



# Critical Eye

Issue 5

Winter 2014

The Faculty of  
**Intensive Care Medicine**

*Inside:*

- » Shape of Training
- » ICM Workforce Census
- » Critical Care Leadership Forum
- » The Future Hospital Commission

# Welcome



**Dr Graham Nimmo**  
Clinical Editor

## State of the Art

*It's the state of the art. He's surrounded by the attendant forms of programmed machines.*

*Stooping before him their console heads bowed with functionary, charted smiles, they proclaim his ongoing god-given right to live with a fanfare of obsequious bleeps. They've no authority to recognise he's always otherwise detained in sleep.*

*I approach him in his realm of tubes and wires, pressure gauges, ventilators, urinary catheters, drips and bags. My fingers fresh with rubbed in alcohol, I cup his hand below the cannula and brush my lips in tribute with a kiss.*

©Angus D.H. Ogilvy August 2012

Welcome to the fifth *Critical Eye* and welcome to Anna Batchelor as Dean and Carl Waldmann as Vice Dean. This edition includes updates on all of the important developments with which FICM is involved and I would particularly signpost the issues of Shape of Training, core standards and the development of the Critical Care Leadership Forum. The second National ACCP Conference will be held in Edinburgh on June 26<sup>th</sup> and should be of interest to a wide spectrum of intensive care staff.

Sadly this will be my last edition as Clinical Editor. It has been a highly enjoyable experience and the support from Anna, James and Daniel has been tremendous. John Butler (EM and ICM) from Manchester is taking over and I wish him well.

And finally: our specialty and services do what they say on the tin: intensive care and critical care. I hope that this is brought out in Angus's poem and that you agree with me that this is what we are all about.

Angus Ogilvy has given permission for the inclusion of this poem. He has produced a book of poetry *Lights in the Constellation of the Crab* very much based on his experiences as a patient with Non-Hodgkin Mantle Cell Lymphoma. All proceeds from the book go to Maggie's Cancer Caring Centres and the book can be sourced through [hermitcrabpoems@gmail.com](mailto:hermitcrabpoems@gmail.com).

# Contents

<b>Dean's Statement</b> Dr Anna Batchelor	<b>3-4</b>
<b>Board Election Results</b>	<b>5-6</b>
<b>Critical Care Leadership Forum</b> Professor Julian Bion and Dr Brian Cook	<b>7-9</b>
<b>Professional Standards Update</b> Dr Carl Waldmann	<b>10</b>
<b>Training and Assessment Update</b> Dr Simon Baudouin	<b>11</b>
<b>Shape of Training</b> Dr Simon Baudouin	<b>12-13</b>
<b>Critical Care Workforce Census</b> Dr Jack Parry-Jones and Dr Matt Wise	<b>14</b>
<b>Recruitment</b> Dr Tom Gallacher	<b>15</b>
<b>Audit Recipe Book Survey</b> Dr Adrian Wong	<b>16</b>
<b>Future Hospital Commission</b> Professor Timothy Evans	<b>17-18</b>
<b>Regional Advisor Update</b> Dr Danielle Bryden	<b>19</b>
<b>Trainee Update and 2014 Election</b> Dr Mike McAlindon	<b>20</b>
<b>Spotlight on Wales</b> Dr Chris Thorpe and Dr Paul Morgan	<b>21-22</b>
<b>FICM Consultations</b>	<b>23-24</b>
<b>FICM Annual Meeting 2014</b>	<b>25-26</b>
<b>ICS Events</b>	<b>27</b>
<b>Clinical Editor</b> Dr Graham Nimmo	<b>Dean</b> Dr Anna Batchelor
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# Dean's Statement



**Dr Anna Batchelor**  
Dean

In the wave of excitement surrounding my election as Dean a little voice said "...Oh, and can you write an article for *Critical Eye*". "Of course", I said. The gentle reminder emails got closer and closer together until the option of further prevarication was gone.

It was very, very exciting being elected Dean, a most amazing honour and privilege and one I am really looking forward to and one I hope I am worthy of.

So how did I get here? As a medical student we were expected to stay in the hospital on the nights our 'firm' was 'on take' (in inverted commas because our younger Fellows may not have grown up with those terms). We managed to get a bleep on the cardiac arrest system and one of my fellow students had a Hillman Imp (very small car) which we would all cram ourselves into for a hair-raising and very exciting trip around the hospital roads to the scene of the emergency. This was in the days before ALS training and algorithms and the only team member who ever seemed to know what to do (and get on and do it proficiently) was the anaesthetist; I wanted to be that person!

So a career as an anaesthetist beckoned. No formal ICM training was available back then but Dr Joe Stoddart, one of my mentors, was a member of the Joint Colleges Committee for Training in ICM which had just hatched the plan for the JACIT posts, up to two years of post-accreditation training in ICM, with 10 posts nationally. I was coming to the end of my anaesthesia Senior Registrar time and was one of the first appointees.

A long journey through Regional Advisor for ICM, Chair of the Regional ICU Committee,

Council member and President of Intensive Care Society to Council member of RCoA and Council nominee to the Foundation Board of the Faculty, and finally to Dean of the Faculty this October.

The Faculty officially came into being in October 2010 and under the excellent leadership of Professor Bion as Dean and Professor Evans as Vice Dean, ably supported by our outstanding 'civil service', the Faculty hit the ground running. In the first year, Faculty regulations, routes to membership, website, finance, recruitment strategy, workforce predictions, assessment processes for equivalence and more all had to be created.

The Diploma exam had to be changed to fulfil its new role as the test of knowledge for our approved standalone CCT curriculum; the FFICM Court of Examiners led by Professor Webster, assisted by the RCoA Examinations Department produced a product fit to pass GMC requirements in an amazingly short time. Work with the GMC, Deans, Regional Advisors and Training Programme Directors along with mapping competencies across different specialty curricula were all necessary in the run up to the first of our two successful rounds of recruitment. All in addition to the Training & Assessment and Professional Standards Committees, which act as the main work horses of the Faculty.

So what does the next three years hold in store for the Faculty? Well I hope it's not all blood, toil, tears and sweat but I suspect some of those may be involved. We face a number of challenges and opportunities including:

- Increasing our number of trainees. We may need to at least double our number of CCT posts just to supply current consultant recruitment levels. ICU burn-out is widely talked about perhaps more by those outside of ICM and I hope it is a feature only of the past. We need to ensure we build a sustainable ICM consultant workforce for the future.
- Embedding ICM single CCT training in the hearts and minds of our fellows, RAs, Deans and TPDs, for anaesthesia, acute medicine, renal medicine, respiratory medicine and emergency medicine as well as ICM. This is happening but we still have a long way to go. The problem of finding slots in a variety of specialties not all of which will actually be required once it is clear what varieties of trainees will be taking up ST3 posts is a real challenge on the ground. But for those of us with long memories we faced very similar problems when ICM training in 3 month blocks and complementary specialty training were introduced. The old Joint system for ICM training was at first universally loathed and “impossible” to implement. Now of course it is remembered with fondness and everyone has forgotten the pain. Resourceful people find ways to make things work, that happened 15 years ago and I’m sure it will happen now; I have faith in our regional training teams.
- As Simon Baudouin will expand on later in this edition of *Critical Eye*, the Shape of Training Review is potentially both an opportunity and a threat to ICM. We are the ultimate broad-based hospital generalists, we have apprenticeship training which is liked by trainees, we pioneered cross-specialty transferable competencies, and we should be a model of how to deliver acute hospital services. But too many remember our ‘add on’ model of training and it would be a sad day for our specialty if we went back to ‘post CST credentialing’ - which as above is where I came in! The Faculty will be a vocal opponent of any system which does not serve the interests of our specialty and our patients.

- Welcoming new Fellows into our Faculty fold. We have decided as a trial to join with the RCoA for Diplomates Day in Westminster Hall in 2014. The College used this venue for the first time in 2013 and it is grand, beautiful and spacious, it made the day a lovely family-friendly occasion. Passing an exam and becoming a Fellow of the Faculty is an important life event, or at least I hope our Fellows feel it is, and one which should be shared with proud parents and partners.
- Jointly with the ICS we have produced the *Core Standards in Intensive Care Units* document and we hope this will be useful to units. This will form the basis of a larger piece of work providing *Guidelines on the Provision of Intensive Care Services* (GPICS).
- Services are reconfiguring, surgical specialties regionalising, trauma centres becoming fully established and recently the Keogh and Willett report on A&E services suggests we will see more reconfiguration. These changes all have knock-on effects on ICM training and service, we need to work with these changes and find solutions to delivering safe patient care.

We had an amazing number of people standing for election to the Faculty this year, this shows the enthusiasm you have for our specialty and the Faculty. Five outstanding candidates were successful and everyone who stood would have made fine Board members. My only regret is we had no female candidates. Alison Pittard and I cannot be the only female intensivists around! We will soon have a fully elected Board earlier than anticipated with the full support of our Trustee Colleges, thanks to the efforts of Professors Bion and Evans in building our effective Faculty infrastructure.

