# TRAINEE EYE

THE TRAINEE MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 15 | SPRING 2021

The Faculty of Intensive Care Medicine

In this issue

WORKFORCE SUSTAINABILITY

NEW ICM ePORTFOLIO

RESEARCH

The Faculty of Intensive Care Medicine

# UPCOMING EVENTS

FICM: Women in Intensive Care Annual Meeting

## STRIKING THE BALANCE

30 NOVEMBER 2021

Follow us on Twitter for updates: **@FICMNews @WomenICM**

## FFICM Exam Prep Course

AUTUMN 2021

More information will be available later this year. Look out for updates on Twitter **@FICMNews** and our Events pages.

**www.ficm.ac.uk/news-events-education/ficm-events**

**@FICMNews**

# CONTENTS

**4** | Welcome

**6** | Workforce Sustainability

**8** | New ICM ePortfolio Update

**10** | Becoming a Consultant in a Pandemic

**12** | Environmental Sustainability

**14** | Fostering Potential in Intensive Care Research

**15** | HEARTfelt: Improving Patient Communication in Critical Care

**16** | New ICM Curriculum

**16** | FICM Thrive

**16** | Critical Eye

**17** | Totum Pro

**17** | WICM Annual Meeting

**17** | FFICM MCQ Online Booking

**17** | FICM Learning

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# Welcome from the Lead Trainee Representative

**Dr Guy Parsons**
Lead Trainee Representative

*"Levin put on his big boots, and, for the first time, a cloth jacket, instead of his fur cloak, and went out to look after his farm, stepping over streams of water that flashed in the sunshine and dazzled his eyes, and treading one minute on ice and the next into sticky mud. Spring is the time of plans and projects."*
Leo Tolstoy, *Anna Karenina*

It feels like a great deal has happened since I last wrote to you all.

Together we've endured an exhausting winter and it finally seems like Spring has broken through the frost. As the weather changes, I detect a slight lifting of spirits amongst my colleagues.

While it would be far too premature to claim the pandemic is over, we can take heart from the successes of the vaccine programme and the research advances that have empowered us to treat this virus more effectively. Indeed, there seems much to be positive about as we look ahead. At the Faculty we certainly have our eyes on building for the future and have been working flat out on the implementation of the new ICM curriculum and e-Portfolio arriving in August – please keep your eyes peeled for further updates on this.

Great challenges remain, however, notably the huge waitlists for elective operations curtailed by the crisis, the deep, deep exhaustion of our workforce, and the harsh light that has been cast upon the relative resource constraints we have in critical care in the UK compared with our fellow countries. The latest Budget does not make for comfortable reading and the posited organisational changes to the NHS are causing considerable unrest.

The unofficial motto of the NHS could well be per aspera ad astra (to the stars through hardships), so it seems right to highlight Spring as a time of opportunity, a time for plans and projects. Seldom are we provided with such a stark appraisal of our values, habits and processes as we have been offered with the pandemic – to let such an opportunity for frank reflection and wholesale innovation pass us by would be a terrible squandering of this unique chance for good.

So, I gently call on all of you reading this to consider what this life-altering experience has taught you, and to ask you what opportunities you can see to create a better future for ourselves and our patients. On a personal level this may be a renewed appreciation for the value of a restorative work-life balance, in which case I ask you what are the barriers you encounter in achieving this and what may be done to address these?

On a collective level you may have identified a novel care pathway or process you've found has brought value to patients and staff, in which case I ask

> To let such an opportunity for frank reflection and wholesale innovation pass us by would be a terrible squandering of this unique chance for good.

you how best can this knowledge be shared? We will all have learned something from this experience and sharing that knowledge can be a real force for good. We at the Faculty are here to listen, to support, and to champion change for our specialty so please feel free to get in touch.

In this issue I am pleased to present:

- an insightful article on the pressing environmental concerns we face with pointers for the intensive care setting from Dr Matthew Baynham
- a poignant discussion of the power of simple interventions to create meaningful change from Dr Dave Baglow
- a unique perspective on the journey to becoming a Consultant during a pandemic from Dr Jacqueline McCarthy
- a timely look at the fundamentals of workforce sustainability from my fellow Trainee Representative Dr Cat Felderhof
- a piece on training in Academia alongside clinical work for those of you who may have long harboured an interest in research but have struggled to know how to develop this, or for those more recently curious having seen the power of research during this pandemic.

As always please feel free to get in touch, we're here for you.

