without them.

It has been an enormous privilege working with the FICM — it has been so devoid of egos and nest feathering and so committed to caring about the specialty. This has allowed me to work behind the scenes to ensure we move projects further forward and keep refining and improving.

It was a further privilege to be made an Honorary Fellow for this, and I am very grateful for the honour. Now from the outside, I commend the Faculty to its members and wish it the best of luck (not that it will need it) for its next ten years.

> **"I look forward to watching from the outside as the Faculty continues to grow, develop and succeed. It has been an enormous privilege working with the FICM.**

FICM10: The Faculty of Intensive Care Medicine: The *Next* Ten Years

Dr Daniele Bryden
Vice-Dean

At the start of 2020, Alison and I were busy making plans for future workstreams to put before the Board. And then life (or rather COVID) got in the way. Looking at the Faculty through the prism of the pandemic has confirmed to me that the direction we have been taking is the right course and those areas that we thought needed further work within the NHS and our specialty, are the points of stress in the response to COVID.

In the next ten years the Faculty needs to consolidate and build on the innovations of its first decade whilst working to ensure that it fulfils a useful role at the heart of the consultation and decision making processes with government and the strategic leaders of healthcare. The pandemic has taught others what the Faculty has been saying all along: that we are at the heart of so much healthcare delivery in secondary care that many services cannot function without us. So what might that mean for the future Faculty and its work?

Greater public awareness

The idea of an ICM specialist was codified with the independent CCT programme. Now there is a much greater awareness within the NHS and amongst the wider public that working in ICM practice is an expert skill and it's not just about the ventilators. In the next ten years I hope the Faculty will continue to develop the 'ICU without walls' concept that was suggested in *Comprehensive Critical Care* in 2000. Critical Care is a pathway with multiple routes of entry to a specialised service, that needs to be properly commissioned as a unique service, not as an 'add on' to aspects of surgical or medical care. This is better for patients and is the route by which we develop the specialty to provide the type of care and support that we know is not uniform across all four nations.

The service patients want and need

Moreover we need to ensure that as an expert service we provide what patients want and need, and that others lack the expertise to offer. For example, that means ensuring the work of the Life After Critical Illness group, due to be published later in 2021, is embedded in every ICM service and that we develop better links with primary care so that patients and their carers are supported.

We also need to have a greater awareness of the benefits and impacts of what we do, so the Faculty will be starting to work more with statutory bodies outside our traditional professional links. The people working within our service need to be recognised for their expert skill and contribution to care. Whilst people may work 'part time' in intensive care

at different points in the week or stages in their lives, the acquisition of their expertise is not done with a 'part time' mentality.

Strategic direction

The team that delivers ICM care has been growing in number and professional backgrounds. It will be inevitable that the Faculty will look towards working much more collaboratively with those groups, perhaps even with direct involvement in the Faculty as has occurred with ACCPs and most recently our pharmacy colleagues.

The pandemic has shown how we can work well with colleagues from other colleges to provide strategic direction for the service, and we will be aiming to do more of this type of collaboration. Projects like Enhanced Care don't just provide a short term solution to supporting activity for an ageing population who need more than ward care, but can provide a road map by which we can develop and recognise more of the NHS workforce (medical, nursing and advanced practice staff for example) to have some critical care skills.

In 2020, we've become all too aware of how we work in a global healthcare environment, and need to share expertise more widely so we do not keep reinventing the wheel. The Faculty is already starting to share experience with other colleges and ICM experts internationally to drive cooperation.

A UK College of ICM?

All of these changes will indicate a mature specialty that can demonstrate its worth to patients, staff and the NHS, and a Faculty that has evolved in its role as the statutory body for Intensive Care Medicine in the UK.

It is inevitable therefore that we should not just talk of 'if' there will ever be a College of Intensive Care Medicine but look more openly and actively to ensuring that we use the next ten years to work to create such a College. Whilst many already acknowledge that it would be ideal for it to happen, the next decade of the Faculty will in part be about ensuring that we can make it happen.

2020 Vision: Arms Around the World

Dr Alison Pittard | Dean

We announced our collaboration with the College of Intensive Care Medicine, Australia and New Zealand, in July last year. Since then, in between dealing with the pandemic, we have been developing a framework to help us determine our priorities.

Underpinning our strategy is a desire to support each other wherever in the world we may be working, something that has become incredibly important during the last 12 months. Our two organisations wish to share good practice, learning from each other across all areas of our work, and promoting diversity. An amazing example of what can be achieved by such a collaboration is the recent offer to support the UK Intensive Care community by sending personnel, albeit a logistical challenge, and other opportunities such as e-learning, telemedicine and wellbeing support.

We had our first official meeting in December to discuss next steps and establish priorities, agreeing that training and exams will be our initial focus. The first thing we have done is share our recently approved curriculum. CICM are reviewing their own curriculum and are very interested in our 'outcomes' based training so this was a logical place to start. We also hope to be able to achieve reciprocal recognition of training and examinations, as well as sharing relevant resources. Once we have established this first phase, we will begin to explore other areas of mutual benefit such as recruitment, education, promoting lifelong learning and diversity of experience. Look out for our updates on the website and, of course, in future editions of *Critical Eye*.

FICM10: The Tim Evans Essay Prize

Read the winning essays in full online at

www.ficm.ac.uk/ficm10-essay-prize-tim-evans-award

Congratulations to all our theme winners!

THEME 1: How do we put the patient and their relatives at the focus of everything we do whilst looking after our staff?

Winner: Dr Tobias Mill

The Tim Evans Theme 1 winning essay believes that the root cause of many problems for doctors and patients is that healthcare professionals too often focus on things which are futile. The philosophy of Stoicism helps healthcare professionals to break their focus on these futile pursuits, and provides the virtues of courage, wisdom and justice as the correct ways to live.

The ancient philosophy of Stoicism is unlike the modern use of the word. Through an initially morbid process of contemplating their own deaths, Stoics find true value in the virtues of courage, wisdom and justice. By imagining parents, partners, patients and colleagues speaking at their eulogies, Stoics understand that a life of virtue is one which puts patients and their relatives first, whilst simultaneously protecting staff wellbeing.

Consider continuing your reading with the full article for an empowering illustration of how Stoical principles can improve the health of staff, patients and relatives.

THEME 2: What contributions can new workforce groups make to patient care in the future?

Winner: Dr Omar Salim

The worldwide response of ICUs to the COVID-19 pandemic has given due consideration to the ways in which rising demands on healthcare services can be met efficiently. It is expected that future patient care will be delivered by integrated teams of medical, nursing, allied and associate staff, with all members of the multidisciplinary team progressively aided by intelligent technologies.

Expertise in interpreting datasets, genomics and artificial intelligence algorithms will be required, driving the establishment of novel workforce groups such as medical software engineers, digital medicine specialists and clinical data scientists. Greater automation will offer the potential for improved ICU workflow, allowing clinicians more time to dedicate to the human aspects of patient care. On an organisational level, tele-ICU facilities have enabled remote clinicians to consult with bedside staff during the pandemic, lowering exposure risks. These hub-and-spoke networks of ICU care will ideally increase in number globally, as they provide a cost-effective model for delivering specialist care to large numbers of patients.

Going forward, it is imperative that investments are made into staff training and future-proofing ICU departments, thereby facilitating optimum patient care and support for the workers who deliver it.

This competition was launched as part of FICM10 to recognise the contributions of the late Professor Tim Evans, the first Vice-Dean of the FICM. We asked for submissions under four themes before choosing a winner from each theme, as well as an overall winner. We would like to thank those who took the time to enter. We are pleased to publish excerpts of the winning essays here.

THEME 3: How would you argue for a post in Intensive Care Medicine being an essential component of every Foundation rotation in the UK?

Overall Prize Winner: Dr Sarah Shuker

"I'll ask the intensive care doctors to come and see your dad, and to talk about putting him on a breathing machine to rest his lungs."

I flinch a bit. I have heard these words spoken through closed hospital curtains many times. I have said them myself as well, before I began to understand the reality that intensive care is one of the least 'restful' treatments available. It therefore seems only fair that doctors referring patients to intensive care have an understanding of what is involved, and what better way to gain this understanding than by working in an ICU?

Working in ICM allows Foundation doctors to develop an understanding of what intensive care can and can't do, and more importantly what it should and shouldn't do. Understanding the limits of intensive care gives doctors like me the confidence to have conversations about appropriate treatment escalation early on with patients and their families, something which should be considered an essential part of all patient's treatment plans.

An ICM placement provides Foundation doctors with a fantastic general clinical educational experience as well as the opportunity to experience and expand their capabilities in a myriad of non-technical and highly transferrable skills including communication, moral reasoning, and multi-disciplinary working.

THEME 4: What should a future critical care service be doing to provide a safe, sustainable service to patients?

Winner: Dr Bennett Choy

Critical care services have come under intense scrutiny recently. The huge demand for ICU services during the peak of COVID-19 clarified the vital role that critical care plays in the NHS. However, factors such as technological advancements, and increasing population size cause providing a robust, safe and sustainable critical care service for patients more challenging.

To manage future demands for critical care services, more resources can be pumped into existing effective initiatives (e.g. Critical Care Outreach Teams, audits, and microbiology MDTs). In addition, to improve early recognition of patients who would potentially require critical care, ICU placements can be incorporated into the training curriculum of junior doctors, GPs, and emergency medicine triage team members. Investing in wards that produce intermediate care allows hospitals to be able to provide high levels of care and monitoring for patients without admitting them to ICU.

On the supply side, we should encourage dual specialisation/overlapping of training programmes, and remove clear distinctions between anaesthetists and critical care doctors by allowing lateral and vertical career advancements during their training pathways. We could also consider employing ward managers and administrative staff so that medical staff can focus on delivering quality care.

FICM10: Ten Jobs on the Intensive Care Unit

As part of our FICM10 celebrations we asked ten staff working on ICUs to explain a little bit about their role, how it fits in with the wider team and what they enjoy about their job.

"Can you give us a few paragraphs about your normal day?" went the email request. But what is normal? What of the 'day job', you may well ask? Do we mean BC (Before COVID)? Or now, in the thick of the second surge (of how many)?

Our huge gratitude goes out to all the intensive care colleagues here who responded to our request, and to all of you reading this who are doing such amazing work in such extraordinary circumstances. Thank you.

Consultant

Dr Sarah Clarke | ICM Consultant | Royal Blackburn Teaching Hospita

I am a Consultant in Anaesthesia and Intensive Care at the Royal Blackburn Teaching Hospital. Pre-COVID we were a 24 bedded unit including a four bedded POCU. We are presently running 40+ beds, and include A (elective), B (emergency) and C (no surprises there) zones.

COVID brought us rotas I never imagined I would experience again after training, and it continues to bring us workforce and educational challenges. I do not imagine we are alone. For me, no two days are the same, and the predictable unpredictability is what keeps me interested and challenged. It is the multi-disciplinary teamwork, the applied physiology, along with the use of advanced technologies and practical skills. Multiple resources and personnel, all working together with the patient the focus of our attention.

One of the most important aspects is the camaraderie and respect of an inclusive team environment. I am proud and humbled to be part of my team, particularly over recent months where the challenges of the pandemic have pushed many of us out of our comfort zones: nurses, doctors, allied health professionals and all our support staff alike. We mourn and grieve with families over our losses, but we also share the joy of our good news and celebrate our successes.

So, what of my day job? I'll keep it thank you very much!

Advanced Critical Care Practitioner (ACCP)

Kate Mayes | ACCP | Hull University Teaching Hospitals NHS Trust

I love my role as an Advanced Critical Care Practitioner (ACCP) where I am able to bring years of ICU nursing experience to critical care provision. The increased career options that the ACCP role brings for nurses and other allied health professionals is great, providing an alternative option to the 'usual' management development within the ICU. The combination of a nursing/medical role as a permanent member of the team brings many rewards and is well received by all specialties and members of the MDT.

Over the last seven years, my ACCP role has developed, as need and desire to do more has come about for both myself and my department. I have been able to broaden the initial scope of the role and have been supported in doing this by the entire critical care team, throughout my training to working as a qualified ACCP and now leading the team of 16 in our Trust.

Each and every day is different, which is both challenging and exciting, and makes the most of the skills and experience I have. This is true now more than ever with COVID-19 making changes to how ICU teams work across the world. The versatility as an ACCP means I can support both medical and nursing teams, whichever has a greater need at the time, improving resilience in the workforce. I feel supported in my role and encouraged to develop my skills. This is my passion, and I wouldn't want to do anything else.

