



CRITICAL EYE

Issue 13 | Winter 2018

Major Incidents
and Intensive Care
Medicine

Women in
Intensive Care
Medicine

Census Update

Getting it Right
First Time

GPICS V2

Quality: Trainee
Survey Update

Bed 14

The Faculty of
Intensive Care Medicine

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<https://www.ficm.ac.uk/news-events-education>

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Clinical Editor

Dr John Butler

Managing Editors

Miss Anna Ripley
Mr Daniel Waeland

Administered by Mrs Dawn Evans

Dean

Dr Carl Waldmann

Vice Dean

Dr Alison Pittard



Dr John Butler
Clinical Editor

WELCOME

2018 is shaping up to be a productive and rewarding year for the Faculty. With GPICS Version 2 due out in the Autumn, the re-writing of the ICM curriculum, the election of new board members (congratulations to all those who were appointed) and projects based on recommendations from Critical Futures, this year promises to be eventful. Reassuringly, this edition of Critical Eye includes information on all the latest developments relevant to our specialty and its future.

In the Vice Dean's update Dr Pittard gives an insight into the origins and impact of two important documents recently issued by the Faculty. 'Critical Futures: A report of the first wave' which was published in October following extensive consultation and makes a series of recommendations on future ICM developments. The update also covers the background to the subsequent document 'Critical Condition: Building a sustainable future for the sickest patients in the hospital' which outlines the importance of ICM to the safe functioning of all acute hospitals.

In other articles, the results of the recent Faculty census provide grounds for optimism, reporting that 80% of the consultants who responded intend to continue in ICM for the remainder of their careers. It is rewarding to appreciate that, despite all the service pressures within the NHS, consultant retention remains good within ICM. The concept of 'Getting it right first time' (GIRFT) started in orthopaedics and has revealed marked variations in practice and results between hospitals. It has now expanded to other specialties including critical care, anaesthesia and peri-operative care. In her article Dr Batchelor explains the plans to derive a series of metrics which will be used to highlight areas of variation and to focus on opportunities for improvement and increases in efficiency within ICM. Further details on these and many other areas can be found in the relevant articles.

Last year the UK experienced an unprecedented series of tragic national events ranging from acts of terrorism in Manchester and London, to the horrific fire at the Grenfell tower. Our sincere condolences go out to all those affected by these incidents and their families. The response from all of the emergency services, including the multi-disciplinary teams working within Intensive Care units was exemplary, under very difficult circumstances. The NHS responded with bravery, professionalism and compassion and has rightly received widespread admiration for the care provided to the victims and their families. In a special series of articles, we hear from colleagues who were directly involved in these incidents. The commentary provides a factual insight into some of the real-life difficulties encountered when dealing with these thankfully rare events. In each article the authors share with us the lessons they have learnt, from both their own personal experiences as well as the experiences of their colleagues.



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



MESSAGE FROM THE DEAN

Dr Carl Waldmann

This is my third article for Critical Eye as Dean. In accordance with our statutes, elections for Dean and Vice-Dean take place annually, and I am pleased to say Alison Pittard and I have been re-elected and have embarked on our second year in office.

We have made some important strides forward this year as you will see in the articles of this publication and we hope to continue, fired up by the progress already made.

The progress is undoubtedly due to the hard work of all our Board members, but would not be possible without the support provided to us by Daniel and his excellent colleagues.

We have said goodbye to Mike Grocott who stood down in January and will be saying goodbye to John Butler and Andy Rhodes when their terms end in October. In 2018 we will also be welcoming our new Board members Jeremy Cordingley, Gary Mills and Julia Wendon, and saying hello again to our re-elected Board members Jonathan Goodall, Pete Macnaughton and Chris Thorpe.

In particular we have honoured one of our co-opted Board members, none other than Carole Boulanger for her services to the specialty in supporting the development of ACCPs. I have attended the last two annual ACCP Conferences and they are not only of the highest quality, but vibrant! Carole was duly honoured at our October 2017 Board meeting with the award of Honorary Fellowship of the Faculty; well done, Carole!



CRITICAL FUTURES: A Report on the First wave Survey

We released this document in October. Many thanks go to Peter Nightingale and Anna Batchelor who laid the foundations to this document and to Anna Ripley and Daniel Waeland for seeing it through to its publication. This is a

modern day equivalent of the 'Comprehensive Critical Care' document that was published by the DH in 2000. As I said on its release:

'For many in the critical care community, the findings of this survey will not come as a surprise, nor mark a sea change in how we view ourselves as a specialty. What this report does is present

a very clear and prioritised framework of 14 recommendations, based on the views of those that make up our community that can be reasonably addressed through agreed work streams.'



The RCPCH and RCEM have already contacted us following this publication and we look forward to some collaborative work with them and others looking to the future.

FUTURE HOSPITALS REPORT

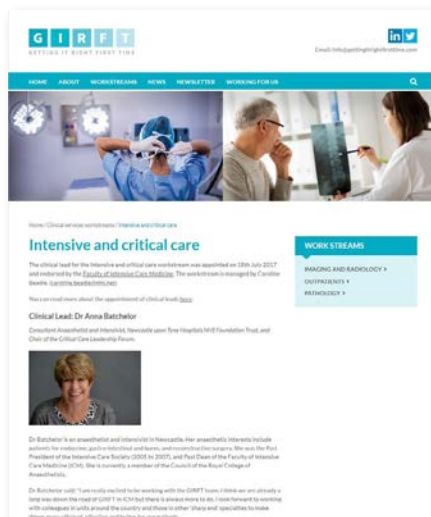
In addition, RCP has just published its 'Future Hospitals Report'. There are six recommendations to work with as we develop the work streams from Critical Futures. The first being 'Ensure patients and carers are at the centre of healthcare design and delivery'. This is something we all strive to achieve but in order for this to be effective we need to see more resources for the NHS.

THE BUDGET

With the RCP, FICM was one of several signatories to a pre-budget letter sent on 15th November to the Chancellor in which the need for more NHS funding was highlighted. Subsequently the budget did provide an increase in funding to the NHS, but will a £350m boost for this winter followed by an extra £1.6bn next year for front line services be enough? Many think this increase is still substantially short.

GETTING IT RIGHT FIRST TIME

In the last Critical Eye, we announced the appointment of Anna Batchelor as our Getting Right First Time (GIRFT) Clinical Lead. We look forward to her observations and wish her luck in visiting over 200 ICUs. Anna made a good point at State of the Art Liverpool 2017 when she said the resources that we spend on investigating incidents could be saved if we 'Get It Right First Time'.



END OF LIFE WORKING PARTY

Joe Cosgrove is chairing a group to look at issues around end of life care; we hope to be able to make recommendations and get some consistency in admitting practices from this group.

I would like to congratulate Ganesh Suntharalingham on firstly becoming President Elect of the Intensive Care Society and also on engineering another first class State of the Art Meeting in Liverpool. Jonathan Handy has continued to do a superb job with JICS and, at last, has managed to get it Pubmed listed.

I would like to finish by stressing that we at the FICM take all feedback seriously and would encourage you to contact us with any observations, ideas or concerns by emailing me, Board members or contact@fcm.ac.uk.

MIND THE GAP

2018 FICM ANNUAL MEETING

Thursday 24th May 2018
Royal College of Anaesthetists, London
£180 (£90 for trainees & nurses)

9:15am REGISTRATION

9:45am **WELCOME**
Dr Carl Waldmann: Faculty Dean

Session 1 **CHAIR: Dr Daniele Bryden**

10:00am **RIVER DEEP**
Exploring the issues around cave rescue; an insight into how a hobby can become something more
Dr Brendan Sloan: Consultant in ICM & Medical Officer British Cave Rescue Council

10:30am **ROCK BOTTOM**
Recognising and managing wellbeing in health professionals
Dr Clare Gerada: Medical Director, Practitioner Health Programme

11:00am **PIGS MIGHT FLY**
A personal view of career choice and maintaining work-life balance
Dr Wendy Aubrey: Consultant in ICM & Membership Secretary the Bowmen of Pendle & Samlesbury

11:30am REFRESHMENTS

Session 2 **CHAIR: Dr Jonathan Goodall**

11:45am **IN THE LINE OF DUTY**
Lessons learnt from the Ebola outbreak
Col James Czarnik: US Medical Liaison to the British Army

12:15pm **NEW MODEL ARMY**
Resilience training on a personal, team and organisational level
Professor Derek Mowbray: Management Advisory Service, Wellbeing & Performance Group

12:45pm **FACULTY UPDATE**

1:15pm LUNCH

Session 3 **Dr Alison Pittard**

2:15pm **WHEN THE GOING GETS TOUGH**
The house believes it is possible to work in full-time ICM until retirement
FOR: Professor Hugh Montgomery: UCL Professor in Intensive Care Medicine
AGAINST: Professor Mervyn Singer: UCL Professor in Intensive Care Medicine

3:00pm **MOUNTAIN HIGH**
A perspective from Everest on how to maintain a good work-life balance
Professor Mike Grocott: Consultant in ICM & Xtreme Everest Executive Team

3:30pm **ON TOP OF THE WORLD**
Exploring the stressors experienced by pilots and the approach to managing them
Mr Chris Henkey: Former British Airways Pilot

4:00pm CLOSE



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CRITICAL FUTURES



UPDATE FROM THE VICE DEAN

Dr Alison Pittard

Vice Dean

I have been Vice Dean for just over a year and this is my first update. It has been a busy year keeping the Dean under control! Behind the scenes, we have been furiously working on a number of projects born from the Critical Futures initiative that I am excited to share with you.

Many will recall completing a survey in 2015, sent by Dr Peter Nightingale. This was the start of a long-term project looking at the challenges faced by the Intensive Care community. Comments from over 500 individuals and organisations were analysed and we are extremely grateful for the time and effort you took to show that you care about the future of our specialty. Your concerns are primarily around the workforce, standards, commissioning, demand and quality of life. We have produced 'Critical Futures: A report on the first wave survey' which can be found here: www.ficm.ac.uk/news-events-education/news/critical-futures-report-first-wave-survey. This takes your concerns and converts them into a number of work streams through 12 recommendations. In the report we have highlighted the work already underway and identified whom we feel should be responsible for the remaining projects; we hope this will begin to address the issues you raised, as well as identifying potential solutions.

In order for 'Critical Futures' to have an impact we feel we need to appeal directly to those with the power to make a difference. 'Critical Condition: Building a sustainable future for the sickest patients in the hospital' does just this. Individuals and organisations outside our community often do not appreciate the extent of our work and therefore cannot begin to understand the challenges we face. What we have tried to do is produce a short, readable document defining how Intensive Care Medicine is pivotal to the

safe, efficient functioning of all acute hospitals and, in simple terms, explains the issues threatening the future of our specialty. We hope the voice of frontline staff will be heard and intervention implemented to avert the predicted crisis and potential impact on patient care. This will be published in the coming weeks and widely circulated.

Recommendation 12 of Critical Futures covers life after critical care. In September last year NICE published their 'Quality Standard for Rehabilitation after Critical Illness in Adults' (QS158). Commissioners and providers of Intensive Care Medicine (Level 3 and Level 2) can use this to promote high quality care. The standard makes four quality statements to drive improvement; agreement of rehabilitation goals within four days of admission to critical care, formal handover of care including the rehabilitation programme when discharged to a general ward, patient information regarding rehabilitation goals at hospital discharge and a review at two to three months following discharge from critical care. The Faculty were involved in the development of this standard and we welcome its publication. We hope it will help those of you struggling to develop or retain a follow up clinic, to promote the necessity and benefit for our patients.

Finally, forgive me for taking this opportunity to promote our annual meeting 'Mind the Gap' on Thursday 24th May. We know working in our specialty can be tough, as Recommendation 7 of the Critical Futures report indicated. Instead of more evidence to prove this, we need to develop strategies enabling us to work in this worthwhile environment. The meeting will explore ways of achieving this and registration is open via: www.ficm.ac.uk/ficm-events/ficm-annual-meeting.



END OF LIFE CARE AND ICM

Dr Joe Cosgrove

Chair: FICM End of Life Working Party

Recent studies indicate that a majority of adults wish to die at home close to loved ones; a reflection of aims within NICE-CG31 (*Care of Dying Adults in the Last Days of Life.*) The reality however is different with increasing numbers of patients (often with disabling chronic co-morbidities) dying in hospital after months of decline and periods of acute illness. An example includes Newcastle upon Tyne (2015-16) where just short of 50% of adult deaths within the local authority area occurred in an acute hospital. Approximately 27% of these in-hospital deaths were on intensive care, something likely to be reflected elsewhere in the UK. By default Intensive Care Medicine must therefore be able to provide effective end-of-life care but should also be in a position to lead discussions that minimise excessive, tortuous treatments being delivered near the end of patients' lives.

The direct provision of end-of-life care is arguably relatively straightforward with many of the basic needs of dying patients already being met via generic physical and pharmacological care instituted at the time of intensive care admission. However, holistic aspects of care are also required and whilst some of these can be provided directly by intensive care staff, a multi-disciplinary approach is beneficial and includes communications with patients (where capacity exists), families, base specialties, palliative care medicine and spiritual or religious representatives.