All the best,

Guy

Contact: Guy.parsons@nhs.net

# Workforce Sustainability

**Dr Cat Felderhof**
FICM Deputy Trainee Representative

The last 12 months have provided us with a mammoth challenge in Intensive Care, a roller coaster ride more akin to that of Oblivion (an 180ft vertical drop into a subterranean abyss) than with the gentle peaks and troughs we might normally expect.

However, here we are a year on, Spring has sprung, schools are returning (I for one could not be more grateful for this) and the vaccine roll-out continues, covering increasingly younger and fitter sections of the population.. If this was a Hollywood blockbuster it would be about this time that we'd be popping champagne corks, high five-ing and riding off into the sunset together. In Hollywood they don't seem to mention the backlog of work stored up for the film's exhausted cast which they are under pressure to start tackling as soon as possible. In reality we are faced with the conundrum of how to reduce waiting times and increase productivity for a population who badly need access to elective procedures, when the workforce who would provide this care are exhausted and broken.

This next challenge is not going to be tackled by a single short burst of effort but by a longer term, sustained endeavour. To manage this, it is now more important than ever that we ensure our workforce is assisted to recuperate while being adequately supported. In recent years we have become well aware of the importance of wellbeing and there have been many initiatives set up targeting this. Like the massive, long-term challenge we face, this wellbeing work must similarly be large in scale and sustained. The development of a healthy and sustainable workforce was the topic of the GMC commissioned UK-wide review ***Caring for Doctors, Caring for Patients*** by Professor Michael West and Dame Denise Coia, published in 2019. This review identified an ABC of doctors' core needs (many of the key features may be extended in some form to all healthcare workers) and this provides a framework and a useful place to start for considering some of the key issues in meeting this challenge.

## A - Autonomy

As doctors in training, it can sometimes feel like we have little to no autonomy in our working lives. Our lives are mapped out for us and it can often seem like the hoops are set up and we are just expected to jump through them at the required rate. We need to ensure that doctors in training have a voice and that they are acknowledged as being highly qualified professionals with opinions that count. Even in my short time as Deputy Trainee Representative at FICM I have been pleasantly surprised by the level of enthusiasm for taking on our views and one of our targets for the year is to improve the two-way communication network

with ICM trainees. On a local level, clinical leaders and managers should also be consulting and gathering feedback from all healthcare staff with a learn, not blame culture. All sectors of the workforce have potentially useful insights into how the service might be improved and by implementing these staff are likely to feel more engaged and enthused about the process.

Additionally, encompassed within this heading are work conditions and work schedules. The impact of having access to high quality rest and food facilities cannot be underestimated. The knowledge that there is access to hot food and drink 24-7 at work feels like it has become a luxury and the standard to which it is provided is variable. When you're lucky enough to work in a hospital where the canteen is open overnight then it's tempting to embrace the catering staff whilst declaring your unending gratitude when they serve up your hot food at 2am, a gesture unlikely to be welcome even in a post-vaccination world. These services may not be directly profitable, but their benefits are far reaching and can't be dismissed.

## B - Belonging

As a member of staff that continually rotates from department to department it can be hard to feel like you "belong" anywhere. On a training level there should be an effort made to reduce the frequency of rotations, allowing doctors in training to feel less like a perpetual temporary member of staff. Feeling integrated into a new department has only become more challenging in the COVID era, spending a lot of time wearing PPE so that people don't recognise your face and a lack of out-of-work socialising means that extra effort is required on the behalf of departments. Sometimes feeling welcome in a department can come down to elements as simple as having a locker (the utopian dream as a trainee). Having that little metal box allocated to you when you arrive says "you're welcome here, and we care that you have somewhere safe to keep your belongings". Peer coaching or mentoring can give a friendly face to turn to and this can be extended to group support which doesn't have to be confined to the medical members of staff, multi-disciplinary members of the team often bring something different to the table, diversity of thought and new communication lines bring many positives.

## C - Competence

As those of us in training know, there is always a fine and delicate balance between the training and service provision elements of our role, the two are not distinct entities but during the post-pandemic pressures we need to ensure that doctors still have access to supportive supervision and educational opportunities. One of the elements identified as having a significant negative impact on doctors was unnecessary administration and excessive bureaucracy, it adds to stress in addition to a potentially heavy clinical workload. It was a key recommendation of the GMC review that organisations should be seeking to use resources in the most efficient way with tasks and activities that do not add value to patient care or doctors' wellbeing being eliminated.