ICM Trainee

Dr Guy Parsons | ICM Trainee | Milton Keynes University Hospital NHS Foundation Trust

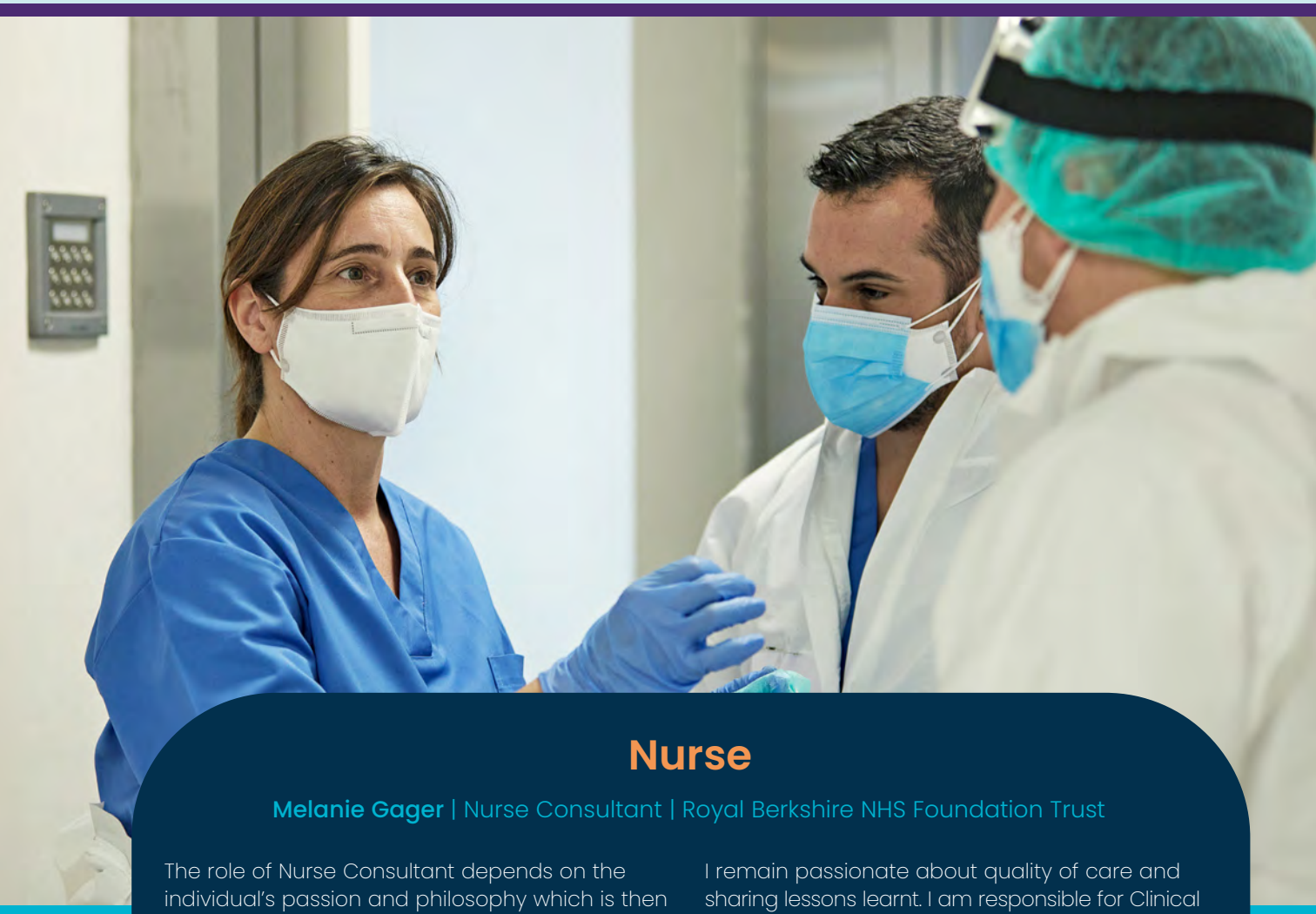
I'm one of the doctors working in ICM, specifically one of the Specialty Registrars. This means I've finally whittled down which specialty is the best (obvious, I know, but it took me a while) and decided to do some further training in it, so I can one day take up the consultant's orb and sceptre or whatever it is they give you.

This means I have the real pleasure of helping to mentor and train my more junior colleagues while still being shielded by my bosses, who I'm still learning from in turn. It means I can have a hefty slice of responsibility and autonomy, which is fantastic for morale, but as I'm not yet fully cooked I'm not expected to know everything, which I definitely don't.

Medicine has a long tradition of apprenticeship and passing on what we learn and I find this bit of my job both hugely rewarding and quite challenging. It can be hard to do well but so satisfying when you do. I bet you can still remember your favourite school teacher's name.

The best thing about my job though? The team I work with. The nurse who's spotted something I've missed, who humanises where our machines and pumps invade, who reminds me of the patient's daughter's name. The dietitian who works tirelessly to find solutions, the physiotherapist who makes rehab possible, probable; the pharmacist who catches my errors and brings in the really cool drugs; the porters who don't break the ventilator moving it around on tired feet; the infinitely patient ward clerk on her hundredth phone call; the domestics who deserve so much more than to be walked past unacknowledged; and my fellow doctors who supply caffeine, bad jokes and a kind word on a crap day.

Everyone I work with each day, they're the best bit of it, and right now they mean more than ever.



Nurse

Melanie Gager | Nurse Consultant | Royal Berkshire NHS Foundation Trust

The role of Nurse Consultant depends on the individual's passion and philosophy which is then translated into practice. My passion has always been patient and staff experience and seeking innovative ways to hear the patient voice, whether that is enabling the 'voiceless' whilst an inpatient or enabling the 'narrative' of their critical illness during recovery.

Recovery after Critical Illness is a major part of my role and journeying with patients and their families provides a rich insight into the complexities and challenges they face. Translating this back into practice means seeking every opportunity possible to keep the focus on the patient experience, whether that is in research, teaching, presenting, patient representation at meetings, or in the bed space.

I remain passionate about quality of care and sharing lessons learnt. I am responsible for Clinical Governance where we focus on the assurances of the quality of the service we provide.

Mortality reviews are a key part of my role too, where we are beginning to embed the Structured Judgement Review process and sharing the lessons learnt.

One of my other passions is the importance of effective leadership and to engage and inspire the next generation of critical care practitioners. To influence the staff experience I coach and provide leadership training to enable our greatest asset, our staff, to realise their potential and empower them to be the best that they can be.

Speech & Language Therapist

Sue McGowan | Specialist Clinical Speech & Language Therapist | National Hospital for Neurology & Neurosurgery, London

Being unable to communicate, eat and drink whilst on ICU is a lonely, frightening and disempowering experience that lives on in patients' memories. Historically the Speech and Language Therapy (SLT) profession has not had much presence in ICUs, but recent evidence has revealed the high propensity of these patients to be dysphagic after extubation or tracheostomy, and our specific expertise is now called upon. I am enormously privileged to work within a fabulous ICU team to help patients communicate, eat and drink as early as is feasible when ventilated, tracheostomised or recently extubated.

SLTs have a few tools up our sleeves, such as Fibreoptic Endoscopic Evaluation of Swallowing, a bedside technique that allows for improved diagnosis of airway patency, vocal cord function, secretion management and swallow safety. It's good to be able to use this information alongside my anaesthetic, physiotherapy and nursing colleagues to better inform tracheostomy and ventilator weaning plans. By using either in-line one-way valves or above cuff ventilation, patients can talk again. This has really helped us to better understand patients' experience of pain, sleep and comfort. It also allows for better MDT assessments of the presence and extent of cognitive dysfunction, delirium, psychosis and disorientation.

Working during the pandemic reminded me afresh of how and why I love my job. When a patient speaks, they can at last have a say in their own care. When they start to eat and drink there is hope that they are homeward bound.

Pharmacist

Greg Barton | Specialist Pharmacist - Critical Care & Burns | St Helens and Knowsley Teaching Hospitals NHS Trust

Critical care really is a team and right from the beginning, as a relatively inexperienced pharmacist more than 15 years ago, I've always felt a welcome part of that team.

A new consultant started around the same time as me and seemed surprised I wasn't on the ward round — I've never looked back since!

Although a large proportion of the pharmacist's input is still reactive e.g. correcting 'errors', an often overlooked and significant part of our role is proactive interventions to maximise therapy, such as dosage alteration secondary to therapeutic drug monitoring (TDM) or in renal dysfunction (and there is no better place to do this than on the ward round at the point the management plan is discussed and set).

I feel the pharmacist is an important cog within the wider machine; improving quality through medicines optimisation and medication error interception, both of which ensure safe and effective prescribing for patients, educating and supporting the medical and nursing staff and providing cost-effective medicines use through standardisation of therapy.

I really enjoy working in critical care as there is a new and different challenge every day. It affords me the opportunity to put my years of experience to good use hopefully contributing to improved outcomes for these sickest of patients.

Dietitian

Ella Terblanche | Principle Dietitian | St George's University Hospitals NHS Foundation Trust

I lead a team of critical care dietitians and have overall responsibility for the service provision. I love everything about food and take all opportunities to share this passion. The dietitian is an essential member of the critical care team and I believe our fundamental role is to advocate for the patients' nutritional needs.

Evidence shows a direct correlation between the amount of dietitians in critical care and improved patient care, including better provision of nutrition support and earlier initiation of enteral feeding. As the nutrition expert, we are best placed to provide nutritional advice to the multi-professional team on the optimal way to manage the nutritional needs of all critically ill patients. Our role involves undertaking in-depth nutritional assessments, advising on nutrition treatment plans and providing on-going monitoring to ensure patient safety and demonstrate outcome benefit.

To be influential, we need to be present on the ICU and participate when important decisions are being made, such as during ward rounds, handovers, multidisciplinary team meetings and clinical discussions with visiting teams. In addition, my team provides ongoing education and training for clinicians, nurses and allied health professionals and acts as the nutrition resource for all professionals.

We also undertake and disseminate nutrition research to widen the evidence base. We are now embarking on extended scope practitioner roles by performing indirect calorimetry to determine energy expenditure. The ICU is a stimulating place to work for dietitians, offering many developmental opportunities. It has certainly provided me with a very fulfilling career.

Clinical Psychologist

Dr Julie Highfield | Consultant Clinical Psychologist | Cardiff & Vale University Health Board

I am a Consultant Clinical Psychologist working in adult and paediatric critical care. In the ICU, myself and my small team provide four key areas of psychological assessment, formulation and interventions with the patients, families, staff members, and at a systems level. I've been doing this job for six years now; I previously covered all of these areas on my own, so I'm glad now to have another person working with me.

We use our psychological problem solving with the team around the patient to help make sense of how they are experiencing the ICU. We unpick if it is delirium, cognition, low mood, anxiety or psychological trauma which is inhibiting the patient's ability to engage in physiotherapy, accept nursing care, wean from the ventilator, etc.

We also provide a psychological safe space for the patient's loved ones to explore the impact of having someone they love so critically unwell, and to stay psychologically well themselves during this process. We see our patients in a follow up clinic, which is my favourite part of the ICU patient work, when you can help a patient to make sense of what they have experienced whilst in hospital.

I help staff to process the emotional burden of their work, through individual or group work, and allow story telling in a way that processes their traumatic experiences at work, and enable new skills and ways of working for self-care and for the care of the patients. Where we can, I try to influence system design and the humanisation of the ICU for staff, visitors, and patients.

Occupational Therapist

Penelope Firshman | Critical Care Occupational Therapist | King's College Hospital, London

In critical care, noisy and restrictive environments are serious obstacles to our usual occupations. This can harm people's health, wellbeing and recovery. Occupations are our everyday activities including personal care (brushing teeth, washing and dressing), leisure (hobbies and socialising) and productivity (work, childcare, managing finances and driving). After critical illness it is often hard to resume occupations previously taken for granted.

Occupational Therapists (OT) focus on what is important to the individual and promote a rehabilitative culture on the units. We encourage humanisation of the critical care experience for patients and staff. OT expertise uniquely spans physical, cognitive and psychological impairments. We treat cognitive impairments such as attention, memory and executive function and have a strong role in management of low mood, anxiety and delirium.

We often work collaboratively with other disciplines, e.g. early mobilisation, feeding and communication. OT rehabilitation is goal-driven and has a strong role in preventing functional deterioration and promoting recovery. It includes specialist seating, positioning regimes, splinting, tone and oedema management. OTs also improve hospital flow through strong discharge planning knowledge and proactive onward referrals.

I enjoy the very varied role of a critical care OT and its great value to recovery. I love supporting the person and their family, improving their time in critical care, keeping connection to their normal lives, and aiding return to previous occupations. Recovery is about quality of life and sometimes what seems trivial to us is life changing. I love being able, through OT, to make that impact on people's lives.

Physiotherapist

Helen Sanger | Advanced Physiotherapist in Rehabilitation after Critical Illness | Newcastle Hospitals NHS Foundation Trust

I am a physiotherapist specialising in Rehabilitation after Critical Illness (RaCI). My job focuses on the physical rehabilitation and follow-up of long-stay critical care patients, taking its title from the 2009 NICE guideline of the same name.

This means I take a small caseload of complex, or long-stay, patients on critical care. I carry out a weekly rehabilitation outreach ward round, reviewing patients on the ward who have recently been discharged from critical care, and can review patients in follow-up clinic.

I also provide support and education to other physiotherapists in key aspects of RaCI, troubleshooting with comprehensive rehabilitation assessments, goal-setting and treatment ideas for patients with critical-illness related morbidity.

I work in Newcastle, in the North East of England. We have four adult critical care units, covering a wide range of specialties. I have been privileged enough to work in each of these units, and have loved the variety of experience this has afforded me!

The most rewarding part of my job is the feedback I receive from patients. They tell me they appreciate having a rehabilitation professional at all stages of their journey who 'gets it' — understands critical illness, and the profound and lasting impact it has. This is crucial for me, as we know, more often than not, we cannot get people back to the level of functioning they had prior to their critical illness. However, if we can support them to optimise their recovery, and adapt to lasting impairments in a way that minimises its impact on their quality of life, then we've done our job.

Critical Futures

Dr Alison Pittard
Dean

The launch of our Critical Futures initiative back in 2017 seems such a long time ago now, especially after the events of 2020, and a New Year is a fantastic opportunity to reflect.

Recommendations and workstreams

You will recall that we made 12 recommendations based directly upon the feedback received from our survey. Some of these resulted in work streams that FICM led, others were already being undertaken by other groups and we identified stakeholders who would be best placed to take the remaining items forward.