Leading aforementioned discussions is however more complex. Patients who die after prolonged periods of decline are frequently referred when in extremis, days into a hospital admission. They have lost capacity and there is often no direct information as to what their wishes are with respect

to instituting or refusing serious medical treatments. Such situations inevitably raise concerns about subjecting the dying to inappropriate interventions when they are in no position to discuss their care. They also present intensive care staff with the dilemma of having to advise relatives as to the pros and cons of treatment and care in a very limited time frame; often when no previous discussions have occurred and where there are (sometimes unrealistic) expectations about survival, rehabilitation and quality of life. Furthermore, little opportunity is available to build relationships with patients and their families, potentially creating conflict and having a likely long-term 'burnout' effect on staff leading these discussions.

There are initiatives within Primary Care which are attempting to address such issues via *Advance Care Planning (Deciding Right)* and the Resuscitation Council (UK) has recently trialled the *ReSPECT* (Recommended Summary Plan for Emergency Care and Treatment) document as a means of outlining patients' wishes via a shared decision making process. Intensive Care Medicine has a pivotal role in such processes.

The FICM has established a multi-disciplinary working party to highlight best practice and increase awareness of the dilemmas to patients, their families and health care professionals. The aim overtime is to develop enduring networks that will allow better national co-ordination of best practice in individualised care for the contexts discussed above.



MAJOR INCIDENTS:

Responses from Intensive Care Medicine

The Intensive Care Unit in Mass
Casualty Events

Manchester: Managing a major incident on
paediatric intensive care

Manchester: The response from
Wythenshawe Hospital

London Bridge: The Royal London Hospital
intensive care response

The Grenfell Fire: An Intensive
Care Perspective

THE INTENSIVE CARE UNIT IN MASS CASUALTY EVENTS

Colonel Jeremy Henning
South Tees Hospital NHS Trust

“Plans are worthless, but planning is everything.”

Dwight D Eisenhower

Major Incident plans often have very detailed guidance as to what organisation is required at the scene, how casualties are triaged and transported and indeed, what hospital reception should look like. However the further away from the incident you are, both in terms of time and geography, the less well articulated plans tend to become. Here we will discuss some of the issues an ICU should consider when reviewing its plans for a sudden influx of patients. It should be noted that Intensive Care staff, through their everyday work, are experts in priority setting, triage and resuscitation so will be needed throughout the whole casualty chain.

Have a Plan: Whilst this may sound self-evident, many hospital plans will merely have an action card for ICU, yet this is likely to be the area that will feel the most strain for the longest time. It is not unusual for an action card to ask the duty consultant to attend ICU, liaise with the senior nurse and identify patients who can be transferred to the ward or other hospitals. However this not likely to lead to much capacity – the average bed occupancy for English ICUs is around 80%, with many units reporting far higher numbers. Even if patients could be identified to move, and beds found, it is likely that the ambulance service will not have the capacity to transfer. Therefore it is clear that extra beds will have to be made if the influx is sustained; NHS England asks for its Major Trauma Centres to be able to double its critical care capacity within 24 hours of a major incident occurring. This needs careful planning, not only as to where the beds are to go, but what equipment is going to be used and how are they going to be staffed at a sustainable level. The rest of the hospital will return to near normal function within hours, yet these beds may be needed for days and how the rest of the hospital functions around these beds should also be planned.

Practice the Plan: Once the plan is written it needs to be practiced. This gives the opportunity to stress test the plan, to see that it works and also gives all personnel the chance to understand it. Whilst the first two objectives can probably be achieved with a table-top exercise involving senior management only, the latter will need a full scale exercise with actors, manikins and all staff. This will take careful planning as it is highly likely to impact on normal hospital running, and can probably only be done every few years.

Be Flexible: Eisenhower explains that emergencies were, by their very nature, unpredictable and therefore every plan must incorporate the ability to change as the incident unfolds. For example, it is highly likely that communications will fail, and pre-alerts from the scene will bear little resemblance to the casualties who arrive.

Be Resilient: Above all, a major incident calls for resilience. Individuals need to be resilient as they may well be looking after patients they are not used to, in areas that are unfamiliar. Units will need to be resilient and ensure they do not exhaust all their staff on the first day, the major incident in ICU is likely to last days. The organisations have to be resilient knowing that normal business will need to continue.

Follow Up: Finally, it has to be noted that the incident is not finished when the last casualty is cleared. Staff will need immediate ‘defusing’ so that they do not go home feeling they had not performed (and those kept in reserve at home will need to know they were doing their part). The unit will need to debrief in order that lessons can be learnt and these will need communicating not only to the organisation so that the plan can be refined, but to the profession in general. Major incidents are thankfully still fairly rare, so everyone needs to learn from everyone else’s experiences. This will take honesty and bravery to admit mistakes, but also to showcase what went well.

MANAGING A MAJOR INCIDENT ON PAEDIATRIC INTENSIVE CARE

Dr Rachael Barber

Manchester University NHS Foundation Trust

On 22nd May 2017 at 22:31 a bomb went off at the Manchester Arena as children, young adults and their families were leaving a concert. Over the next five hours, 22 children and five adults presented to Royal Manchester Children's Hospital with blast injuries. Six of these children required admission to Paediatric Critical Care and one died in the Emergency Department.

A major incident was declared at 22:46. Critical Care staff were immediately contacted using established text burst and social messaging groups. An additional nine nurses, two middle grades and two consultant staff were on site within 30 minutes and additional staffing was identified for the following 48 hours. Outside of critical care, colleagues responded promptly and enabled five emergency theatres to be opened during the night and plans to be made to ensure that an adequate workforce was available for the following days. At the time of declaring a major incident, no patients were medically fit for discharge and the critical care unit was full to capacity; ten PICU beds were made available within one hour.

In accordance with our major incident protocol, all patients were resuscitated in PED, underwent a whole-body CT scan and were then transferred to theatres or the ward/PICU. The first critically injured patient arrived in PED at 23:30 and was admitted, ventilated, to PICU at 00:30, two hours after the explosion. Patients were inevitably less stable on arrival to PICU than would usually occur and therefore a dedicated team consisting of a PICU consultant, PICU middle grade and two nurses were deployed to meet each patient as they arrived. Of the six patients admitted to PICU, two were transferred straight to theatres and two required emergency surgery within two hours of admission to PICU. Initial plans were made to admit non-ventilated patients with major injuries to PHDU however, these were altered during the night when it became clear that they were more unwell than their initial assessment suggested. The last patient admitted

to PICU was at 21:00 (almost 24 hours after the blast occurred) after extensive maxillofacial surgery.

The workload on PICU remained very high for the following two weeks and the maintenance of adequate staffing after the initial 48 hours was challenging. Across the hospital, a global view was maintained through twice-daily major trauma ward rounds. These brought our staff together to facilitate seamless coordination of their activity, delivering the complex care and multiple operations required by both the victims and other in-patients. The final patient was discharged from intensive care one month after the event.

It is important to note that all children with major injuries were correctly identified on the scene and consequently moved to RMCH. We are particularly proud that we were able to keep families together; parents were admitted to our short-stay ward and seen by adult teams, from our co-sited adult hospital, whilst their child was in RMCH. Families and staff also benefitted from early psychological support, provided by the CAMHS team. This need had not been identified in our major incident plan but by our local team and was quickly accommodated through the flexibility of our staff. Unfortunately, resource has not been available to provide a prolonged period of psychological support and the ongoing input has been limited. The department is seeing staff leave as they are unable to deal with what they have witnessed. Nothing can prepare you, or protect you, from seeing children intentionally injured in a bomb. Sadly, I fear this may not be the last time the Paediatric Intensive Care community has to deal with such tragedies.

The support and good-will from the local population other hospitals and the public in general was amazing. When finishing a gruelling shift, reading a letter from a school-child in Canada thanking you for your work, helped you come back another day and do it all again.

MANCHESTER: THE RESPONSE FROM WYTHENSHAW HOSPITAL

Dr Andrew Bentley

Manchester University NHS Foundation Trust

The events on the night of the 22nd May horrified us all. A shrapnel laden homemade bomb was detonated in the foyer of the Manchester Arena at the end of a concert. The devastation resulted in the deaths of 22 children and adults and injuries to 250.

The response of Manchester's Emergency Services and hospital staff demonstrated an unerring, selfless sense of duty. The initial rapid deployment of 60 ambulances to the scene was achieved with the assistance of units from surrounding Ambulance Trusts. 59 people were taken to 8 local hospitals with the first adult patients and children transferred to Manchester Royal Infirmary and Royal Manchester Children's Hospital. Specialised neurosurgical support was provided by Salford Royal Hospital and plastic surgery support by Wythenshawe Hospital.

“GREATER MANCHESTER HOSPITALS HAD RECENTLY REHEARSED THEIR MAJOR INCIDENT PLANS AS PART OF A REGIONAL MASS CASUALTY EXERCISE... THERE IS NO SUBSTITUTE FOR PRACTICE AND REVIEW OF MAJOR INCIDENT PLANS.

Greater Manchester Hospitals had recently rehearsed their major incident plans as part of a regional mass casualty exercise. This was beneficial in maintaining individual heightened awareness and responsibilities, and identifying actions to be taken from an organisational perspective. There is no substitute for practice and review of major incident plans.

At the time of the incident Wythenshawe Hospital's Emergency Department was full with over 30 patients waiting. As part of our major incident dispersal plan we were required to prepare for 20 priority 1 patients. 13 patients were admitted, 7 to critical care between our cardiac and general units.

The Hospital's strategic command and control room function collated current critical care capacity, identified patients designated to move from critical care and the number of empty beds and potential discharges from the receiving wards whilst maintaining safe staffing. We created capacity for 5 patients within the acute ICU immediately. Additional intensive care staff were not required in the first few hours until the arrival of patients from theatre and for the following days. Our general anaesthetic medical teams provided

care to patients in A&E and during transfer to theatre. 4 theatres were opened, both CT scanners were staffed and operational for whole body CT trauma series, and additional staff were called in for radiology, pharmacy, blood bank, pathology and portering. The actions of the senior on call medical team made a difference by walking the wards

reviewing in-patients and rapidly freeing up beds for new patients and ICU discharges.

Off-duty staff heard about the events through multiple media. This led to immediate, spontaneous offers of assistance from staff of all groups and grades which needed to be coordinated carefully to ensure there were the appropriate number of staff required both

on the night and for the ensuing days. Although the scene was stood down at 05:50, we needed to prepare for the aftermath. Social media platforms, such as WhatsApp, were utilised as a means of communicating to teams who should come in and who should stay at home on standby.

The psychological impact on staff being advised to stay at home if not required immediately should not be underestimated.

Our acute general intensive care unit admitted 4 patients from theatre, the first arriving at

07:00 the following morning. With the nature of the injuries it was clear that secondary transfers for specialist care might be required following initial damage limitation surgery. A normal service also had to be maintained.

Injuries were predominantly ballistic, penetrating trauma, soft tissue and orthopaedic with 1 tympanic membrane rupture and a blast heart. The type of injuries required multiple trips to theatre and had an impact on length of stay in ICU and on vascular, orthopaedic and plastic surgical lists. Due to the dispersal of patients throughout Greater Manchester, 5 plastic surgeons from Wythenshawe Hospital operated at hospitals across the city from the time of the incident and for days after.

“ THE RESPONSE OF MANCHESTER’S EMERGENCY SERVICES AND HOSPITAL STAFF DEMONSTRATED AN UNERRING, SELFLESS SENSE OF DUTY.

Early debriefs and the role of the major trauma consultant were invaluable. The designated major trauma consultant oversaw daily MDT rounds, co-ordinated surgical specialty plans and undertook secondary surveys. In the first 10 days after the incident an additional 139 hours of theatre time were needed.

We were grateful for the early debrief by the military team from Queen Elizabeth Hospital, Birmingham. This provided reassurance that our surgical and critical care management was appropriate, and provided advice in areas not immediately familiar to us in critical care.

“ WE CREATED CAPACITY FOR 5 PATIENTS WITHIN THE ACUTE ICU IMMEDIATELY... 4 THEATRES WERE OPENED, BOTH CT SCANNERS WERE STAFFED AND OPERATIONAL FOR WHOLE BODY CT TRAUMA SERIES AND ADDITIONAL STAFF WERE CALLED IN FOR RADIOLOGY, PHARMACY, BLOOD BANK, PATHOLOGY AND PORTERING.

The psychological impact on patients and staff is, understandably, considerable. Downtime to express feelings and discuss concerns is paramount and making it clear how to access the support right from the start was critical. Individuals will have different needs and the provision of one to one consultations, as well as group psychological de-briefs were required. We are all aware that PTSD may be delayed and on-going recognition and provision of support needs to be available for weeks after the incident.

Lessons for the future should focus on major incident planning review, a ‘surgeon commander’ to provide guidance as to surgical priority, improved communications both internally and with external agencies, including equipment and supplies, training exercises and not forgetting lockdown and security on site.

I would like to thank and express my gratitude to all the services that responded to the dreadful events on the 22nd May with dedication and professionalism.

LONDON BRIDGE: THE ROYAL LONDON HOSPITAL INTENSIVE CARE RESPONSE

Dr Parjam Zolfaghari, Dr Andrew Leitch and Dr Peter Shirley
The Royal London Hospital, Barts Health NHS Trust

In a terror related attack on June 3rd 2017, a hired van was used to strike multiple pedestrians on London Bridge. The three occupants then ran into nearby Borough Market randomly stabbing members of the public as they did so. This is a busy area and was filled with people enjoying a night out in the adjacent bars and restaurants. Eight people died and another 48 were injured. The Royal London Hospital received 13 casualties, of whom five were cared for in the Adult Critical Care Unit (ACCU). All of the critical care patients had required immediate surgery for penetrating injuries and one needed surgery for blunt force trauma to the head.