During the pandemic the NHS demonstrated we could achieve incredible feats in short periods of time, often assisted by reduced levels of bureaucracy. We are now faced with a crisis in staff wellbeing and we need to treat workforce health and sustainability with the same urgency. We need a long-term strategy on a wide scale. The first step is to encourage staff to take the annual leave they are due. It may be a while before we can travel any significant distance but in the meantime, we can use the time to rest and rediscover the activities that bring us joy, hopefully in some spring sunshine. Before long we hope to catch up with those who are nearest and dearest to us. Oh, and when I come back to work please can I have a locker?

"Sometimes feeling welcome in a department can come down to elements as simple as having a locker.Having that little metal box allocated to you when you arrive says "you're welcome here, and we care that you have somewhere safe to keep your belongings".

# New ICM ePortfolio Update

**Natalie Bell**
FICM Board & Training Projects Manager

As you know, we are developing a new ePortfolio (Lifelong Learning Platform (LLP)) that will be launched alongside the new curriculum on the **4 August 2021.** The project is progressing well and we have just two more sprints and some more testing to do before completion.

I recently demonstrated the current functionality of the new system for the new curriculum at our Training Leadership Annual Meeting, with ICM Regional Advisors, Faculty Tutors and Training Programme Directors in attendance. Click here to view a video of the demonstration of the LLP on our website We hope to be able to send login details to everyone in June 2021 to enable people to familiarise themselves with the new system before the go live date.

We do not expect you to upload all your prior/existing evidence from your NHS Education for Scotland (NES) ICM ePortfolio account onto the new system. We are going to be issuing transition guidance shortly that will help clarify for StRs and trainers the most pragmatic way to move to the new curriculum using the new LLP.

Written guidance for FICM's new LLP and short videos for specific functions will be published once complete. Please keep checking the website for updates.

## Stage 1 and Stage 2

All doctors in Stage 1 and Stage 2 will be expected to move to the LLP to record their training from the 4 August 2021. No placements should be added to your NES ICM ePortfolio account after this date.

## Stage 3 trainees

Anyone that is due to CCT by 31 August 2022 has the option to move to the new LLP for their final year of training, or they can choose to stay using the NES system. If you are already in or are going to be entering Stage 3 on 4 August 2021 AND will CCT by 31 August 2022 AND want to move to the LLP you will need to contact us so we can issue you with your login details. For those in Stage 3 wanting to stay on NES you do not need to contact us; we can pull a report of all the doctors in Stage 3 in the system and will keep those accounts active unless informed otherwise.

If you are a Stage 3 trainee but will not CCT by 31 August 2022 then I'm afraid you will not have a choice, you will be required to move to the new LLP as maintaining two ePortfolio systems for an extended period of time is cost prohibitive.

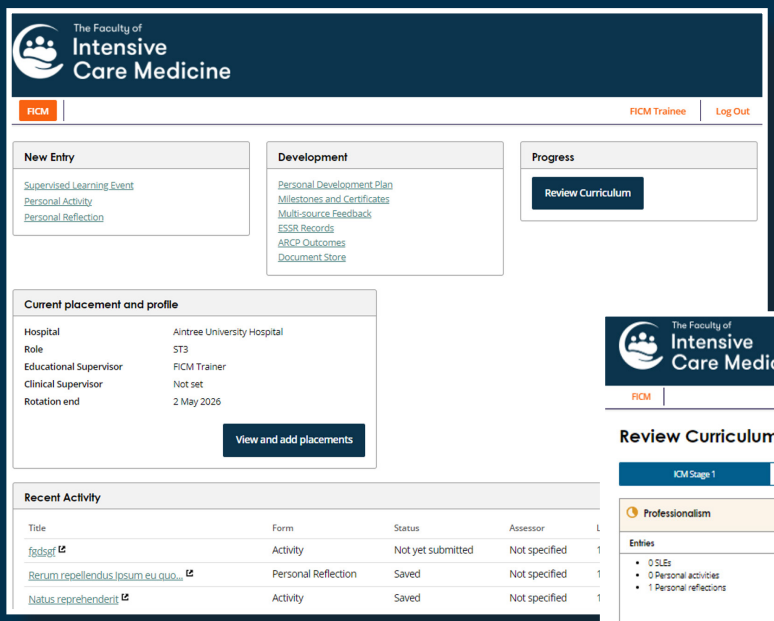
Anyone that has moved to the new LLP will have until the **31 December 2021** to download anything they may need from their previous training record in NES. Access will cease for most people after this date but will be available in exceptional circumstances. If you anticipate this being a problem for you, please do get in touch so we can advise accordingly.*

Click here for guidance on how to download your data from the NES system.