Of the three FICM-led workstreams, *Care at the End of Life* was published in 2019 (recommendation 10), *Guidance for the Development of Enhanced Care* was published in 2020 (recommendation 4) and *Life After Critical Illness* (recommendation 12) will be published this year.

Effects of the pandemic

Some of the other recommendations have been achieved as a direct result of the pandemic, whilst others have been delayed. Little did we know, when *Care at the End of Life* was published, that we were about to be hit by a global pandemic, however this created a platform upon which to address the difficulties faced when discussing such an important area with our patients. It led to further collaboration with NICE, RCP and many other organisations to help ensure that our patients voices are heard.

Opportunities from challenges

One of the positive outcomes from COVID is the opportunity to rethink how we deliver care. We achieved so much by breaking down professional and specialty barriers and it is vital that we take this forward. The restoration of non-COVID NHS activity presents challenges and critical care capacity is pivotal in this.

Enhanced Care was seen as way of unlocking the NHS and we collaborated with the Centre for Perioperative Care to publish *Guidance on Establishing and Delivering Enhanced Perioperative Care Services*. As with the original guidance, there is a framework to support local development based upon the needs of the patient population and the service.

Of course until we publish our *Life After Critical Illness* guidance we won't know its impact but, again, COVID has highlighted some of the issues that can follow being sick and how debilitating this can be be. We know only too well the long-term effects of critical illness from seeing patients in our follow up services and hopefully this guidance, and awareness of 'Long COVID', will see a much more uniform approach across the country to providing support for our patients as they recover.

Where next?

So where now? Our January Board meeting started off with an 'Away' morning, where we discussed our strategy and focus going forward. We will be looking at the Critical Futures initiative and deciding where we go next with this so, watch this space.

CRITICAL EYE *Interview:* Simulation and Preparing for COVID-19

In an interview with *Critical Eye*, two members of the Education Sub-Committee, **Dr Sarah Marsh** (Deputy Chair) and **Dr Andrew Jacques** (Simulation Lead) compare their experiences of using simulation in preparing for the COVID-19 pandemic and surge.

Why did use simulation to prepare your teams?

SM: Despite being someone that had not really ventured into the world of simulation, it quickly became obvious that it lent itself to helping to prepare and train our staff to work in new ways. A few centres internationally had used simulation and had documented their experiences on social media, which became my main source of inspiration.

Simulation has been defined as a situation in which a particular set of conditions is created artificially in order to study or experience something that is possible in real life; or a generic term that refers to the artificial representation of a real-world process to achieve educational goals via experimental learning.[1]

This was exactly what we needed to do to get ready for the approaching pandemic. Not only was the simulation incredibly useful in providing experiential learning for our staff, it enabled us to see flaws in our guidelines and protocols, and allowed us the opportunity to rectify them in a safe environment. In order to protect ourselves and our patients we had to rewrite pathways and processes that recognised the mode of transmission of COVID-19 from putting on PPE to intubation and ventilation. It also allowed us to ensure that we had the right equipment for use in different circumstances, and in the correct receptacles. From pre-patient encounter to cleaning the area following patient contact we were able to plan and prepare for the whole journey.

AJ: We already run a routine programme on our unit of multi-professional in-situ simulation. Initally we used simulation to test and refine a local COVID-19 intubation guideline. Having finalised the guideline we needed an educational intervention that would allow us to disseminate the new guidance and information to a rapidly expanded and diverse healthcare group. Simulation not

only allowed us to teach and drill rehearse, but also brought together teams of people to start working together before being clinically required to do so. Appreciation of roles of staff who traditionally would not work closely together was of great value during later patient care, with theatre staff working in an ICU environment and ICU staff working in our expanded ICU within theatres.

How did you decide what to focus on?

SM: We started with the basics of donning and doffing – the message from Italy had been clear that you needed access to appropriate PPE and to know how to use it effectively and appropriately. So, a few colleagues and I watched the PHE videos on how to don and doff properly, printed out their quick action cards and went on a road show around critical care and theatre complexes to get everyone practicing. Once that was in full swing we started to look at the more specialised procedures such as intubation and ventilation, CPR and proning. As we were doing all of this, so were many others up and down the country. This then led to a huge outpouring and sharing of information which made going forward much easier.

AJ: Similarly to Sarah, donning and doffing was chosen as there was considerable and understandable anxiety about the risks posed to healthcare workers caring for COVID-19 patients so we wanted to ensure staff were familiar with the buddy system and the procedure of applying and removing PPE. With regard to intubation and ventilation, there were so many adaptations to our normal practice, and with this being regarded as one of the highest risk interventions it seemed a sensible subject to cover. Whilst we had experience of proning prior to COVID it was a relatively infrequent event and given the evidence suggested proning would be beneficial, we thought ensuring as many people as possible were familiar with the technique would be of value. A significant proportion of our patients subsequently received multiple episodes of proning.

How did you use simulation?

SM: We commandeered empty theatres as well as side rooms on ICU to run drop in sessions morning and afternoon where staffing allowed.

We used it not only to train staff, but also to adapt pre-existing protocols and tweak interventions to make them 'COVID-safe'. We were able to deliver a truly multi-disciplinary approach to patient care as we were not only training existing critical care and theatre staff, but also cross-skilling staff members not used to working in such areas. Being deployed to work in an unfamiliar environment is incredibly stressful, in addition to then working in a pandemic, and we hoped that the sessions would help to reduce some of that anxiety about being unfamiliar with equipment and procedures. Simulation also allowed us to incorporate new and existing team members into collective groups.

AJ: We ran four sessions a day for five days with a few extra sessions one weekend and a couple of evening sessions for those who only worked nights. Each session was 90 minutes long consisting of three stations; donning and doffing, proning and intubation, and ventilation of the known or suspected COVID-19 positive patient. Each session was multi-professional with doctors, nurses, ODPs and physiotherapists from both theatres and ICU. Additional staff from other acute areas of the hospital also attended when word spread of what we were offering.

How many people did you manage to train?

AJ: We managed to train over 200 staff in less than a week.

SM: We trained the critical care and theatre teams as well as staff on delivery suite. We managed to get over 100 staff through the simulations prior to starting for real!

What was the hardest part?

AJ: From a personal perspective, I felt at one stage that we were going to be overwhelmed with cases before we had the opportunity to provide some targeted focused training which made me feel very anxious. There were some robust discussions around the timing of decisions to cancel elective surgery but ultimately, we were well supported by the trust and provided with the resources and time we needed to prepare staff in time (just!).

As an educator, the subject material is usually well established and you can draw on a wide and stable evidence base. At the beginning of the pandemic surge there was a wealth of new information on an almost daily basis so trying to decide how best to integrate and adapt it to our

own local environment, and then teach it, was challenging.

SM: The hardest thing was starting. Two consultant colleagues, two ODPs and I locked ourselves in an empty theatre with several bags of sweets for a day to work out what we needed to work out. A couple of scenarios regarding intubation and ventilation had been published on social media so with those in hand, we started to meticulously work through the whole process of caring for a critically ill COVID-positive patient. At first it felt very overwhelming as we just didn't know what to do, and felt enormous pressure to get something nailed down and quickly. We started the day with brain freeze but, like with anything, we just got started and everything fell in to place after that.

We walked several different scenarios through and created trollies of equipment likely to be required at each step which were later converted into grab boxes. We photographed each stage so we could also create presentations to deliver to the masses.

Did you get any feedback from staff?

AJ: We didn't collect immediate feedback as the primary focus was on delivery to as many relevant people as possible, but we collected some data post surge. Specific aspects mentioned were: development of confidence and competence with practising new skills, standardised training enabling standardised care and facilitating teamwork, addressing knowledge gaps, improved safety and appropriate timing to retain knowledge and skills for the pandemic. The universal

theme throughout the feedback was increased confidence and reduced anxiety over and above acquisition of knowledge or technical skills.

SM: We had informal feedback to say that the experience was a valuable one. Staff tended to want more simulation, and on an increasing number of scenarios, however we ran out of time and then had to stop practising and start using the knowledge gained once COVID arrived.

If you had to prepare for another surge, would you do anything different?

SM: Those initial few weeks were so important for the whole critical care and anaesthesia community to get procedures and protocols right to keep staff and patients safe. Following the sharing and adaptation of such information and the pooling of resources on a national website, I feel we now have a raft of materials to help us through further surges. We have experienced how valuable simulation can be and I wouldn't hesitate to use it again.

I feel, however, that there was huge disparity between what training opportunities we were offering in a critical care and theatre setting and what was available at a ward level. The focus was firmly on critical care at the outset and I think that led us to taking our eye off the ball somewhat in terms of how to care for patients on the general wards, and to keep the staff on those wards safe.

AJ: I think similar to Sarah, and reflected in our feedback would be to try to ensure a greater parity of preparation across the trust for our acute care areas. Feedback also suggested more familiarity for theatre staff with the ICU ventilators and conversely ICU staff with the anaesthetic machines would be valuable if we were in the position of spilling over into theatres again.

References

1. Making patient safety the focus: crisis resource management in the undergraduate curriculum. Flanagan B, Nestel D, Joseph M. *Med Educ*. 2004 Jan; 38(1):56-66

How are our ICU staff right now?

Dr Julie Highfield

Consultant Clinical Psychologist &
ICS Wellbeing Project Director

I'm a jobbing ICU Clinical Psychologist and having worked in the environment for several years now, I know what a challenging place it can be. Most of the staff thrive on this challenge and enjoy the variety and the pace of the work. Providing dignified care whether a patient lives or dies is a privilege, not a chore.

However, this is a workplace that can take just as much as it can give, and it is a delicate balance. Several researchers now have highlighted ICU staff are at risk of anxiety, depression, post-traumatic stress disorder (Coleville et al, 2017) and burnout (Vincent et al, 2019).

Research also indicates that satisfaction with the work can mitigate against mental health problems (Highfield & Parry-Jones, 2019).

Pulling out all the stops

Now we find ourselves within the midst of a pandemic, where a new disease has presented challenges to our teams and surges in demand, with the majority of units going above their capacity in both wave one and wave two. I observed a great sense of anxious anticipation in wave one, we just did not know what we were facing. I also saw a huge amount of energy and teamwork. Someone described it to me as the energy of snow days: staff pulling together against all odds.

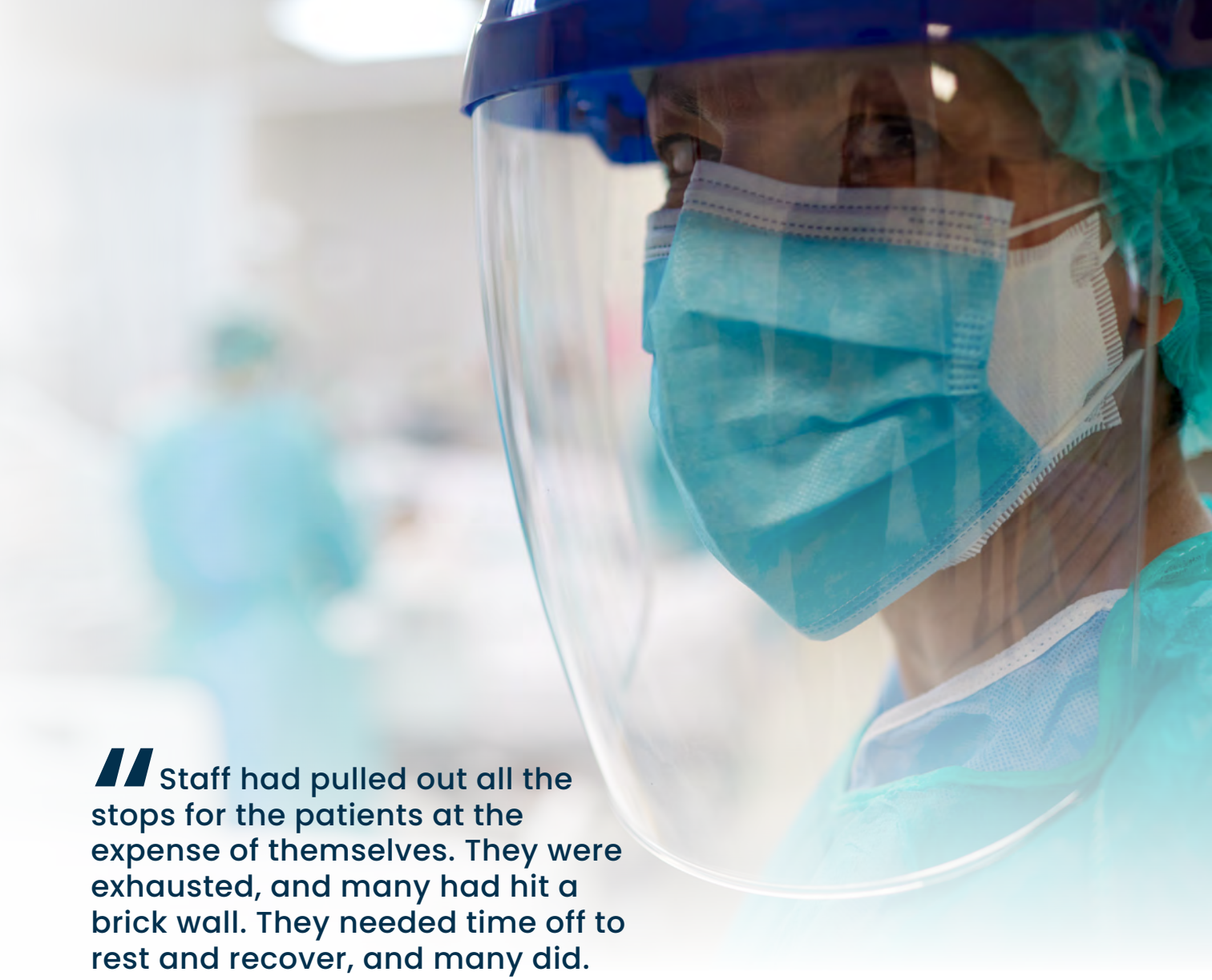
I know a lot of staff saw this as a challenge to rise to, and experienced joy at being able to apply their skills. ICM became known, understood and appreciated in the public eye.