“EXPERIENCE OF PREVIOUS MAJOR INCIDENTS AND EXERCISES AT THE HOSPITAL HAD IDENTIFIED EFFECTIVE COMMUNICATION AS CRUCIAL TO THE EFFICIENT MANAGEMENT OF SUCH EVENTS.

This event came shortly after another similar attack on Westminster Bridge and a suicide bombing in Manchester, both of which were also multiple casualty incidents. By the time that Royal London hospital officially declared a major incident, many staff from critical care had started making their way to work, having learned of the attack from the media or from colleagues. The ACCU team put into action our local major incident plan (MIP) and set up a control room within the 44-bedded critical care unit.

Experience of previous major incidents and exercises at the hospital had identified effective

communication as crucial to the efficient management of such events. It has taken the persistence of a small group of dedicated individuals both from the ACCU and more widely in the hospital to get this acknowledged. Following the Manchester attack, we had created and tested a WhatsApp group of all of the ACCU consultants. This proved to be a highly effective method of communication on 3rd June, not only to alert all the members of the team, but to provide short succinct messages about progress, the whereabouts of each consultant and to plan an emergency rota for the next few days to manage the extra workload.

There are mixed opinions about the use of social media platforms as methods of communication but there are some advantages of using WhatsApp. It is not solely reliant on the mobile phone network, so that if this becomes non-functional during an incident, group communication is still possible via WiFi at home or

work. Additionally it has end-to-end encryption and so is a secure method of communicating potentially sensitive information.

The ACCU staffing at the Royal London includes two consultants on-call overnight. On the night of the attack, the first on-call consultant took on the role of incident commander for the unit, while the second on-call consultant became a roaming intensivist, with a liaison and information gathering role within the hospital. This involved physically travelling to the operating theatres and emergency department, providing consultant input and support to the clinical teams

looking after the patients. This individual also regularly fed back information to the ACCU team with the names, severity of injury and estimated time of arrival of patients to help allocate appropriate staffing and equipment at the bedside. Furthermore, they assisted the major incident organisers to direct ICU staff, as they arrived at the hospital, to the location where they would be most useful. Additional consultant presence on the night also meant there was face to face input to the main hospital incident control room again providing up to date information.

The workload following such events can be overwhelming and exhausting as we have experienced in previous incidents. With this in mind, the ACCU coordinating team made appropriate staffing arrangements for all tiers of staff from consultants and trainees to nursing staff and technical team, with an eye on the increased workload over the coming days.

As there had been multiple penetrating injuries, potentially with the same weapon, we felt that there was a real risk of spread of blood-borne infections. With advice from our microbiology colleagues, all the casualties had bloods taken for viral serology and received hepatitis B and tetanus vaccines. Guidance on management of potential blood-borne virus exposure following severe serial penetrating injury attack have been provided by Public Health England.

Some of the victims and their families required psychological support following the event; the attack itself and its aftermath had a significant impact on all involved. This manifested as post event stress and anxiety, grief, anger and a sense of vulnerability. The nursing staff provided much needed emotional support. We are also very fortunate to have two psychologists embedded in the ACCU, who provided

support and follow-up for patients, families and the team. This is an invaluable resource that has helped many of our patients and their families cope, and come to terms with, critical illness and trauma.

“ THE HOSPITAL RECENTLY RAN A LARGE MAJOR INCIDENT EXERCISE DURING WHICH WE TESTED OUR LEARNING FROM THIS EVENT. ONE OF THE CHALLENGES HAS BEEN TO KEEP STAFF FOCUSED ON OTHER NON-TRAUMA RELATED MAJOR INCIDENTS (PANDEMICS, FIRE, FLOODING). WE HAVE AN ACTIVE FACULTY FROM MEDICAL, NURSING AND OUR TECHNICAL TEAM WITHIN ACCU WHO ARE REGULARLY REVIEWING LIKELY RISKS AND ADAPTING OUR MAJOR INCIDENT PLAN ACCORDINGLY.

The hospital recently ran a large major incident exercise during which we tested our learning from this event. One of the challenges has been to keep staff focussed on other non-trauma related major incidents (pandemics, fire, flooding). We have an active faculty from medical, nursing and our technical team within ACCU who are regularly reviewing likely risks and adapting our major incident plan accordingly. We have tried to make the action cards brief and relevant to staff. These have been placed on our shared drive on the computer system and staff are encouraged to download their particular one to their mobile phone. We have also made use of published resources to disseminate this information. This is a dynamic process and with the constant turnover of medical and nursing staff, we have increased the frequency of our major incident teaching. With our colleagues in London's four major trauma networks we stand ready to respond to the next major incident which will undoubtedly come.

THE GRENFELL FIRE: AN INTENSIVE CARE PERSPECTIVE

**Dr Edward Watson, Dr Andrzej Jandziol,
Dr Catherine Sands, Dr Linsey Christie and Dr Marcela Vizcaychipi
Chelsea and Westminster Hospital, London**

Chelsea and Westminster (C&W) Hospital declared a major incident (MI) almost two hours after the fire at Grenfell Tower started; the first patient arrived four minutes later. By chance, the fire had been seen from the hospital by Burns ICU (BICU) staff at 2am. This time period proved invaluable as informal communication began between frontline staff and all patients suitable for ICU discharge were promptly identified and provisionally handed over. When the incident was declared, immediate and safe discharge occurred.

C&W Emergency Department (ED) treated 20 patients (17 adults) during the incident, as well as delayed presentations. Three adults were intubated in ED following arrival and admitted directly to ICU, three were admitted to a medical ward (one was later intubated in theatre) and one to the Burns ward. One child required external transfer to PICU, two were admitted to PHDU. There were 21 critical care admissions across London. Both BICU beds at C&W were already occupied; a third bed was made available but was not needed. Our four ICU admissions were to the general ICU for inhalational injuries, no patients had major burns.

Unlike MIs involving trauma, the requisite skills were primarily anaesthetic. Inhalational injury protocols were emailed to other centres via the critical care network. The anaesthetic team relocated to ED to assess and manage casualties. The ICU team assumed responsibility for safe discharge or ongoing care of current patients. Three patients were discharged to the ward and two transferred to other ICUs. As extra ICU staff arrived, they assumed responsibility for casualties on the unit.

Respiratory deterioration was rapid and a large admission load was anticipated. Post-intubation bronchoscopy demonstrated significantly worse severity of inhalational injury than initially apparent. This resulted in a lower intubation threshold for subsequent patients. Time-intensive assessments such as nasendoscopy were abandoned.

Inhalational injuries had been triaged as P3 (low risk) on-scene, had the toxicity score been used they would have been identified as critical earlier. This was not rectified in upward communication to Gold command, leading to underestimates of workload in our centre. As such, no operations were cancelled the next day despite significant deployment of anaesthetists. No ventilator-capable ambulances were available for non-clinical transfers to create ICU beds. Children's Acute Transport Service (CATS) transfer incurred inherent delays to definitive treatment and temporary admission to an adult ICU may have been appropriate.

As this was not a terrorist incident, no police were allocated to the ICU. Security staff were overwhelmed and clinical staff helped manage large volumes of distressed relatives and press. Mobile use proved far superior to traditional bleep systems, allowing faster, time-logged communication and rapid, encrypted group messaging. However, ease of communication between Bronze teams resulted in an unintended reduction in information relayed via Silver command.

The London supply of IV hydroxocobalamin was exhausted, further stock had to be procured from Derby. There is now a plan to introduce regional fire contingency pods, including doses for 100 casualties. The unit benefited from the disposable bronchoscope; surplus stock permitted bronchoalveolar lavage of multiple casualties without three-hour delays incurred by sterilisation. Inhalational injury patients are not cared for on BICU as they do not need specialist burns care and heated rooms. Unlike BICU, our general ICU patients do not qualify for psychology support and this cohort were at an extremely high risk of post-traumatic stress. Equally important was the need for identification and support of stress from the incident amongst staff.



CAREERS, RECRUITMENT AND WORKFORCE

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee

“Change will not come if we wait for some other person, or if we wait for some other time... We are the change that we seek.” Barack Obama

The CRW committee has been busy focussing on the Faculty’s stated aim of supporting the workforce from ‘recruitment to retirement’; we cover a lot of ground at each meeting. 2017 has also seen a widespread focus on staff welfare with many external agencies producing reports relevant for CRW.

NHS Providers has produced ‘*Eight high impact actions to improve the working environment for junior doctors*’¹. A short report, it includes examples of good practice, and from the ICM point of view it’s reassuring to know that we’ve been ahead of the curve in recognising many of these. We’re now in the process of promoting some of the actions such as in joint working with the AAGBI and recommendations on fatigue which will shortly appear on the Faculty website.

The IHI (Institute for Health Improvement) also produced their ‘*Framework for Improving Joy in*

Work’². Any cynicism you might have at the title (they admit it’s flaky) is worth putting aside to take in the messages that ‘getting by at work’ is not good enough and that quality improvement techniques can and should be applied to staff welfare and engagement. The IHI approach is to leverage existing assets to develop solutions by focusing not just on gaps but also on what’s working in an organisation and team. The project to showcase job plans and rotas is progressing nicely and through the WICM group we’re looking at how coaching and mentoring can be used to support our staff. 2018 will see more information appearing on the website and a new look workforce survey so do please let us know what you think.

1. NHS Improvement. *Eight high impact actions to improve the working environment for junior doctors*. Accessed at <https://improvement.nhs.uk/resources/eight-high-impact-actions-to-improve-the-working-environment-for-junior-doctors/>. 2. Institute for Healthcare Improvement. *IHI Framework for Improving Joy in Work*. Accessed at <http://www.ihl.org/Topics/Joy-In-Work/Pages/default.aspx>



WOMEN IN INTENSIVE CARE MEDICINE

Dr Rosaleen Baruah

Chair: WICM Sub-Committee

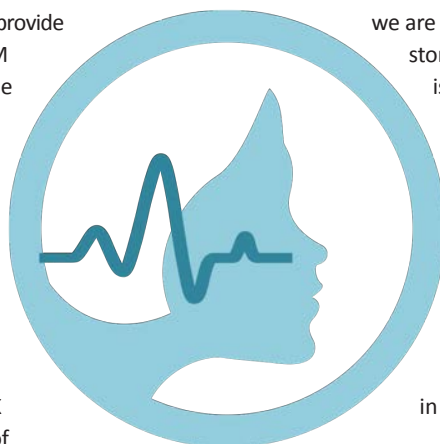
The Women in Intensive Care Medicine (WICM) group, a sub-committee of the Careers, Workforce and Recruitment Committee, met for the first time in September 2017. The nine women in the group come from a variety of backgrounds and career stages, but we have several strongly held beliefs in common: Being female should not be a barrier to a career in ICM, having caring commitments should not be a barrier to having in career in ICM and promoting balance between our working and our personal lives is beneficial for *all* intensivists, at all career stages.

The WICM group was formed to provide representation of women in ICM recruitment, training and in the general ICM workforce. To this end, we have several projects in the pipeline.

Intensive care medicine in the UK remains a male dominated speciality. Currently 37% of ICM trainees and 22% of Faculty-registered consultants in the UK are female. The elected Board of the Faculty is only 15% female. There are many reasons why women may be less likely than their male colleagues to put themselves forwards for nominations for Board positions. Lack of clarity in job descriptions could be one of those reasons, and WICM plan to work with faculty staff to produce job descriptions that describe, in greater detail, the commitments expected in terms of time and travel. WICM itself will plan to hold a significant proportion of its meetings via videoconference to minimise disruption to our already busy schedules by long travel times to London.

A strength of ICM as a specialty is the diversity of clinical backgrounds found amongst us. This could potentially be isolating to some; if you are the only dual acute medical LTFT trainee in your training area it could very helpful to be able to swap battle stories with a similar trainee in another deanery. Similarly, if you are interested in a career in academia or management but have no female colleagues in your region to draw upon for advice or support, having access to a database of colleagues keen to offer such support could be invaluable. To this end, WICM plan to establish a voluntary online database of female Faculty members and

we are exploring platforms in which to store this information. Our hope is this will grow into an active, supportive online community of UK female intensivists. We will also develop an existing resource on the website, 'Choosing a Career in ICM' with career stories, job plans and 'a day in the life' articles to give a realistic picture of what life as a female intensivist in the UK involves.



Face to face interaction is also very important and we are working towards developing a one day meeting aimed at women in ICM but accessible and hopefully relevant to all. We were also at the ICS State of the Art in December and hope to see many of you there. We are very keen to hear from members of the Faculty who have ideas or comments on the work streams we are proposing, or who wish to propose further projects for the group to develop. Please email us at contact@ficm.ac.uk or tweet @FICMnews with the hashtag #WomenICM.

ADVANCED CRITICAL CARE PRACTITIONERS



Ms Carole Boulanger

Co-Chair: ACCP Sub-Committee



Dr Simon Gardner

Co-Chair: ACCP Sub-Committee

It has been another busy and eventful period for the ACCP Sub-Committee. The current challenges around regulation reached sharp focus with the Department of Health consultation on the regulation of Medical Associate Professionals (MAP) recommending that ACCPs do not require separate regulation. This sparked a high intensity of activity, which has illustrated the considerable support ACCPs have amongst the critical care community. Support came not only from FICM but the ICS, HEE, ICU steps and many others, reinforcing the developing position of the role as part of the fabric of critical care. We are very grateful for this.