If you have any queries, please don't hesitate to contact us

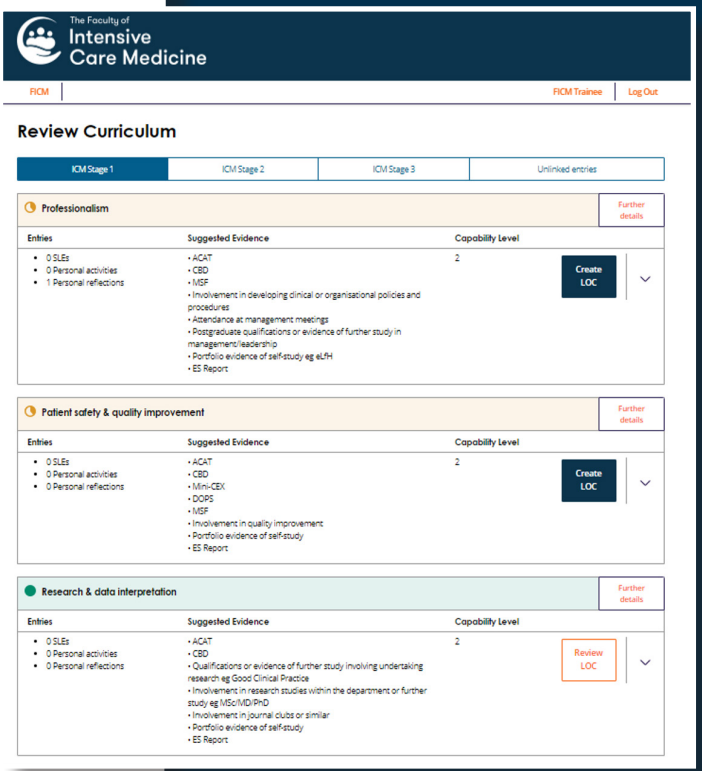
## Key points:

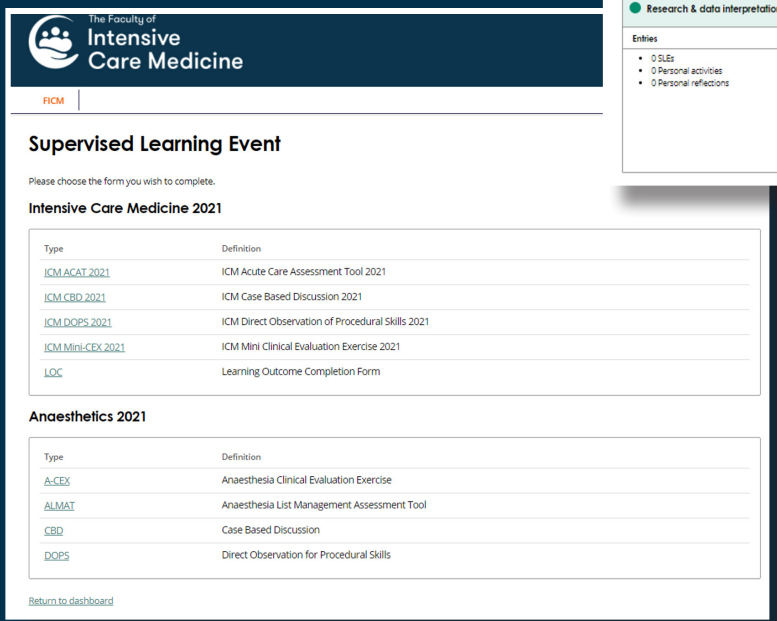
- Go live 04 August 2021
- Login details to be issued in June 2021
- Documentation needs to be downloaded from NES by 31 December 2021. Access will cease for most people on this date*
- Stage 3 trainees that will CCT by 31 August 2022 but would like to move to the new Lifelong Learning Platform should contact the Faculty




Screen shot 1: The dashboard a trainee sees when logging in

Screenshot 2: The Curriculum page viewed by clicking on 'review curriculum' button on dashboard (only shows 3 High Level Learning Outcomes (HiLLOs) out of the 14)




Screenshot 3 – New ICM Supervised Learning Event Forms (old WpBAs). Anaesthetic SLE list will be updated when the new Anaesthetic curriculum is developed in the LLP.

# Becoming a Consultant in a Pandemic

**Dr Jacquline McCarthy**
ICM & Anaesthetic Consultant
NHS Ayreshire & Arran

Timing has never been my strong suit. I had my first child mid-way through my final FRCA. I had my third as I entered my final years of training, when the quest for "CV points" was in overdrive.