However, as the first wave slowed, I saw that staff had pulled out all the stops for the patients at the expense of themselves. They were exhausted, and many had hit a brick wall. They needed time off to rest and recover, and many did. Many also told me how what they had been through had only just started to hit them and they often struggled to recall much of the detail: it had all been such a whirlwind for them. In my experience, this was disproportionately the nurses rather than the doctors or allied health professionals.

Moral distress

For those who could articulate freely, the overwhelming themes were about not being able to do as much as they would like to do for patients and their families and being limited in what support they could give to their colleagues. These are the kinds of dilemmas we often label as moral distress, and they do leave staff vulnerable to experiencing longer term psychological trauma.

This second wave feels different: the energy is not there, we have not had long enough to recover, many staff have left, and we have not had the same levels of redeployment.



> **"Staff had pulled out all the stops for the patients at the expense of themselves. They were exhausted, and many had hit a brick wall. They needed time off to rest and recover, and many did.**

The energy of 'snow days' has dissipated and in the new normal it feels more like we have moved to Alaska. I now see more staff for 1:1 support than I have ever seen in my entire career. These staff are showing signs of an overactivated stress system such as not sleeping, constantly thinking of work, hallucinating alarms, being tearful or experiencing labile mood. Recent alarming questionnaire data from research studies in ICU have suggested problems at a diagnostic level (Greenberg et al, 2021), but such labels are not always helpful. It's less a case of what is wrong with you, it is more a case of what has and is happening to you.

The eye of the storm

A meta-synthesis of the psychological responses of healthcare staff to SARS suggests that symptoms are high in the core active phase, but there was natural recovery for most once work returned to normal (Allan et al, 2020). We are in the eye of the storm; it is hard to know what will happen next. What I know is that I have helped staff who have felt able to approach me for 1:1 professional psychological support. I am glad to be in a position where I can support wider UK intensive care units with the Intensive Care Society Wellbeing project, which other ICU-related organisations have been incredibly supportive of.

However, it is wider than mental health: it is about wellbeing. I wonder how people will come to think of their experience of working within ICU, and I hope that we can restore it to an environment where staff can once again thrive when caring for our sickest patients. To access our programme, please go to www.ics.ac.uk/wellbeing.

The Faculty of Intensive Care Medicine

FIC

2010

- Regulations approved by seven original parents
- First Board meeting held (October)

2011

- New curriculum approved
- New website launched
- Foundation Fellowship opened
- First Training Leadership Conference held

2012

- First national recruitment
- First FFICM Examination
- *Critical Eye* launched
- First FICM Annual Meeting held
- Pioneered transferable competencies with dual programmes
- Faculty helps launch ICCQIP

2013

- *Collaborating for Quality* launched, founds CCLF
- E-portfolio launched
- PHEM approved as a subspecialty
- First ACCP Conference
- Academic training guidance launched
- First trainee survey – launch of Quality Nexus

2014

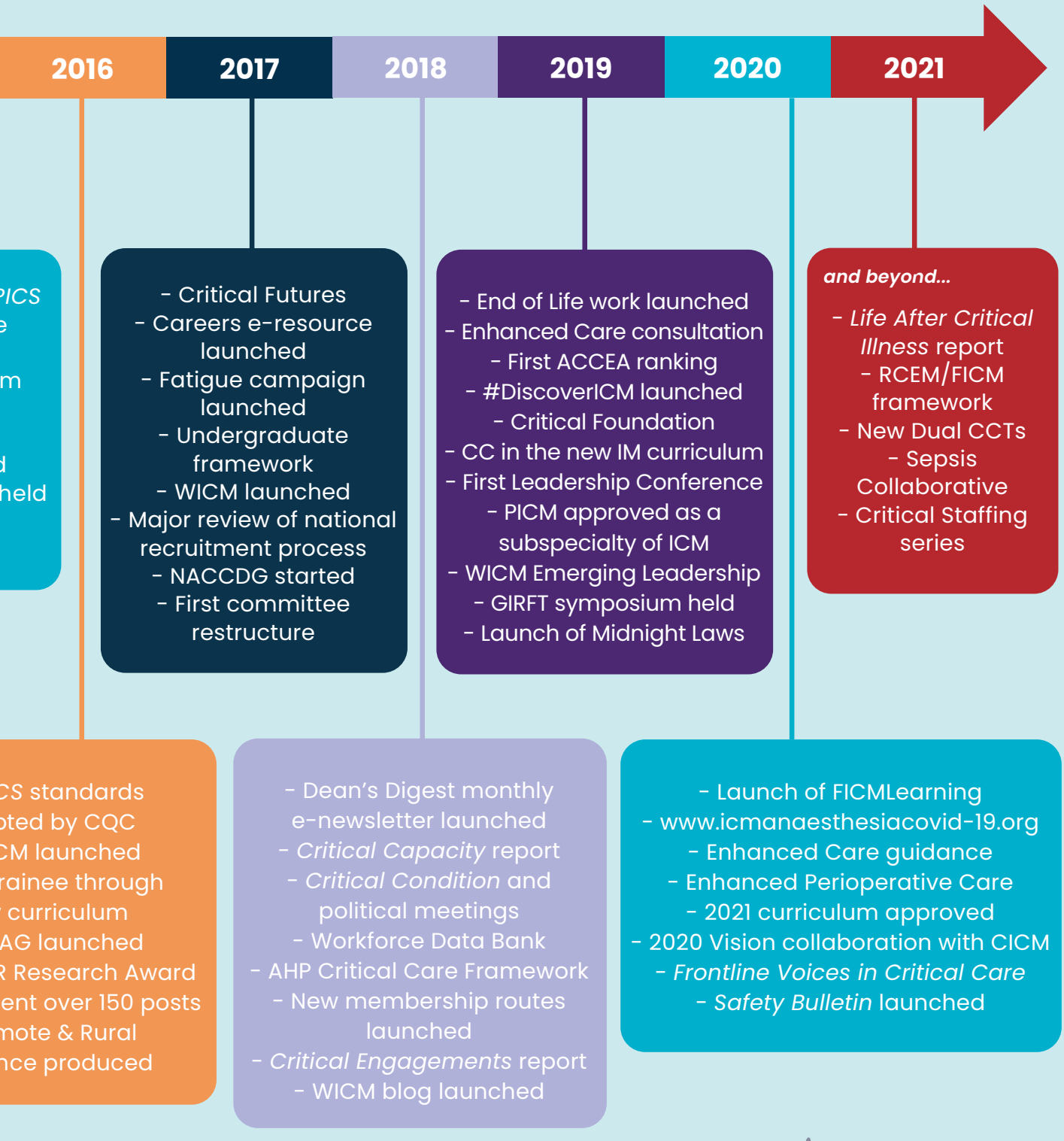
- First annual census
- Guidance on revalidation launched
- *Trainee Eye* launched
- More Special Skills Years added to curriculum
- Admitted to the AoMRC

2015

- Launch of first *GP*
- First workforce engagement
- ACCP curriculu launched
- CfWI report
- LEPU launched
- First prep course

- *GPIC* adop
- e-IC
- First t new
- SSU
- First NIHR
- Recruitm
- Ren guidan

M10: Celebrating the First Ten Years of the Faculty



Training, Assessment & Quality (FICMTAQ)

Dr Chris Thorpe
FICMTAQ Chair

The new curriculum has been approved by the GMC. The next steps involve ensuring that everyone understands what the process is and to this end there will be a handbook and guidance for trainers and trainees. The transition plan is being worked through as we speak, and you can expect to see a big increase in communications from the Faculty once all the elements are ironed out.

There remains work to be done on aligning the curricula of the dual CCTs, which will be undertaken jointly (or should that be dually?) with the partner specialties.

The good news is that there will be a drop in the amount of assessments needed, which has been a consistent concern for trainees over the last few years. The focus instead in on outcomes, so there will be less paperwork for both trainers and trainees. Our Curriculum Lead, Dr Matt Williams, discusses the new curriculum in more detail further on in this edition of *Critical Eye*.

A time of transition

It goes without saying that times of transition create great stress to all involved. This is compounded by the fact that a new ePortfolio platform is also coming into being. It is extremely frustrating that we have not been able to get consensus between the royal colleges and faculties on having a single ePortfolio for all medical trainees. To me, this is an obvious mistake and the ones paying the price are trainees who have to manage two separate portfolios that do not talk to each other. Unfortunately each college has their own independent view on which ePortfolio best suits their needs. I can only apologise that we are unable to provide a straightforward single platform for *all* of our dual trainees — it is simply beyond our control.

Nevertheless Dr Andy Gratrix and his team have taken the battle forward for the Faculty in putting together a great new Lifelong Learning Platform for our ICM trainees and this should be up and running in August 2021. There is more information on the project elsewhere in these pages.

Training in a pandemic

Training has been affected considerably by COVID-19. Effort was made by the GMC in advance of the ARCP season to understand the problems, consequences and likely outcomes for trainees, and to make an appropriate plan.

Overall the efforts were successful; the new COVID-19 outcomes of 10.1 and 10.2 allowed trainees to progress despite not having all the requirements laid out in the curriculum. Most trainees who did not fulfill the usual outcomes were caught by the 10.1 outcome, in which training continues as planned but with some adjustment going forward to compensate for what has not been achieved, the exam for example. There were fortunately few 10.2 outcomes in which trainees needed extra time before moving on.

Thank you and well done

Thank you to all of the trainers and consultants who coped superbly with the ARCP season while still under the cosh, and of course all the trainees who had to continue completing their ePortfolios while dealing with the biggest crisis to affect our specialty in living memory.

Trainee Update

Dr Richard Benson
FICM Trainee Representative

By the time you read this, I will have come to the end of my tenure as the FICM Trainee Representative. I want to thank all of the trainees for their efforts over the last year. The clinical and educational demands of 2020 have been unprecedented. We have all had to readjust our lives.

The disturbance to us, both personally and professionally, will have had an impact and for some may have caused psychological and moral injury. It will take time to adjust to this..

Mental health and wellbeing

It is not enough that we pay lip service to mental health and wellbeing. We have to continue to fight for improvement in our working lives both, as trainees and intensive care doctors This improvement will be driven locally with 'hygiene factors' such as rotas and rest facilities. Nationally it will be aided by the change to the new outcome based curriculum focusing on the quality of assessments rather than quantity. This is an important change.

Longer term

When the dust does settle we need to be careful not to lose the educational core of our specialty. The demands on our workforce have put us all under strain. Having the time to teach, nurture and develop our future workforce is what drew many of us to ICM. The COVID-19 ARCP outcomes may have allowed many trainees the ability to progress but, we need to protect the learning environment for the future.

Keep in touch

Having spent the last couple of years with the Faculty I know that collectively they share a vision to continually improve training and work tirelessly to fulfil this. I am optimistic about ICM and the training programme but it remains a collaboration. As trainees we are in the best place to push for and enact changes, as training is very much our experience. Your input is valued and suggestions will be discussed as part of this collaboration. Please do continue to keep in touch through your STC representative, RA or via the FICM trainee representatives.

A real privilege

It has been a real privilege to represent your views and work alongside you as part of the wider ICM team. I will hand over to Dr Guy Parsons who is your new Trainee Representative and Dr Catriona Felderhof your new Deputy Trainee Rep. Look after yourselves and each other and I wish you all the best as we move forward with optimism to 2021.

Supporting Excellence: Update on the new ICM Curriculum

Dr Matt Williams
Curriculum Lead

Despite the most hectic and stretched of years for the Faculty in 2020, significant progress on the revised curriculum *Supporting Excellence* has been made. Following the consideration of and incorporation of points that came from the consultation held in the autumn of 2019, the final version was submitted to the GMC in February 2020. We all know what happened then…

Following the hiatus in activity, the GMC's Curriculum Oversight Group (COG) returned questions on five points in July. Specific points, such as on the exam and assessment, were answered by members of the Training Assessment & Quality (TAQ) Committee, with these submissions returned in September. The Faculty were delighted to be able to announce the full approval of our new curriculum on the 4 November 2020.

Huge thanks must be extended to Tom Gallacher for his leadership in driving the massive amount of work that was needed to get this far. Tom's attention to detail, clear thinking and understanding of the processes involved in curriculum development were crucial to ensuring a (relatively) smooth path to fulfil the GMC's requirement for all curricula to be re-written and to meet the standards set out in its *Excellence by Design: Standards for Postgraduate Curricula* document.

Thanks must also go to the curriculum writing group, members of TAQ, and the FICM secretariat staff (particularly Natalie Bell) who have contributed to this huge piece of work over the last four years.

Tom has stepped down from his role as Chair of TAQ and Curriculum Lead; we wish him well in his well-earned retirement. No doubt work on his golf handicap will now get the same level of attention and be driven down!

Now that we have confirmation of approval of the new curriculum, work has already started in earnest to ensure we can implement it as planned on 4 August 2021. Tom has written previously in this publication on the structure of the new curriculum, so I won't repeat that in great detail here, but I will aim to summarise the key points and next steps.

