



TRAINEE EYE

12th Edition | September 2019

The Faculty of
Intensive Care Medicine

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HELLO AND FAREWELL FROM THE LEAD TRAINEE

Dr Andrew Ratcliffe

Lead Trainee Representative

Firstly, and most importantly, a warm welcome to all our new ICM colleagues who have taken up posts since August! We hope you are all settling in well and have been able to meet with fellow trainees and trainers to help explain the process of ICM training. You have joined a great specialty at an exciting time in our history – particularly as we look to celebrate the 10th Anniversary of the Faculty next year. Similarly, many congratulations to all those recent CCT holders who will be leaving the training programme over the coming weeks and months to take up substantive posts around the country. We wish you all the very best in your future careers.

With so many new starters at this time of year, it seems apt that this month's edition has a strong educational slant to it. The importance of maintaining a contemporaneous logbook will form a key part of your progression at ARCPs throughout your training. Dr Tan, who established the NW ICU Logbook, updates us on his progress and reflects on the intricacies of developing such a tool.

Many of you will face challenging and sometimes unexpected scenarios during your training. We are fortunate to have a highly supportive and approachable group of consultants and trainers to provide additional advice during such events. Whilst we cannot prepare for all eventualities, experiential learning through simulation can provide us with a safe environment to hone the knowledge and skills that we can call upon at a later date. The in-house simulation course established at Leeds has done just this. We hear from the organisers as they reflect on its success over recent months.

ICM training offers us huge opportunities – both within the UK and elsewhere. Training can, and in many cases will, take you down many different routes to get you to your CCT. These may include additional modules, specialist study years, fellowships and research posts to name just a few. In this issue,

Drs Leith and Scott outline their experiences from two very different perspectives – one based firmly on the ground within the hospital ultrasonography department, whilst the other takes his ICU training up into the clouds as an aeromedical retrieval doctor.

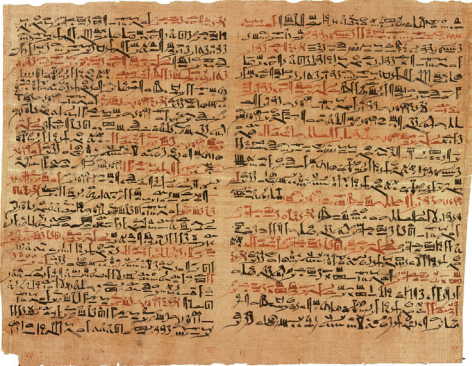
The rotational nature of training often creates difficulties in undertaking extensive research or project work. The realisation of quality improvement projects within our curriculum now means all trainees must partake in a small number of larger QIPs during their training. A group of trainees in the northwest has established the National Audit and Research Cooperative of Trainees in Intensive Care Medicine (NARCoTIC). As Dr Johnston explains, this exciting new development will enable trainees from around the country to come together and undertake larger scale research projects – something that is sorely needed within our specialty.

And finally, this will be the last edition of Trainee Eye that I will help to edit. As the twilight of my own training begins to set in and my time as Lead Trainee Representative comes to an end, I must take this opportunity to offer my sincere thanks to the Faculty for all their help and encouragement over the last couple of years; for the opportunity to sit on the Board and hopefully make some small positive contribution to our training; to Dr Gould (my predecessor) and Dr Benson for their ideas and guidance, and finally, but by no means least to the unwavering support from the secretariat who work tirelessly behind the scenes to make sure our training runs as smoothly as it possibly can. To those of you who might be considering taking up the role in the future – go for it! It's hard work, but one of the most rewarding and enjoyable roles I've taken on during my training. Good luck!

Dr Mark ZY Tan

Dual trainee in Anaesthetics and Intensive Care Medicine

In 1862, one of the most important ancient Egyptian medical manuscripts in history was bought by dealer Edwin Smith. Named the Smith Papyrus (c.1600BCE), it is presented as a list of 48 case histories of various injuries. That these descriptions were likely collated experiences from physicians of old meant that observations about patterns had been made, a process that is supported by written or mental logs of patient encounters.



In August 2018, I launched the NorthWest ICU Logbook; a free, personal, fully editable spreadsheet-based logbook for ICM practitioners of all levels. While the form of logging might have changed since the times of the Smith Papyrus, medical professionals continue to log cases to aid learning, develop clinical acumen, hone pattern recognition skills and partake in clinical governance and accreditation.

Over a year since its launch, I follow its uptake and spread, reflect on lessons learnt and share some future plans. My hope is that it may serve as an encouragement for other projects that will further enrich and develop our growing speciality.

Logbooks in medicine

One could pick many examples from other specialties to demonstrate the importance of logbooks.

The Royal College of Surgeons' pan-surgical eLogbook boasts 31000 users. It remains a key part of their

ARCP and revalidation processes. For the trainee, it serves not only as evidence for procedures, but allows them to identify gaps in competence, aids in reflective practice and provides a quantitative way of gaining confidence as they progress through their training. For the College, the ability to interrogate procedural numbers has allowed them to maintain their standards of competence, while being realistic about achievability after the implementation of the European Working Time Directive. Likewise, the Royal College of Obstetricians and Gynaecology stipulates recommended numbers of various procedures for progression through stages of training.

Logbooks also play a vital role in many procedural accreditation modules. Most ultrasound accreditation modules make use of a logbook to evidence minimum numbers to achieve competence. These not only include FICE and CUSIC within our speciality, but also Emergency Ultrasound from Royal College of Emergency Medicine, Echocardiography from British Society of Echocardiography and Pleural Ultrasound from the British Thoracic Society, amongst many others. The use of a logbook allows different supervisors to ensure trainees achieve competence through deliberate practice, which is evidenced by the logbook and later on, the actual procedural accreditation. This standardised, transparent approach to governance ensures patient safety and practitioner competence in a system focused on providing safe, effective and efficient care.