So to work! I can only do this with your support, please feel free to contact me directly or through the website. Good ideas don’t only come from people sitting in (an always too chilly for me) Council Chamber in London.

And for anyone who is wondering, all nine of our hatchlings this year were cockerels, *coq au vin* anyone?

# Board Election Results

The Faculty of Intensive Care Medicine held an election for Board Members on Tuesday 26<sup>th</sup> November 2013. There were five vacancies for which there were 24 nominations and all Fellows of the FICM were eligible to stand and vote. The full results are available online at [www.ficm.ac.uk](http://www.ficm.ac.uk).

The Board congratulates the successful candidates and thanks the other nominees who put themselves forward for election. The biographies of the successful candidates can be found below.



## Professor Mike Grocott

Mike Grocott is the Professor of Anaesthesia and Critical Care Medicine at the University of Southampton (UoS) where he leads the Centre for Human Integrative Physiology. He is a consultant in Critical Care Medicine at University Hospital Southampton NHS Foundation Trust (UHS) where he leads the critical care research area of the UHS-UoS NIHR Respiratory Biomedical Research Unit.

Mike trained in London at St George's Hospital Medical School and UCL. He completed an MD within the UCL Centre for Anaesthesia and established the UCL Centre of Altitude Space and Extreme Environment Medicine (CASE) and the UCLH/UCL Surgical Outcomes Research Centre (SOuRCe). In 2007 he led the Caudwell Xtreme Everest medical research expedition and summited Everest.

Mike now leads the Xtreme-Everest Oxygen Research Consortium and the Fit-4-Surgery Group. He is the founding director of the NIAA Health Services Research Centre and chairs the HQIP funded National Emergency Laparotomy Audit. He is Joint Editor-in-Chief of the BioMedCentral journal *Extreme Physiology and Medicine*. His research interests include human responses to hypoxia, measuring and improving outcome following surgery, acute lung injury, and fluid therapy.

He has been awarded the Featherstone Award (2013) and the Pinkerton Medal (2008) of the Association of Anaesthetists of Great Britain & Ireland and the Silver Medal of the Danish Surgical Society (2005).



## Dr Jonathan Goodall

Jonathan Goodall is a consultant in ICM and Anaesthesia at Salford Royal NHS Foundation Trust. Alongside clinical medicine his major interest is teaching and training. Currently the RA in ICM at the NW Deanery, Jonathan has been instrumental in the introduction of both ICM and ACCS training programmes.

Having been elected to the Council of the ICS in May 2009, Jonathan is now Honorary Treasurer for the Society. He sits on the FICM Training & Assessment Committee and the Recruitment Sub-Committee, and has recently taken on the role of QA Lead. He chairs the Intercollegiate ACCS Training Committee, having previously served as a member of this group for a number of years.

Over the past few years he has developed an increasing interest in medical careers and in providing career guidance to trainees. He recently completed a Masters in Managing Medical Careers at Brighton University: his dissertation 'ICM: New Era, New Careers New Guidance' examined the motivation of doctors choosing to train in the speciality.



### Dr Andrew Rhodes

Andrew Rhodes trained in Medicine at the University of London qualifying in 1990. He underwent specialist training in anaesthesia and Intensive Care Medicine and became a consultant at St George's Hospital, London in 1999. He is a Fellow of the Royal College of Physicians, the Royal College of Anaesthesia and the Faculty of Intensive Care Medicine of the UK. He is currently the Clinical Director of Critical Care at St George's Healthcare NHS Trust.

Andrew has held leadership roles at both a national and an international level. He is a current Council member of the UK Intensive Care Society and is the Chair of the Education and Training Committee. In addition he is a past chair of the Cardiovascular Dynamics Section, the Congress Committee and the Division of Scientific Affairs for the European Society of Intensive Care Medicine (ESICM). He is the immediate past president of the ESICM. He is also a member of the European Board of Intensive Care Medicine that is the statutory body for Intensive Care Medicine in the Union of Medical Specialists (UEMS) in Europe. He has been the Honorary Secretary of the Board for the last three years. He has research interests in the fields of surgery, sepsis, haemodynamics and outcomes related to Intensive care Medicine. He is widely published in these areas and is regularly invited to lecture on these subjects all around the World.



### Dr Chris Thorpe

Chris Thorpe was brought up in Swansea and qualified from Kings College London in 1985. He trained mainly in London, Bristol and Edinburgh but also worked in Moshi, Tanzania; Christchurch, New Zealand and as an expedition doctor in Arctic Norway during an age where training was more flexible. He returned to Wales in 1997 to take up a post as a consultant in Anaesthesia and Intensive Care Medicine in Bangor, Gwynedd.

He has been actively involved in ICM training throughout his career, starting as an ICM Tutor in 1997, followed by Regional Advisor and Training Programme Director for Wales. He led the setup of the ACCS scheme for Wales and continued to run the scheme until earlier this year. He has played an active part in the Welsh Intensive Care Society council over many years and has represented ICM on a number of Welsh committees, including working for the Welsh Assembly on workforce issues. He is currently the Lead Regional Advisor representing Tutors and RAs on training and other issues, and is an examiner for the FFICM. He is involved in developing Quality Assessment of ICM training, and is part of the Faculty sub-committee charged with implementing national recruitment for ICM.



### Dr Peter MacNaughton

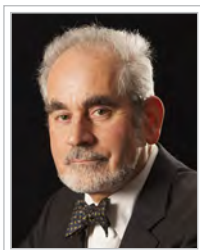
Peter MacNaughton trained at Westminster Medical School, qualifying in 1982 and then completed general medical and anaesthesia training in London. His previous appointments include: MRC Training Fellow, National Heart and Lung Institute, Royal Brompton Hospital (1989-91); Senior Registrar Anaesthetics, South Western Region (1991-95); Senior Fellow in Intensive Care, Westmead Hospital, Sydney, Australia (1994).

Peter has been a consultant in Plymouth since 1995 when he was appointed as the clinical lead for intensive care. He has seen the service develop from an 8 bed unit with 2 intensivists supported by anaesthetists with an interest to a 26 bed unit with 14 intensivists. He works in a busy unit which admits over 1600 patients per annum and supports the secondary and tertiary care services provided in Plymouth including major trauma and neurosurgery.

Peter's academic interests are in applied respiratory physiology and mechanical ventilation. He has been actively involved in a number of critical care multicentre trials as local principle investigator including TRACMAN and OSCAR. He is interested in point of care ultrasound including focused echocardiography and has been active in providing and developing training in this area. He stepped down as Clinical Director earlier this year and is looking forward to using the time that this has freed up to support the development of the speciality nationally.



# Critical Care Leadership Forum



**Professor Julian Bion**  
CCLF Chair



**Dr Brian Cook**  
CCLF Deputy Chair

When the Faculty was founded by seven Trustee Colleges in October 2010, we knew that our core aims – improving patient care through setting standards for life-long learning and professional development – could only be realised through collective effort involving collaboration between the many players involved in the specialty of Intensive Care Medicine. Preliminary enquiry identified at least 17 organisations with widely varying remits and interests, including the Intensive Care Society, the Intensive Care Audit and Research Centre (ICNARC), the British Association of Critical Care Nursing and other nursing organisations, the devolved nations’ intensive care societies, the critical care networks, several research bodies, and numerous critical care subsets of organisations representing allied health professionals (AHPs). We also had to consider the impact of the most ambitious restructuring of the NHS to have been undertaken since its inception, and the potential effects of the concurrent reorganisation of the whole of healthcare education. The most obvious opportunity – or threat – was that professional bodies would only retain validity and utility in a fragmented and devolved health service and educational system if they were seen to deliver value as active participants in improving patient care and provider performance.

Given these political realities, it was clear that if ICM were to survive and flourish, we needed to develop a common national – UK-wide – strategy which harnessed the varying histories, skills and ambitions of these different groups<sup>1</sup>. We began the process with informal conversations to determine the level of interest that might exist in forming a common platform for ICM. We found an impressive level of activity and creativity, covering standards of practice, audit and research, education and continuing

professional development, and training frameworks, but very little effective coordination of effort, particularly since the dissolution of the Critical Care Stakeholder Forum. There was a clearly expressed desire amongst the great majority for greater cooperation, and recognition that the establishment of ICM as a primary specialty brought with it both challenges and important opportunities for which a common national strategy was essential.