What is different in the new curriculum?

In keeping with the GMC's requirements, the new curriculum moves away from detailed evidencing of individual competencies to an outcomes based approach of assessment. There will be a reduction in the assessment burden which both trainers and trainees will welcome. The assessment strategy will now emphasise the use of Supervised Learning Events (SLEs) to formatively help drive learning. The usefulness of the SLEs will be dependent on good

qualitative information in the form of considered verbal and then written feedback following the supervised learning episode. The MSF will continue to be an annual exercise, and will be expanded to include more questions.

The three stages of training remain, with three key progression points at completion of each stage. For each stage, the 14 High Level Learning Outcomes (HiLLOs) will need to be achieved at the level required, and to leave Stage 2, the trainee will need to have completed the FFICM exam.

In order to achieve some of the HiLLOs, professional activities such as teaching, journal clubs and CPD, quality improvement and involvement in research will still need to be conducted by the trainee and the activities considered by the Educational Supervisor (ES). The ES will need to make an overall judgement based on all the information available to them as to whether the HiLLOs are achieved at the expected level at each key progression point. This is going to be the main shift in mindset that is required. So, I would urge all trainers and STs to start considering this.

Dual training with the partner specialties of emergency, acute internal, renal and respiratory medicine, and anaesthesia will still be possible. Towards the end of 2020, it was confirmed by the GMC that acute/respiratory/renal medical trainees will be able to continue to train with ICM in addition with the requirement to dual with general internal medicine which will continue to enable the plurality of background of future intensivists, something that is acknowledged as a very good thing. Single CCT trainees will still need to undertake one of the previously approved Special Skills Years.

Implementation, information, dissemination

The FICM have and will continue to send key updates via the website, Twitter and in e-newsletters to key educators and trainees. The curriculum will be a key agenda item at the Training Leadership Annual Meeting on 30 March 2021, which is being delivered virtually and is attended by Regional Advisors, Faculty Tutors and Training Programme Directors. Members of TAQ are also attending regional Specialist Training Committees virtually to present and take questions on the curriculum. A Frequently Asked Questions list is being compiled and will be posted on the FICM website, and updated regularly, including with learning points that are gleaned after implementation.

Still to do

Guidance on transition for trainees to the new curriculum needs to be completed. The aim is move all Stage 1 and 2 trainees to the new curriculum on 4 August. Those in Stage 3 have the option to remain on the 2010 curriculum. Guidance will be published on those who are in mid stage. Whilst there is still much work to do ahead of the implementation in August, all during an on-going pandemic, I remain very optimistic that the move to the new curriculum will be well worth it.

Understood and implemented well, its framework should enable a better, constructive experience for trainers and trainees. When you have a spare moment, please take a look at the Faculty's website for more information, https://www.ficm.ac.uk/curriculum/new-icm-curriculum-2021, or our Twitter feed @FICMNews.

What are HiLLOs?

High Level Learning Outcomes are broad categories of what Intensive Care Medicine doctors do. The outcomes describe what we do rather than breaking down what we do into smaller parts — for example:

Can admit a patient to ICU

rather than

Can take a history, can examine, can make a diagnosis, can put in lines, can prescribe vasopressors, etc.

In November 2020, FICMTAQ received a letter from a group of ICM trainees regarding the selection of the new ePortfolio platform. In response, Dr Chris Thorpe (FICMTAQ Chair) and Dr Andy Gratrix (ePortfolio Lead) provided the following statement to explain the rationale behind this decision. A number of factors have motivated the development of this new ICM ePortfolio.

The N

First, a desire to improve the trainee experience of recording progression while simultaneously reducing the burden of assessment. Second, an aim to provide a more responsive and trainee-led portfolio that can accommodate future changes. Finally, a need to ensure platform sustainability over the longer term.

Several Royal Colleges decided to leave the NHS Education for Scotland (NES) ePortfolio platform that has historically hosted many training portfolios. The Royal College of Physicians in particular has not yet confirmed whether it will continue using NES.

As NES operates on a shared funding stream, whereby all hosted parties are financially responsible for its maintenance and development, this exodus puts the future viability of the NES platform in jeopardy.

One of the difficulties we are unable to overcome is the autonomy of the colleges to choose their own platform. Clearly it would be much better to have one platform for all trainees however, unfortunately this has not been a high priority for the various specialties.

Sustainability and building for the future

We began looking into alternative providers in 2018 and engaged with several major providers, including the company hosting the RCoA's Lifelong Learning Platform (LLP). A thorough options appraisal was provided to the RCoA, to whom the Faculty of Intensive Care Medicine (FICM) is legally and financially responsible and following careful consideration, the LLP was selected as the most appropriate platform based on the following factors:

- Through integrating the ICM ePortfolio within the LLP we gain greater autonomy over the platform's customisation and the ability to make changes ourselves without charge and without the need to seek permission via a joint committee like we currently have to do with NES. This will prove invaluable when implementing our new curriculum in 2021.
- The LLP does not operate on a cost-per-user basis, as NES does, so we may be able to broaden access to specialty doctors, CESR applicants, Advanced Critical Care Practitioners and Critical Care Pharmacists in future. This gives us greater flexibility and control to support more of our fellows and members which is of great benefit for our progressive specialty.

lew ICM ePortfolio

- The NES platform does not easily allow cross-linking of evidence (more below).
- In having both intensive care and anaesthesia trainees on the same platform we will develop a shared corporate knowledge for the platform's maintenance and development. We will also benefit from greater financial security in partnering with the RCoA, ensuring the platform will be sustainable.
- Although the choice of platform was based on the above factors, at present, the largest cohort of ICM trainees are those on ICM and anaesthesia dual CCT programmes who are already familiar with the LLP. This option also minimises the number of trainees and trainers that would need to become accustomed to a new platform.

Meeting trainee needs

We recognise the burden of non-communicating electronic portfolios and acknowledge the considerable strain this causes for dual trainees. Since the inception of the ICM ePortfolio on the NES platform the Faculty have investigated the possibility of greater ease and simplicity in cross-linking evidence across portfolios within NES. The NES platform cannot accommodate this due to a number of inbuilt technological restrictions and to even look into this further would require significant financial investment with no guarantee of eventual success. The Faculty feel that this is not a responsible or appropriate use of funds.

Throughout this decision-making process we have advocated for the needs all ICM trainees irrespective of training programme and do not in any way wish to disadvantage any particular group. Unfortunately, it is neither financially viable nor practical to maintain and update two separate ePortfolio systems, so we cannot pursue the option of implementing the new curriculum additionally in NES. This would also not solve the various cross-linking issues between ePortfolios as described above.

What we can and will do is simplify and streamline all processes within our control to recognise non-ICM programme trainee development within the LLP for dual trainees. We will provide comprehensive information and training materials on this in due course and want to reassure trainees that this will be more intuitive than the current process.

Positive change

The LLP ICM ePortfolio will be trainee-led, intuitive, flexible, and, importantly, fully under our control. Through it we can implement a curriculum that greatly reduces the burden of assessment for all ICM trainees, that is responsive to trainee needs, and that is sustainable for the multidisciplinary, cohesive, ambitious future we all desire for our specialty.

We hope to share more details of our progress shortly as we are nearly half way through the development. Please do not hesitate to contact us should you have any questions: contact@ficm.ac.uk.

You may also find the following page on our website useful: https://www.ficm.ac.uk/e-portfolio/new-icm-eportfolio.

The First Remote FFICM Examination

Dr Victoria Robson
Chair of FFICM Examiners

The Final FFICM examination has been held twice a year since 2013, and continues to be an integral part of the assessment strategy of the standalone ICM CCT programme. Due to the extraordinary circumstances caused by COVID-19 pandemic, in 2020 the spring OSCE/SOE and July MCQ were cancelled.

The exams team and Examiners were then faced with designing and testing a new format which would enable the October 2020 and subsequent exams to go ahead. The new format had to be viable whatever lockdown rules might be in force at the time and without needing to increase the cost to trainees. The exam itself needed to test, as far as possible, the same competencies at the same standard as the face to face exams. After testing, the commercial platform Zoom was chosen as it was the only suitable option for the OSCE. with all Examiners and candidates being remote.

Modifying the format

A huge amount of work was put in to modify the format of exam questions pulled from the question bank and work out the logistics of how to deliver this. The solution included multiple remote breakout rooms, additional time for security checks, candidates to be moved between stations, reading the station instructions, and for potential internet delays. All this made the overall exam much longer (but with the same actual examination time) so the OSCE was split with a break for candidates and Examiners. Question artefacts had to be put onto PowerPoint slides (and projections checked), simulation stations were redesigned and sets of guidance and regulations written (and rewritten after testing). By comparison, the SOE was somewhat easier to move to remote format. All Examiners and exams staff underwent practical training on how to deliver the new format. To inform potential candidates, a webinar was held at the beginning of August and supplemented by guidance, FAQs, example artefacts and a video demonstrating the exam published on the FICM website.

Dr Jerome Cockings (Deputy Chair) and I went to the College to be with the exam staff running the exam, and we all sat (socially distanced) in a very empty College building, surrounded by strangely quiet London streets; London was under Tier 2 restrictions at the time.

Working with technology

We expected some internet issues during the exam itself. As all Examiners had done their remote exams training on the Zoom platform, almost all of their internet issues had been resolved in advance; only one examiner's connection failed in one station (2% of examiners). This contrasts with 15% of candidates having significant internet

issues mid-exam (some more than once), as well as a laptop failure, candidates dialling into the wrong 'meeting' and several dialling in late.. Some of those with internet problems did not appear to have tried to maximise their internet in advance (for example by sitting near the router or having a cable connection to the router).

The team did their best to ensure all candidates did complete their exams, such as talking through how to 'hot spot' onto a phone when the internet connection was poor, adding in a missed station at the end and holding up the exam to allow rejoining, but there is limited capacity to do this. All of this, of course, led to delays for other candidates and Thursday morning's OSCE was particularly affected. However all candidates who started, did complete their exams.

All exams were recorded to enable investigation of both technical issues and any suspicion of cheating. Three technical issues (in almost 1,500 OSCE stations) were identified where a candidate might have been disadvantaged and extra marks to compensate were awarded to each of the candidates affected.

118 candidates were examined over four days; almost 1,800 examination 'stations' were run.

The OSCE, which consists of 13 stations (including one test station which does not contribute to the total mark), had 109 candidates, of whom 64% passed. The SOE, which consists of four sets of two questions, had 93 candidates, 74% of these passed. The overall examination pass rate was 60% and all pass rates are within the expected range. For candidates who failed on this occasion, this exam will not count towards their maximum of six attempts.

Standard setting

The standard of the examination is set at the end of Stage 2 training. The examination aims to test as wide a range of the ICM CCT Stage 1 and 2 curriculum as possible, so includes the more specialist areas within Stage 2 such as paediatric ICM, as well as Stage 1 anaesthesia and medicine. The Chair of Exams writes a report (published on the FICM website) which highlights areas where a number of candidates struggled; applied basic sciences, radiology and ECG interpretation continue to feature in the reports.

The next FFICM MCQ, in January 2021, will be hosted on the TestReach platform, which is a commercial cloud-based examination delivery system. Guidance for candidates and a 'test tutorial' are already available.

The future

The intention is to go back to face-to-face oral examinations in London, whenever the COVID-19 situation allows. At the time of writing I suspect this will not be possible for the spring oral examination, but the final decision has not yet been taken. However, for the MCQ, the remote format has the advantage of significantly reducing travel for many trainees with little, if any, disadvantage (except increased cost), and the option of continuing in the remote format is being explored.

The size of the task undertaken to redesign the whole oral exam in a very short time (while all working remotely) should not be underestimated. The small exams team at the College and the senior Examiners achieved this task, which usually takes years, in three months.

The exams staff and Examiners themselves worked much longer hours than usual (hours of downloading and uploading questions, score sheets, scores, videos etc in addition to examining candidates); my thanks to them all for making this first remote FFICM exam a success.

FFICM Prep Course

Dr Sarah Marsh
FFICM Prep Course Lead

2020 has been the most difficult of times for us as professionals, family members and as human beings. There has been a huge toll on our community, including on our trainees in ICM who have had their training and progression impacted upon by the pandemic. The first wave of COVID-19 saw our postgraduate exams cancelled alongside other colleges.

Then as spring moved into summer, the regrouping and planning began to deliver a digitally based exam in the autumn, with much trepidation. Alongside the formal exam, the FICM wanted to host a virtual preparation course too, reaching as many people as possible. The discussions for this began in June, with the final go-ahead given at the end of July and a date set for less than eight weeks later.

New ventures

Like most things this year, this was a new venture for the FICM and the exam preparation course faculty. We knew that we needed to deliver a meaningful course, that was value for money and that offered some level of exam practice (which at the end of the day is what the people want!). And as the first digital event that the FICM had run, this was rather a test case for the future of FICM events.

We developed a tiered system for access to increasing levels of content; this included pre-recorded lectures, exam practice and a live day with speakers. The team at the FICM (Lucy and Anna) undertook the unenviable job of sourcing the right platform to host the day, as well as all of the editing of the material produced.

Our 'normal' course usually runs over two days, with day one focusing on small group lectures and tutorials and day two centring on exam practice in the form of OSCEs and SOEs. In view of this we wanted to offer a hybrid of this original design, by giving access to pre-recorded lectures from our speakers in tier 1, access to 16 pre-recorded OSCE and SOE exam questions and model answers delivered by our faculty in tier 2, and the invitation to join our speakers for an interactive day in tier 3. This way tier 1 and 2 could be accessed by an unlimited number of people in the first instance, which we felt was extremely important. As we were new to digital course delivery, we limited tier 3 to 30 people to have breakout rooms with ten candidates in each, to retain some of that small group session feel. In total we were able to facilitate 121 bookings across all three tiers.