Progress

I was very fortunate to have the support of the Training Programme Director, Head of School and Regional Advisor in my region. Soon after its launch, I found myself speaking at my own ST3 induction, introducing the logbook to fellow new trainees in the region. From there, various channels of dissemination occurred through online professional groups and word of mouth. Uptake was slow but steady. The logbook website gained a big boost in traffic after it was presented and approved by the Training,

Assessment and Quality (TAQ) committee for listing on the FICM website.

Three versions have been released since launch, with improvements and corrections made from user feedback. This has helped to keep the logbook relevant and responsive.

Lessons and Reflections

“Doesn’t that sound a little absurd...”

Audacious as the rest of the song might be, it is the bottom line from Robbie Williams’ song, ‘I Will Talk and Hollywood Will Listen,’ which sums up my disbelief with the current success of the logbook thus far.

Getting help and advice early on from key trainers and consultants was extremely helpful for the development of the project. They not only gave valuable advice regarding how the logbook would fit into ARCP requirements for trainees, but also expressed interest in the logbook for their own use. As a result, a few fields were added to cater to consultant use, increasing the target population of the project. Moreover, they sent draft versions to other FICM tutors in the region to gain further advice and input. With their input, the first release of the logbook was already useful for practitioners of various grades and seniority.

Analytical software built into the website allowed me to track the spread of the logbook. This provided a quantitative measure of the success of the logbook. Despite the initially steep learning curve to programme the software into the website, I am very pleased that I had taken this into account at the start of the project. The software has given me data to prove that the logbook indeed had good uptake, but it also gave me reason to continue developing both Mac and Windows versions.

A project like this occupies a significant amount of time, which for a dual trainee with a young family and multiple other responsibilities outside of the curriculum, was extremely stressful. I experienced burnout through the last year, not just due to this project, but several other situations both at work and at home. Fortunately, my wife and some close friends provided essential support during these struggles. I’m

thus still in the process of learning how to prioritise and juggle different projects at different times while letting some opportunities pass me by.

Future directions

Both Mac Numbers and Windows Excel versions will continue to be updated and supported. I am trying to further improve and refine the dataset and summary graphs, while retaining the ability to edit the spreadsheet. This will continue to make the logbook relevant and appealing. I might be unable to keep up with all the diverse interests across our specialty, but the ability to edit the spreadsheet will enable others to personalise their own logbooks easily. I depend on feedback for further version upgrades, so am keen to receive feedback and sharing of edits.

Training data provided by logbooks has the potential to play a larger role in the ICM training scheme. It will allow a more in depth view of each stage of training, provide insight not just into procedural numbers to achieve competence, but also into caseload, which in turn will help influence the evolution of our specialty. We are aiming to analyse pooled logbook data to understand current areas of training excellence and inform improvements where needed.

If you have benefitted from the NW ICU Logbook, please share it with friends and colleagues. I will also be very happy to receive any comments about it.

The NW ICU Logbook is freely available via the Manchester and Mersey Anaesthesia and Critical Care training website: logbook.mmacc.uk

The author can be contacted at: nwiculogbook@gmail.com

THE VALUE OF MULTI-DISCIPLINARY HIGH-FIDELITY SIMULATION AS AN EDUCATIONAL TOOL IN CC

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Simulation, which is allied with the constructivist theory of experiential learning, has become commonplace in the training and education of all healthcare professionals. As such, the [Royal College of Anaesthetists Simulation Strategy 2018-2023](#) describes the role of simulation as “a proven and powerful tool for learning in healthcare at the level of individual and team-based practice, which can offer a unique method to identify and rehearse the development of critical non-technical skills, as well as key team working skills and behaviours that underpin effective and safe clinical practice”¹.

The value of simulation within the critical care community is such that within the updated GPICS v2 section 2.3 ([Workforce, Induction & Training of](#)

[Medical and Nursing Staff](#)) the provision of a “regular multidisciplinary educational programme, including simulation involving medical, nursing and allied health professional staff”² is a recommendation which should form routine practice in UK Intensive Care Medicine.

Advances in technology have brought about a change from low to high-fidelity simulators, which along with an investment in the value of the process itself, have led to the provision of more in-situ simulation opportunities such as those recently described in our institution in the setting of major trauma³. Previous authors in Faculty publications have described the objectives, experiences and challenges of simulation development in critical care^{4,5}, and I recently read

with interest and a degree of reflection, an article entitled, “What do non-critical care residents actually learn during an intensive care unit rotation: time to find out!”⁶. Although I hasten to add that we have not provided the answer here, it is important that we consider “learning” at both the individual and organisational level⁷.

In common with other Trusts across the UK, at the Leeds Teaching Hospitals NHS Trust we have invested in the process of developing a multi-disciplinary high-fidelity critical care simulation course. In common with other critical care-based

simulation programmes, there are a number of shared objectives based on the knowledge and skills required to manage the clinical

“Advances in technology have brought about a change from low to high-fidelity simulators, which along with an investment in the value of the process itself, have led to the provision of more in-situ simulation opportunities

scenarios (common but mismanaged emergencies, rare situations but with potentially devastating consequences, and those pertaining to local critical incidents), as well as the functioning of the critical care team (communication, teamwork, leadership and human factors).

The development of the course has benefitted immensely from the availability of a dedicated simulation fellow, and rotational multi-disciplinary faculty representing each of the candidate backgrounds, as well as shop floor consultants with an interest in simulation and education. As a one-day course it typically runs with candidates including 4-5 doctors on current ICM rotations, some of whom are new to the UK in MTI roles, and 8 band 5/6 nurses, with an increasing attendance

from our Advanced Critical Care Practitioner cohort, which reflects the bedside staffing levels during emergency situations out of hours. We have well-developed scenario templates with variations in scenario progression dependent upon candidate decision-making, and benefit from the support of the in-house simulation audio-visual team with both a 'live' faculty room and 'cold' observation room with eye-in-the sky live action footage and video playback. There is a formalised debrief session splitting nursing and medical learning objectives separately, but delivered together, and followed by a whole group MDT discussion about non-technical skills and human factors. Further evidence-based learning points are disseminated after the course to cement core knowledge, including relevant guidelines, protocols, pathways and resources.