Achieving this step-change in organisational behaviours required external review. We were fortunate to have been able to persuade Professor Sir John Temple, Dr Judith Hulf, and Professor Jon Cohen, to accept the role of Commissioners to take evidence from the various organisations concerned, and to provide an independent view of the current state and future directions for Intensive Care Medicine. Their concise and incisive report, *Collaborating for Quality in Intensive Care* (CfQ) published on March 21<sup>st</sup> 2013<sup>2</sup> made a number of key recommendations which were accepted by all participants. The first of these was to re-establish a national forum for ICM. We have called this the Critical Care Leadership Forum (CCLF).

The CCLF incorporates all national professional organisations with a remit for critical care, including physicians, nurses, allied health professionals, and researchers. The Forum provides an essential bridge between these professional groups and the commissioning arm of NHS England by including the National Clinical Director and the Chair of the Clinical Reference Group for critical care. The Forum is also UK-wide, linking developments in England with those in Wales, Scotland and Northern Ireland to maintain unified professional standards and support across an increasingly diverse NHS. The aim of the Forum is to improve patient care through

integrating the energies and skills of its participating organisations, to which it is subservient, not superior: authority derives from the senior representation of each participant.

The CCLF met formally for the first time on July 16<sup>th</sup> 2013, having elected Professor Bion as Chair and Dr Cook as Deputy Chair. Three meetings a year are planned, with administrative support and hosting by the Faculty. We have focused initially on five workstreams identified as priorities by our CfQ Commissioners:

#### **Case-Mix Programmes** (Lead: Dr B Cook)

This workstream brings together several national case mix programmes (CMPs), including the Intensive Care National Audit Centre (ICNARC) and the parallel activity in Scotland managed by the Scottish Intensive Care Society Audit Group (SICSAG).

The aim is to harmonise equitable access to and use of public data for audit and research. Concurrently ICNARC has set up an independent Data Access Advisory Group (DAAG) which includes members of the CCLF-CMP workstream, and which will adjudicate on applications specifically for access to the ICNARC CMP. This group has already met to approve a number of applications.

#### **Research** (Lead: Professor T Walsh)

The Research workstream brings together the NIHR speciality group for critical care, the ICS Foundation, ICNARC, and participants in the UK Critical Care Research Forum, with the Faculty providing the framework for research training for intensivists. The CCLF provides an unique multiprofessional platform for sharing information and ambitions for research, and has already stimulated improved funding for the UK-CCRF annual meeting.

#### **Workforce** (Lead: Professor T Evans)

This workstream focuses initially on the physician workforce, and the work is therefore being undertaken by the Faculty which has now commissioned an annual census through the Royal College of Physicians' Workforce Unit. The workstream will in time broaden its remit to consider other critical care professionals. The BACCN is also undertaking a survey of nurse staffing, and the Clinical Reference Group intends to perform a risk analysis of the entire critical care workforce. The working group will integrate these activities.

#### **Standards** (Lead: Dr C Waldmann)

The standards workstream incorporates three overlapping and complementary activities. These are the Service Specification for Critical Care developed by the CRG, a minimal set of metrics for commissioning specialist (and by extension general) intensive care services; a larger set of *Core Standards* developed jointly by the ICS and Faculty; and *Guidelines on the Provision of Intensive Care Services* (GPICS), which is the overarching programme of quality indicators led by the Faculty and ICS but with all other groups as partners. GPICS will encompass not only clinical standards, but those for reciprocal peer review, training and education, and audit and research; it will incorporate prior work in peer review undertaken by the West Midlands Quality Review Service and the Midlands critical care networks.

#### **UK Critical Care Nursing Alliance** (Lead: Ms A Berry)

The CCNA incorporates the Royal College of Nursing, the BACCN, and nursing representation in the critical care networks. It will support the national critical care nursing competencies developed by the Critical Care Networks-National Nurse Leads (CC3N) in 2013. Through the CCLF the Faculty will support close collaboration in training across all critical care disciplines, linking physician training with nursing, pharmacy, and Advanced Critical Care Practitioners (already represented on the Faculty Board). Competence mapping will demonstrate shared skills, roles and responsibilities and will promote teamworking between these complementary disciplines.

How will we know that the Critical Care Leadership Forum is 'working', and not just another committee? We anticipate both 'hard' and 'soft' measures of success. Hard measures include transparent and productive access by the critical care community to case-mix programmes; multidisciplinary engagement in national research projects and activities; a stronger evidence base for workforce planning and development with expansion of the Advanced Critical Care Practitioner grade; a comprehensive and evolving set of multiprofessional standards for intensive care with evidence of improved delivery; and a national critical care nursing training programme which will sit alongside that of physicians and allied healthcare professionals.





First meeting of the CCLF, 16<sup>th</sup> July 2013

Photo: Anna Ripley

Just as important, but less easy to measure, is the promotion of attitudes and behaviours which characterise good working relationships, at organisational level, translated through to the clinical front line.

Intensive care has a good track record of collaboration and transdisciplinary working to improve patient care. Royal Colleges have been criticised in the recent past for being too partisan<sup>3</sup> and for lacking a strategic view on quality improvement<sup>4</sup>. Our new specialty of Intensive Care Medicine has shown through the formation of the CCLF that it can rise to this challenge<sup>5</sup>, providing a single united voice by combining diverse skills in a clinical quality improvement community which is patient-focused, research-inspired, and professionally-led.

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## Organisations represented in the UK Critical Care Leadership Forum

- Faculty of Intensive Care Medicine (FICM)
- Intensive Care Society (ICS)
- Public and Patient representative
- Intensive Care National Audit and Research Centre (ICNARC)
- Scottish Intensive Care Society Audit Group (SICSAG)
- NIHR-CRN-Speciality Group for Critical Care (SG-CC)
- UK Critical Care Research Forum
- Paediatric Intensive Care Society (PICS)
- British Association for Critical Care Nursing (BACCN)
- Scottish Intensive Care Society (SICS)
- Welsh Intensive Care Society (WICS)
- Northern Ireland Intensive Care Society
- Royal College of Nursing Critical Care & In-Flight Forum
- National Clinical Reference Group (NHS - England) and Clinical Director for Critical Care
- Critical Care Networks (CCNs)
- National Nurse Leads Forum (CC3N)
- National Outreach Forum (NORF)
- UK Clinical Pharmacy Association Critical Care Group
- Physiotherapy and nutrition will also be invited to provide representation

# Joint Professional Standards Committees



**Dr Carl Waldmann**  
Vice Dean, Outgoing FICMPSC Chair

The FICM and ICS have benefited from a Joint Standards Committee almost since the inception of the Faculty. For our Fellows and members this means that we benefit from the joint experience and skills of both committees and avoid any waste through duplication. The JPSC agreed its Terms of Reference for the year ahead at our most recent meeting. We see many further years of productive cross-work and cross-pollination in the years ahead.

The ICS Safety, Standards and Quality Committee still retains its individual identity and produces great work for its key interests in the multiprofessional sphere of standards. The FICM Professional Standards Committee, as the Faculty matures and grows, must also consider how best to keep its own house in order and, with that in mind, the FICMPSC will begin to have short individual meetings to see through the various issues of important to the work of the Faculty, such as revalidation and consultations. Dr Simon Baudouin will have the enormous pleasure of taking over this area of work from 2014, having lots of previous experience chairing the ICS SSQ and the FICMTAC. The opportunities and spectres on the horizon for this division of the Faculty are wide and varied:

## **Core Standards for Intensive Care Units**

The JPSC, the ICS Council and the FICM Board approved the *Core Standards* document and this has now been published. Thanks to Chris Danbury for leading on this document and to Tim Gould for being the Faculty co-lead. The Committee discussed the consultant/patient ratio and decided that a range should be suggested rather than an absolute number to reflect the various factors which might affect patient care and consultant numbers, i.e. the number of trainees. The JPSC decided on a range of 1:8-15. This will be accompanied by some more explicit comments to contextualise the figure.

## **GPICS**

The FICM and the ICS have agreed to produce a document called GPICS (*Guidelines on the Provision of Intensive Care Services*). This is a resource designed to assist clinical staff, healthcare managers and administrators who are seeking to increase their understanding of the provision of care to the critically ill. This will be produced very much in connection with the *Core Standards* work. The JPSC will lead on this piece of work which will be inputted to by the Critical Care Leadership Forum. The CCLF, with multiprofessional representation from nurses, pharmacists, dieticians and physiotherapists, will ensure the document is produced with the entire ICU in mind.

## **Commissioning**

Service Specifications were now completed for the local area teams. Negotiations are ongoing with ICNARC regarding the National Dashboard which has been commissioned by NHS England; this would initially be looking at the best flow for patients and the effectiveness and use of facilities.

## **Reciprocal peer review**

A template had been created and piloted. The new document has been produced for critical care inspections which could also be used for peer review. The information collected can be useful in creating a database of critical care information.

## **Revalidation**

In a series of emails between the FICM, ICS, GMC and NHS England, we have had confirmation of the position that where it is not possible to seek MSF from individual patients, whole ICU feedback will be sufficient. NHS England will be working with Responsible Officers to get this message out.