The deadline of November 5th 2017 saw the end of the notice period for the current system of application for FICM Associate Membership using the 2008 National Competency Framework as the foundation. As the FICM ACCP Curriculum 2016 has become embedded, anyone who has started training after this deadline will be subject to this criteria when applying for Associate Membership. This remains important as pending regulation; FICM Associate Membership remains the surrogate for the quality knowledge, skills and competency standards expected of an ACCP. We all remain registered and regulated according to our base profession (i.e. NMC or HCPC for our physiotherapy ACCPs).

It is important to acknowledge we are all working at the very limits of our license hence the focus on regulation. Associate Membership also ensures we can 'funnel' Higher Educational Institutions [HEI] course development practices to eliminate variation, a risk to a transferable quality standard. From now, only courses meticulously aligned to the FICM curriculum will be accepted for assessment towards FICM Associate Membership. The 'grandfathering' period has been important and essential to support this alignment of courses, given the nature of the development of the role and some of the challenges of HEI provision. We are proud we have reached over 100 FICM Associated ACCPs now. This is key for quality and safety assurance for clinicians, trusts, patients and relatives alike.

In the meantime the work continues. We are working on ACCP Scope of Practice, Code of Conduct and increasing advice for employers of the role. We are developing ways to provide appropriate and effective evidence to support the efficacy and benefits of the role in practice. One of the initial projects will be to work with the FICM Trainee Representatives to investigate the impact of ACCPs on medical training. There is on-going work to review how the ACCP role can support the workforce challenges in smaller units; we are working closely with the SSUAG to ensure effective training, support and, importantly, CPD for ACCPs is integral to this.

The 6th National ACCP Conference will be held on Wednesday 6th June 2018 and is in the final stages of planning. It will be hosted by Royal Stoke Hospital with case based discussions and current topics in a programme based on ACCP feedback. We aim to continue our track record of sell out conferences so book early to avoid disappointment.



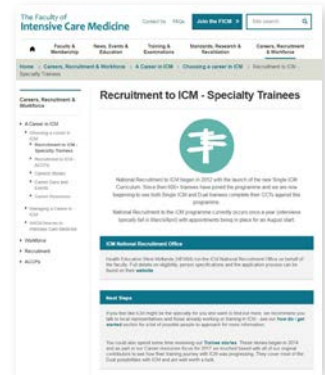
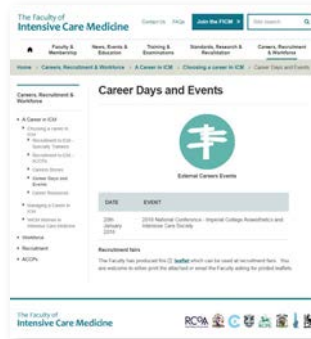
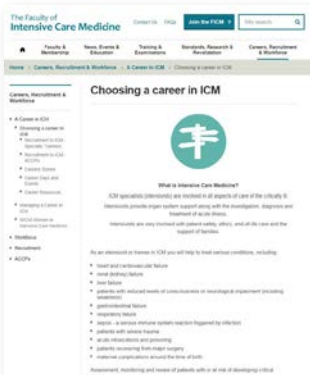
CAREERS

Dr Jonathan Goodall
Careers Lead

Over the past few months the Careers, Recruitment and Workforce Committee (CRW) has described a plan to support a career in ICM under the following four broad headings:

- Choosing a career in ICM
- Training in ICM
- Managing a career in ICM
- ICM Consultants and Professionals

As a result, the careers section of the FICM website has been redesigned and is now providing career resources to help colleagues at all stages of their career. Early efforts have been concentrated on helping trainees facing career choices. The website now includes presentations and information to help those trying to decide if a career in ICM is for them. There are career stories from current trainees, written resources and links to other websites which may help those making career decisions.



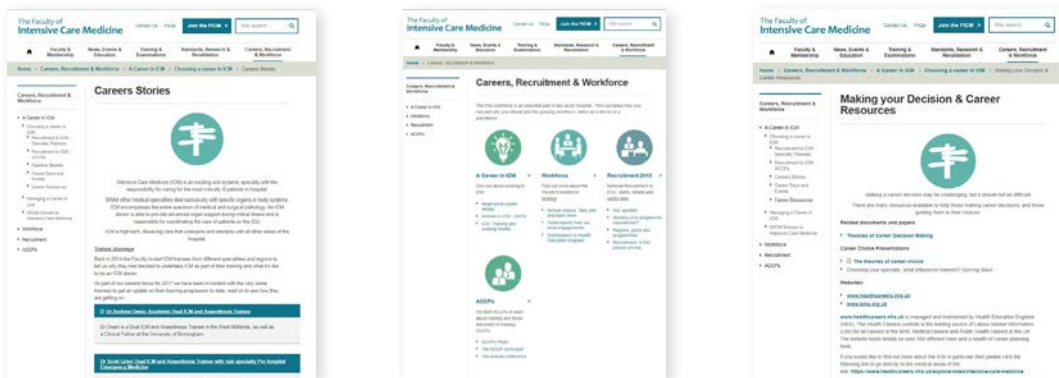
Such web-based resources are only part of the support that is needed. Trainees also need direct help from trainers when making career decisions. One of the traditional ways of providing such support has been to organise career-related events, days or evenings where trainees and trainers get to meet each other, where information is shared and discussed, and where advice is given. National 'Careers Days' have been held by Colleges and Societies for many years, and many deaneries provide similar events for their regions trainees.

FICM CRW: A Novel Approach to Career Events

The organisation of careers evenings is time consuming; speakers spend considerable time and effort researching facts and producing presentations. Similar events are held around the country, often within days of each other. Although some of the information which needs to be discussed is specific to a particular region, most of the facts are generic and appropriate to all; for example, how to research a career in ICM or the recruitment timeline for applications and the processes involved.

So, rather than provide another, ‘traditional-style’ FICM-led Career Day, the CRW have decided to take a different approach to providing career support. We are working to produce a ‘Virtual Careers Resource’, which will provide core, generic factual information. The information will be accurate, continuously updated and will include presentations and fact sheets that can be used in one of two ways:

- The information will provide a stand-alone ‘virtual’ career event, giving trainees the opportunity to ‘attend’ as an on-line virtual event at any time they wish.
- The information will be available for use by local trainers. Presentations and fact sheets can then be used to deliver accurate, up-to-date, FICM endorsed information to trainees at locally organised career events. Perhaps more importantly, trainers will be able to tailor the information provided by the FICM to include regional and local information, making it more relevant to their local population of trainees.

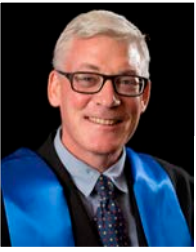


We hope that this approach will be useful to both trainees and trainers. We aim to improve the accuracy of information given to trainees, whilst reducing the burden on trainers involved in delivering such events; presentations will be produced for them, rather than by them!

We have decided to focus information on the following areas:

- What to expect from a career in ICM?
- What is training in ICM?
- Core training options
- Specialty training in ICM
- Application processes and timelines:
- Core training programmes (ACCS, CAT and CMT)
- Specialty Training in ICM
- ‘Making the most of yourself’ - how to improve your application for ICM training
- What to expect at interview

These virtual career resources will be developed over the coming months. Some information will be available for those applying for the next round of FICM ST3 posts in March 2018, with the complete version of the ‘FICM Career Event’ available to help those making core training applications in Autumn 2018. As with all aspects of the career strategy, help or suggestions from colleagues will be gratefully received. If anyone would like to be involved in developing the materials, please contact the Faculty.



FICM WORKFORCE CENSUS

Dr Jack Parry Jones

Workforce Lead

“Long is the way and hard, that out of Hell leads up to light” Paradise Lost, Milton

I’m not so naive to believe that we will ever achieve paradise in critical care staffing levels but I do think that if we equip ourselves with robust data and couple this with hard work, we can make the case and improve the situation. The FICM Census results for 2017 provide some interesting insights into changes in how we medically staff critical care. I have picked out some headline results. I would urge you, as usual, to complete the 2018 census when it arrives in your in-box at the end of February 2018. The overall response rate for 2017 was just below 40%. This is a fairly standard response, but for a specialty that is so critically dependent on staffing levels to deliver high quality care clearly the higher the response rate the better.

As a specialty we don’t want to be accused of ‘Fake News’ for lack of robust data if we have to highlight to our employers a growing critical care staffing problem. This is especially so for staffing at a regional level which we already know is very variable. The regional breakdown of responses for England does show the North West and Merseyside well ahead of everyone else; it is a big region but the response rate probably also reflects a very proactive, well led group. We haven’t provided the denominator data for Faculty member’s response rate per region or per home country; in an era of both real, and desired fragmentation by some, a good collective response at this stage seems desirable. Playing on your competitive instincts can currently remain in the sporting arena - Pob lwc i gymru.

The most striking change since the census started is the number of units employing Advanced Critical Care Practitioners (ACCPs). A quarter of the responding units (129) now employ at least one ACCP. Some of these units are clearly providing a full tier of ACCPs

with five units employing six or more. This radical change in unit staffing has developed rapidly over the last ten years. ACCP staffing is about much more than filling a junior doctor vacuum but, this is clearly a driving force for many units and managers facing worsening holes in junior rotas and spiralling locum costs. The continuity of staffing, continuity of care, and retention of staff with years of critical care experience that ACCPs can provide is invaluable to see how many units are now run. It will be interesting to see how this change continues to develop and most likely becomes the norm. If you aren’t already training ACCPs now is a good time to start with the expertise available to help. The failure of the Department of Health to see the need to formally regulate ACCPs is surely going to need to be relooked at.

The majority of critical care consultants (84% of responders) continue to provide sessions in anaesthesia. The number of other specialities in which critical care consultants also deliver sessions is growing with pre hospital emergency medicine (PHEM) making an increasing contribution. 55% of critical care consultants job plans are more than 50% critical care. 80% of consultants intend to continue in critical care medicine for the remainder of their careers. It is reassuring that, despite the pressures that we work under to deliver the service, and despite the risks of burnout this retention of consultants remains so good. There is no room for complacency here though.

The benefits of a job in critical care must continue to evolve over an individual’s careers, but also more generally as our specialty ages and matures. There are five consultants out there continuing to do critical care over the age of 65. We need to develop flexible job plans to retain older consultants in the specialty. We also need flexible job plans to allow other interests to flourish, and to allow good work life balance for all of us, female and male.

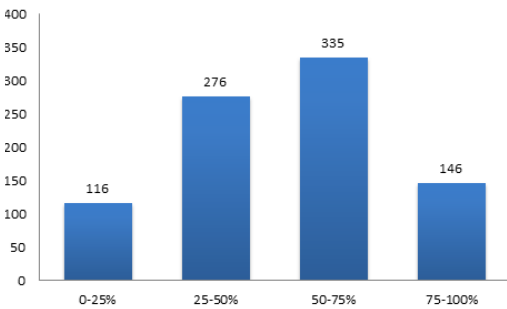
On the theme of fatigue and wellness, in the 2018 census our aim is to gather more data from you about your wellbeing. This is clearly an area of growing concern for all of us and we would really appreciate your help by maximising the census return rate. We have enlisted the help and expertise of Dr Julie Highfield, Consultant Clinical Psychologist in Cardiff, to design the questionnaire and we need your responses so that we get meaningful results which provide the basis for implementable, shareable solutions. The general main section of the

census for all members remains largely unchanged and should be easy to complete within five minutes. The section for clinical leads/clinical directors is unchanged; you do need the critical care minimum data set figures for your annual bed days at hand. We look forward to hearing from you, and working with you to try and help highlight the problems to staffing critical care units now and in the future. More importantly we need to help find solutions, and share those solutions amongst us.

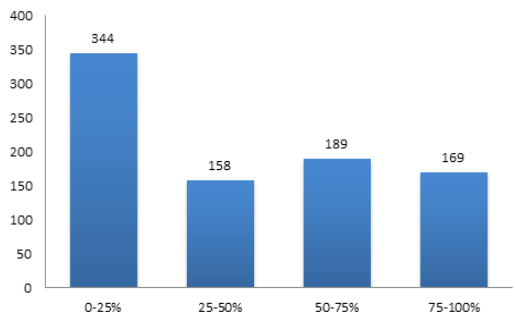
2017 Census Data

Below is a selection of data from the 2017 Census.

ICM COMMITMENT



Over a 12-month period, what percentage of clinical time (DCC) is spent in intensive care?



Over a 12-month period, what percentage of non-clinical time/SPA is spent in intensive care?

SPECIALTIES

Other Specialty	Number	Percentage
Anaesthesia	734	84%
Acute Medicine	12	1.40%
Respiratory Medicine	15	1.70%
Renal Medicine	6	0.70%
Emergency Medicine	15	1.70%
Cardiology	8	0.90%
Other	58	6.60%

96% of responders confirmed they work in ICM. Consultants were also asked if they worked in any other specialty, their responses are detailed below; The others category included 19 specialist areas; the most referenced of those was PHEM with 16 Consultants stating this and PICU with eight.



RECRUITMENT

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee

ICM has run a successful national recruitment since 2011 when the first interviews for 72 posts were an unknown quantity for all involved. Since then, adjustments have been a process of iterative change based on feedback from previous applicants and interviewers. For 2018, we're at West Bromwich Albion again with a format of four face to face and one written station to assess candidates for 160 places.