The feedback collated from candidates show that the format is universally well received with 98-100% of all candidates from all backgrounds rating it as above average or excellent in all domains. Over 90% of all candidates have rated the overall course, its relevance to their practice, and importantly the debrief as 'excellent'. When the feedback comments are reviewed subjectively, the themes receiving the most positive feedback are those relating to the multi-disciplinary presence and natural escalation pathways, the opportunity to observe others and be observed in a non-threatening high emotion and environmental fidelity scenario and the value of the debrief and its relevance to each individual's scope of practice. Our experience and the feedback from the Leeds Intensive Care Simulation Course, suggests and supports the growing body of evidence showing the benefits of simulation-based education in Intensive Care, and the possibility to broaden the opportunities to instil in-situ simulation into routine critical care service provision can only add to its value – both for the individual learner and as a means of testing environmental system error and by strengthening organisational learning⁷.

References

1. RCoA Simulation Working Group. Simulation strategy 2018-2023. RCoA 2018. Available at: <https://www.rcoa.ac.uk/system/files/Simulation-Strategy-FINAL.pdf> [accessed 7 August 2019].
2. Gallacher T, Cook S, Platten J. Workforce, Induction and Training of Medical and Nursing Staff. In Guidelines for the Provision of Intensive Care Services 2019;2:40-43. Available at: <https://www.ficm.ac.uk/sites/default/files/gpics-v2.pdf> [accessed 7 August 2019].
3. Menon R, Holmes C, Davies A, Taylor M. Multidisciplinary major-trauma in-situ simulation. Available at: [RCoA Bulletin 2019;116:40-41](https://doi.org/10.1177/1743284419844411)
4. Khan S. Human Patient Simulation in Intensive Care Medicine Training. Available at: [FICM Critical Eye 2012;2:19-20](https://doi.org/10.1177/1743284412261920)
5. Jacques A. Simulation. Available at: [FICM Critical Eye 2017;11:24-25](https://doi.org/10.1177/17432844177112425)
6. Cao S, Ladowski S, Goffi A et al. What do non-critical care residents actually learn during an intensive care rotation: time to find out! Available at: [Canadian Journal of Anesthesia 2019;66:874-876](https://doi.org/10.1111/anae.14874)
7. Castren E, Kumar S, Hutchinson S. Can in-situ simulation influence organisational learning? Available at: [RCoA Bulletin 2019;116:32-33](https://doi.org/10.1177/1743284419844411)

Achieving Level 1 British Society of Echocardiography (BSE) accreditation during a Clinical Fellowship in Intensive Care Medicine with Echocardiography & Ultrasonography

Dr Donald Leith

Clinical Fellow in Intensive Care Medicine

Echocardiography & Point Of Care UltraSound (POCUS) offer rapid and accurate diagnosis of multiple life-threatening conditions. It is therefore unsurprising that the recent Guidelines for the Provision of Intensive Care Services (GPICS) document recommends access to both at a patient's bedside, and that transthoracic echocardiography is a standard of care for patients requiring cardiovascular support¹.

Over the last year, I have been a clinical fellow in Intensive Care Medicine with Echocardiography & Ultrasonography at East Surrey Hospital, Redhill. I had completed Core Medical Training, had aspirations to follow an Acute Medicine and Intensive Care dual accreditation pathway and was keen to further explore Intensive Care Medicine as a career. Most importantly, I had recognised the value of adding Echo and POCUS to my clinical skillset.

The goal of the fellowship was to achieve FICE (Focused Intensive Care Echocardiography) and CUSIC (Core UltraSound in Intensive Care) accreditation in addition to gaining experience in critical care medicine.

Each week, half a day of designated scanning time was built into the busy critical care rota to facilitate training and completion of my logbooks. Through a combination of excellent tutelage, making full use of my designated scanning time, and by scanning in my free time, I was able to complete my FICE logbook within three months. Keen to build on this achievement, and with support from my enthusiastic, fully BSE accredited supervisor (Dr Theophilus Samuels, Consultant in Intensive Care Medicine and Anaesthesia), I began working towards the relatively new Level 1 BSE qualification. I had not fully appreciated the challenge I had set myself at the time, however after four months of hard work and additional hours, I was rewarded with accreditation and am currently one of nine practitioners to hold this qualification.

FICE & CUSIC: Both FICE and CUSIC are run by the Intensive Care Society and require a formal training course, submission of a logbook, and completion of a triggered assessment within one year. FICE also includes an e-learning module. Training, assessment and logbook sign-off are overseen by a mentor and a supervisor, roles which may be held by the same individual².

FICE answers binary questions about the heart and its function: Is the left ventricle impaired or dilated; is the right ventricle impaired or dilated; is there pericardial fluid; is there evidence of hypovolaemia; and is there pleural fluid? The logbook requires 10 supervised and 40 independent scans. CUSIC assesses the chest, abdomen and deep veins for pathologies such as pneumonia, pulmonary oedema, pleural effusions, pneumothorax, ascites, hydronephrosis and deep vein thrombosis. The CUSIC logbook currently requires 30 chest, 25 abdominal and 10 deep vein scans. It also requires evidence of ultrasound guided vascular access as well as pleural and ascitic procedures. Notably, a new combined FICE/CUSIC qualification called FUSIC (Focused Ultrasound in Intensive Care) is due to be launched in December 2019 by the Intensive Care Society².