# Training and Assessment



**Dr Simon Baudouin**  
Outgoing FICMTAC Chair

## Examinations

The FFICM examination has proved to be very successful under the leadership of Professor Nigel Webster as Chair of Court of Examiners. Sixty-one of the 66 candidates who sat the recent MCQ section of the exam passed this stage. The SOE/OSCE examinations were held on the 8-9 October and were also successful with a very high candidate standard and pass rate. The FFICM examination has attracted a good number of highly motivated and talented examiners since recruitment commenced. Their efforts, in terms of exam and question design and delivery of the exam have been vital in ensuring the smooth running of the exam and I would like to extend my personal thanks to all.

## ePortfolio

The ePortfolio project has provided the usual case study in the management and delivery of large(ish) IT projects with some delays and overruns. The success of NHS Education for Scotland (NES) has paradoxically contributed to the delays. NES has become the main provider of ePortfolios to the Colleges and Faculties in the United Kingdom. NES acknowledge that their original structure and governance arrangements have not been able to manage the increasing work load and have taken steps to improve their service. Despite these issues the ICM ePortfolio project is reaching a point where field testing of the whole system will soon be possible. A target full roll out date of August 2014 is still achievable.

Finally I have stepped down as Chair of the FICMTAC as of the meeting in November 2013. I have had the privilege of Chairing the Committee during both exciting and "interesting" times with the transition from the old Joint CCT to the new

standalone ICM CCT programme. I have also had the good fortune to have worked with very able colleagues (both administrative and medical) on the committee. I would like to thank all of them for their huge efforts and I leave with the knowledge that the Committee will be in good hands chaired by my successor Alison Pittard.

## FFICM Examination Update

The second sitting of the Fellowship examination of the Faculty of Intensive Care Medicine (FFICM) took place in July (MCQs) and October (SOEs and OSCEs) 2013. The Court of Examiners, chaired by Nigel Webster and Andy Cohen, and ably assisted by the FRCA Examinations Department, delivered another high quality examination. The main focus of the Core Groups over the last 12 months has been on question design and writing, curriculum mapping and the all important standard setting measures. As Nigel Webster's article outlined in Issue 4 of *Critical Eye*, standard setting for the FFICM examination is intricately designed to ensure the fairest outcomes, in line with established FRCA and GMC processes.

76 candidates sat the July MCQ, of whom 61 passed (80%). Of 52 candidates, 46 passed the October SOE (88%) and 39 of 46 candidates passed the OSCE component (85%). The high pass rates reflect the high calibre of the candidate cohorts.

Feedback from examinees has remained positive. The significant amount of Joint trainees and Affiliate trainees (formerly General Registration trainees) who have opted to undertake the exam points towards the established national standard this exam has already carved for itself within one year.

# Shape of Training



Dr Simon Baudouin

There have been five major inquiries into medical education in the last decade. The General Medical Council (GMC) has recently published a sixth report entitled 'The Shape of Training'. This review, led by Professor David Greenaway, was tasked with examining the ways in which Medical Postgraduate training should change in order to successfully care for patients in the future. The first sentence from the recommendations is worth quoting in full. "The main thrust of the Review is to put in place a structure that will produce Doctors who are able to work in *general areas* of their specialities" (italics added). Are we now looking at the definitive blueprint for changes in training? I will give a personal view of the report in an attempt to answer this question.

The report describes a number of drivers for change including an aging populations, multiple co-morbidities and rising health care expectations. The main solution that the report offers to these issues is to increase the number of 'generalists'.

“The main thrust of the Review is to put in place a structure that will produce Doctors who are able to work in general areas of their specialities”

The loss of generalists is perhaps most evident in Medicine where most consultants are now specialists in an 'ology'. Significant numbers of physicians still participate in unselected general medical takes but a number would withdraw from these general duties if possible. This is a theme that is echoed in the recent Royal College of Physicians reports of the "crisis" in acute general medicine and in the Future Hospital report.

This problem in acute care is not unique to Medicine and recruitment and retention in Emergency Medicine is also a major issue at present. The report acknowledges the need for specialists (or rather super specialists) but challenges the current balance of generalists to specialists. The solution that the report proposes is to increase the amount of general training but also to reduce its duration.

The new training structure will commence with the existing 2 year Foundation programme. This will initially remain unchanged but the report does raise the possibility of subsuming the second Foundation year into specialist training in the future. This will be followed by a 4-6 year training block (confusingly called specialist training). These blocks will focus on "themed" training with the examples given

of women's health, child health and mental health. A one year elective period is proposed as part of this period allowing some diversity and individualisation of training experience. The end point of this training will be a new Certificate of Speciality Training (CST) after which independent practice can commence.

For trainees, and in particular critical care trainees, the report has a number of positive features. It places a great emphasis on the acquisition and retention of those skills needed to care for acutely ill patients. It states that most doctors will need to retain these skills throughout their careers. Transition from one speciality to another should also become more straightforward by the adoption of sets of transferable competencies (the FICM has long campaigned for this approach).

In addition a more general base of training should allow both trainees (and possibly those post-CST) to rapidly re-train or expand their skills depending on future service needs and personal choice. The proposed introduction of post-CST credentialing would allow further super-specialisation; so for example ICM CST holders who wish to manage home ventilation services would credential in this area using a GMC approved training programme.

A number of key issues remain. In many current specialties training time will need to be reduced. This will prove difficult as many view current programmes as only just sufficient to ensure competency and confidence. There is therefore a possibility of creating a generation of less experienced consultants (or rather CST holders).

One motivation for the generalist model is to provide more 'first line' doctors for the acute specialties. There remains a strong suggestion that acute care could be delivered by trainees if only there were sufficient numbers. The possibility that this medical trainee delivered model is not tenable and will not give the best outcomes for the acutely ill needs more debate.

The proposed changes may also create a two-tier hospital system with old style consultant specialists rapidly abandoning frontline medicine to the new generation of CST holders. It is of course possible that after a period as a CST generalist doctors will then move to super specialist posts. This could solve some of the career problems that will be a consequence of much longer careers. However, no such move could be guaranteed and the attraction of a 40-year career on the frontline of medicine is debatable.

Finally the details of the move from recommendations to actual change have yet to be given. A timeframe of 2-5 years is suggested to move all curriculae to broad-based training. This seems ambitious and the yet to be constituted UK-wide delivery group is likely to be busy. Expect further reports soon.

I will now give a view on the possible impact of the report on ICM training specifically. In many ways the current ICM CCT has a very similar design philosophy to that proposed by the GMC for the Completion of Specialist Training (CST) programmes. The ICM CCT fully embraces

the concept of a prolonged period of general training in acute care by incorporating multiple possible entry routes and in effect using a process akin to transferable competencies to define training needs of individual trainees. The competency template for our Stage 1 training would perform well as the basic curriculum for generalist acute training. Our CCT also already fulfils the criteria of allowing some degree of career flexibility in terms of moving to alternative specialty training (e.g. to anaesthesia or Emergency Medicine). The GMC proposed CST also recommend a flexible year of training. Again the ICM CCT already has such a year in place with the purpose of allowing trainees a more flexible and diverse training experience.

One implicit outcome of the new CST programme would be a reduction in the total length of training. The Report recommends a maximum CST training time of 6 years (with the acknowledgment that some trainees may need longer to acquire competency). Any additional training would then be in the form of post-CST credentialing. The indicative duration of the ICM CCT is 7 years so we would need to remove a year from the programme. This is not simply a question of reducing all the stage and modules by an equivalent amount. We would need to consider whether some aspect of the current CCT would fit into the post-CST credentialing model. One possibility would be to remove the flexible Special Skills year but this is recommended in the GMC report. Another possibility would be to consider the attachments to paediatrics, neurosurgery and cardiothoracic critical care as post-CST training and develop credentialing training programmes in these areas. However the loss of these would leave future ICM CST holders with a significant skill gap when asked to manage such patients on presentation outside of specialist units. All of the above stands against the most illogical and unhelpful possibility of ICM itself being pushed into post-CST credentialing.

More information about the Shape of Training Review and the full Report can be found online via [www.shapeoftraining.co.uk](http://www.shapeoftraining.co.uk).



# Critical Care Workforce Census



**Dr Jack Parry Jones**  
Intensive Care Consultant



**Dr Matt Wise**  
Intensive Care Consultant

*“Working from seven to eleven every night, It really makes life a drag, I don’t think that’s right. I’ve really, really been the best of fools, I did what I could”*

– Led Zeppelin

Intensivists over a certain age have a tendency to go on about how hard it was in their day. When the number of consultants who both could and wanted to do critical care was small they did what they could to cover service demands. This may have been as the “best of fools”. The unintended consequences for them have been workforce and domestic casualties - early retirements, movement back to anaesthesia alone, work related illness and domestic unpopularity. Those intensivists, in scant recompense can now say “it’s not like it was in my day”.