True to form, I began my career as a critical care Consultant in the midst of a once in a lifetime global pandemic which led to unprecedented pressure on my chosen specialty. What could possibly go wrong?

In February 2020, I was delighted to secure an ICM Consultant job at a fantastic hospital and all the trials and tribulations of training felt worth it. The bubbles in my champagne had barely popped when a trickle of steady stories from China about a new respiratory virus suddenly became a deafening waterfall. My initial hope that it would "only" be like previous SARS or influenza outbreaks rapidly vanished as I watched the scenes from Italy on the news. This was clearly a different adversary entirely.

My initial reaction was more focused on how I could help with our local efforts to deliver rapidly expanded access to critical care. My second concern was how I would ensure I managed to complete my training to CCT in this rapidly changing clinical environment. I knew the team I would be joining would be looking forward to having another member with whom to share this mammoth task. Perhaps foolishly, I actually didn't give much thought to how it would affect me personally at this stage.

In order to facilitate my progress to CCT, I was asked to press on with subspecialty blocks and actually had very little experience of COVID-19 in the first wave. Once my CCT was approved, this began to weigh more heavily on my mind. I began enthusiastically reading everything I could about this new disease in preparation for my start date. I had hoped to find certainty and firm guidance to help me, but the level of uncertainty and often entrenched opposing stances about ventilatory strategies left me even more confused than when I started.

When the day finally arrived and I pitched up to my new place of work, for once my timing was less than awful. In Scotland at that time there had been a regression in the COVID-19 tide following national lockdown and we only had one patient in our "red" ICU. The need for additional capacity above our usual six beds also meant there were two critical care Consultants on each week, which was a welcome safety net for advice and encouragement for a new Consultant like me. My first week was busy, but with a more familiar mix of pathologies.

This honeymoon period didn't last very long however and our numbers steadily increased, then exploded at the turn of the year. The clinical part of my job was the least of my worries at this stage, as I was often tasked with the logistics of too many sick patients and too few critical care beds. My learning curve became as vertical as the worrying graphs I saw of infection rates and I leaned heavily into the support offered from my consultant colleagues.

You really find out what a team is made of when you are pushed to the wire and I was relieved, though not surprised, to find that I was part of an exceptional one. One unintentional benefit of the intense pressures of the pandemic was that it forged strong bonds and I rapidly felt like a valued and integral part of that team. Another was that since my workload overwhelmingly consisted of a single pathology, I needn't have worried about my previous relative inexperience!

It wasn't all rosy, however, as becoming a new consultant in critical care during such a once in a life-time crisis pushed me uncomfortably close to the boundaries of my clinical skills and psychological reserve. COVID-19 proved to be a chameleon of a disease, which played havoc with my nerves, as patients who seemed to initially improve suffered setback after setback. I very quickly became au-fait with the complexities of our ventilators as I struggled with some of the worst respiratory disease I have ever encountered. Many of our patients deteriorated beyond reprieve and I became sadly all too familiar with bad news conversations with distressed relatives, separated from their most loved ones at their time of greatest need. I took great comfort in their relative's firm belief that we had looked after their dearest as we would our own. I knew from watching our incredible nursing staff in action that this was indeed the case.

Just like our trainees, who have had little experience outside of COVID-19 over the last year, I too am aware that my development as a new Consultant has been hindered by the overwhelming nature of this single pathology. As our workload diversifies, I'm preparing myself for another steep learning curve. I've been comforting myself with the knowledge that if I can survive long stretches of over 200% capacity as a new Consultant, returning to our baseline "busyness" should feel comparatively much more manageable. I'm hoping to become involved in our local ICU follow up programme to help those patients who made it home from ICU with the next part of their recovery. I think it will fortify me as much as them.

"The clinical part of my job was the least of my worries at this stage, as I was often tasked with the logistics of too many sick patients and too few critical care beds. My learning curve became as vertical as the worrying graphs I saw of infection rates and I leaned heavily into the support offered from my consultant colleagues.

# Environmental Sustainability

**Dr Matthew** Baynham
**Glasgow Royal** Infirmary

I should preface this article with a disclaimer – I am not an expert in sustainability. I have, in the past, even used desflurane. When I was asked to write an article on what we have achieved in our department when so many others are achieving so much, I confess I felt something of a fraud.

It's an exciting time to be interested in the environmental impact of healthcare. In the last month there has been a publication from the AAGBI (*Anaesthesia News*) on ecotoxicology and anaesthetic waste. The Scottish Environmental Anaesthesia Group (SEA-G) has also published its first newsletter with articles on reducing nitrous use, and NHS Lothian's plans to pilot new scavenging technology that reduces and reuses volatile waste. Departments up and down the country are starting to look at their carbon footprint and question what they can change.