British Society of Echocardiography (BSE) Level 1 Accreditation:

BSE level 1 trains candidates to assess the ventricles in more depth than FICE, looking for major regional wall motion abnormalities in addition to overall function. It also trains them to detect significant aortic- and mitral-valve abnormalities using 2D and colour flow doppler imaging, and to recognise aortic root dilatation and echocardiographic features of cardiac tamponade.

Level 1 training is overseen by a fully accredited BSE echocardiographer. Candidates collect and interpret a logbook of seventy-five scans and must undertake a practical assessment (held twice per year) to earn their

qualification. The logbook, collected over a maximum of 12 months, is evaluated during the practical assessment, and must contain a specific case-mix. The other components of the exam include a practical scanning station, and an observed reporting station³.

Level 1 does require more work by comparison with FICE. There is a larger curriculum, scans require new views and introduce colour flow doppler, reports aim to detect more subtle abnormalities, and finding specific pathologies (eg Aortic root dilatation) for the logbook can be challenging. The additional diagnostic information that can be taken from these bedside scans in emergencies however, is an enormous advantage to intensive care doctors.

Clinical Value: Over the course of my fellowship, there have been many cases in which my use of echocardiography and ultrasonography have altered patient management. A few of the more memorable cases include:

- A patient who presented at night with hypotension and collapses having recently been discharged after an aortic valve replacement. I discovered a large pericardial collection causing right ventricular embarrassment on echo, which helped us to expedite his transfer to a tertiary centre for definitive management.
- A patient whose septic shock was resistant to noradrenaline, in whom I found new left ventricular (LV) impairment (retrospectively diagnosed as a septic cardiomyopathy) which responded rapidly to low-dose adrenaline.
- Several patients in respiratory failure with unremarkable chest X rays in which a CUSIC scan found an interstitial syndrome consistent with pulmonary oedema, and Echo demonstrated a newly diagnosed impaired LV function.
- A patient for whom my finding of significant restriction of the aortic valve, confirmed on formal transthoracic echo, prompted transcatheter aortic valve replacement once he had recovered from his critical illness.

Challenges: Doctors wishing to train in Echocardiography and POCUS face several challenges. A significant amount of time needs to be invested in training, with bookwork, attendance at courses and scanning time required to complete the logbooks. Combining the demands of clinical practice with post-graduate examinations and training in a new skill is a daunting prospect. Furthermore, there is a significant time commitment for supervisors in training doctors in these skills. Not every hospital has supervisors for FICE, CUSIC or BSE level 1 and if they do, finding sufficient mutually agreeable times over 12 months for training and logbook review can be extremely difficult. The value of the designated training time in my rota during this fellowship therefore cannot be understated.

Conclusion: Echocardiography and POCUS offer great diagnostic and procedural value to patient care and form part of national guidelines for intensive care¹. FICE and CUSIC are well-established training programmes that provide a very useful skillset. Level 1 BSE accreditation is a relatively new qualification that offers additional, important diagnostic information on top of FICE, but has a more arduous curriculum, scanning skillset and assessment.

It can be a significant challenge for trainees to find supervisors and protected time to scan in order to achieve these qualifications while simultaneously managing the clinical demands of a busy training job. A year out of programme for clinical experience (OOPE) in a clinical fellowship such as that offered by East Surrey Hospital Critical Care overcomes many of these challenges and offers trainees dedicated scanning time and teaching in addition to enormous experience in applying these skills to critically unwell patients.

References:

- 1 Faculty of Intensive Care Medicine & Intensive Care Society (2019). [Edition 2. Guidelines for the Provision of Intensive Care Services London.](#)
- 2 Intensive Care Society [internet]. FICE & CUSIC Accreditation [cited August 2019]. Available at: <https://www.ics.ac.uk/ICS/Accreditation/ICS/Accreditation.aspx?hkey=c88fa5cd-5c3f-4c22-b007-53e01a523ce8>
- 3 British Society of Echocardiography (2019) [internet]. Accreditation in Level 1 Echocardiography. [cited August 2019]. Available at: https://www.bsecho.org/media/248079/level_1_accreditation_pack_2019.pdf

EUROPEAN AEROMEDICAL REPATRIATIONS AND TRANSFERS

Dr Liam Scott

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The words 'air ambulance' usually conjure images of helicopters, orange flight-suits and pre-hospital transfers to nearby Emergency Departments. There is, however, another less familiar aspect of aeromedical work: elective transfers across international boundaries in 'fixed-wing' aircraft, flying faster, higher and further than our rotary colleagues. I have always loved flying, but my ambition to study Medicine won over any inclination to become a pilot like my brother. However, a chance conversation with a colleague during ST3 opened my eyes to the many aeromedical flights occurring in European skies on a weekly basis. It seemed the perfect role to combine my love of aeroplanes with the intensive care 'day-job'. So for the last two years alongside my dual training, I have flown 2-3 days per month with Capital Air Ambulance, based in Exeter.

The transfers are predominantly funded by travel insurance, bringing holidaymakers or business travellers back home for specialist treatment or ongoing rehabilitation. We provide a bed-to-bed service, including road transfers before and after each flight. The medical work is highly varied: from well, stable patients with straightforward problems (e.g. isolated long-bone or pelvic fractures, post-operative recoveries), through to ventilated, unstable ICU patients on multiple inotropes or infusions (e.g. severe sepsis, polytrauma, post-arrest). The majority of my missions have been to Portugal, Spain and the Spanish islands, with an eclectic selection of other destinations thrown in - Norway, Croatia, Latvia, Iceland, even Kosovo. Patients can be repatriated to anywhere in the UK or Ireland; occasionally we fly patients from the UK back to their home country, or fly one segment of a much longer journey as part of a 'wing-to-wing' transfer. Capital also provides the emergency provision for the Channel Islands; on-call days can see us dispatched at short notice to transfer unstable patients to tertiary services on the mainland. The majority of European missions are completed in a single day, but every so often, a longer trip to a further destination

(or an unexpected medical, avionic or meteorological complication!) results in an overnight stay abroad.