Many of you know how well organised West Midlands HEE staff are in getting people to the right boxes on time, but the paperwork could be a nightmare, no one wanted to be called out in front of their peers (and a bit of gentle teasing) to account for an incorrectly completed scoresheet at the end of the day! This year ICM is moving to digital scoring using iPads, as HEE has mandated this for all specialties. Although there is a slight learning curve which requires some additional training each morning, people who have used the technology in the HEE pilots say it works well and the benefits, in terms of reduced administration time on the day, are considerable. As interviewers, we should have less time hanging around when we want to get home, and more chance for real time checking of the marks.

One added benefit for ICM will be the ability to use the iPad data to really drill down into the characteristics of successful candidates, to ensure fairness and to identify if we're selecting the right people into training. Quality assurance of the interviews has been designed to monitor consistency of questioning and the scoring matrices are designed to improve consistency of marking. Inevitably it's tempting to wonder if different people do mark differently. Jerome Cockings has done a very helpful review of 2017 marking in the written reflection station. Whilst there are 'hawks and doves', the difference in marks is not any different to that observed in other forms of assessment and applicants should be reassured that, whilst we have tried to make the process as fair as possible, we are continually

vigilant to ways in which this could be impacted. Please get the message out to your trainees that ICM is doing everything it can to give candidates the opportunity to shine at interview regardless of their training background. It most definitely is not all about the CV and portfolio score.

So what about interviewers? New interviewers are always welcome, and the Faculty runs an annual training day, this year on 6th March 2018 (which carries 5 CPD points) so people can hit the ground running at the actual interviews. Over the years, discussion at these days is always highly rated. There is also a good social programme for those staying over during the interviews organised by Lead RA, Mark Carpenter. I really look forward to catching up with colleagues from other parts of the country to 'chew the cud'. I hope to see you many of you this year, 10-12 April 2018 to help select the next generation of intensivists. Do please get involved and come and see for yourself.

2018 Recruitment Dates

24th January

Advert appears on NHS Jobs, BMJ and Oriel

31st January

Application window opens

21st February (4pm)

Application window closes

19th March (onwards)

Candidates invited to attend interview

10th-12th April

Interviews held at West Bromwich Albion Football Club

25th April

First wave of offers sent

2nd May

Deadline for holding offers



UPDATES

1

Improving the Safety of ICU-MRI Transfers

2

Smaller and Specialist Units Advisory Group

3

Getting it Right First Time

4

NIHR Award Winners

IMPROVING THE SAFETY OF ICU-MRI TRANSFERS

Dr Andrew Jacques, Dr Aoife Fitzgerald and Dr Payashi Garry

Royal Berkshire Hospital NHS Trust and Oxford University Hospitals NHS Trust

Transfer of critically ill patients to the MRI scanner is an infrequent event with a particular set of unique risks.

The usual challenges of providing safe critical care outside of the critical care environment, such as haemodynamic instability, respiratory deterioration and displacement of invasive lines and tubes, are compounded by hazards that are particular to the scanner. These include limited access to the patient (with an inaccessible airway during the scan), a noisy environment, heating effects on metals (such as in clothes or ECG dots), interference with monitoring equipment and restrictions on the equipment that is safe in the context of the strong magnetic field. This is especially important during a cardiac arrest, as there will be a long delay to CPR while the patient is evacuated, and potential risks to members of the cardiac arrest team if they enter the scanner to assist

Our experience with ICU-MRI transfers in a large District General Hospital, along with a fatal critical incident in the scanner, prompted us to design an MRI transfer checklist to streamline the transfer process and improve safety.

In our centre, if an intensive care patient required a MRI scan, this would be booked onto the CEPOD list, with transfer being performed by the on-call Anaesthetic consultant, who may not be familiar with the patient. The transfer of intubated and ventilated patients to MRI is a relatively rare event (13 were recorded in the year prior to commencement of this Quality Improvement Project), therefore it was not surprising that the majority of the respondents in a survey to collect baseline data had never (59%) or only performed one (25%) ICU-MRI transfer in the past year.

The critical incident described above highlighted the need for standardisation of the transfer process, and the need to provide a safety framework for this relatively rare event. There is increasing

evidence for the role of safety checklists (such as the WHO Surgical Safety Checklist) in identifying and minimising hazards. We decided an ICU-MRI transfer pathway that encompassed all the steps involved in the transfer would be the best way to improve and streamline the process.

We drew from experience from other trusts, discussions with the multidisciplinary team (including MRI radiographers) and the clinical staff. One important feature was the incorporation of the MRI safety checklist as an integral part of the pathway. Another safety feature was a list of baseline physiological parameters that had to be met to ensure the patient was stable enough for transfer, as the transferring clinician may not be familiar with the entire clinical course of the patient. This was to decrease the possibility of the patient deteriorating whilst in the scanner.

We presented the pathway and the rationale behind its inception at our monthly clinical governance meeting. We have ensured that information regarding its use has been disseminated to theatres and on the critical care unit. We have also organised a half day study and simulation session where we used the pathway to transfer a 'patient' to the scanner. We plan to run further sessions in the future, and hope that the pathway becomes established over the next few years, decreasing the number of critical events associated with such transfers.

We faced several challenges. Rare events pose a challenge when measuring outcomes, therefore our project focused on making the process safer and easier for all staff. The pathway provides a checklist-based solution at no cost which can be adapted to the local setting to improve safety and efficiency of ICU-MRI transfers.



SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

We had the first meeting with specialist groups joining the fray and it was very productive, with considerable overlap between the groups. One of the aspects that provoked a lot of interest is the Core Medical Training proposal that would mean that all Core trainees would spend three months in ICM. If this comes to pass, there will be potential for a surge in resident trainees on our units, albeit at a junior level. In our ICU we have foundation doctors contributing to the workforce, and we have found them to be an excellent addition, so I can only see the additional workforce as a positive step. I can also only see positives in training all our future physicians to feel more in tune with the deteriorating patient, and giving them a feel of what patients or relatives might realistically expect from escalation to Intensive Care.

So how do you organise your resident staffing?

The out-of-hours workforce on our unit has changed over the years and has F2, F3, ACCP and ACCS trainees as a core group, supplemented by anaesthetists and perhaps one ICM trainee. Most of the Anaesthetic SpRs in Wales do their three month ICM blocks in tertiary centres so the availability of more senior anaesthetists for ICM is restricted in the DGHs. Although we do have some excellent staff grades already in post, recruitment is not easy at present even if funding is available. We have certainly found it easier to staff an extra tier with non-airway trained doctors (although they are ALS trained) and they work alongside the theatre anaesthetists and the obstetric anaesthetist as a team during out of hours. We have been very impressed with the way that this in-hospital support works, and we have also experimented with trying to keep the same three together, to develop stronger team working.

The anaesthetic trainees have been great, very supportive, and spend their time on the unit if quiet elsewhere so it does seem to build some extra resilience into the system. The skill set varies depending on the

doctors, of course, but one of the plus points is that in a DGH everyone knows each other, so there is no mystery about the resident on call or the consultant on call, and this helps communication greatly. Although some of the trainees are relatively junior a big plus point is that they are trained in your unit, so they know the system, when to call and what is expected of them. We find them excellent, enthusiastic, diligent and sensible.

Lastly there have been a number of requests for guidance from smaller units, and a decision was made to develop some interim guidance on governance until GPICS v2 comes out with a more definitive take next year. This was duly put to the Board and released for general consumption. This is a dynamic document and we are happy to work with any feedback to adapt the guidance with time.

Faculty Calendar

2nd February

FICM/ICS Joint Standards Committee

5th March

Regional Advisor/Faculty Tutor Day

12th March

FICM Careers, Recruitment & Workforce Committee

20th March

FICM Training, Assessment & Quality Committee

9th May

FICM Board

24th May

FICM Annual Meeting: Mind the Gap

8th June

6th Annual ACCP Conference

11th June

FICM Careers, Recruitment & Workforce Committee

21st June

FICM Training, Assessment & Quality Committee

11th July

FICM Board



GETTING IT RIGHT FIRST TIME

Dr Anna Batchelor
ICM Clinical Lead

Coming soon to your unit, an exciting opportunity to benchmark yourself against other units in England. Are you Getting It Right First Time? Does your unit have something great we can all learn from?

Getting It Right First Time (GIRFT) started in orthopaedics and has revealed marked variations in practice and results between hospitals in, for example, the number of joint replacements on a list, infection rates, litigation costs, length of stay and more. It has now expanded to all surgical specialties and many medical ones (35 specialties in all) including critical care, anaesthesia and peri-operative care and mental health.

Intensive care has a huge amount of high quality data in ICNARC; however, there are big areas particularly relating to patient selection, admission policies, post ICM and outcomes where we are less well informed. There are many metrics we could use and many areas we could explore but, are they the right places to go? I am seeking input from everyone and, if you have ideas, I'm happy to hear them. We are fortunate to be working with ICNARC to collect data from their dataset and others such as HES etc.

Once we have a basic set of metrics, these will be collated for all units and each hospital will receive a data pack showing their units performance compared to the rest of England. I and a team from GIRFT will visit your

unit to discuss this data. Is it right? Are their reasons? Are their areas of excellence or problems in delivering the standards? Each unit will receive feedback from the visits and a specialty report will be prepared highlighting the areas of variation and opportunities for improvement and increase in efficiency.

A feature of the orthopaedic report was the opportunity to save money by getting things right and improving quality. Infection rates vary several fold; patients who develop deep joints infections have a very poor quality recovery and incur significant costs. It's win win if infection rates are reduced.

The initial visits are just the start of the process. Regional implementation teams are being set up to follow up, drive any necessary change, and repeat visits to see what difference the information has made. Many specialties currently have very little experience benchmarking themselves against their specialty in other hospitals but intensive care has been doing this work for many years and has a great deal of information. Counting hip replacements is easy; ICM though will be much more challenging to find valid, useful and helpful metrics.

My hope is that ICM is up for this and embraces this opportunity to work together and across specialties to Get It Right First Time.

FFICM Examination Calendar 2018

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications & fees not accepted before	Thursday 4th January	Monday 9th April
Closing date for Exam applications	Thursday 22nd February	Thursday 31st May
Examination Date	Tuesday 24th April & Wednesday 25th April	Tuesday 10th July
Examination Fees	Both: £570, OSCE: £315, SOE: £285	TBC

NIHR WINNERS 2017

Established Clinicians Award



Dr Matt Wise

Consultant in Critical Care,
Cardiff and Vale
University Health Board

I joined the University Hospital of Wales in 2005 as Consultant in Critical Care and established a unique research infrastructure within critical care, with a team of research nurses recruiting to studies 24/7. As Critical Care Research and Development lead for the Cardiff and Vale University Health Board from 2010-2015, I increased opportunities for patient participation in critical care research exponentially, optimising consent and implementing 24/7 recruitment.

Now, Cardiff is consistently amongst top recruiting sites for many studies, with recruitment increasing from less than 45 patients per year in 2010 to a total in excess of 1,800 in the last five years. Moreover, it has been possible to attract a number of landmark trials including SPICE III (www.spicestudy.org/), SUP-ICU (www.sup-icu.com/), RGNOSIS (www.r-gnosis.eu/) and TTM. The Target Temperature Management (TTM) trial was published in the New England Journal of Medicine in 2013 and has >900 citations to date, with an Altmetric score of 785 it is in the 99th centile of medical articles and was a major contributor to national and international consensus guidelines on post-resuscitation care.

I think that effectively communicating the importance of research in emergency medicine, including areas such as critical care, is extremely important. It has been shown to optimise opportunities for patients, relatives and healthcare professionals to participate in portfolio research.

Early Years Award



Dr Duncan Chamblor

Consultant in Intensive Care Medicine and Anaesthesia,
Dorset County Hospital
NHS Foundation Trust

I have been a consultant for 18 months. In that time, I have taken on the role of principle investigator for my Trust to recruit to the SPICE 3 trial. This is a multi-national trial studying two strategies for achieving ideal sedation in critically ill patients. I must credit our research department staff Sarah Williams, Patricia Williams and Stephanie Dukes for guiding me through my first PI role – they've taught me a great deal about the CRN, assessing feasibility and the ethics of consent.

Secondly, I have been involved in web-blogging for the past three years alongside Steve Mathieu and David Slessor. The project, called The Bottom Line, produces a weekly critical appraisal of important research digested and summarised for busy clinicians. We now have around 1,500 hits per day and over 1,000 healthcare professionals subscribe to our weekly newsletter.

I'm delighted to win the award, which recognises how non-academic clinicians can engage in the conduct of research trials and the dissemination of research findings into clinical practice. I encourage other newly appointed consultants to engage with their Research and Innovation departments as they will become better clinicians as a consequence.



PROFESSIONAL STANDARDS

Dr Peter Macnaughton

Co-Chair: Joint Standards Committee

Although the focus of the Joint Standards Committee over the next nine months will be in producing the revision of GPICS, there are a number of other major areas of work for the Committee. The ARDS guidelines that have been in preparation for sometime are now at a stage where they should be published in the near future. Other guidelines that are being developed include revised standards for renal replacement therapy in ICU and guidance for the management of delirium. In addition to producing standards and guidelines, the remit of the Committee includes patient safety and revalidation.

At the last JSC meeting, we reviewed a preliminary analysis undertaken by NHS Improvement of patient safety incidents reported to the National Reporting and Learning System (NRLS) associated with prone ventilation in the ICU. The analysis focused on eye and facial damage and was undertaken after a report of sight loss following prone ventilation. Of over 300 reported incidents in prone patients, reassuringly there were no other reports of significant sight loss. This appears to be a significantly lower incidence of

eye trauma compared to the reported harm in the peri-operative setting. However, due to the nature of our patients, we may not always be aware of sight loss complicating prone ventilation so there could be under-reporting. NHSI plan to undertake further analysis of all types of harm associated with prone ventilation. I hope this is the start of an ongoing productive working relationship between the Committee and NHSI in analysing and learning from the ICU incidents reported on the NRLS.