Climate change is swiftly becoming one of the most important issues in global geopolitics. In November, the 26th United Nations Climate Conference (COP26) will be held in Glasgow, where leaders of UN states will meet in an attempt to accelerate action towards the Paris Agreement and the UN Framework Convention on Climate Change. Additionally, on the 6-7 November the 4th Global Conference on Health and Climate Change (organised by WHO) will be held at Glasgow Caledonian University, which hosts the Centre for Climate Justice, undertaking research on climate issues and social change.

## I understand that climate change is a problem – but how does that affect my work?

The NHS produces roughly 4% of all UK waste, and 3% of all UK carbon emissions. A third of all NHS waste comes from perioperative areas, with each operating theatre produces roughly 2300kg/year anaesthetic waste and 230kg/year in sharps waste – it's estimated that approximately 40% of this could be reclassified as domestic waste or recycling, with significant financial and environmental benefits.

In the last 18 months, the pandemic has had mixed effects on human environmental impact. It has significantly improved air quality in different cities across the world, reduced greenhouse gas emissions, and lessened water pollution. However, this has gone hand in hand with increased medical waste, and increased community use and disposal of disinfectants, mask, and gloves. As economic activity returns it is likely that this shifts towards net negative impact. NHS England Improvement data suggests that where the NHS generated 220 tonnes of infectious waste per day prior to COVID-19, it is now 660 tonnes per day.

## What have we done in our department?

We decided to look at small projects with a quick turnaround that could be easily and rapidly achieved despite the acutely changing environment of working in a pandemic. QI projects have been technically challenging due to the ever-changing balance of elective theatre work and critical care escalation and redeployment.

Looking around the theatre complex it was obvious that our waste disposal had radically shifted due to COVID and never returned to pre-pandemic standards. Due to concerns about waste contamination with coronavirus, everything was now clinical waste stream, even those in the small offices adjoining theatres and in the break rooms. For our first project we looked at the available stream options in anaesthetic rooms and scrub areas within the theatre complex, utilising the audit recipe mapped out in the new RCoA Quality Improvement Compendium. We mapped the bin locations and type, and then performed 20 random bin checks looking at clinical vs non-clinical waste by volume and weight. On average 80% of the waste was non-clinical, and could have been reclassified as domestic waste or recycled. The cost implications for this are enormous – orange bags cost £467 to be treated/incinerated, whereas black bags cost £115 – and this is before we even consider recycling options.

Our intervention had been to reintroduce domestic waste streams, with the ultimate goal of expanding and introducing cardboard, paper and plastic recycling. To allay concerns about contamination of clinical waste we introduced clear bin bags in anaesthetic and scrub areas so that visual inspection was easier. Out with this project we hope to replicate the success of other hospitals in establishing a green QI group, and have already completed several other successful projects with many more proposed.

## How can I apply this to critical care?

There is a lot of crossover between theatre and critical care work, in particular relating to the burden of PPE at present. In a similar project to ours, McGain et al. published an audit of their 10-bed intensive care unit waste in ***Anaesthesia,*** concluding that whilst the unit generated 5% of the total hospital waste, 60% of it was recyclable. This is a quick, simple, repeatable audit project that lends itself well to interventions, provides a wealth of data for further projects. In our department it has led to more questions – what PPE is reusable? Can we use non-sterile gowns for AGP to reduce waste?

It is also possible to reframe QI to achieve environmental goals, all financial waste is environmental waste – for example the cost of inappropriate stress ulcer prophylaxis prescription carries a sizeable financial burden.

As I mentioned at the start, this is not something I'm an expert in. It's an exciting and rapidly evolving area of anaesthesia that is going to become a major determinant of how we work in the future – across all medical specialities. The majority of the work we have started in our department is applicable to critical care and ward areas, and there is a host of excellent resources online and enthusiastic individuals championing the cause. I would encourage anyone with an interest to look at their department and see what QI initiatives could be applied there. Even if you're not an expert, enthusiastic amateurs can promote change too.

# Fostering Potential in Intensive Care Research

**Dr Guy Parsons**
NIHR Academic Clinical Fellow

The coronavirus pandemic has highlighted the key importance of clinical research for the development and implementation of effective treatment options for our patients. From the vaccination programme to Long-Covid to clinical trials of Remdesivir and other medications, the need for high quality science for Intensive Care is clear.