They were hosted on Vimeo and edited in Openshot. These sessions were available one week prior to the course and up until the exam day itself. The faculty recorded themselves delivering eight OSCEs and eight SOEs that were also available to access at any stage in the time frame above, with the ability to stop and pause the question and refine the answer given. This was more difficult to do than we imagined, as it involved memorising the question and answer to maintain eye contact with the audience (camera) and many retakes (blooper reel available on request) until we got it just right. We did however find a teleprompt app which was fantastic and made life a lot easier.

On the prep course day itself, each speaker gave a synopsis of their topic to their audience via Zoom and then discussed questions that had been sent in prior to the course, as well as answering any points that came up from the candidates either in person or via the chat function.

Building on our learning

There were so many 'firsts' for us running the course in this way and we learnt a huge amount that we can build on for the next course. We had a very short time frame in which to put the course together and had to think outside the box in many ways to deliver the event in a different way (and also get to grips with the technology of doing so!). We strongly believe however that we did deliver an accessible, interesting and ultimately useful course that was value for money.

The feedback was positive, both in terms of the technology and content. One hundred percent of the candidates were happy to attend a Zoom event at the FICM in the future. The overwhelming request was for live exam practice which wasn't possible this time due to the time constraints on the team and unfamiliarity with the technology but we are aiming to facilitate for the next course. We will keep the tier system for next time too, which allows a greater number of trainees to access the material but will, as always, need to limit the numbers in the exam session. We need at least one examiner (consultant) for each exam station and therefore require over 25 consultants to do so, which is a big ask particularly at the moment.

My thanks as ever go to Lucy Rowan and Anna Ripley at the FICM for making the event happen (and actually appear in front of our eyes), and to the faculty Dr Steve Lobaz, Dr Sharon Moss, Dr Paul McConnell for their hard work during a difficult time. We also said goodbye and thank you to Dr Jane Howard who was an original faculty member; we wish her well in her new endeavours, and welcomed Dr Kate Flavin to the team. Kate has a huge amount of experience in both teaching and exam preparation and will be a valuable asset. Plans are already underway for the spring prep course, being held on 4 and 5 March 2021, so please keep an eye on the FICM website for details.

Regional Advisor Update

Dr Matt Williams
Curriculum Lead

2020 has been a very busy year for the Faculty and its representatives, and not just because of COVID, but certainly complicated by it. Alongside their clinical day-to-day activities, the RAs have continued to deliver their educational and training responsibilities with commitment and reliability, for which I would like to extend my gratitude.

Together with the Faculty Tutors and Training Programme Directors, (TPDs), the specialty is in a good place to meet the challenges of training the next generation of intensivists over the next few years.

Our outgoing Lead RA

I want to give huge thanks to Sarah Clarke, outgoing Lead RA, for all she has done during her term as RA for the North West and in the Lead RA role. Her energy, enthusiasm, inclusivity and eye for detail are notable characteristics I will look to emulate. She has been a trusted source of guidance and support to me as Deputy Lead RA, and to all the RAs. Thank you Sarah, and all the very best for your next venture, elected to the FICM Board!

Our new Deputy Lead RA

I would like to congratulate Andrew Sharman (RA for the East Midlands) on his election to the Deputy Lead RA role. The Faculty is fortunate to have such a keen advocate for education and training in this role. He won't shirk a challenge and will be seeking the solutions to the hurdles that will come along.

New curriculum

As Sarah referred to in the last edition of *Critical Eye*, we had the fantastic news in early November that the GMC approved the curriculum rewrite, and formally uploaded it to their website on 1 December.

After all the efforts of the curriculum writing group and the FICM secretariat getting this far, there is a lot of work now to do to transition its smooth implementation in time for 4 August 2021.

The curriculum will form a major agenda item of the (virtually arranged) Training Leadership Annual Meeting in March 2021, which is attended by the key stakeholders to make this happen, namely the RAs, Tutors and TPDs. More on the curriculum is detailed elsewhere in this very edition of *Critical Eye*.

National Recruitment 2021

Recruitment for 2021 will be going ahead in the Spring (again, virtually). With the specialty very much in the spotlight, hopefully we will be able to welcome another expanded cohort of training posts, particularly if all the UK's Statutory Education Bodies follow Scotland's lead — well done to Monika Beatty, Lead RA for Scotland, in securing an increased number of posts.

Stay safe and well

I am writing this in a brief, very necessary step away from the 'coalface' and in the week that the first SARS-CoV-2 vaccines have been administered. Maybe, just maybe, we might be seeing some light at the end of what has appeared an ever-lengthening tunnel this year. With this, I hope that we can all keep ourselves safe and well through the next few months.

Education Sub-Committee (ESC) and FICMLearning

Dr Pete Hersey
FICMESC Chair

The Education Sub-Committee is still a relatively recent but very active addition to the Faculty structure. Our main visible output remains **www.FICMLearning.org**.

FICMLearning

Since FICMLearning's launch in February 2020, we have delivered 21 blogs (in addition to hosting the WICM blog), 12 Cases of the Month, and 22 podcasts.

We hope that in the next few months we will also be launching a toolkit resource to support the delivery of in-situ simulation. The leads for these workstreams are always keen to hear ideas for content and improvement, so if you have any please let us know.

e-ICM

Programme development and new session production for e-ICM is still ongoing. e-ICM has seen over 63,000 session launches during the past year, which has resulted in over 25,000 hours of learning activity.

Behind the scenes we also continue to coordinate and oversee the Faculty's education strategy and collaborate with other groups both within and outside the Faculty.

COVID-19

COVID has, of course, had an impact on our work. We unfortunately had to postpone the 2020 Annual Meeting but are working hard to deliver the 2021 Annual Meeting digitally on 6 May.

We made a conscious decision early on that we would not provide clinical education relating to COVID. This was to ensure we would not overlap with the excellent www.icmanaesthesiacovid-19.org.

Exam Prep Course

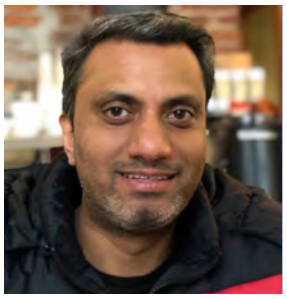
The FFICM exam preparation course took place remotely in September 2020 with great success. This took an immense amount of work from all involved, but we are particularly grateful to Dr Sarah Marsh and Lucy Rowan for their efforts. The next digital FFICM exam prep course will be held on 4 and 5 March 2021. We are incredibly grateful to everyone who continued to work with the ESC in whatever form during the pandemic whilst being so busy elsewhere.

Get in touch

As always, we value your feedback and offers to help produce content so please get in touch at contact@ficm.ac.uk.

We are also still maintaining our calendar of educational events, so if you would like your event to be listed just complete the form in the events section of the site.

Supporting International Medical Graduates



Dr Shashikumar Chandrashekaraiah

FICM MTI Lead

International medical graduates (IMGs) have their primary medical qualification outside of the UK and have variable experience with some having completed postgraduate training. 55% of the doctors registered with General Medial Council (GMC) between 2018 and 2019 were IMGs and there has been an annual increase in IMGs registering with the GMC since 2016.

It is estimated that around 4,000 residents are required to staff UK ICUs in order to meet the *GPICS* recommendation of 1:8 resident to patient ratio. With only around 600 ICM trainees nationally, there is an urgent need to look at other staff groups like ACCPs and IMGs to address the staffing crisis.

GMC registration with a licence to practise and knowledge of English to communicate effectively are prerequisite to work in the NHS. There are multiple ways to achieve both of these compnents.

Routes of entry

Professional and Linguistic Assessment Board (PLAB) still remains the popular route for GMC registration with wide variation in candidates experience making them suitable for a range of junior and senior posts.

The Medical Training Initiative (MTI) scheme allows a limited number of overseas doctors who have completed postgraduate training to enter the UK for a two-year period of specialised training before returning to their home countries. The RCoA manages the MTI scheme for Anaesthesia, ICM and Pain Medicine through their Global Partnerships Office. The posts can be exclusively in ICM or combined with anaesthesia. PLAB exemption and training opportunity on par with UK trainees are its attraction and are ideal for IMGs looking for a short period of NHS experience.

Further experience

IMGs obtaining GMC registration after completing MRCP or European Diploma in Intensive Care (EDIC) come to gain further experience or settle in the UK.

IMGs can be appointed to specialty doctor posts and depending on their experience, look at entering the ICM training programme or CESR pathway to become consultants in the NHS. Some of them also accept permanent specialty doctor posts.

In addition, an acceptable score in the International English Language Test (IELTS) or Occupational English Test (OET) fulfils the English knowledge requirement.

An integral part of the NHS

IMGs are hardworking and highly motivated, with a good knowledge base and competent skills.

They need support in getting used to UK culture, working in the NHS, developing communication and interpersonal skills, end of life care, multidisciplinary working and understanding various guidelines/ protocols specific to NHS. With the right support and guidance they can become an integral part of the NHS and provide a stable workforce.

ICM National Recruitment 2021

Dr Tim Meekings
Recruitment Lead

As I write this, the second COVID-19 pandemic surge seems to be reaching its peak and the vaccination programme is now underway. The current high workload in critical care across the UK has led to some major changes having to be made to ICM recruitment for 2021.

The show must go on; now more than ever we need to recruit a highly skilled and talented workforce, from a diverse background to add to our ranks. We need to continue to deliver high quality and specialised care to our critically ill population now and into the future.

Self-assessment

ICM recruitment for 2021 will once again have to utilise the self-assessment portfolio scores across 10 separate domains already submitted by applicants. We had also hoped to be able to deliver an online interview this year, with two interviewers and the applicant logged on from their homes or workplaces.

Unfortunately, with many intensive care units currently over-capacity by as much as 300% in some cases, all of our consultant and trainee workforce are rightly focused on treating critically ill patients. There simply isn't the time and resource available to set up an online interview process, train consultant intensivists that will be interviewing to use the platform, and then free up both applicants and interviewers to attend and run the interview process this year, even in an online format.

For this reason, we have had to take the difficult decision to once again rely upon the self-assessment portfolio scores as a way of scoring applicants across the UK and then matching them to posts according to their own preference and their ranking, compared with other applicants applying to the same region.

Robust and reliable

To ensure the self-assessment portfolio scores are as robust and reliable as possible this year, a system of verification will be implemented to review and verify all submitted scores.

A team of trained assessors (all working consultant intensivists) will review the applications and verify the scores using evidence that the applicant has uploaded for each domain. There will be an appeal process for any candidate who feels their score has been judged unfairly; these applications will be scored by another independent assessor and whichever of the overall scores from the two different assessors is the highest will be awarded. The main goal of the verification process will be to ensure that the scores are fairly awarded, and credit is given wherever it is due for experience and excellence demonstrated during previous training.

Unprecedented times

These are difficult times and the radical change to the recruitment process has been forced upon us by the unprecedented current demands on critical care. Our primary goal is to still successfully recruit a high-quality workforce, despite the current challenges we face. We wish you well in your applications and look forward to working alongside you in the future.

Careers, Recruitment & Workforce (FICMCRW)

Dr Jack Parry-Jones
FICMCRW Chair

Even with the imminent arrival of several vaccines, it is difficult to see life beyond SARS-CoV-2. Forget polio, this particular virus managed to thrust critical care into the limelight, where we blinked a bit, adjusted our masks, and got on with the necessary. Being honest with ourselves, it has been difficult at times.

The images of bruised, tearful faces and unrecognised colleagues in PPE don't compare to the memories we will continue to carry within us of conversations with distraught families, on phones and iPads. Worse still, some of you will have looked after colleagues who have died, and some of you will have lost family members.

Frontline Voices

We surveyed you all, and published the findings in *Voices from the Frontline of Critical Care*. It forms a powerful testimony to the effort and self sacrifice you all put in, individually and collectively. This effort often came at considerable cost to you as individuals, both physically and mentally, and also to your families. You should be very proud of your achievements, and those of your departments to rapidly expand capacity.

As we all already knew, critical care has never, and won't ever be about a ventilator; it's about the dedication of a multidisciplinary workforce, and the care we collectively deliver, with the necessary equipment, in an appropriate environment.

Diluting the standards we have set as a specialty in the *Guidelines for the Provision of Intensive Care Services* reduces our effectiveness, and is a compromise borne only out of dire necessity. There is a deep sense of gratitude to our nursing staff, junior intensive care doctors, allied health professionals and also to those from anaesthesia, respiratory medicine and further afield, who helped to mitigate that dilution of standards so that the results of our care remained good.

Capacity and demand

Due to the huge increase in clinical demand, many units expanded their capacity two, three or fourfold, and many had to change the way their units were covered, with consultants remaining resident at night being commonplace. Without doubt we need to increase critical care capacity, with phased expansions in a planned fashion, targeting those geographical areas with least critical care capacity for their respective populations.

Dr Anna Batchelor, leading on Getting It Right First Time (GIRFT) for critical care, highlights the disparity between different units. We cannot increase capacity without increasing staff, and whilst we have seen an increase in ICM training numbers in all four home nations, this increase will need to continue.

Life beyond COVID

There is life beyond COVID-19. The challenge for CRW and our specialty is to continue the increase in staff recruitment, and ensure that we retain staff by looking after them, and each other. The future Enhanced Care Units will help to deliver a far more resilient critical care service that can meet a big surge in demand, without impacting so heavily on all other NHS services.