The Committee discussed the lack of publications and guidance relating to best practice in how to undertake prone ventilation in ICU safely. It was agreed that it would be useful to undertake a survey to collate current practice in managing prone ventilation with a view to producing a guidance document on best practice. With the imminent publication of the ARDS guidance which is likely to result in an increased use of prone ventilation, this would appear to be timely. Whilst I mention eye problems in ICU, I would like to highlight an excellent article on eye care in the ICU written by Professor Sue Lightman and

Professor Hugh Montgomery. This was reviewed and supported by the JSC.

The Committee discussed difficulties in obtaining patient feedback for the purposes of revalidation for those with a sole ICU practice. This was in response to some concerns highlighted by consultant colleagues. The current FICM guidance published in 2014 and, following communication with the GMC, clarified that patient feedback is not mandated for intensivists and that other forms of feedback could be used in lieu. It is clear from the experience of the Committee members that there is significant variation on what is required by individual responsible officers within Trusts regarding whether any patient feedback is obtained, and if it is, how it is undertaken. One of the

main recommendations of the Pearson review of revalidation (2017), which was commissioned by the GMC, was that mechanisms for obtaining patient feedback should be strengthened by being more real time and accessible. It would therefore seem timely to review and collate current practice and provide updated guidance for intensivists. Please provide feedback of your experience of obtaining ICU patient feedback in the survey that is planned.

Finally, I would encourage you to submit any lessons from patient safety incidents that you would like to share with the wider community through the safety section of the website: www.ficm.ac.uk/safety-and-clinical-quality/learning-patient-safety-incidents

GPICS V2

You may be aware that the FICM and ICS Joint Standards Committee (JSC) are in the process of updating the Guidelines for Provision of Intensive Care Services (GPICS). Version 2 will be published in Autumn 2018 after a full stakeholder and public consultation expected during Summer 2018.

We sent out a survey to all FICM and ICS Fellows and Members and received extensive feedback. We have taken this into consideration for V2 and plan the following changes:

- Clinical Sections – the JSC agreed to remove the clinical/disease management chapters from the document. These are the most likely to go out of date between revisions and there is often more detailed evidence based guidance available from other organisations (e.g. NICE). There will now be a section that focuses on service provision for the different types of organ support provided within the ICU while the related clinical practice external guidelines will be signposted and referenced.
- New Chapters – a chapter on the provision of critical care in smaller remote and rural units and one on the care of the critically ill child in the adult setting will be included.

- An expanded section on emergency preparedness and resilience planning including major incidents, fire safety, serious infection outbreak and staff support.
- Removal of the Core Standards Section – the JSC agreed to remove the Core Standards section from GPICS V2 as the standards will be integrated in the relevant chapters. An executive summary will highlight the key standards.
- Authors – one of the main criticisms of GPICS V1 was that the authors were mostly from large tertiary centre units in England. We have tried to rectify this for GPICS V2 by ensuring representation from a cross section of units throughout the UK. Each chapter will have at least 2 authors from different areas of the country (with a few exceptions) and each author will only be allocated to 1 chapter (again, with a few exceptions).

The aim is to produce a more succinct and significantly shorter document. The authors have now been contacted and will be sending their first drafts to the editors in the next few weeks. If you have any queries or suggestions regarding V2, please contact us at contact@ficm.ac.uk.



AHP Framework

Mr Craig Brown

Lead, AHP Framework Writing Group

The Allied Health Professional (AHP) Career Development Framework is progressing well and is on track for its first phase consultation with key stakeholders this month.

The writing team have undertaken a comprehensive review of existing competency and development frameworks which have included:

- Modernising Allied Health Profession' Careers in Wales – a post registration framework (2016)
- Post Registration Career Development Framework for Nurses, Midwives and Allied Health Professionals in Scotland (2016)
- The Macmillan Allied Health Professions Competence Framework (2017)
- BDA Dietetic Career Framework (2013)
- RCOT Career Development Framework (2017)
- CSP Physiotherapy Framework (2013)
- RCSLT Newly Qualified Practitioner and Tracheostomy Competency Frameworks (2007)
- RPS Advanced Pharmacy Framework (2013)
- FICM Curriculum for Training for Advanced Critical Care Practitioners (2015)
- CC3N National Competency Framework for Registered Nurses in Adult Critical Care (2015)
- FICM Curriculum for a Certificate of Completion of Training in Intensive Care Medicine (2015)
- RPS Critical Care Expert Professional Practice Curriculum (2014)

From this review, the structure, language, assessment criteria and implementation was distilled into a structure that the writing team felt was proportionate for our workforce. The structure will closely follow similar professional frameworks with pillars of practice and skills that practitioners can progress across as they develop in their career.

The proposed titles for these pillars are below however, these may however change during the consultant phases:

- Clinical Practice
- Leadership
- Facilitating learning
- Research and Quality Improvement

The content has been drafted for these pillars along with the broader context and implementation strategy to support clinicians in applying the framework. This has been sent to some supportive individuals for their initial thoughts.



At the start of 2018 we will be looking for wider consultation across professional bodies and ODNs.

We would be keen to hear from services that are interested in constructively supporting this development; please contact Dawn Tillbrook-Evans at the FICM (dtillbrook-evans@ficm.ac.uk).

A full public consultation will follow.



The aim and ambition is to provide the critical care community with the relevant tools to support staff development and ensure patient care is delivered to the best of our ability.



ARDS Guideline

Dr Simon Baudouin
Co-Chair: ARDS Group

The joint FICM/ICS evidence based guidelines on ARDS have been published and I would like to personally thank all the writing group members for their hard and sustained work on the project. In particular I would like to acknowledge Dawn Tillbrook-Evans's sterling work (and patience!) in supporting the group and Professor Mark Griffiths in the key role of co-chair.

The guidelines are focused on ten major areas of therapeutic intervention in ARDS which were chosen because of their importance and the fact that some evidence (in the form of randomised controlled trials) was known to be available. The methodology used to create the guidelines was that of GRADE which is an internationally recognised system for evidence appraisal and recommendation making. In brief recent, relevant systematic reviews and meta-analyses were identified from 'long lists' produced by our Information Technologist using multiple data base search strategies. GRADE is focused on key outcomes (e.g. hospital mortality) and data on these outcomes was extracted, where available, for each chosen topic by writing group members from meta-analyses. A quality judgment was then made on the evidence, using pre-defined criteria, and a treatment recommendation finally made by the whole group based on the balance of evidence and its quality. This would include possible treatment risks as well as benefits.

Our 'strong recommendations', in GRADE parlance, were not surprising. We were strongly in favour of lung protective, low tidal volume, ventilation and prone positioning. We were strongly against the routine use of high frequency oscillatory ventilation. For ECMO, conservative fluid management, neuro-muscular blockers and PEEP we were weakly in favour (i.e. some patients will benefit). Finally we made research recommendations about corticosteroids and extra-corporeal CO₂ removal.

The time required, participant effort and resources needed to reach these conclusions has been considerable. Only the most dedicated Evidence Based Medicine practitioner would ignore, what economists call, the opportunity costs (i.e. what else could you have done) of this sort of programme. I believe that the outcome does justify these costs. Medical specialties produce high quality evidence based guidelines because it fundamentally underpins the service that they deliver. One of my inspirations for the FICM/ICS project was the impressive guideline programme run by the British Thoracic Society. Over many years they have produced a series of high quality, evidence based guidelines that have not only influenced clinical practice, but have also impacted on NHS policy.

Most importantly I would like to see that the ARDS guidelines improve clinical practice in the UK. However, on their own, they will probably have a negligible impact. Almost all practitioners will claim that the use of low tidal volume ventilation is routine on their units. However numerous publications (both international and conducted in the UK) demonstrate that this is not the case. For example a recent study based on the analysis of UK ARDS trial data showed that a significant number of participants did not receive lung protective ventilation in either arm of the studies, with worse outcome compared to the group that did receive this approach.

So how can we translate the evidence into practice improvement? In the longer term 'smart' ventilators may be the answer but in the shorter term large scale audits can be effective. Other specialties are already well established in this area and a recent NCEPOD audit on acute non-invasive ventilation, based on BTS guidelines, is being actioned at Trust Board level. The ARDS guidelines also provide recommendations that would enable a national audit to be performed.



LEGAL AND ETHICAL POLICY UNIT

Dr Chris Danbury

Chair: Legal and Ethical Policy Unit

DOLS – yet again (last time)!

“In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care.” So said the Court of Appeal in Ferreira. As mentioned last time, the Supreme Court refused leave for appeal on the basis that the Court of Appeal’s analysis of the case was correct. This means that the majority of people admitted to ICU with acute disorders of consciousness related to their illness are not being deprived of their liberty. In my view, some good common sense.

This has been reinforced by two other recent Court of Appeal decisions ([2017] EWCA Civ 1169, [2017] EWCA Civ 1695). So I hope not to comment on DOLS again, although we will wait and see whether the government has time to replace it with the Law Commission’s suggestion of ‘Liberty Protection Safeguards.’

LEPU has a couple of workstreams now being developed. The first on ‘information disclosure and consent’ and the second on ‘guidance for police access to ICU patients’. I hope these will be finished by the end of 2018. If you have any other suggestions, please contact the Faculty, particularly if you are prepared to lead on developing it. In addition to LEPU initiated work, we are participating in other workstreams on Devastating Brain Injury, End of Life Care and the next version of GPICS.

The Court of Protection decided not to renew Practice Direction 9E, which states that that all decisions to

withhold or withdraw clinically-assisted nutrition and hydration (CANH) from patients in a persistent vegetative or minimally conscious state should go via the Court. A joint working group has been convened to look at this including representatives from the Faculty, the Intensive Care Society, the British Medical Association, the General Medical Council and the Royal College of Physicians. The guidance was due to be published in May 2018 and consultation is expected beforehand. There may be overlap into other areas of withdrawal and withholding treatment, so do look at the consultation when its published. The deadline for consultation is likely to be extremely short.

“THIS MEANS THAT THE MAJORITY OF PEOPLE ADMITTED TO ICU WITH ACUTE DISORDERS OF CONSCIOUSNESS RELATED TO THEIR ILLNESS ARE NOT BEING DEPRIVED OF THEIR LIBERTY. IN MY VIEW, SOME GOOD COMMON SENSE.

The Civil Justice Council has published an Interim report on Alternative Dispute Resolution and Civil Justice, which can be found at www.judiciary.gov.uk/wp-content/uploads/2017/10/interim-report-future-role-of-adr-in-civil-justice-20171017.pdf. It’s interesting as it uses data from NHS Resolution and clinical negligence: “Claims are often for relatively modest sums, especially in cases where death has resulted. Yet even though claimants cannot claim for more than modest damages, they sue because they want non-monetary extra-legal outcomes, even though they actually cannot obtain them from a judge.” There is a consultation process, so do contribute.

WHO NEEDS OCCUPATIONAL THERAPY IN INTENSIVE CARE?

Mr James Bruce

Occupational Therapist

Occupational Therapy (OT) continues to be a relatively new profession within the arena of Critical Care in the UK. Data collected through the 2015 *National Critical Care Non-Medical Workforce Survey* confirmed this. Of the 146 units who returned data on occupational therapy staffing, only 14% reported specific funding allocation for their critical care OT staff, and only five of these units reporting whole time equivalent OT staffing dedicated to their critical care service. The remaining units received only minimal OT services, often for one-off specialist consultations for positioning, seating or interventions aimed at minimising secondary complications. This highlights a need for improved role definition of occupational therapy in critical care and a greater understanding of the value of OT in the assessment, management and treatment of the complex rehabilitation needs of the critical care patient cohort.

The NICE *Clinical Guideline 83: Rehabilitation after Critical Illness* (2009) and more recently *Quality Standard 158* (2017) emphasise the need for goal directed multidisciplinary rehabilitation addressing physical and non-physical needs. The *Guideline for Provision of Intensive Care Services* (2015) included standards and recommendations for OT provision in ICU and was instrumental in highlighting the need for the profession to be part of the ICU team. Further support for the profession in the ICU came, in the same year, as the Royal College of Occupational Therapy acknowledged the area of clinical speciality through the development of a Critical Care Forum.

The Royal College of Occupational Therapy (2017) define OT as 'providing practical support to empower people to facilitate recovery and overcome barriers preventing them from doing the activities that matter to them. This support increases people's independence and satisfaction in all aspects of life.' OTs are unique amongst allied health professions as, from a graduate level, they

Ms Lauren Maher

Occupational Therapist

are equipped with the skill and expertise to assess and treat both physical and non-physical impairment. This provides OTs with tremendous core skills beneficial for the heterogeneous critical care patient group.

“THE GUIDELINE FOR PROVISION OF INTENSIVE CARE SERVICES ... WAS INSTRUMENTAL IN HIGHLIGHTING THE NEED FOR THE PROFESSION TO BE PART OF THE ICU TEAM.