I hope that this emphasis on the value of research has sparked an interest for many in exploring how they may develop their research expertise. The Faculty is clear that "research training is an essential component in creating a high-quality specialist workforce for Intensive Care Medicine [and] the national curriculum in intensive care medicine provides the framework for several levels of research training, from a common core to advanced academic scholarship." Indeed research has been identified as a core activity of the NHS in the Health and Social Care Act 2012.

## Opportunities

There are many opportunities for those interested to gain insight into an academic career and multiple potential paths to develop research skills. These range from the more informal local opportunities to gain experience from assisting with departmental projects to the more formal national academic training schemes such as those provided by the NIHR's Integrated Academic Clinical pathway. I strongly recommend those with research ambitions explore the integrated academic clinical pathway options such as the Academic Clinical Fellowships (ACF) which are advertised via Oriel. These ACFs provide an ideal starting point for early career researchers, providing dedicated research time, academic training, and a network of further opportunities. I found my ACF to be hugely valuable in providing training in research methods, dedicated time for research work, and insight into the development of an academic career, something that can often feel distant from the outside.

## Clinical Research Training Schemes

Those who have developed a taste for research may go on to further develop their interests through Clinical Research Training Schemes offered at a host of providers (the MRC, NIHR, and Wellcome Trust to name a few), and through completion of doctoral study leading to a senior academic career. These schemes are highly competitive but offer excellent opportunities to develop research acumen with considerable support.

There is huge appetite and ambition to expand the numbers of intensive care clinicians involved in research and a substantial need to develop our specialty's research abilities. With the rise of Big Data and technological advancements democratising research opportunities, and with the growth of multi-centre research networks, now is a better time than ever to get involved. So, if you have an interest in an academic career please consider the many opportunities available to get involved - our specialty needs you..

# HEARtfelt: Improving Patient Communication in Critical Care

**Dr David Baglow**
**Worthing Hospital**

We are all different people. Our feelings are arguably what make us who we are and when we are unable to communicate our thoughts, we can lose our self-perceived individuality and dignity. Protecting that dignity involves enabling people to communicate effectively so that we can recognise their individuality.

This is often hard to achieve for our patients but with the rise of COVID-19, and the consequent increased use of PPE, communication with our patients has become even more difficult. Preserving their dignity can then be even harder to achieve. The widespread use of non-invasive ventilation has also complicated matters; it is difficult to communicate effectively with staff, family and friends while strapped to a noisy mask or under a noisy hood. I'm sure we have all been deeply affected by repeatedly witnessing so many patients cut off by such measures.

## Spare pair of earphones

The HEARtfelt scheme, which aims to address these communication difficulties, started with a spare pair of earphones with a built in microphone being brought to work and anonymously gifted to a patient who was living on CPAP, enabling them to hear and communicate much more easily. Our staff now bring in earphones they don't need for our patients and our Trust charity have purchased further sets for both our hospital sites. To see the reaction of a patient provided with these is enough to realise the immense benefit these provide. The HEARtfelt initiative means that people are now able to communicate with the people they care about much more easily with people outside the hospital. Our Trust charity has also provided iPads for our Intensive Care Departments to use, and we make sure that our earphones can be used with them. This expands the communication options available and provides another outlet for patients.

The HEARtfelt scheme is for all patients that find themselves isolated in Intensive Care. It's a team effort and we are aiming to offer help as widely as possible. Alongside the hardships of the pandemic we have learned many valuable lessons too; I believe this is one – the great value of simple measures enabling our patients to communicate and preserve their individuality. It is now clear that these earphones can provide much more than simply easier conversation for our patients; music, mindfulness, religious services, translators and audiobooks are just some of the many options that can help.