Working all the time does make life a drag and juniors will and are choosing to go elsewhere. We need a specialty that attracts junior doctors into it and keeps them to the end of their careers. This means providing an attractive balance between what is a very interesting, stimulating and rewarding specialty with the out-of-hours and weekend working.

Intensivists can and have as a professional group discussed and to a lesser extent agreed what junior and senior medical staffing requirements we think are necessary. Some models of care such as a resident consultant service are contentious<sup>1</sup>. Recent publications of critical care medical staffing including the Welsh Government’s *Delivery plan for the Critically ill*<sup>2</sup> acknowledges that critical care staffing arrangements cannot and need not be the same in every hospital. The proposed solution is a three-tiered approach ranging from Tier 3 units in large DGHs and teaching hospitals to Tier 1 in the smallest DGHs. A similar but two-tiered approach is proposed in the rearrangement of Emergency Departments

in NHS England. The joint UK publication *Core Standards for Intensive Care Units*<sup>3</sup> is clear about how the authors see an ICU should be staffed at consultant level. Further work will be required to determine future workforce requirements based on the number and size of critical care units required in the UK, staffed to those core standards and with some agreement on what constitutes a sustainable rota. We need to have as clear a picture of where we are now and for this we need your unit’s staffing, working arrangements and individuals’ plans for the future. The shortfall can then be mapped from where we are now to where we need to get to.

The FICM Workforce Advisory Group has been working in collaboration with the Royal College of Physicians Workforce Unit to develop an in-depth questionnaire. We urge you to please fill this in when it comes out via email in February 2014. The data will be collected over several months so you will be urged, cajoled and finally pestered.

It is in all our best interests, for present and future generations of intensivists to have this information submitted accurately. Budding intensivists might listen to the oldies but they won’t chose to work in the same way without a good work/life balance. A Dolly Parton ‘Nine to Five’ is too appealing.

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3. *Core Standards for Intensive Care Units*, 2013: <http://www.ficm.ac.uk/news-events/core-standards-intensive-care-units>

# Recruitment Update



**Dr Tom Gallacher**  
ICM National Recruitment Lead

Preparations for 2014 Recruitment are well under way and in general the format will follow that which has been very successful over the past two years. The posts will be advertised on NHS Jobs, in the BMJ and on the dedicated ICM Recruitment website from 3<sup>rd</sup> February 2014 and applications will close on 3<sup>rd</sup> March. Interviews will be held at The Hawthorns, West Bromwich Albion Football Ground, Birmingham on 31<sup>st</sup> March, 1<sup>st</sup> and 2<sup>nd</sup> April. For 2014 we have increased the number of interview slots by 50% from the 2013 availability by adding an additional day in order to maximise a trainee's opportunity of securing a place at our selection centre.

New for Recruitment 2014 will be a dedicated ICM Recruitment website from West Midlands Deanery which will be a one stop portal for all information relating to ICM Recruitment 2014 including careers advice, FAQs and the online application form. The FICM website will continue to maintain its own National Recruitment page.

Trainees who wish to pursue a career in ICM and who are applying from core training will need to consider carefully their choices during the 2014 Recruitment round. Firstly, they will need to decide on whether they are likely to wish to undertake a dual programme in conjunction with one of our partner specialties. If this is the case, they must consider carefully in which Deanery they would wish to undertake their training.

It must be emphasised that in order to undertake a dual programme in England, Wales and Northern Ireland they will require to be appointed in separate recruitment rounds (i.e. 2014 and 2015) to both CCT programmes within the same Deanery. This will mean that they should research the

number of training posts currently available in both specialties in their Deanery or Deaneries of choice and refer to the most recently available competition ratios to inform their choice of unit(s) of application.

Core trainees will also have to decide which programme – ICM or partner specialty – they wish to accept if offered a post by both specialties in 2014 and which they will reject in favour of re-application in 2015. There is clearly no correct answer to this and the trainee must make their decision based on the points above. However, it is important that the trainee considers the scenario where they are unsuccessful in acquiring a second CCT programme in 2015 despite being offered a post in that specialty in 2014. This may occur as a result of competing with a different cohort of applicants in 2015. That is to say that the choice of specialty in 2014 may be their ultimate career pathway due to an inability to secure a second CCT programme in the same Deanery in 2015.

For trainees who are applying from a partner specialty, or from ICM to a partner specialty, there is currently no upper limit on applicant seniority. However, we are in the process of consulting with our partner Colleges and early indications are that an upper limit of the end of ST5 is very likely to be introduced for Recruitment 2015.

Finally, for the first time, in Recruitment 2014, we will introduce a standardised feedback process to all applicants who attend the selection centre. This will hopefully inform applicants' future career choices by allowing them to see how their performance compared the expected standard as well as comparison in relation to their peers' performance.

# Audit Recipe Book - Survey Results



**Dr Adrian Wong**  
ICM Trainee

The FICM and the ICS aim to set the highest standards of care for all critically ill patients. Clinical audit plays a vital role in maintaining good clinical governance and also forms the stepping-stone for quality improvement projects at the heart of which is patient care.

The Royal College of Anaesthetists' Audit Recipe Book already lists 16 audits in their Intensive Care Medicine chapter<sup>1</sup>. However the FICM Professional Standards Committee and the ICS Standards, Safety and Quality Committee are developing a more comprehensive Audit Recipe Book and are aware that many units throughout the country already have high quality, robust audit programmes. Hence we were keen to hear from colleagues and invited proposals for audit projects to be considered for inclusion in the Audit Recipe Book.

An online submission form<sup>2</sup> was developed and members were invited to contribute by email, social media and the Society's website. A total of 90 individual projects were submitted from various regions across the country. Of note, it was encouraging to receive a number of submissions from nurses and allied health professionals. The submissions were analysed and categorised into several broad themes. There were a number of recurrent themes which have been interpreted as an indication of their significance to the FICM and ICS memberships.

The top five audit submissions were:

1. ARDSnet ventilation compliance
2. Intubation practice and capnography
3. Tracheostomy care
4. Central venous catheter bundle compliance\*
5. Renal replacement therapy practice\*  
(\*included in RCoA Audit Recipe Book 3<sup>rd</sup> edition)

What is the next step? There was a clear message from respondents that the Audit Recipe Book should focus on subjects with an underlying, well-defined evidence base. This approach should result in effective changes in care that have been demonstrated beyond doubt to result in improved outcomes for patients. The potential list of audits that can be conducted on ICU is vast but units' audit programmes should always include a core group of topics with a strong evidence base for improved outcome. The Audit Recipe Book's suggested audits will also help guide the clinical audit activity of members as part of the revalidation process.

In the longer term, the audit recipe book together with documents such as *Core Standards for Intensive Care Units*<sup>3</sup> and the upcoming *Guidelines for the Provision of Intensive Care Services* (GPICS), will play an important role in clinical governance and ensuring a high standard of care for all patients. It is anticipated that commissioning bodies will incorporate the content of these documents into their decision making when reviewing and performance managing units.

Both the FICM and ICS would like to thank each contributor to the survey and we look forward to keeping you updated on the progress of the project.

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1. RCoA Audit Recipe Book: <http://www.rcoa.ac.uk/system/files/CSQ-ARB2012-PRELIM.pdf>
2. Submission form: <https://docs.google.com/forms/d/1yneRSRITvPvbkygW4NIMJDYvgXWiomUpTXypgJXZgY/viewform>
3. Core Standards in ICUs: <http://www.ficm.ac.uk/news-events/core-standards-intensive-care-units>



# The Future Hospital Commission



**Professor Timothy Evans**  
Immediate Past Vice Dean

Aneurin Bevan announced famously at the birth of the National Health Service (NHS) that even the sound of a dropped bedpan would be heard in Westminster. From the perspective lent by 60 years, it might seem we have moved both forwards and backwards from such an innocent position. Specifically, Westminster no longer presides over a truly national health service, responsibility for which has been devolved to Wales, Scotland and Northern Ireland and (in England) to Foundation Trusts, or the Trust Development Agency. Indeed, the powers of the current Secretary of State to close even a single Accident and Emergency Department appear to have been strictly curtailed by legislation<sup>1</sup>.

By contrast, in July 1948 the NHS took control of around 480,000 hospital beds and 5000 consultants, which cost £248m to run in the first 12 months. The figures for England alone today are 136,487<sup>2</sup>, 40,394<sup>3</sup> and £95.6bn (2012-13) respectively. Secondly, the failures of care so clearly and painfully detailed by Robert Francis in his report on the Mid-Staffordshire NHS Foundation Trust were neither noted nor acted upon in the hospital within which they happened<sup>4</sup>. Third, we are confronted by a service under increasing strain at the beginning of the 21<sup>st</sup> century; characterised by an inexorable rise in emergency admissions, an increasing proportion of frail, elderly inpatients with cognitive impairment and multiple other co-morbidities, poor continuity of care and deficiencies in out-of-hours services.