Capital flies two types of aircraft (five Beechcraft KingAirs and three LearJet 45s), all specially modified and fully equipped for aeromedical transfers. The twin-turboprop KingAirs are semi-pressurised aircraft flying up to 28,000ft, and feature heavily in the fleets of many international air ambulances. The luxurious LearJets are modified private business jets; flying above weather systems (and commercial airliner routes) up to 50,000ft, they are very fast, smooth, spacious and comfortable.

As an adjunct to the usual ICU day-job, aeromedical work has plenty of attractions. There's the excitement of flying around Europe in the back of small aircraft, ducking in and out of different countries for just hours at a time. At the airports, we get to work behind-the-scenes: out on the tarmac while holiday jets taxi nearby, then popping in and out of countries through small security back-gates. We get to experience hospitals, healthcare systems, ambulances and medical practices quite different from our own. Patients and their families are usually very pleased to see us, often being the first English-speaking, UK-trained medics they've encountered since falling ill. The flight nurses I work with are all highly skilled and experienced, and there is a strong sense of camaraderie between the medical and flight crews. The planned (and unplanned) overnight stays abroad are also a welcome bonus!

The work is not without its challenges. The days can be very long; a single-day mission in a KingAir to southern Portugal might typically involve 4-5 hours of flying each way, not including the time spent packing kit, travelling in land ambulances, or preparing, stabilising and handing-over patients on the ground. The nature of repatriation also means that clinical work usually happens in the second half of the day, when fatigue may be starting to set in. The information and handovers we receive abroad can be incomplete, non-

existent, or completely incomprehensible (my Spanish is pretty basic!). The working environment is small and isolated, and as a family member often travels along too, we are very much 'on show' the entire time. Upon arriving in the UK, we also occasionally face the challenge of explaining to receiving teams that we have done our best with our limited space, time and resources, but that ultimately we have only been looking after the patient for the preceding 3-6 hours,

and can't unfortunately justify the previous three weeks of foreign management decisions!

In summary, fixed-wing aeromedical work is an exciting, highly satisfying and relatively unusual medical job in which to utilise knowledge and skills in a unique environment with its own specific risks and challenges. It is definitely worth it - there are not many ICUs with a view of the Alps from 28,000ft!



Image 1. Refueling the LearJet in Leeds, before departure to Alicante



Image 2. Unloading the medical kit from a KingAir in Majorca.

NATIONAL AUDIT AND RESEARCH COOPERATIVE OF TRAINEES IN INTENSIVE CARE

Dr B Johnston (Northwest), Dr A Waite (Northwest), Dr A Boyle (Northern Ireland), Dr P Bamford (Northwest), Dr R Goss (Southwest), Dr P Turton (Northwest), Dr S Williams (ICS Trainee Research rep), Dr N Williams (WICM rep), Dr J Gardner (SICS rep).

NARCoTIC Committee/Representatives

The National Audit and Research Cooperative of Trainees in Intensive Care (NARCoTIC) was launched at the UK Critical Care Research Group meeting in June 2019. Trainee-led research collaboratives offer the opportunity for trainees to conceive and run large-scale multi-centre audits and research studies. The multiple routes of entry from Medicine, Emergency Medicine and Anaesthesia into Intensive Care Medicine (ICM) means that ICM trainees are ideally placed to conduct audits and research across a number of acute specialties, with potentially significant and far-reaching impacts on patient care and outcomes. Whilst trainee-led research networks are not new, NARCoTIC is the first network specifically representing ICM trainees.

The NARCoTIC committee had its first meeting in April 2019 and agreed the following mission statement: *“We are a UK-wide group of ICM trainees who aim to facilitate and inspire audit, quality improvement and research in ICM trainees. We will coordinate national audits and research studies, and support trainees in the development of projects that could be run across the UK. We are open to all trainees and ICM-affiliated clinicians, and will establish partnerships with ICNARC, the ICS, FICM, and other national bodies to collaborate on trainee-led and delivered projects.”*

We are inviting all ICM trainees to get involved by following the NARCoTIC Twitter feed @NARCoTICUK and registering interest via the NARCoTIC website <https://narcoticuk.wordpress.com> or emailing us at narcoticuk@gmail.com

We are looking for keen and enthusiastic ICM trainees to register their interest in helping establish local trainee groups nationally. We know that many regions will already have trainee-led research groups and we hope to engage with and collaborate with these groups.

Similarly, we hope to strengthen links and collaborate with trainee groups in Scotland, Wales and Northern Ireland and we are glad to say that these regions are represented on the NARCoTIC committee.

Whilst we envisage that the majority of members will be ICM trainees, we are keen to develop relationships with the wider ICM multidisciplinary team and hope that NARCoTIC membership will include Advanced Critical Care Practitioners, physiotherapists and any member of the MDT interested and passionate about getting involved in and conducting research in critical care.

We are currently developing our first national research project that will be an observational study and audit of current clinical practice and management of new-onset atrial fibrillation (NOAF) in critically unwell patients admitted to an intensive care unit. NOAF is the most common arrhythmia seen in intensive care and affects up to 15% of general intensive care admissions and up to 46% of patients with septic shock. It is thought that the aetiology of NOAF during critical illness differs from NOAF in non-critically ill patients, however specific guidance for the management of NOAF in critically unwell patients is lacking due to the lack of available evidence. A recent poll conducted by NARCoTIC highlighted the variation in clinical practice when treating NOAF, in the choice of first line agent used and at what heart rate clinicians choose to treat NOAF. However, we do know that the increased risk of thromboembolic events and mortality associated with NOAF result in a significant clinical and economic burden and have an associated impact on quality of life for patients. This project aims to determine the incidence of NOAF, define risk factors for the development of NOAF and evaluate the management of NOAF in intensive care units across the United Kingdom. It is hoped that this national project will inform further research into

NOAF and lead to the development of long overdue guidelines for the management of NOAF in critically unwell patients.