It is acknowledged widely in the literature that effects on ICU survivorship can include muscle weakness, anxiety and depression, long-term cognitive impairment, negative effect on return to work and overall reduced quality of life, all of which can persist for five or more years after an admission to ICU. The impact of post critical care syndrome and increased emphasis on long-term outcomes for patients, further supports a greater focus on and financial support for, rehabilitation services both within ICU and in follow-up clinics. As many OTs have skills and knowledge of community services, the hospital to community transition can be instigated alongside in-patient rehabilitation from the first assessment on ICU. An early OT process can reduce inpatient length of stay and ensure patients receive the correct discharge services at the right time.

Evidence of the value of OT for ICU patients is continuing to emerge. The necessity for functional rehabilitation and occupational engagement in critical care and beyond continues to gain recognition. The support for further development of the role of OT in critical care is imperative to ensure continual improvement in quality of life and patient outcomes beyond critical care survival.



TRAINING AND ASSESSMENT

Dr Tom Gallacher

Chair: Training, Assessment and Quality Committee

The requested amendments to our 2016 curriculum, to replace the requirement to undertake a Quality Improvement Project rather than an audit and to remove the Expanded Case Summaries were accepted by the GMC and were implemented from 1st August 2017. We also had a meeting with the UK Shape of Training Steering Group who confirmed that our current training pathway for ICM is fit for purpose.

We are re-writing our curriculum to comply with the new GMC curricular requirements. These standards require us to dispense with the need to provide evidence for all 97 competencies and will instead only require evidence sampling from the various descriptors with the sign off of the high level domains being left to the judgement of the Educational Supervisor. This will mean the Educational Supervisor has much more accountability in signing off trainees as competent in the relevant domains.

The committee have had many enquiries as to the post placements and competencies which can be achieved in each of the Stages of ICM training for trainees undertaking Dual programmes. The curriculum, as approved by the GMC, requires us to place a number of progression points in our curriculum and these we have named Stages. The requirements for each Stage (progression point) of training must be completed before a trainee can progress to the next Stage of training. A similar progression point is the need, in anaesthesia for example, to obtain the FRCA before

progressing to higher training. When a trainee is appointed to a Dual programme, the modules they have already undertaken in the partner specialty will be recognised for the Dual programme. The order of the placements are flexible within each Stage of training but a further placement cannot be undertaken in Stage 2 until all of Stage 1 is complete following appointment to the dual programme. Similarly, no Stage 3 placement can be undertaken before Stage 2 is complete and no Stage 2 training can be undertaken after Stage 3.

The recognition of Stage 2 competencies for those appointed late to a dual programme has been agreed as an exception by the GMC to facilitate plurality of access from different specialties and at different stages of training. We conducted a trainee survey to look at the quality of their ICM training and I am pleased to say that we had a 62% return rate, so thank you to all the trainees who took the time to provide us with this very valuable information. More information can be found in Chris Thorpe's Quality article with full details included in the Quality Assurance report which will be published on the FICM website.

The Board have agreed to an amendment to our examination regulations. From Summer 2017 if you are a member of the Faculty who left an approved training post in the UK no more than five years before the published starting date of the examination sitting being applied for, you will be permitted to sit the FFICM exam.

TRAINEE UPDATE



Dr Richard Gould
Lead Trainee Representative



Dr Jamie Plumb
Outgoing Trainee Representative

As we get stuck into a new academic year, it's great that the curriculum changes from last summer have been confirmed. We're sure you'll all be more than aware of these by now, but they serve as great examples of how the Faculty does respond to trainee feedback. It also demonstrates how curriculum changes can be a slow process, requiring precise timings and edge-of-your seat waiting for confirmation. This process should be improved in the future; more on that later.

With ARCP season now behind us (momentarily!), Expanded Case Summaries (ECS) should be a thing of the past for all trainees. Whilst there was nothing wrong with the concept, it became increasingly clear that they resulted in a significantly increased workload in an already crowded curriculum. Equally, we're sure you'll all agree that focusing on Quality Improvement Projects is much preferred to audit, and reflects the types of projects that we want to undertake on ICU. In August we welcomed the latest group of successful applicants to intensive care training (to whom ECS are already historic!). This year we distributed a welcome guide that we hope will be useful to those just starting out.

During 2017, the 'Guidance on Competency sign off' document was approved by the Board and distributed

across the Faculty. We hope that this will be informative to both trainees and trainers alike, and help to smooth and streamline the process of curriculum sign-off. As we begin 2018, the Faculty has many projects that will directly affect trainees. The most obvious one is the curriculum rewrite. This is required by the GMC to comply with its latest guidance Standards for Curricula and Assessment Review (SCAR).

As trainees, the objectives of SCAR should be welcomed. The new curriculum will move away from the many specific competencies to fewer 'higher level outcomes'. This will be associated with a reduction in the number of workplace based assessments and less need to evidence all elements of an outcome. In addition, any future curriculum changes can be submitted and approved much more quickly.

The Faculty has already begun work on the new curriculum, but as the idea is not simply to 'copy and paste' across the current competencies, then this project will take some time to complete. Your trainee reps sit on the Faculty's writing group and we will of course keep you updated.

The FICM website is also evolving. We would encourage you to regularly check for changes and updates. We hope it will continue to provide information that you find useful in all aspects of your work. Expect to see some new resources soon covering areas such as fatigue.

January is also the time of year where the trainee rep baton is handed over. Jamie has been a superb advocate over the last two years and deserves praise for the changes he has instigated. As Richard steps up to the role of Lead Trainee Representative, we are delighted to welcome Andrew Ratcliffe as the new Deputy.



e-PORTFOLIO

Dr Andy Gratrix
e-Portfolio Lead

It has been about a year since our last update regarding the FICM e-portfolio. It has been a relatively quiet year in terms of major changes or improvements. We continue to receive feedback from trainees and trainers. We always try to consider all options within the framework of the e-portfolio with an aim to make the product as user friendly and educationally beneficial as possible. We understand the issues and burden of most ICM trainees in having to use two different portfolio systems and strive to assist with this as much as we can.

The main focus of the last year has been the future of our e-portfolio. We were notified some time ago that NES (NHS Education for Scotland), the provider of our e-portfolio, intended to progress from Version 2 to Version 3 of their system, and would therefore begin a new specification phase by August 2017. This was to involve a no cost data migration and a potential opportunity to make some of the changes we were unable to do in Version 2. We had started to prepare a list of further potential improvements to try to incorporate in Version 3.

However, other colleges also use NES e-portfolios and some of these have elected to look for or have selected other portfolio providers. This makes the plan to move to Version 3 less likely as there must be enough Colleges and Faculties moving to the new system to make it cost effective. We are contracted to NES Version 2 until the spring of 2018 and will sign a fresh contract into 2019. We continue to explore all options available to us with a focus on providing the best product we can for our trainees and trainers within our usual resource restraints. We are currently

engaging with two other e-portfolio systems (and their providers): the system the RCoA are developing and the system which most ex-NES Colleges have elected to move to. We will do a full appraisal of these options in the Spring and will feed back to all Fellows, Members and Trainees then.

As always, I have some thanks to say. As part of the e-Portfolio Sub-Committee we have two trainee members, Dr Dafydd Williams and Dr Hywel Garrard. They have come to the end of their term and I would like to express my gratitude and thanks on behalf of all the e-Portfolio Sub-Committee for all of their hard work and engagement with the project and for bringing a trainee focused view point to our work. Two new trainees representatives have been elected Dr Sarah Ng and Dr Melissa Evans and we look forward to working with them on the next phase.

“THE MAIN FOCUS OF THE LAST YEAR HAS BEEN THE FUTURE OF OUR E-PORTFOLIO. WE CONTINUE TO EXPLORE ALL OPTIONS AVAILABLE TO US WITH A FOCUS ON PROVIDING THE BEST PRODUCT WE CAN FOR OUR TRAINEES AND TRAINERS.

I would also like to thank the FICM admin team who, without their hard work and dedication, none of this would be possible. Thanks to Susan, Rohini, Anna and Daniel. My sincere thanks also go to Pete Hersey as deputy e-portfolio lead who, without his input and knowledge, the e-portfolio would not be as good as it is today.

Moving forward over the next year will, I feel, have some new challenges. As always, please contact us with any questions or suggestions for improvement and we will endeavour to reply and address any issue as soon as possible.



SPOTLIGHT ON: Wessex

Dr Matt Williams
Regional Advisor

Wessex is the name given to the area that covers Hampshire, Dorset, and part of Wiltshire, with the ancient capital of England, Winchester, at its centre. The Solent, Jurassic coastline and South Downs entice many to want to live in this beautiful area of the country. The relative proximity to London is also appealing.

The Wessex region encompasses eight hospitals stretching from Dorchester in the west to Portsmouth on the east side, and from Southampton to Basingstoke in the north of Hampshire. All of our hospitals contribute to Stage 1 and 2 training, with the specialist ICU modules on Stage 2 being delivered at the regional University Hospital Southampton, and the Stage 3 year split between Southampton and Portsmouth.

There are two remaining Joint trainees to complete training; of the other 24 trainees on our programme, five are single, two dual with EM, two with medical specialties and 15 with anaesthesia.

“THE CASE MIX ACROSS THE VARIOUS HOSPITALS PROVIDES FOR A VERY VARIED EXPERIENCE FOR OUR TRAINEES, WITH THE WHOLE PROGRAMME ABLE TO BE DELIVERED IN REGION.

The region prides itself on providing high quality training and having excellent trainee/trainer relationships. Intensive Care Medicine sits within the School of Anaesthesia, within which there is an active Specialist Training Committee including trainee representation. The case mix across the various hospitals provides for a very varied experience for our trainees, with

the whole programme able to be delivered in region. Specialist interest years, so far, are or will be being undertaken in echocardiography and neuro-intensive care. Other opportunities include pre-hospital training and academic fellowships. There are three Academic Clinical Fellows from the Wessex ICM training programme working in Professor Grocott's Critical Care Research Area at the University of Southampton. There is also a very active trainee collaborative research and audit group, SPARC.

Wessex trainees' pass rates for the FFICM examination have been consistently high. To prepare them, there has been a monthly regional training programme of study half-days running since 2008 to complement other CPD opportunities. In addition, the PINCER course, hosted at Portsmouth, was the first FFICM preparation course in the country. Led by Poole, BASIC and Beyond Basic – Mechanical Ventilation courses are offered to regional and national delegates. Each hospital has FICE mentors available, with FICE courses actively hosted by two of the centres currently.

The Wessex region has a very vibrant regional Intensive Care Society (WICS) that hosts an annual summer scientific meeting and has an excellent website full of useful resources. The Bottom Line, an e-journal review website, is another of our acclaimed local innovations. Trainees, both current and former, have actively contributed.

In summary, Wessex provides for excellent training in supportive and innovative units of varying sizes and case mix. We are situated in an attractive area of the country close to London and links to Europe, and catering for a wide variety of personal interests. If you are interested in training in Wessex, feel free to contact myself, or the TPD, Dr Ben Skinner, Consultant at Southampton GICU.



QUALITY

Dr Chris Thorpe
Quality Lead

The FICM trainee survey hit new heights this year with a response rate of 65%, so thanks to all those trainees who took time to fill in the questionnaire. Regional Advisors received an in depth report on their region to help them shape training going forward. Overall the training scheme is in good shape and there were lots of good comments throughout. Below is a summary of the main areas of difficulty identified in the survey.

The percentages relate to a single question: 'How would you rate the standard of training in this placement?' For each question, there were three possible answers; excellent, adequate or inappropriate. A full breakdown of answers can be found at the FICM website.

Stage 1 ICM attachment: 47% of respondents regarded the training as excellent. Formal teaching is still not as good as other areas but has improved from last year. Where feedback is negative, this usually focuses on poor training ethos within the department.

Stage 1 Anaesthetics: 47% regarded training as excellent. There was an increased proportion of 'inappropriate' standard of training from 2016 (15% v 3%). This is mainly through individual attachments not fulfilling desired experience, or service needs having been prioritised. Overall feedback confirmed good training however.

Stage 1 Medicine: 16% regarded training as excellent. There was an increased proportion of 'inappropriate' standard of training from 2016 (30% v 12%). There were a variety of reasons for this but prioritising service needs and poor educational supervision feature more prominently. Very good feedback is seen in some attachments but it still seems that some blocks are less geared up to ICM trainees which the Faculty and RAs need to keep under close review.

Stage 2 Cardiothoracic: 29% regarded training as excellent. This had improved from 2016, with most trainees happy. Negative comments were mainly around training structure, particularly formal teaching, and training ethos.

Stage 2 Paediatrics: 21% regarded training as excellent. Comments were seen around the anaesthesia / PICM split, mainly that there was not enough PICM but also that the Stage 2 year can impinge on anaesthetic training.

Stage 2 Neurosciences: 37% regarded training as excellent. Again, several comments echoed the concern of trying to sensibly combine anaesthetic and ICM training. Others commented that training could be improved, in particular formal training.

Stage 2 General ICM: 44% regarded training as excellent with generally good feedback. There were some comments on having inappropriate responsibility for grade, and some on training ethos.

Stage 2 Special Skills: 46% regarded training as excellent. This is the first time we have had feedback from trainees at this stage. There were 12 replies, all single specialty trainees. Three trainees undertook ECHO training, two research and others included renal, ECMO, Quality Improvement, Neuro ICU and Pre-Hospital Emergency Medicine. All the attachments received good feedback and, along with Stage 3, have the best feedback across the domains. Presumably because at this stage they have a bespoke programme organized by enthusiasts.

Stage 3: 54% regarded training as excellent and there was generally good feedback throughout. There were mild comments on pointless WBAs and again formal teaching could be improved, but overall the year was well received.