This demand-side nightmare is set against restricted funding, with some £20bn to be removed from the healthcare budget by 2014<sup>5</sup> and a looming medical workforce crisis in which trainees working towards careers in hospital medicine regard appointments involving the delivery of acute medical services as being something to avoid rather than relish.

Against this background the RCP established the Future Hospital Commission, the Strategic Board for which was chaired by Sir Michael Rawlins. The Operational Steering Group was led by the author, and 5 workstreams, with 4 cross-cutting themes, were identified for close scrutiny. In each case, groups of experts from both the RCP and elsewhere in the clinical community, accompanied in all cases by representatives of patient and carer groups, sought evidence of best practice. One year later, 650 pieces of oral and written evidence gained from individuals and groups via a dedicated website, multiple stakeholder events and 50 site visits led to the production of a 184 page report which was launched amidst significant media interest in September 2013<sup>6,7</sup>.

What were the principle findings and recommendations? First, the Commission advocated the introduction by each healthcare system of the concept of a 'Citizenship Charter', a term used to define a broader responsibility than taking on the clinical care of an individual patient, but rather the assuming of a wider responsibility for the quality of basic care provided throughout their care pathway; coupled to a contractually enforceable obligation to take action wherever inadequacies emerged, regardless of whether the patient is "under their care" or not. In short, the standard of care provided in any part of the hospital should be regarded as the concern of everyone working within it, a responsibility extending beyond traditional ward or team boundaries. Such a Charter would be developed by each healthcare delivery system in collaboration with its members and governors (Foundation Trusts), staff, patients and carers and community; both to see these principles embedded and put them into practice. In this way, the kinds of deficiencies identified by Robert Francis would become the concern of all<sup>5</sup>.

Second, the Commission believes much more clinical care should be delivered in or close to the patient's home. In future clinicians should expect to spend part of their time working in the community; providing expert care within a single healthcare system integrated with primary, community and social services within a specific geographical area. Optimising the care of patients with long term conditions and preventing crises should be a particular preoccupation.

Third, the report recognises that the huge range of services and expert staff needed to treat patients across the spectrum of all clinical conditions on a 7 day per week basis. New systems of 'hub and spoke' hospital care need to be developed, coordinated across health economies centred on the needs of patients based on the principle of collaboration. In many areas, it is probable that the health economy will be served by a smaller number of acute centres hosting Emergency Departments and trauma services, acute medicine and acute surgery. These hospitals will be surrounded by intermediate hospitals which will contribute to step-down inpatient and outpatient care, diagnostic services and increasingly close integration with the community.

Fourth, within the hospital will be a single, unified Medical Division which will assume clinical, managerial and budgetary responsibility for all inpatient beds (with the exception of those aligned to paediatrics, obstetrics and possibly some specialised surgical wards). The Division will have access to, but may not necessarily administer, relevant diagnostic and laboratory services, ED, intensive care, mental health and palliative care services; but its clinical responsibility will extend outwards to community-based, intermediate care services including virtual wards, admission avoidance schemes and post acute community- or home-based rehabilitation/ recuperation services. Direct clinical input from primary care will be required to provide the relevant skill mix to facilitate collective working. The Medical Division, led by a Chief of Medicine with professional, budgetary and administrative authority will take an overview of the individual needs of all patients both in hospital and within relevant parts of the local health system. Information technology and other systems will need to be established that permit the effective exchange of information, both clinical and administrative, to facilitate this.

Fifth, a focus on preventing crises in health and personal care provision, through self-care and optimising contact with primary care during periods when increased clinical, physical, social and psychological support is needed must also become a healthcare priority, by developing integrated and seamless services provided at, or close to, home. For the patient who presents as an emergency in the future, a key question must be "can this patient be managed in the community"? Alternatives to admission supported by a comprehensive range of services including integrated care, ambulatory care, continuing secondary care management in the community and expanded rehabilitation services have been shown to reduce admissions (The Kings Fund, 2010).

To some, the scale of these suggested changes will seem daunting. However, many of the ideas put forward by the Commission emerged from examples of good practice already being implemented by clinicians in all parts of England. Its recommendations therefore need to be adapted by those with knowledge of their own health economy and communities, and fundamentally to the needs of the patients they serve. The Commission recognises its findings imply that tough decisions lie ahead; reconfiguration not only to service provision but also to education and training of medical staff. Every hospital cannot provide the range of services and expert staff needed to treat patients across the spectrum of all clinical conditions on a 7 day per week basis, although this must be our aim. Public awareness of the growing evidence base supporting complex treatments means these must be made available, but delivered consistently and safely to those that can benefit from them, 7 days per week and 24 hours per day.

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# Regional Advisor Update



**Dr Danielle Bryden**  
Deputy Lead RA in ICM

*“One part of the captain’s job is visible to all. He is the one who leads the rest out of the pavilion... But there is also another side... where he assesses, plans and prepares” – Mike Brearley, ‘The Art of Captaincy’*

One of the biggest developments of the move to the single CCT in ICM has been the growth of the Training Programme Director role in ICM. TPDs are now springing up in Deaneries and LETBs to manage and co-ordinate the new ICM programmes, a job that was often previously left to the Regional Advisor when ICM was considered an ‘add on’ to another CCT specialty.

Has this impacted on the significance of the RA role considering they are appointed by the Faculty and have no paid role in the Deanery structure, and where negotiations locally are potentially viewed as very much the remit of the TPDs and Heads of Schools? Has the RA role been reduced merely to that of ‘Regimental Goat’ to be wheeled out at official functions such as ARCPs, the signing of FICM related paperwork and to pronounce on the suitability of applicants for consultant posts at Advisory Appointment Committees?

My view is that the current crop of RAs are very much putting paid to that notion and their influence and activity can be seen in many of the Faculty’s functions. With regard to training, RAs have been helping to write modules for the Special Skills Year of the new single CCT curriculum, have been developing the new ePortfolio and leading on and continuously developing the processes and materials of trainee recruitment. In addition they are working with the Training & Assessment Committee (FICMTAC) to ensure that ICM training continues to be of a high standard. They are

considering how the quality of ICM training can be assured in an environment of multiple visits from other groups and agencies and a surfeit of surveys that are designed for the needs of bigger specialties, rather than those specific to ICM. At the time of writing, Scotland is still not confirmed as taking part in national recruitment, but Scottish RAs have from the very beginning, contributed to the above processes.

Chris Thorpe was elected Lead RA at the beginning of last year, and having been elected as his Deputy shortly after, I have found his support and advice invaluable. However my respect for all the RAs and their contributions is considerable. Between them they are friendly, helpful, knowledgeable and unafraid to say when, in their view, the Emperor is not wearing any clothes. Constant pressure from the RAs has produced more manageable documentation than was initially proposed for the assessment of progress of training in the new CCT scheme, and has quickly brought to light small issues of local difficulty that without prompt action and central FICM involvement could have progressed to far greater problems, e.g. in relation to local recruitment and Deanery processes.

It is clear that the opinion of the RAs is held in high regard by the Faculty Board. I am aware of the trust they place in me having elected me to represent them on the FICMTAC, and am respectful of their knowledge and have confidence that they will tell me if things are not to their liking. RAs have not been mere observers in the growth of the Faculty but remain in the thick of its ongoing development, shaping training long after they have handed over to others to continue the work. Their place at the head of their local ICM teams is truly merited.

# Trainee Update



**Dr Mike McAlindon**  
FICM Trainee Representative

Since the last issue of *Critical Eye* we have had another successful round of recruitment. Our FICM Trainee membership continues to grow and evolve. We now have Trainees within all the partner specialties forming dual training programmes with ICM. We are pleased that PHEM is now the latest addition to ICM training and is now a recognised sub-specialty programme.

The GMC Shape of Training (SoT) report was recently published. If the recommendations of the report are rigorously imposed this could potentially change the landscape of medical training dramatically. For those of you not familiar with the report then I would encourage you to review the one page summary published online.<sup>1</sup>

The future of ICM in this context remains uncertain. Our training scheme offers much to fulfil the recommendations set out in the review and would form a sound basis for the 'Acute Care' theme of training. Paradoxically if this were to take place then ICM specialist training could be relegated to post-CST credentialing as a result. It remains uncertain what changes will occur but we, as trainees, must be vigilant to ensure our training and the future of our specialty is protected. The FICM will naturally continue to fight for what is best for the specialty.

In addition to the SoT review, we have been working closely with the Centre for Workforce Intelligence (CfWI) during their review of critical care services. Their final report will hopefully reinforce the central role critical care services play in the modern acute hospital and evidence the need for expansion in the ICM workforce. Our work on a census will be another positive step towards protecting the ICM workforce.