Dr Nishita Desai
FICM Thrive Lead

FICM Thrive

The fundamental values of WICM are to be open and inclusive, to support others to achieve their full potential and strive to ensure parity of opportunity within ICM. WICM are proud and enthusiastic to introduce FICM Thrive, a career mentoring and personal development programme for all doctors working in ICM in the UK.

Personal growth

Mentoring is a powerful tool for personal growth, development and empowerment to reach one's own full potential at any stage of life. In September 2019 at Striking the Balance, our first ever WICM meeting, we held a mentoring workshop where there was clear enthusiasm and interest in mentoring as a vital tool for personal and career development. In November 2019 we launched a short survey which provided more evidence of this need..

We first revealed a glimpse of the title of our mentoring programme on Twitter in October 2020. We recognise that ICM as a specialty is both rewarding and challenging, the COVID-19 pandemic has indeed reminded us of this. With a demanding career it can be hard to strike a balance between professional and personal life. In particular, there are important transition points and intense learning events throughout our career when mentoring can be highly effective. The overall aim of the programme is to facilitate a strong, productive mentoring relationship based on mutual, equal and collaborative development and learning between mentors and mentees.

Our key objectives

- To empower and support ICM doctors in their careers.
- To provide a strong network to enable suitable matching of mentees with mentors.
- To provide resources and support to ensure that the mentoring relationship and interactions are fulfilling and produce tangible outcomes for both mentees and mentors.

Pilot launch

FICM Thrive will launch in May 2021 and will focus on new consultants in ICM, in their first five years post-appointment. We identified the change from a trainee to consultant as a significant transition point within a career in ICM.

Often this is a vulnerable time, a period of change and uncertainty, where there is limited guidance and the path forward can often appear unclear. This first phase is intended to act as a pilot, so your feedback is vitally important. Following this the programme will be reviewed to increase its availability to individuals at all stages of their career.

Become a mentor or mentee

We are looking for any mentors or mentees interested in joining the programme. Mentoring is fulfilling, enabling development of inter-personal skills and building connections for both mentors and mentees. If you're interested in being a mentor or mentee, please email **wicm@ficm.ac.uk** telling us where you're based, your training level (mentee) or job title (mentor) and any particular areas of interest.

Women in Intensive Care Medicine (WICM)

Dr Liz Thomas
WICM Chair

I am honoured to have taken over as Chair of WICM from Rosie Baruah and I would like to take this opportunity to thank her on behalf of the whole sub-committee for all of her hard work and leadership over the last three years. I am pleased to report that the WICM Sub-Committee have managed to forward our projects despite the constraints of the COVID-19 pandemic.

FICM Thrive

We will soon be launching our mentoring scheme, 'FICM Thrive'. I have benefitted from mentoring and from being a mentor and I am very excited WICM can launch this project. Initially we will be starting the project inviting consultants, of any gender, in their first five years of appointment to take part as mentees, with the aim of expanding the scheme as soon as possible. You can read more about FICM Thrive in Nish Desai's article, including how to get involved.

Emerging leaders

The first cohort of FICM Emerging Leaders have completed their fellowship year. They have attended various FICM committee meetings and each taken a turn to Chair their Fellows' meeting, as well as completing an Open University Module and having personal reflection sessions with FICM Board members. We are very keen to have another cohort of Emerging Leaders and are aiming to run the project during the next academic year. Please look out for updates on the FICM website: https://www.ficm.ac.uk/wicm-/WICMEL, and Twitter.

WICM online

We have other exciting things to develop in 2021. We remain active on social media and we regularly contribute to the Faculty publications; we have a regular blog post on ficmlearning.org and run regular twitter campaigns.

We are @WomenICM on Twitter – follow us and tag us! Our annual meeting is all planned but we have no date yet as we are still hoping to run a face to face meeting. Our first meeting, held in 2019 was so successful, and the delegates really enjoyed the small group workshops and meeting other ICM doctors face to face.

The committee

The committee has 12 members, 10 consultants and two trainee members. Our primary aim is continuing to promote ICM for all and work to increase the proportion of female ICM doctors. We are an active group and all working on projects to help achieve this aim.

Get involved

One of our forthcoming projects is to re-energise the wider WICM group and to involve the wider field of women in intensive care medicine in our work. If you have any ideas or are keen to be involved in our projects then please get in touch – we can be contacted via wicm@ficm.ac.uk.

Smaller & Specialist Units Advisory Group (SSUAG)

Dr Chris Thorpe
SSUAG Chair

The Nuffield Trust has just released a review of the disparity in support between urban and rural areas: *Rural, remote and at risk: Why rural health services face a steep climb to recovery from COVID-19*. It is worth a read even, or perhaps especially, if you are in a big centre. The headline points are that waiting times have taken a bigger hit, emergency admissions likewise.

The pandemic has also exacerbated workforce issues in remote trusts, and the financial situation, already worse in these services, is likely to have worsened. Increased resources have also favoured urban areas. The Nightingale Hospital concept, for example, is less beneficial to those in remote areas.

Variation and commonality

Within ICM, although there has been variation between hospitals, there have been some common themes during COVID. One of these has been network support; our local network in North Wales has ramped up communications exponentially between the three units, and feedback from other areas is also positive.

For example Jon Sturman, who works in Carlisle and Whitehaven, similarly found the regional network "immensely useful and supportive". Catriona Barr from the Shetlands commented that "we have been extremely well supported by our mainland ICU colleagues over this period, despite the fact that they have been very busy." I think the pandemic has shown how important these critical care networks are.

Increased communication

The theme of increased communication extends wider than the networks. We found that intra-hospital relationships were much improved, for example respiratory and other medical specialties, management, and wider staff members who helped with proning, increased staffing etc. In addition, national communication increased with rapid dissemination of clinical information but also the involvement with research such as the RECOVERY trial.

Local difficulties

There were also difficulties as Eleanor Checkley from Airedale said "A few extra patients make a huge difference to a small unit. We do not have that many staff anyway so the practicalities of managing two streams of patients and keeping both supplied and staffed is still challenging despite help from non critical care nurses. Rolling or proning an obese patient when you only have five or six people on shift in total, and some are in full PPE, with other patients is difficult. Luckily in a small hospital we have had great support from other services like physiotherapy and pharmacy, as well as nurses from quieter areas."

What is certain is that this pandemic has stretched us in many ways. There are differences between small and large units, but the main factors of funded beds and staff affect us all.

A National Evaluation of the ACCP Role

Sadie Diamond-Fox
Project Lead

Advanced Critical Care Practitioners (ACCPs) are just one of many advanced practice roles that currently exist within England, Scotland and Wales. There are currently 205 qualified ACCPs who have successfully gained ACCP Membership to the FICM along with 107 trainee ACCPs on the FICM voluntary register.

It is now 16 years since the key work of the *New Ways of Working in Critical Care Team* as part of the NHS Modernisation Agency, saw the dawn of the ACCP role. Increasing life-expectancy, complexity and disease burden, and the European Working Time Directive and a subsequent shortage of medical personnel have all long been cited as drivers for the implementation of advanced practice roles.

The development of the ACCP role has come a long way since the seminal work by the initial pilot sites and collaborators identified within the original Department of Health discussion document back in 2006. As such, ACCPs have been acknowledged within landmark publications for their contribution to the delivery of critical care services. There have been numerous key initiatives that have advanced the development of the role, including a national curriculum for training and a pathway for continued professional development and appraisal. However, despite ACCPs now being well-embedded within the critical care workforce, to date only local quality-assurance datasets that evaluate the perceived effectiveness and/or safety perceptions surrounding the introduction of the ACCP role have been published.

Aim

In summer 2019, a collaboration was formed between the FICM ACCP Sub-Committee (FICMASC) and ACCP programme leads at Northumbria University, to address the shortfall in national evaluation data concerning the introduction of the ACCP role. The study had several objectives:

1. Evaluate the perceptions surrounding the ACCP role within the critical care workforce.
2. Assess the level at which current qualified ACCPs were perceived to be working to the expectations of the role described by the Department of Health (DoH) and the Faculty of Intensive Care Medicine (FICM).
3. Evaluate whether the introduction of the ACCP role had a negative impact on Medical, Nursing and/or Allied Healthcare Professional

(AHP) training.
4. Identify areas of concerns in regard to inter-professional working.
5. Assess the scope for the development of the role.

Method

Previous work conducted by colleagues at Newcastle Hospitals NHS Foundation Trust informed the objective and design of this study. We designed and distributed an online anonymous electronic survey to multiple centres within England, Scotland and Wales via multiple networks. Access to the survey was open for a six-week period.

Key findings

- 591 clinicians responded to the survey. The majority of respondents (25%) were medical consultants, staff nurses (24%) and senior nurses (20%). The remainder were doctors of varying grades,Pharmacists and allied healthcare professionals.
- Respondents ranged across all regions in which ACCPs are currently known to be in post. Most of the respondents were from the North East region (15.6%), followed by South West (Peninsula) (12.2%) and West Midlands (12.2%), respectively. This may reflect the locations in which a large number of the overall ACCP workforce are known to reside.
- The majority of respondents either strongly agreed, or agreed that ACCPs were working to the expectations of the role described by the Department of Health (DoH) and the FICM.
- Results reflected favourable outcomes in regard to the validated Interprofessional Collaboration Measurement scale.
- The majority of respondents believe that ACCPs enhance patient care (*Fig.1*).
- Qualitative analysis of free text data provided by respondents is ongoing, however initial thematic analysis identified several common themes concerning the perceptions surrounding the ACCP role:
- They improve workforce stability and enhance patient safety.
- There are variations in the training of ACCPs.
- The level at which current qualified ACCPs were perceived to be working to the expectations of the role is dependent upon personal attributes of the individual ACCP.
- ACCPs may de-skill other members of workforce, namely medical and nursing colleagues. However, both qualitative results and quantitative analysis also reflect that the majority of respondents feel that the presence of ACCPs positively supports and improves medical, nurse and AHP training/teaching.
- The role is sometimes impeded by inability to request certain diagnostics (CT & MRI) and Non-Medical Authorisation of Blood Components.
- ACCPs have limited career progression and/or sustainable job plans and should have scope for further development (*Fig.2*).

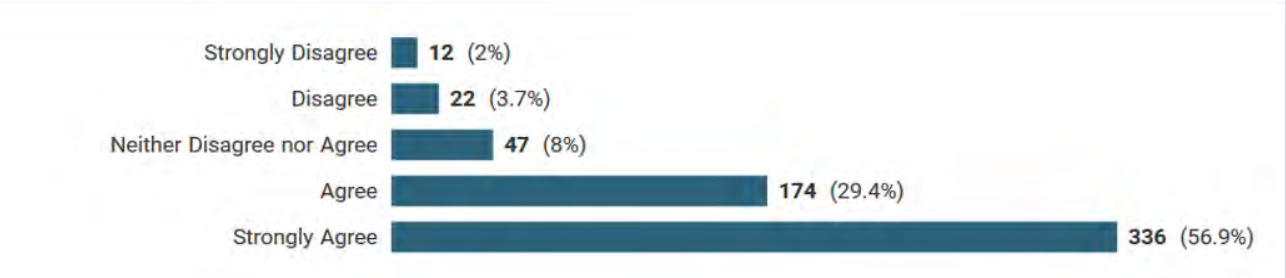
Principal recommendations and conclusions

In summary, the ACCP role continues to develop. However, several themes have been identified that warrant further exploration to inform effective and sustainable future development, particularly those which have been highlighted in the thematic analysis.

A national impact study as part of the Principle Investigator's Doctorate thesis will also begin in

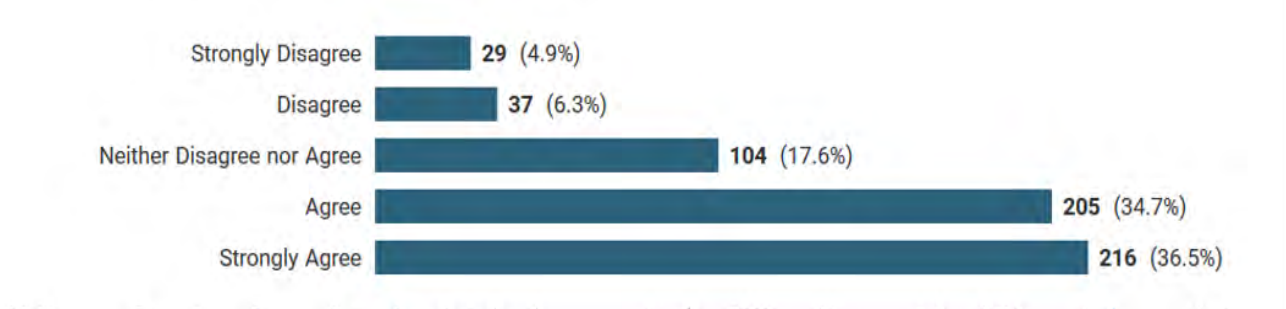
> **"Disparities in initial training provision should be addressed on a national level. The advent of FICM accredited Higher Education Institutes (HEIs) is imminent and will address this issue going forward. Role sustainability and workforce development requires further exploration.**

Fig.1 **Enhance Patient Care**



Multi answer. Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

Fig.2 **Should have scope for further development**



Multi answer. Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

Spring 2021 with the aim to explore the unique role and value that ACCPs may bring to patient care, not as a physician replacement model, but rather an advanced practice model of care.