We are grateful for the support from intensive care organisations including ICS, FICM, UKCCRG and ICNARC. But to succeed in this project and ensure the establishment of an ICM trainee led research network we need motivated trainees to drive it forward, so please register your interest via Twitter, the website or email, and look out for information in your inboxes about how to get involved.

References

1. Yoshida T, Fujii T, Uchino S, Takinami M. Epidemiology, prevention, and treatment of new-onset atrial fibrillation in critically ill: a systematic review. Available at: [Journal of Intensive Care. 2015; 3\(1\):19](#)
2. Meierhenrich R, Steinhilber E, Eggermann C, Weiss M, Voglic S, Bögelein D, et al. Incidence and prognostic impact of new-onset atrial fibrillation in patients with septic shock: a prospective observational study. Available at: [Crit Care. 2010;14:R108.](#)

FACULTY LEADERSHIP: FICM DEPUTY TRAINEE REPRESENTATIVE

Notice is hereby given that an election for the FICM Deputy Representative will be held on 24 October 2019.

The elected candidate will take office at the Board Meeting on 15 January 2020.

The current Deputy Trainee Representative thinks you should apply:



Richard Benson
@RPBensonICM

Following

ICM Trainees. Today you will receive an email inviting you to stand to be a trainee representative for FICM.

This is a fantastic opportunity. A year ago I was uncertain about applying, I am so so glad I did.

Please feel free to get in touch with me and good luck
[@FICMNews](#)

11:23 AM - 2 Sep 2019

7 Retweets 19 Likes

19

Please see the Faculty website for more information on the role and on how to apply. If you are interested in standing in the election, you need to submit your paperwork to contact@ficm.ac.uk by **5pm on Monday 30 September.**

REFLECTIONS ON BEING THE LEAD TRAINEE

Dr Andrew Ratcliffe

As the year heads towards its closing months, so does my tenure as Lead Trainee, a role that I never anticipated holding nor indeed ever felt quite ready for. Yet it is a role that has been one of the most rewarding, eye opening and enlightening roles I have taken up during my training.

I have never been one of the most outspoken of trainees; some of my colleagues would undoubtedly consider me “quiet.” Yet over the last two years, I have become your national representative, and have had to very rapidly develop my “voice”. So what have I learned about the Faculty, myself and what it takes to represent a diverse group of, often very opinionated, trainees?

The Faculty...

Without meaning to sound too sycophantic, this is made up of some of the most hardworking, dedicated educationalists I have ever met. Constantly striving to improve our lives as trainees – often to the detriment of themselves through the sheer volume of work that implementing any change takes – the Board members and the equally hard working secretariat are driving our specialty forward. In the last 18 months, I have witnessed huge advances in trainee wellbeing, support and working lives as well as the enormous amount of effort that goes into recruitment, examinations and the unenviable task of the curriculum re-write.

As trainees, we very often moan the seeming lack of, or pace of, change. I have received numerous comments asking if anyone is listening to our concerns about training/exams/courses/study leave/OOPes etc etc. Indeed the pace of change is very slow, but it is happening. It takes time and patience to make things change. Those seemingly endless feedback questionnaires, “death by SurveyMonkey”, are poured over and analysed to the “nth” degree, until every bit of information we can gather is extracted, acknowledged and, although perhaps not acted on immediately, recognised as an area to improve upon. So please, be patient, be proactive, fill in the surveys. They really do listen!

Myself...

I found my voice! I found myself sat in Board meetings, committee meetings, forums, Academies, and the occasional pub with some of the most well-known names in the UK intensive care community – often feeling out of my depth (through my own self confidence), but always acknowledged and included in the conversation. My voice, your voice – the trainee voice being listened to, questioned and understood.

Finding one’s voice in a boardroom full of senior, very well respected intensivists, with life-size portraits of past presidents looking down at you is somewhat daunting to say the least. Understanding the nuances of boardroom etiquette comes with time – rule number one: don’t spill coffee into the lap of an eminent consultant colleague during your first meeting whilst you frantically try to work out how to plug in your dying laptop under the table! But with time, observation and patience, comes the confidence to speak up and express the views that you are there to represent. And, actually, those views are equally as well heard as those of the coffee-drenched consultant sat next to you.

The real skill of representing a group of individuals as diverse and as vocal as many of us are, is to know what, when and how to say something to make the greatest impact for the largest group of people. Clearly, if I brought every email, text or conversation I had from trainees into the boardroom I would very quickly lose my voice and the attention of most of the room. What I have tried to do is take a pragmatic approach to the role. The easiest route to take is a negative one. It is very easy to cast aspersions on an idea, project or potential change to the shape of training. It is much harder to come up with the fully rounded package that is going to suit everyone. I have tried to speak up when I felt that we needed a voice (curriculum changes), when the opinion of the trainee body has been strong about a particular topic (paperwork overload, assessment burden), if the same area of concern had been raised by several individuals at different times (exam format, OOPes) and, arguably just as importantly, kept quiet at times

when the trainee voice is one that is either not needed, or perhaps not the most important one at a particular time. Finding a voice is one thing, finding a balanced one is something quite different.

And as a trainee representative...

Over the last 18 months, I have been asked my opinion on everything from the colour of the Faculty logo, through to changes to the exam regulations. The Faculty are keen to hear our views. It is our training and we need to take ownership of it. As trainee representatives, both regional and national, we can only represent your views if you let us know about them. We will not be able to address every single niggle you have, but if you have a question, concern or issue, I can almost guarantee that someone else has exactly the same issue. Do use your local and national representatives to do just that – represent you. If we are unaware of a particular issue, there is very little that we can do about it.