We have recently been reconfiguring the FICM website. The Trainee member page is being updated with information concerning training and assessment,

educational resources, FFICM examination resources and career development advice. Of note we have recently secured a half price subscription rate for *Intensive Care Monitor*. We will have a link available on our webpage shortly. A separate page for prospective ICM trainees is also in development.

I would like to take this opportunity to thank on behalf of the Trainee membership Professors Bion and Evans for their tireless work as Dean and Vice Dean of the FICM. They have been a great source of support during my time with the Faculty and will be a tough act to follow. As always if you have any issues to address then please feel free to get in touch.

## Trainee Representatives Election

It has been determined by the Faculty that trainees would be best served by having **two Trainee Representatives**; a Lead and a Deputy (with the Deputy then assuming the Lead role after the current Lead's term ends).

**An election for TWO new Trainee Representatives will therefore be held on 4 April 2014.**

Self-nomination material has been sent to all registered ICM CCT trainees congruent with the publication of this issue of *Critical Eye*. The highest ranking candidate in the election will become Deputy Rep in April before assuming the Lead role when Dr McAlindon steps down in October 2014. The second highest ranking candidate will then assume the Deputy Rep role before becoming Lead Rep in October 2015.

Please see the election material distributed via post and visit [www.ficm.ac.uk](http://www.ficm.ac.uk) for more information.

1. <http://webappmk.doctors.org.uk/SRedirect/72DB75B4/www.fmlm.ac.uk/sites/default/files/pictures/Shape%20of%20training%20final.pdf>

## Regional Focus - Wales



**Dr Chris Thorpe**  
Lead RA in ICM



**Dr Paul Morgan**  
Chair, WICS

The challenges faced by Wales are similar to the rest of the UK though the structure of delivery and accountability is diverging all the time. The concern and drive for change accompanying the Mid-Staffordshire scandal and the Francis Report has the potential to radically alter the way that NHS services are provided and managed in all parts of the UK. There are several structures in England that do not apply in Wales however, examples being the Health and Social Care act, Foundation Trusts, payment by results and the Care Quality Commission. This is not to say that Wales is totally immune to changes in NHS England, nor is the Welsh Government ignoring what happens in the rest of the UK.

A great deal of work is being done to ensure that standards of care for Welsh patients are appropriate and in line with the rest of the country. There are also services that English hospitals provide for Welsh patients – for example, major trauma cases in North Wales are taken to Stoke-on-Trent.

The structure of the NHS in Wales is now radically different from England in that our acute hospital services are not run by Trusts in isolation from community services. There are currently seven Health Boards containing a total of 18 acute hospitals, with 16 general critical care units of varying sizes and models of care. However, while England basks in the “luxury” of an average of four Level 3 critical care beds per 100,000 of the population, Wales struggles with just 3.2 – the lowest figure in Europe. By way of contrast, the equivalent figure for USA, Belgium and Croatia is around 20 while Germany has 24.6. This shows the importance of workforce data to our specialty and the launch of the new census is key to this.

From a Welsh training perspective, one of the great assets Intensive Care Medicine has had is a very supportive Deanery. From the inception of the new single CCT, there has been appreciation and understanding of the complexity of the scheme, and of the need for financial independence. The Welsh ICM scheme controls its own finances and is therefore able to tailor posts to suit the individual trainee. We also have strong ties with the other linked specialties of anaesthesia, medicine, and Emergency Medicine and in a time of constant change the benefits of working as a team to solve organisational issues cannot be underestimated. The programme takes in a range of ICUs in different areas and one of the challenges we are addressing is to ensure a robust formal teaching programme tailored towards the exam. Organised regional and local teaching alongside streaming of national teaching is our current aim – we will see how this develops!

The recently published *Core Standards for Intensive Care Units* echoes work previously done in Wales which led to the Welsh Government publishing *Designed for Life: Quality Requirements for Adult Critical Care in Wales* in March 2006. Despite a great deal being done to improve standards the ambitious targets set out in this document have not been reached. The establishment of critical care networks across Wales has helped to bring clinicians together to raise standards in many aspects of critical care provision, but other aspects such as staffing models have not shown the major improvements needed.

After a review, the critical care networks (with input from the Welsh Intensive Care Society) wrote a new Strategic Vision document, which was published in March 2013, alongside a delivery plan. One of the most striking figures to come out

of the Delivery Plan was that delayed transfers of care (DTOCs) in Wales take up the equivalent of 13 beds per year. This huge waste of resource has been allowed to develop despite a reduction in DTOCs having been a service improvement target for several years.

Reconfiguration continues to lumber its way slowly across the landscape. One of the main conundrums for us to address is the geographical challenge of having such a widely spread population. It is far easier to reconfigure and amalgamate services within an urban environment, but when there is a substantial rural population the loss of local services becomes less palatable if it involves long journeys to access emergency health care. Where can the line be drawn? The decision has to take into account the journey time and the number of patients but there is no easy formula. Reconfiguration has begun

however and we await the eventual outcome with a combination of interest and trepidation.

The other big news from Wales is the passing of the Human Transplantation (Wales) Bill. Wales becomes the first UK country to change from an opt-in system of organ donor registration to a soft opt-out system. It is hoped by the Welsh Government that this will eventually result in an increase of about 15 donors per year, equating to around 45 extra donor organs being transplanted per year. This may not seem an ambitious target, but it's necessary to bear in mind that the population of Wales is only around 3.5 million people and that Wales already has one of the highest donation rates in Europe thanks to the hard work put in by Clinical Leads and Specialist Nurses for Organ Donation in recent years as the recommendations of the Organ Donor Taskforce have been implemented. Will the rest of the UK follow suit?

## Faculty Events Calendar 2014

February			
	14	MEETING:	FICM ICM RA and FT meeting
	25	MEETING:	FICM/ICS Joint Professional Standards Committee
March			
	7	EVENT:	<b>FICM Annual Meeting</b>
	17	MEETING:	FICM Recruitment Sub-Committee
	18	MEETING:	FICM Training & Assessment Committee
April			
	28	MEETING:	FICM Workforce Advisory Group
May			
	15	MEETING:	FICM Board Meeting
	22	MEETING:	FICM/ICS Joint Professional Standards Committee
June			
	9	MEETING:	FICM Recruitment Sub-Committee
	10	MEETING:	FICM Training & Assessment Committee
	26	EVENT:	<b>ACCP Conference</b>
July			
	10	MEETING:	FICM Board Meeting

# Consultations - FICM responses

## NHS England consultation on NHS Hospital Data and Data sets - September 2013

**Aim:** The stated aim of this consultation is to seek opinion and advice for a wide variety of stakeholders concerning:

- The advantages and disadvantages and feasibility of extracting items of information listed in an illustrative data set.
- Any items that stakeholders consider should be added or deleted from the data set.
- Ways to minimise any additional burden placed on hospital staff by assembling such data.
- How to maximise the quality completeness and timeliness of data extracted.

**Commentary:** The Faculty of Intensive Care Medicine recognises the value and importance of accurate health system data for administrative, clinical, research and quality improvement purposes. As a speciality at the forefront of information technology and patient safety, we welcome initiatives designed to improve the range, utility, accuracy, security, and availability of data about patient care and resource utilisation, and proposals to improve integration of disparate datasets. In general terms therefore, we strongly support efforts to improve data quality, and to use data intelligently for quality improvement and organisational reflective learning.

However, we have concerns about several of the proposals in this consultation.

1. The justification for the exercise is not well made, given the scale and work required.. In the executive summary the authors state that it will be 'extremely challenging or impossible' for some hospitals to provide a complete data extract within the timeframe required (beginning of April 2014). Nevertheless the justification provided is that "the Francis Report into the failings of mid Staffordshire Hospital stressed the urgent need to improve hospital data". It is not evident that this general statement provides an adequate

foundation for a massive change to NHS data acquisition and the extremely demanding timetable proposed.

2. The proposed granularity of data collection is surprising and its utility uncertain. While the appendix contains selected examples from other health systems of how data has been used for administrative and research purposes, Table 2 does not explain how patient level data such as vital signs charting, or interaction with "associated AHPS" could be useful at national level, even though this data may well be valuable at a local level in terms of early warning systems or staff rostering. If patient-level data is to be used for performance management or to empower patient choice (patients rarely have genuine choice outside major conurbations) it will require aggregation in some manner. Moreover, how will verification of this level of data be assured?
3. The authors indicate that "many hospitals already have electronic processes in place to meet our likely new demands". The Health and Social Care information centre presumably has (or certainly should hold) precise details of exactly how many hospitals have the capability to provide the data that they seek. If not, an early and important exercise would be to carry out a pilot study to establish precisely these facts. Indeed, rather than expanding or seeking advice concerning an expanded data set (shown in Appendix B), ascertaining what capacity Trusts in the UK have in order to undertake this exercise would seem to be indicated.
4. Whilst in the Introduction the authors indicate that eventually this process will extend to general practice, mental health, community health, and health and social care; the consultation seems to be entirely aimed at the hospital data set, thereby (presumably) excluding a very large proportion of the data that will be needed to achieve the stated aims (increased patient safety, improved outcomes, reduced waste, minimised healthcare inequalities, removal of

variation, empowering citizens and staff and delivering high quality healthcare for all).