## Dr Cliff Mann OBE

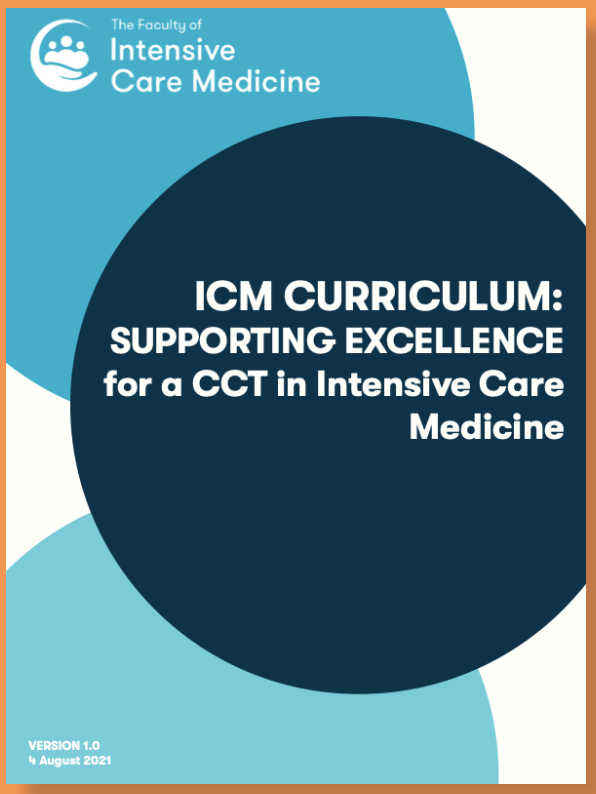
A person who galvanised my thoughts in this area decades ago sadly recently passed away. I was a hospital porter at the time with no intention of pursuing medicine but he still showed me repeatedly how important it is to help people maintain their independence and dignity. Dr Cliff Mann OBE was incredibly heartfelt in his actions and demeanour to patients and staff. The truth is that we can all do a lot with a little. Consider starting by simply providing earphones for your Trusts' Intensive Care patients and see the benefits this can bring.

## New ICM Curriculum

The new ICM Curriculum: Supporting Excellence will be implemented on 04 August 2021. Our main priorities at the moment are:

- Developing comprehensive guidance and resources for trainees and trainers to guide them through the changes so they know what is expected.
- Meeting with our partner colleges to develop updated guidance for the dual/ triple CCT programmes mapping the new outcomes-based curricula.

Do keep checking our curriculum pages and the FAQs for updates and further information, as we will be publishing new guidance and resources as and when they are finalised. If you have any queries, please do not hesitate to contact us.



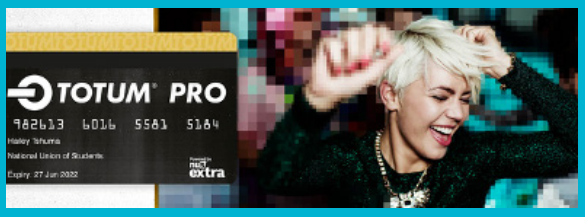

FICM Thrive

Are you about to CCT? Then you might be interested in FICMThrive! FICMThrive is a mentoring scheme led by the Women In intensive Care medicine sub-committee, if you're wanting a little additional support with your first year as a consultant then keep your eye's peel for the launch of the scheme in May 2021! More information will be available at ficm.ac.uk shortly!


The latest, Critical Eye is now available on the FICM website. This issue can be found here. If you would like to contribute to future issues (the next one is out in July 2021) please get in touch at contact@ficm.ac.uk

## TOTUM PRO

TOTUM PRO is the only discount card available for professional learners to purchase giving discounts from a wide range of high street and online retailers. Discounts range from travel and eating out, to health, technology and fashion. Professionals using the card are able to benefit from a whole host of exclusive discounts. To apply for this please e-mail: contact@ficm.ac.uk




## FICM TRAINEE SURVEY COMING SOON!

In the next few weeks you will receive a link to the 2021 FICM Trainee Survey. Look out for updates on Twitter @FICMNews and an email in your inboxes.

## FFICM MCQ June 2021 ONLINE BOOKING OPEN

The June 2021 FFICM MCQ exam bookings are now open.

Closing date: 6 May 2021

CLICK HERE TO BOOK

## FICM Learning

**Serving up Constructive Feedback – How to avoid those Inauthentic Sandwiches**

Gillian Fleming

April 8, 2021
Education, Non-Clinical
Blog

Giving effective feedback is a core skill for medical professionals and the ability to do it well is a hallmark of a good teacher and colleague.

But let's face it – giving negative feedback can be hard, and we've all felt anxious in anticipation of those conversations. All of us can easily pull to mind several, often painful, examples of situations where we've either given or received poor quality feedback. But why is this?

Well, part of the reason might be that, although it's an essential part of working in large teams, supervising and developing junior colleagues, and continuing our own professional development, the majority of healthcare professionals giving feedback on a day-to-day basis don't actually feel confident with the delivery of constructive feedback[1]. As a result, our colleagues and trainees may be being underserved in the

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New blogs include **Who I am not and Serving up constructive feedback - how to avoid those inauthentic sandwiches.** Look out for any tweets with the hashtag #FICMLearning on @FICMNews. If you would like to contribute content to FICMLearning, please get in touch via contact@ficm.ac.uk.

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