To some degree, it has been reassuring that the issues that concern trainees in my own region are the same

ones that the regional representatives are having in theirs. Where possible, I have attempted to reassure, direct, guide and facilitate many of your colleagues and their questions over the last couple of years, some resulting in significant changes to policies and procedures, some, for various reasons, less so.

Regardless of the outcome, what I can happily report is that the trainers around the country and in particular within the Faculty take our views seriously, are hugely supportive of us and when necessary, examine individual requests and cases with rigor and great consideration. As a group of trainees, we are very lucky to have the backing of this group.

It has been hard work, but an honour to be your national representative over the last couple of years and although small, I hope the changes that have taken place during my time are having their desired impact. I would encourage any of you with an interest to strongly consider applying for the position and help continue to improve and further develop this great specialty.

EDUCATION AND E-ICM

Recent trainee Focus Groups demonstrated that we wanted greater flexibility within our training programme and greater support for training. Flexibility is being addressed in the current curriculum re-write, whilst a further step to improve educational support and provision has led to the formation of the Education Sub Committee. This subgroup, that will feed into the Training, Assessment and Quality (TAQ) Committee, will take the lead on e-ICM modules, educational events and aim to host regular podcasts as blogs on key areas of the curriculum, thus broadening the reach of the traditional “London centric” courses. If you’re interested in contributing, let us know.

e-ICM www.ficm.ac.uk/news-events-education/e-icm continues to grow and develop as a hugely beneficial resource for all trainees. e-ICM is a joint venture between FICM and [e-Learning for Healthcare \(e-LfH\)](#). There is a wealth of information online that is free to access and covers many of the more challenging

aspects of the curriculum. Regularly updated with new modules and now with updated new learning paths to help locate the most relevant topics, e-ICM should be one of your first “go-to” choices not only when revising but also for your continued CPD post exams. To access e-ICM you must first register with e-LfH. You will then be able to complete the modules and link them to your ICM curriculum in your ePortfolio.

UPDATED GUIDANCE ON STUDY BUDGETS

Health Education England (HEE) has recently produced new guidance for the provision of study leave and allocation of study budgets. This ties in with the Enhancing Junior Doctors' Working Lives project to address concerns raised by doctors in training.

The new guidance aims to provide transparency regarding budget allocation and deliver equitable access to educational resources based on individual trainee needs. Whilst it remains the responsibility of the employing trust to provide time for mandatory training and approval, study leave remains at the discretion of placement providers to ensure that the overall needs of the service can safely be delivered. There is a new emphasis on an individualised approach to study leave, based on discussion between trainees and their educational supervisor.

The document also details HEE's position on study leave within OOP placements, grace periods and on attendance at educational courses and conferences.

The full document can be found [here](#).

TRAINEE SURVEY 2019

Thank you to all of those that took part in this year's Trainee survey. We are busy working through the data and aim to produce the 2019 report towards the end of this year.

In addition to the annual questions concerning work placements, this year's survey also included targeted questions addressing LTFT, rest facilities and ACCPs. Your answers are invaluable for the ongoing work of the Faculty and its Committees and are used to observe trends and target areas for future improvement. Thank you for taking the time to complete the survey and for providing such insightful comments.

PUBLICATION AND GUIDELINES

[GPICS v2](#) officially launched in June this year.

This document outlines the core standards and recommendations that should take place as routine practice in UK intensive care units. Endorsed by all critical care key stakeholders and written in conjunction with the Intensive Care Society, this document forms the definitive reference for the planning and delivery of Adult Critical Care Services in the UK. I would implore you to familiarise yourself with this document and its recommendations.

CURRICULUM UPDATE

The re-write of the curriculum, under the direction of the Training, Assessment and Quality (TAQ) Committee, has now finalised all 14 High Level Learning Outcomes (HiLLOs) and mapped them to the new curriculum. These have been written in conjunction with other key stakeholders – notably the Royal College of Physicians, Royal College of Anaesthetists and Royal College of Emergency Medicine. The aim is to ensure that all elements of the curriculum are included in at least one HiLLO and that skills and capabilities of the curriculum that are assessed whilst in any partner specialty can be easily transferred to any other specialty, thus maximising the opportunity for flexibility whilst simultaneously standardising training requirements regardless of base specialty.

The focus of TAQ in the coming months will be on the completion of the assessment strategy for the new curriculum as well as the development of educational tools to aid the implementation of the curriculum, which we currently hope to be in August 2021.

#DiscoverICM – GET INVOLVED

Those of you who are active on Twitter may have seen the #DiscoverICM campaign that ran in the lead up to the 2019 recruitment round. The campaign that featured short quotes from intensivists on why they love working in ICM, was very well received and we plan to make these Twitter releases a regular feature throughout the year to inspire and capture the interest of the Intensivists of the future.

We would love as many Intensivists as possible to be involved, if this sounds like something you would be interested in why not follow [Richard's lead](#) and tell us what you love most about working in ICM. Drop me an email at shall@fcm.ac.uk and I will send you the details.



#discoverICM
www.fcm.ac.uk/careers

"ICM combines diagnostic uncertainty and the intellectual challenge this brings with the ability to utilise practical skills, novel and exciting equipment and various medications to make a real difference. Best of all I get to do this as part of a team who strive to make a difference.

Downtime is important and days off during the week are fantastic at allowing me that important time with family. For me ICM gives that perfect work life balance."

Dr Richard Benson
FICM Deputy Trainee Rep

RAISING AWARENESS OF MEETING FULL SCOPE OF WORK DECLARATION

As part of raising awareness with regard to declaring the full scope of your work at ARCP (or equivalent), please find links to [guidance](#) and [supporting FAQs](#).

FFICM EXAM INFORMATION

The next sitting of the FFICM Final OSCE/SOE will take place on 15-16 October 2019.