REGIONAL ADVISORS

Dr Mark Carpenter
Lead Regional Advisor

The RAFT will this year be on the 5th March 2018. We've had a full house for the last two years so apply early to avoid disappointment. The RAFT day will be once again focussing on issues that RAs and FTs have been concerned about and have highlighted at our recent RA meeting in London. We aim to include feedback from Faculty Committees and, as usual, we have the Chairs of the Faculty Committees and the Dean to keep us up to date on Faculty matters. The revision to the curriculum is ongoing; we have a session on this with Tom Gallacher taking us through where we are and what a new curriculum will look like. The new trainee contract will have been real for us for the best part of nine months and after we heard from Ros Tilley last year, we have an update as to how implementation is going. Sleep and rest are important to all of us both trainees and consultants (and other members of the multidisciplinary team; we musn't forget our nursing and ACCP colleagues also work nights!). We are pleased to announce that Michael Farquhar will be speaking to us about how we can use up to date evidence from sleep medicine to enhance the working lives of ourselves and our trainees (and also improve the care of our patients in the 'wee small hours'). We have a session on social media and a new session this year aimed at listening to the concerns of our TPDs. As RAs, we know they have the difficult job of transferring what is, by necessity given our multiple pathways of training, a complicated curriculum into an individual training scheme for our future colleagues.

Recruitment continues to be a major part of the RAs and TPDs roles and we will again be making the familiar trip to Birmingham in April to recruit the brightest and the best trainees to our specialty training in ICM. Many of you reading this will be being asked for advice about recruitment and how the selection process works for trainees. There is wealth of information available on the Faculty and HEE West Midlands websites. For anyone who has not been

involved in recruitment before then please get in touch if you would like to be involved. We require a large number of consultants to run the recruitment centre and are always looking for new people to join the established cohort of recruiters. The Faculty offers training in recruitment and it is always easier to advise trainees after someone in the department has taken part in the recruitment process. We also take the opportunity to sample some of Birmingham's premier eating establishments; not to be missed.

Since the last Critical Eye we have welcomed three new RAs; Ian Smith (North East Yorkshire and North Lincolnshire), Raymond McKee (Northern Ireland) and Stuart Dickson (South West). Congratulations to you all on your appointments and thank you to Andy Gratrix, Conn Russell and Mark Sair for all of you hard work.

The RCoA with the Faculties of ICM and Pain Medicine have recently released an undergraduate curriculum. Coming on the back of the perioperative medicine agenda, it shows how doctors in Anaesthesia, Critical Care and Pain Medicine are ideally situated to educate the doctors of the future. I would encourage all of you to think whether you can take part in teaching students from your local medical school. I have found it both interesting and educational myself.

As always as lead RA I am anxious to hear about issues that arise in the regions relating to training and within the FICM more generally. We need to continue to publicise our specialty for the all the good things it entails. At the moment we are not in the dire straits in terms of recruitment that Primary Care, Mental Health and Emergency Medicine are but we must not be complacent. Get in touch if you feel that we can help in any way. Contact details are on the website or tweet me on @mcarpenter1967.

NEW FICM BOARD MEMBERS

Professor Julia Wendon

I was appointed to a consultant post back in 1992 at Kings, London. During my consultant career I have been, and remain committed to the development of critical care as a specialty, recognising the development and support of sub specialty critical care training and delivery to optimise outcome and quality of care.

Ensuring effective multi professional, multidisciplinary team working to delivery optimal care, training and research is an absolute need for us all to deliver against. Being on the clinical floor, delivering care and talking to patients, relatives and colleagues is the best part of the life of any consultant and I am privileged to have had such wonderful colleagues to work with. It is this clinical exposure that drives, for me, the questions that develop into research questions and thence research programs, which deliver a change that can be implemented to improve outcome, be that clinical intervention or service delivery change. I have always been and remain committed to delivery of clinical care on the floor. My personal specialty focus is that of liver disease, with a research focus on extra corporeal systems, prognostic models and immunological dysfunction in acute and chronic liver failure alongside liver repair and regeneration in the context of critical illness.

I am immensely privileged to have been appointed to the FICM Board and will do my utmost to deliver against expectations in this role. I will always ensure that my passion for all aspects of critical care are represented to the best of my ability with a specific focus on clinical, research and educational aspects.

Dr Jeremy Cordingley

Since 2016 I have been a Consultant in Intensive Care Medicine and Anaesthetics and Director of Critical Care in the Department of Perioperative Medicine at St Bartholomew's Hospital, London. Prior to this I spent 16 years as a Consultant at Royal Brompton Hospital, London.

I have a longstanding commitment to education and training in Intensive Care Medicine and have been a DICM and FFICM examiner since 2008; I am currently lead examiner for the new OSCE examination. I also serve on the FICM Equivalence Committee providing advice to the GMC on applications for recognition of specialist training.

My main clinical interest is extra-corporeal respiratory and cardiovascular support and, with colleagues, I have successfully developed ECMO services, most recently in the newly opened Barts Heart Centre.

I have been a member of the Adult Critical Care Clinical Reference Group since 2013 and was Chair of the North West London Critical Care Network from 2014 to 2016.

Professor Gary Mills

I have been an enthusiastic intensivist since I was treasurer of the original trainee committee. I initiated ICM training in our region and was RA for 9 years. I passed the UKDICM as an established Consultant and am currently Lead Examiner for the FFICM SOE section.

I am a full time NHS Consultant in ICM/Anaesthesia, with an Honorary Chair at Sheffield University in CCM. In this role I have designed six international research studies. I have assisted BMedSci students, trainees and RAFT in producing the best evidenced based medicine and developing an interest in ICM. I have also helped create studies lead by critical care pharmacists and physiotherapists.

I am a member of the National Perioperative Medicine Innovation and Practice Committee, Hon Secretary of the BJA Research Forum/ARS and an Editor of the BJA Ed. My research interests have focussed on the respiratory system and outcomes in older patients and I have advanced these areas clinically. I worked on the European Charter for the Inclusion of Older People in Research and presented this at BMA House and the European Parliament.

It is an honour to be elected to the Board to help ensure ICM is an attractive and sustainable specialty.

Dr Andrew Ratcliffe - Trainee Representative

First and foremost I would like extend my gratitude to all those who supported me during the recent FICM Trainee Representative Election. I am delighted and honoured to be elected to the post and look forward to representing the views of the trainee body to the Board and its Committees.

I am currently based in West Yorkshire as a Stage 2 Dual ICM/Anaesthetic trainee. After completing my undergraduate training at the University of Leeds I have, for the most part, remained within the Yorkshire region. I took time out of training between CT2 and ST3 to broaden my horizons and work with the South Australian retrieval service. This primarily involved initiating critical care in remote parts of the country before transferring patients back to the tertiary centres in Adelaide. I have since developed on-going interests in remote site anaesthesia and critical care.

I am passionate about the future of our specialty and improving the quality of training. I appreciate that our training needs are evolving rapidly and concerns exist ranging from assessment overload, geographical variations in access to training opportunities through to burnout and rota inequalities. I am keen to deliver clear lines of communication and collaboration between the trainee body and the Faculty. With this in mind please do not hesitate to contact me about any issues you wish to highlight and be addressed by the Board.

MEMBERSHIP UPDATE

FELLOWS

Jennifer Abthorpe
Fuhazia Arif
Umar Rahim
Peter Bamford
Omar Bani-Saad
Graham Barker
Rakesh Taranath
Oliver Blightman
Alexandra Bond
Craig Brandwood
Mike Browning
Zoe Brummell
Hannah Burns
Dean Burns
Matthew Charlton
Katherine Chatten
Laura Coleman
David Connor
Sarah Cooper
Adam Czapran
Anand Damodaran
William Dean
Hemant Deshpande
Michael Dixon
John Dixon
Thomas Eckersley
Robert Ferguson
Matthew Frise
John Glazebrook
Richard Greenhow
Jennifer Gwyn
Sameer Hanna-Jumma
James Hardwick
Robert Hart
Emma Hartley
Philip Henderson
Emily Howells
Jonathan Hughes
David Hutchinson
Benjamin Jones

Selin Kabadayi
Elisa Pui Yina Kam
Deborah Kerr
Helen Langrick
Clare Macewen
Colin Mcadam
Jamie McCanny
Michael McEvoy
Sarah Milton-White
Gareth Morrison
Diane Murray
Alice Myers
Virginia Newcombe
Cristina Niciu
Jonathan Paige
Mark Patek
Amit Patel
Jaimin Patel
Sunil Patel
John Porter
Benjamin Porter
Clare Quarterman
Carla Richardson
Fayaz Roked
Gurmukh Sandhu
Jill Selfridge
Rahman Shaheedur
Daniel Shuttleworth
Daniel Silcock
Emma-Jane Smith
Brendan Boyd
Alexander Stewart
Darryl Stewart
Nazneen Sudhan
Emma Temple
Ruth Tighe
Matthew Varrier
Laura Vincent
John Whittle
Alan Williams

ASSOCIATE FELLOWS

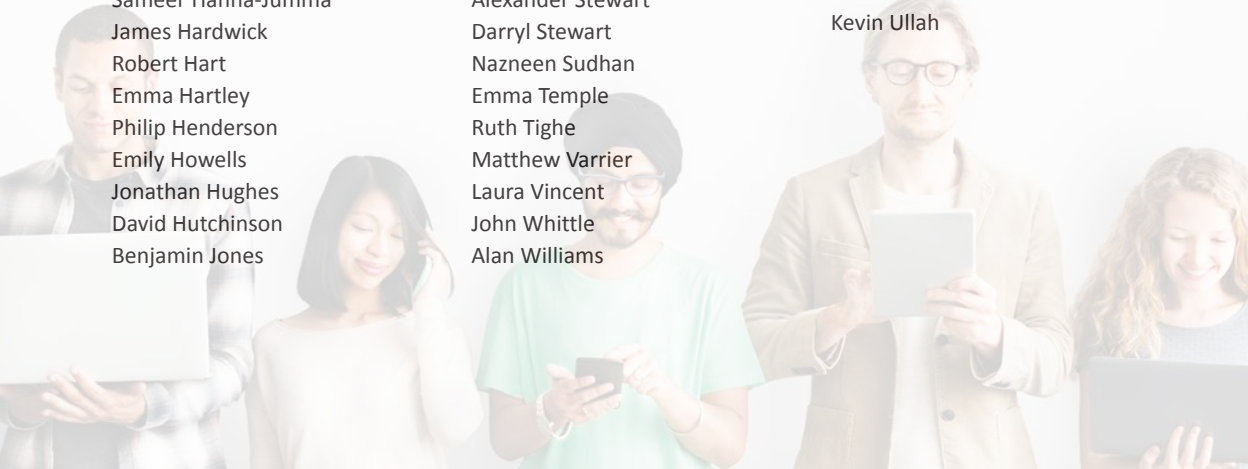
Eissa Dalia Essam
Tamas Geller
Sancho Rodriguez-Villar
Neill Roux
Riccardo Scano
Konstantinos Tasopoulos

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Arif Akbar
Ganesh Hanumanthu
Jayathilaka Jayathilaka
Akshay Nair
Rasanee Wanigasuriya

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Graham Basnett
Suzanne Blinman
Johan Campbell
Jennifer Cater
Sean Conaty
Jane Dean
Zoe Elliot
James Higson
Michael Jennings
Rachel Patterson
Heather Reading
Susan Rose
Suman Shrestha
Paul Sinnott
Kevin Ullah



Edinburgh Radiology Course for ICM

Thursday 22nd & Friday 23rd February 2018

Edinburgh Training and Conference Centre, St Mary's Street, Edinburgh

Course fee: £400



Topics Include:

- Basic Principles of Radiology
- Indications & Limitations of Different Imaging Modalities
- Interpretation of CXR & AXR including tubes & lines, CT Chest & Abdomen/ Pelvis including venous & arterial phase and angiography
- CT Head & C-Spine including Neuro-Interventional Radiology, Pan CT Trauma including common injuries & fractures.

REGISTER YOUR PLACE NOW!

For more information and to register online please visit:

<http://edin.ac/2pZYT80>

OR

Contact Dawn Campbell: **Email:** dawn.campbell@ed.ac.uk **Tel:** 0131 242 6395



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Wednesday 21st February
FFICM Prep Day 1



Friday 16th March
Legal & Ethical



Monday 30th April
Medicine for Intensivists



Thursday 3rd May
CUSIC: Train the Trainer



Tuesday 22nd May
FICE 1



Monday 11th June
Trainee Committee



Monday 10th September
Microbiology for Intensivists



Tuesday 18th September
FFICM Prep 2



Friday 21st September
ICS ARDS Symposium



Thursday 5th October
CUSIC



Monday 24th September
Bronchoscopy



Tuesday 20th November
Liver Study Day

And many more....

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6th ANNUAL ACCP CONFERENCE

Wednesday 6th June 2018

Royal Stoke University Hospital

Cost: £45

Booking and abstract information can be found at:
www.ficm.ac.uk/ficm-events/accp-conference

Abstracts are invited from trained ACCPs or ACCPs in training on any of the following areas:

Clinical | Audit | Quality Improvement | Education | Research | Patient Safety

ACCPs will be given the opportunity to present their abstracts to the rest of the delegates. Further information can be found on the FICM website.

**THIS EVENT HAS SOLD
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BOOK EARLY TO AVOID
DISAPPOINTMENT**

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Churchill House | 35 Red Lion Square | London | WC1R 4SG
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