5. Most clinicians would consider that HES data is used currently entirely for “secondary uses” (page 16). Indeed, data analysis, presentation and the public release of data (e.g. via Dr Foster inc) relies partly or wholly on such data; yet we are told it is “inappropriate” for monitoring and for quality improvement. It would seem important for this extremely sensitive issue and apparent contradiction to be addressed within the document in some detail. In this respect it should be noted that the evidence that HSMRs and SHMIs actually predict care quality is extremely weak, as was acknowledged in the Keogh report.
6. In the section entitled “Future Hospital extracts” (page 18) the authors should state precisely how they believe the modifications that they propose to make to the data set will achieve their desired aims (see 3 above).
7. Pages 22 and 23 indicate that patients, commissioners, providers and researchers could have access to data. It is extremely important for these groups to see how this access will be regulated, and how clinicians (page 24) will be involved in this exercise.
8. Above all, the document has a “top down” feel about it that does not in anyway attempt to address, help or support the institutions that will be tasked with carrying out this exercise. Whilst under the Health and Social Care Act 2012 NHS England has the power to direct the HSCIC to establish information systems and to take account of the standards published, no guidance is provided anywhere within this document as to how this will be financed, regulated or implemented.
9. NHS England should focus on assuring quality project management and ensuring adequate buy-in from frontline staff and the public.

## Intravenous Fluid therapy in Adults in Hospital

- June 2013. The FICM response can be found on the website: the following statement was provided by the Faculty on publication of the guideline:

1. We particularly support the recommendations to appoint hospital fluid leads and to report untoward events related to fluid therapy to facilitate learning.
2. We would propose that training should begin during the undergraduate education of both doctors and nurses.
3. We support the need for further research and would welcome a recommendation that until the outcomes of this research are known given the current absence of clear benefit from more expensive colloid solutions that their use should be restricted.

## Clinical practice guideline on Head Injury (update) for use in the NHS in England, Wales and Northern Ireland - October 2013

The document predominantly addresses pre-hospital care and emergency department care of head injuries; therefore there was only a limited amount of material that directly interested the Faculty.

1. The guideline fails to provide clear guidance on indications for transfer of patients to a neurosciences centre.
2. The guideline fails to highlight dangers of hypocarbia in patients with a severe head injury.
3. The guideline fails to address the issue of removal of the cervical collar in patients where radiological imaging has been completed, reported and demonstrates no radiological injury.
4. For the majority of Faculty members, research would be welcomed into which patients with head injury would benefit from specialist care and the implications on resources if all such patients were transferred in a timely manner.

The full FICM responses to these consultations as well as the full details of the individual consultations themselves can be found online at <http://www.ficm.ac.uk/standards/consultations>.





The Royal College of Anaesthetists



The College of Emergency Medicine



**RCPE**  
The Royal College of Physicians of Edinburgh



**Royal College of Physicians**



The Royal College of Physicians and Surgeons of Glasgow



The Royal College of Surgeons of Edinburgh



The Royal College of Surgeons of England

# The Faculty of Intensive Care Medicine

**Annual Meeting**  
**Friday 7th March 2014, RCoA, London**

**Hard times: Delivering high quality healthcare during a world recession**

**What consultancy can offer: case studies in driving efficiency**

**The role of the regulator in a time of financial constraint**

**The role of external review**

**Assessing Quality**

**How should we assess quality?**

**Patient safety: How to measure it**

**Environmental extremes: relevance to critical illness**

**High altitude**

**Diving medicine**

**Hibernation in the biological kingdom - parallels to critical illness**

**Annual Faculty Lecture**

**The Faculty Annual Report and Award of Fellowships**

Online booking available via:

**[www.ficm.ac.uk](http://www.ficm.ac.uk)**

**PLACES STILL AVAILABLE**

**£160** for Consultants

**£85** for Trainees

**5 CPD credits**

# Advanced Critical Care Practitioners Conference

**Thursday 26<sup>th</sup> June 2014**

**The Royal College of Physicians of Edinburgh**

The FICM are running the second National Advanced Critical Care Practitioners Conference at the RCP Edinburgh, following on from the success of last year's event. The day will appeal to ACCPs and trainers/educators as well as those with an interest in the field. Booking will be open soon.

## *Proposed Topics:*

- Intra/inter hospital transfers
- ACCP – retention & development – career progression
- ECMO
- Delirium
- '5 critical care papers that you need to know'
- Medical-legal/litigation & advanced practice
- Practical break-out sessions
- Advanced ventilation

**Fee:** £40

**CPD Credits Anticipated:** 5

**Availability:** *Available soon*

**Event organiser(s):** Dr G Nimmo & Ms C Boulanger

## EVENTS APPLICATION FORM

Payments will be processed by the Royal College of Anaesthetists Finance Department Please complete this form in **BLOCK CAPITALS** and return to Churchill House, 35 Red Lion Square, London, WC1R 4SG or via fax (020 7092 1730).

### Your details

Full name:

\*Faculty Reference Number:

GMC:

Address:

Postcode:

Please ensure you complete your full postal address

Is this your main mailing address?

Telephone:

Email:

Hospital:

### Event details

Date:

Code:

Event title:

Registration fee:

### Payment details (please use BLOCK CAPITALS)

A cheque is enclosed made payable to the Royal College of Anaesthetists

I wish to pay by the following debit/credit card: (please tick)



Cardholder's name:

Signature:

Card Number:

Valid from:

Expiry date:

Issue number:

Security code:

### Terms and conditions

- Additional copies of this form can be downloaded from [www.ficm.ac.uk](http://www.ficm.ac.uk).
- Please be aware that programmes are subject to change and you should check the Faculty website for regular updates.
- Our events are open to all grades, unless specifically stated otherwise.
- When an event is full, this will be publicised on the website. To be placed on a waiting list, please contact the Faculty of Intensive Care on 020 7092 1746. We will then contact you as soon as a place becomes available.
- Lunch is included in the registration fee unless otherwise indicated.

### Booking and payment

- Bookings will be accepted by post or fax only on a first come, first served basis.
- Bookings will not be accepted unless the appropriate fee and application are received together.
- Please note that places are not reserved until payment is received.
- Confirmation of a place will be sent to you within 14 days of payment being received. If you do not receive this, please contact the Faculty.

### Cancellation policy

- Notice of cancellation must be given in writing to the Faculty of Intensive Care or by email to: [ficm@rcoa.ac.uk](mailto:ficm@rcoa.ac.uk) at least ten working days prior to the event to qualify for a refund.
- All refunds are made at the discretion of the RCoA Finance Department and are subject to the deduction of an administration fee.
- Delegates cancelling less than ten days before the event will not be entitled to a refund.
- Name changes for attendees will be accepted; please inform the Faculty of Intensive Care seven days prior to the event.

\* If you are a member of the RCoA, this is the same as your college reference number. If you do not know your Faculty number, please contact us.

# Forthcoming Events 2014

## JANUARY

16 **ICM Career Day North**  
Mayo Building, Salford Royal Hospital

## FEBRUARY

4 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London

26 **ICS Practical Seminar - The ICS National FICM Exam Preparation Course**  
Churchill House, London

## MARCH

26 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London

## APRIL

1 **ICS Seminar - Acute Kidney Injury - what is new?**  
Churchill House, London

## MAY

12 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London

## JUNE

16 - 17 **ICS Practical Seminar - BASIC Assessment and Support in Intensive Care**  
Churchill House, London

## SEPTEMBER

9 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London

## OCTOBER

15 **ICS Practical Seminar - An Introduction to Chest Ultrasound for Intensivists**  
Churchill House, London

## NOVEMBER

10 **Trainee Day**  
Churchill House, London

19 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London

## DECEMBER

8 - 10 **The State of the Art Meeting**  
ICC East ExCeL, London

Save the dates - Registration details coming soon

## MORE DATES TO BE ADDED

Focused Intensive Care Echocardiography Course, Neuro Intensive Care Update, Cancer in Critical Care - Dates and location TBC


Dates and topics subject to change, for further information please contact [events@ics.ac.uk](mailto:events@ics.ac.uk)

The Intensive Care Society  
Churchill House, 35 Red Lion Square  
London WC1R 4SG

T: 020 7280 4350 F: 020 7280 4369 E: [events@ics.ac.uk](mailto:events@ics.ac.uk)

[www.ics.ac.uk](http://www.ics.ac.uk) [www.intensivcarefoundation.org](http://www.intensivcarefoundation.org)

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