The next sitting of the FFICM MCQ examination is 7 January 2020. Applications for this examination open on 7 October 2019 and close on 21 November 2019. The format of the examination has now changed to include 50 MTF and 50 SBA questions answered over 3 hours. For more information and example questions, visit the [FICM examination page](#) on the website.

Details about the FFICM exam, including regulations and fees can be found [here](#)

CRITICAL EYE

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 January 2020) please get in touch at contact@fcm.ac.uk

NEW FICM DEAN AND VICE DEAN

Many Congratulations to Dr Alison Pittard and Dr Danny Bryden on their successful appointments as Dean and Vice Dean respectively. We wish them all the very best as they take up their new roles on 30 October 2019.

ICM EPORTFOLIO UPDATES

Summary Overview page

This can be found under the Progression menu. This has been updated to make it more user friendly.

Two tabs have been incorporated into the Summary Overview.

Existing Forms (see screenshot 1 below)

The Existing Forms tab allows users to view all the forms they have created in one place as well as carry out “Actions” on those filled forms (i.e. Create a new form, send a Ticket for a new form, View or Edit the existing form, or Link to the existing filled form).

Screenshot 1

The screenshot displays the 'Summary Overview' page. At the top, there is a 'Select Year or Post:' dropdown menu set to '-- Select All --'. Below it is a 'Form Groups:' section with a 'Select' dropdown and a 'Refresh' button. The main content area has two tabs: 'Existing Forms' (active) and 'Available Forms'. A search bar is located on the right side. The list of forms is organized into groups:

- ACAT SLE CMT**
 - ACAT SLE CMT 20 Dec 2017 (Acute Internal Medicine), (Test, Test) - Actions: View, Link
 - ACAT SLE CMT 26 Aug 2017 (Acute Internal Medicine), (test, test) - Actions: View, Link
- Audit**
 - Audit (20 Sep 2018) Ross testing - Actions: Edit, Link
- MSF Self**
 - MSF Self (03 Oct 2017) - Actions: View, Link
- Quality Improvement Project Plan**
 - Quality Improvement Project Plan (20 Dec 2017) - Actions: View, Link
- Reflection on Learning Event**
 - Reflection on Learning Event (25 Sep 2018) test - Actions: Edit, Link

Available Forms (see screenshot 2 on following page)

The Available Forms tab lists all the forms available to that particular user with Create/Ticket options where permissions allow.

The new look page should be easier to digest and navigate, and uses a consistent approach to the listing of forms. The Summary Overview page previously excluded Declarations and Agreements plus Reflection forms and often listed forms in an inconsistent order, the new Summary Overview page contains all forms in alphabetic order. The form published title and filled form title, previously shown in two separate columns,

have been concatenated to improve readability. Button sizes have been increased to further improve usability on small/touch screen devices.

The new page also includes a ‘Search’ bar allowing users to quickly and easily locate content in either the Existing Forms view or the Available Forms view. Users with a large amount of existing and/or available forms should also find the ability to filter down to specific form groups of benefit.

Screenshot 2

Summary Overview

The screenshot shows a 'Summary Overview' page with a search filter set to 'CT2 - Kerala (India) (01 Dec 2017 to 31 Dec 2018)'. Below the filter, there are tabs for 'Existing Forms' and 'Available Forms', and a search input field. A list of curriculum items is displayed, each with a pencil icon, a '+ Create' button, a 'Ticket' button, and an 'Info' icon. The items include: Attendance at organised teaching, Audit, Reflection on Clinical Event, Reflection on Learning during an Attachment, Reflection on Learning Event, Reflection on Management and Leadership experience, Reflective Practice After Events, Research Publication, and Teaching you have delivered.

Curriculum Overview page (see screenshot 3)

This can be found under the curriculum menu. This has been updated to improve the usability.

Previously the Curriculum Overview page was inconsistently aligned, often appearing jumbled, and, importantly, did not lend itself well to display on smaller screen devices. The small pencil placed adjacent to each rateable curriculum item was difficult to spot and it was unclear what it actually did. The update should now benefit from a more usable page and mobile/tablet friendly page. The larger, right-aligned, rate button (still with a pencil icon) along with the link button should be more obvious

and will improve usability on small/touch screen devices. For some devices, you may need to use the scroll bar at the bottom of your screen to scroll all the way to the right hand side to see the 'rate' and 'link' blue buttons.

Furthermore, the Curriculum Overview page previously contained help text at the top (before the curriculum items themselves). This took up a lot of space on the page and meant that anyone using the curriculum on a small/touch screen device had some serious scrolling to do! The curriculum help text is now hidden by default. An (i) icon is now present and when clicked, this shows the curriculum help text in a pop-up.

Screenshot 3

Broad Based Training (Broad Based Training Programme Curriculum)

The screenshot shows the 'Broad Based Training (Broad Based Training Programme Curriculum)' page. It features a 'Competencies' section with an 'Expand All' button. Below this, there is a 'Communication' section. A list of communication items is displayed, each with a pencil icon, a 'Rate' button, a 'Link' button, and a 'View' button. The items include: History taking, 05/07/2019 Above Expectations Ross Meikle (NES TEST) "You are doing well", 05/07/2019 Above Expectations Ross Meikle (NES TEST) "I am excellent at this", Initial Meeting with Educational Supervisor (31 Jul 2018) (Brian Brilliant), The patient as central focus of care, 05/07/2019 Below Expectations Ross Meikle (NES TEST) "You can improve in this area", 05/07/2019 Above Expectations Ross Meikle (NES TEST) "Needs work", Initial Meeting with Educational Supervisor (31 Jul 2018) (Brian Brilliant), Reflection / Learning Log 06 Aug 2018 (Test 1) (Significant Event Analysis), Screen_Shot_2017-09-05_at_14.27.29.png, and 25-April-2018-SCOTLANDS-DIGITAL-HEALTH-AND-CARE-STRATEGY-published.pdf.

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