Disparities in initial training provision should be addressed on a national level. The advent of FICM accredited Higher Education Institutes (HEIs) is imminent and will address this issue going forward. Role sustainability and workforce development requires further exploration.

A national network has since been set up to address this issue via the development of the Advanced Critical & Clinical Practitioner Academic Network (ACCPAN), founded by two FICM ACCPs who hold joint academic and clinical posts. The ACCPAN aims to address these issues from both an academic and clinical viewpoint, with the support of the FICM, the Intensive Care Society and Nottingham and Northumbria Universities.

A National Evaluation of the Advanced Critical Care Practitioner Role within the United Kingdom was recently presented at ESICM LIVES Digital 2020 as a poster presentation. I would like to thank Carole Boulanger, Daniel Waeland, Simon Gardner, Jane Poynter and Alan Platt for their contributions to this project.

References for this article are available upon request.

A New Era for Critical Care Pharmacy

Mr Greg Barton
FICMPSC Chair

It goes without saying that this has been a busy year full of new challenges but, in the thick of it, a new chapter for Critical Care Pharmacists started. In the brief lull between the first and second waves of COVID-19, a new group within the FICM was launched, the Pharmacy Sub-Committee (FICMPSC).

The six members that make up the sub-committee are from different hospital backgrounds (DGH to large university hospital), have a range of experience in critical care (from just a couple of years through to decades), and are from diverse geographical locations. The members were selected for their individual experience in relation to the various planned workstreams.

Our members

Richard Bourne, Consultant Pharmacist in Sheffield, and myself have long been involved with the United Kingdom Clinical Pharmacy Association (UKCPA) Critical Care Group and partnering with FICM felt like the next natural step in the journey towards building a recognisable and sustainable critical care pharmacy workforce.

Emma Boxall, another longstanding member of the UKCPA team, has for many years supported and delivered the foundation level education to an ever growing and engaged pharmacy workforce. The other members of the sub-committee, Emma Taylor, Lorraine Moore and Dereck Gondongwe, all have strong backgrounds in education and training and/or workforce development at either a Trust or national level.

Our work

Together our long term goal is to see every UK critical care unit have a suitably trained and experienced critical care pharmacist. To achieve this we have embarked on a number of workstreams:

- **Workforce:** work with pharmacy colleagues is already underway to define the current workforce position. The group will then work on ways to support the transition from where we are now to the gold standard of an appropriately trained seven day service being the norm across the UK.
- **Education and training:** partnering with other organisations, such as the UKCPA, we aim to develop advanced practice training aimed at pharmacists but ideally also open to the wider multi-professional team.
- **Credentialing:** this process will be a route to recognition for pharmacists wanting to show they are working at a given level of practice.
- **Mentoring:** we aim to develop a support network of suitable mentors from across professions and disciplines to support credentialed pharmacists in developing areas of identified weakness.
- **Membership engagement:** to build a sound and representative FICM pharmacy membership. For more, visit: www.ficm.ac.uk/membership/pharmacist-membership.

These are exciting times for UK critical care pharmacy!

Professional Affairs & Safety (FICMPAS)

Dr Peter Macnaughton
FICMPAS Chair

I write this update as our specialty is again facing very challenging times managing a major surge in COVID-19 as a result of the new variant, coupled with the increased social interactions during the Christmas holidays. In between surges, the work of the Committee has managed to continue and I am very grateful for the continued hard work and commitment of its members.

The collaborative safety work with NHS England and Improvement led by Professor Gary Mills has been very productive as evidenced by the publication of our first FICM *Safety Bulletin* in December. This summarises safety incidents from critical care units reported to the national reporting and learning database over a 12-month period. The aim is to share the lessons from incidents and changes in practice that can improve patient safety. I would encourage you to read the bulletin, as it is better to learn from someone else's incident rather than your own!

Better Together

The soon to be published framework for collaborative working between Emergency Medicine and Intensive Care Medicine was opened for public consultation was held at the end of 2020. This is the output from a joint working group of the Royal College of Emergency Medicine and the Faculty. The document recognises the close working and interface between the specialties and makes a range of recommendations for collaborative working to ensure best possible patient care. Both specialties are key to the smooth running of an acute hospital and developing links, learning from each other and standardising care can only improve patient pathways and outcomes. One factor than can enhance these links is through joint appointments between ICM and other specialties such acute medicine, emergency medicine and respiratory medicine. From the experience in my own department, I would strongly encourage such joint appointments whenever possible.

Appraisals

COVID-19 has impacted on the appraisal process for many during 2020. In March 2020 appraisals were suspended and reinstated in a limited format with the publication of updated guidance from the Academy of Royal Colleges in August 2020, *A Guide for Professional Medical Appraisals in the Context of the COVID-19 Pandemic*. Recommendations are made minimise the time needed for preparation with a considerable reduction in the need for pre-appraisal documentation and rebalancing appraisal with an enhanced focus on wellbeing and development in the context of COVID-19.

It also recognises the value of verbal, rather than written, reflection in demonstrating that doctors are working in line with the principles of Good Medical Practice (GMP). More recently, responsible officers were informed that you are at liberty to decline your appraisal invitation due to current pressures without any negative implication. If you do press ahead, you should use the 2020 model and spend a very limited amount of time on preparation (around 30 minutes). The guidance can be found here: https://www.aomrc.org.uk/revalidation-cpd/appraisal-revalidation-during-covid-19.

Legal & Ethical Policy Unit (LEPU)

Dr Chris Danbury
LEPU Chair

Writing about the actions of LEPU during the middle of the second wave of COVID-19 is an interesting experience. Like the majority of readers, I am swamped by clinical shifts and the seemingly unending wave upon wave of new critically ill patients. And yet, during all this it is so important to remember the individual people who are suffering and to make nuanced decisions with patients who are referred to critical care.

Personalised decision making

Whilst assessment tools can help point in a particular direction, the humanity and compassion of our specialty makes it imperative that we personalise our decision making as far as possible. Involving patients in the decisions about their care — 'no decision about me, without me' — should remain a core facet of our practice.

Patients are not just numbers

Why should we do this? Firstly, because people, our patients, are not just numbers, however busy we are. They are our parents, children, brothers, sisters, partners. Everyone has a story to tell, a life lived. Secondly, our decisions will be examined in the future. I'm proud to be an intensivist, as I see in our specialty many human, humane clinicians making person centred treatment decisions. But these traumatic times will end and afterwards there will be a review. It is important that our decisions are justifiable and stand the test of time. The effects of critical illness leading to Post Intensive Care Syndrome and paucity of ICU follow-up services is likely to prove a major challenge for the future.

Ongoing work

In amongst all of this clinical activity, LEPU has been active and is involved in a number of legal cases. Unfortunately as they are currently sub judice, I can't say more at the moment. We are willing to look at any situation that has global implications for the specialty. End of life cases continue to be heard, for instance that of Pippa Knight [2021] EWHC 25 which Katie Gollop QC analysed well on Twitter: https://twitter.com/katiegollop/status/1347541149704138752?s=20.

There is also University Hospitals Plymouth NHS Trust v RS & Anor [2020] EWCOP 70. It seems to me that in both cases, the cases were brought at the correct time with appropriate discussions with the interested parties beforehand. In Pippa's case mediation was tried. It seems that the Plymouth case, mediation would have been tricky due to the international nature of the situation.

I hope that the second wave of the pandemic is over soon, for us all and that there is not a third wave.

FICM Safety Incident

Securing equipment during intra-hospital patient transfer to prevent injury

Situation

A patient sustained a right mid-shaft tibial fracture during an intra-hospital transfer, when a transport ventilator fell on them.

Background

A ventilated adult patient was being transported from an ICU to the hospital trauma theatre on the ICU bed. During the transfer the bed hit an uneven floor surface and the transport ventilator (Draeger Oxylog 3000 plus) fell from a stack and hit the patient's legs. This resulted in a fractured tibia.

Assessment

The portable ventilator was not adequately secured for transport.

Recent guidance from the Faculty of Intensive Care Medicine and Intensive Care Society has reinforced the concept that inter- and intra-hospital transfers should be treated in the same way.

However, this guidance is not explicit in specific recommendations on moving patients on a hospital bed, which is a common practice.

It is common in this situation for items to be placed on the bed, including monitoring, oxygen cylinders and ventilators. As well as potentially toppling onto the patient, they may fall from the bed, resulting in other damage or disconnections.

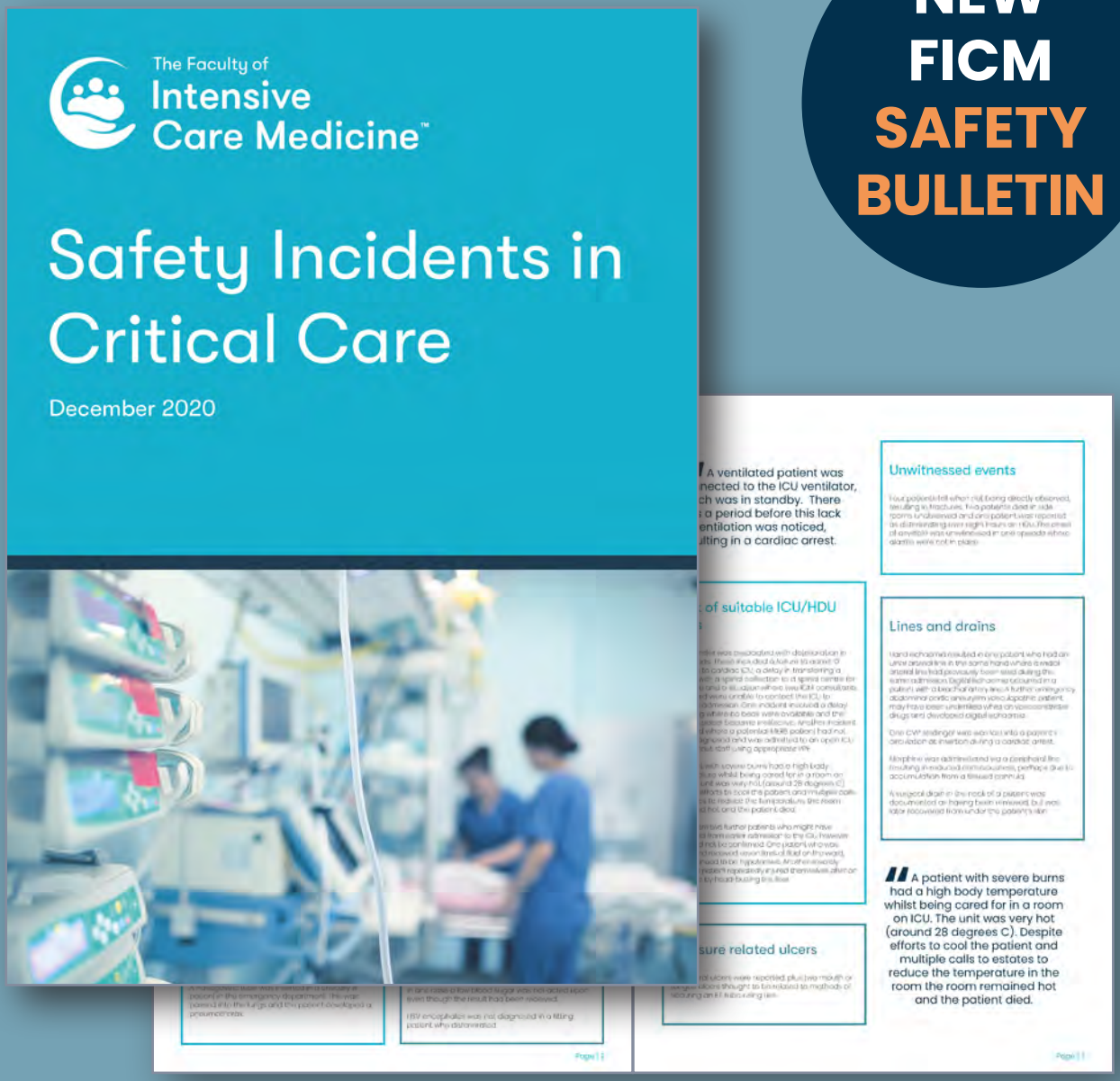
Professor Gary Mills | FICM Safety Lead
Dr Peter Shirley | FICMPAS Member
Mr Wayne Robson | NHS Improvement

Recommendations

- The use of check lists is encouraged in the 2019 ICS / FICM transfer guidance to ensuring equipment is properly secured is strongly advised.
- The manufacturers instruction manual also advises on securing the ventilator during transport (see below):

  'The Oxylog 3000 plus can be hung on various rail systems measuring up to 35mm by the claw. ***Warning:*** *Be careful when placing the ventilator on the rail or bed rim. Risk of damage to property or personal injury* ***Caution:*** *The Oxylog 3000 plus is only held by its own weigh when hung on a bar or rail. The Oxylog 3000 plus must be secured additionally when being transported, otherwise vibrations may cause accidental dislodgement.'*
- Other ventilators (such as the Hamilton T1 transport ventilator) have similar claw attachment systems and must be treated in the same way.
- The movement of patients is a high-risk intervention and this case reminds us of this.

NEW FICM SAFETY BULLETIN



A new bulletin from FICM to extend the coverage of safety-related issues on a quarterly basis, together with special editions covering specific topics. This will complement the COVID Safety Bulletins (ViRUS), COVID Safety Alerts, Safety Checklists for Invasive Procedures and Learning from Past Safety Incidents.

It is planned that this will expand to cover safety-related issues of all types including drugs, equipment, planning and practice.

www.ficm.ac.uk/safety/safety-bulletin

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