CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE ISSUE 23 | WINTER 2023

Sustainability and looking to the future

The Faculty of Intensive Care Medicine

In this issue

VISION FOR THE FACULTY

SUSTAINABILITY IN CRITICAL CARE

TRAINEE RESEARCH

UPCOMING EVENTS 2023

www.ficm.ac.uk/events

BOOKINGS NOW OPEN!

Training & Leadership Annual Meeting (TLAM)

2 February 2023
Online

BOOKINGS NOW OPEN!

FFICM Prep Course

27 February 2023
Online
and
7 March 2023
RCoA, London

SAVE THE DATE!

ACCP Conference

12 June 2023
RCoA, London

Advertised programmes may be subject to change

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WELCOME

Dr John Butler
Clinical Editor

Can I begin by wishing everyone a happy and productive new year and also by welcoming our new Dean and Vice Dean to their roles on the Faculty Board.

Following the election in July 2022 Dr Bryden becomes the fifth Dean of the Faculty since its inception 12 years ago. She is ably supported by Dr Parry-Jones who succeeds Dr Bryden as the new Vice Dean. Between them they bring a wealth of experience and knowledge to these roles and I wish them every success over the next few years.

The Faculty has plenty to look forward to in 2023. I am sure that everyone applauded the public announcement in October 2022 that the Faculty, supported by the Royal College of Anaesthetists trustees, is aiming towards the establishment of an independent College of Intensive Care Medicine. The goal of an independent College was always the ultimate ambition from the very early days of the formation of the Faculty. At the outset FICM was created with the considerable support of colleagues from other medical specialities. Since then, substantial strides forwards have been achieved and the Board has now taken the progressive view that an independent college is the next necessary step for greater membership representation, credibility and autonomy. This journey will take some time and considerable commitment to navigate but the prize of having our own 'home' college at the end of it will make all the effort worthwhile.

In her first Dean's statement Dr Bryden outlines how the Faculty will explore our vision for the future of Intensive Care Medicine in the UK and how the Faculty can best represent the views of its fellows and members. She highlights the benefits of having independent college status and how it is crucial to hear the opinions and aspirations of the fellows and members of the Faculty during the initial engagement phase of this development. I would strongly encourage everyone to fully engage in this process.

I hope you enjoy reading this edition of the newsletter. We welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

Message From The Dean

Dr Daniele Bryden
Dean

Identity matters. What contributes to our own identity is highly personal and considerably more than a few random facts that might form a picture. I'm the fifth Dean of the Faculty, the third woman in that position and work in adult intensive care in Sheffield. I'm also someone who was not part of the Faculty Board at its inception twelve years ago (so don't consider myself hidebound by the past) and was rejected the first time I applied to become an examiner. Now I've got a few paragraphs to introduce myself to you and outline why now is the right time for us all to explore our vision for the future of ICM and how a future college can better represent our own professional identities.

Making a public announcement of starting work to scope the move to an independent college is an ambition that has been in plain sight from the outset. Julian Bion's first statement as our founding Dean indicated "*The new Faculty is not a destination. It is a starting point. This unique opportunity will only bear fruit with the full support and active participation of the profession.*" FICM was created with the direct and indirect support of colleagues from other medical specialties and professional groupings. This support and friendship are emblematic of the way we intend to move forwards with advice and help as we all look towards the next step of this journey.

Engagement

When FICM first started, its Board consisted of appointed members and representatives. In the intervening years we've moved to an elected Board that is increasingly diverse, including in their individual opinions and experiences. We recognise that to create for a common future, one viewpoint or opinion cannot predominate and the drive for diversity and inclusivity continues. Whilst the Faculty is the statutory professional organisation whose responsibilities inevitably determine some of its actions, we're all individual Fellows and members within it and should have a voice in determining how we're represented. Understanding that the organisation is the sum of our Fellows and members influences decisions and actions, but as we start this process of engagement, we want to know

> **"Our vision for the future is for a college that is a trusted and authoritative professional organisation, that is bold enough to recognise opportunity and work differently, more sustainably and as a more inclusive, global organisation.**

what more we can do for you. The Board has a clear vision that a college is the next necessary step for greater membership representation: as a Faculty we do not fully control our own future, as a college we will have greater autonomy.

As an example, a move to independence would allow us to determine our financial and work priorities and associated staffing more directly: it is right that you tell us what those priorities should be. It's both noteworthy and gratifying that in her public statement after the announcement, Fiona Donald, President of the RCOA, recognised not just the desire of the RCOA to work with us but the enormous development of ICM since the Faculty was established. We've punched above our weight as the Faculty; to continue to do so and achieve what we would like for the future, we need to do that as a college.

Each Dean has moved the Faculty forwards and it is my great honour and responsibility to be part of that continuum. My role as Dean is to stand on their shoulders and steer us closer to that collegiate vision. That's why we're starting this process of engagement and fact finding so we can listen to community voices, discover your values and aspirations for the future of our specialty and the college we eventually create together.

Professional identity

Our vision for the future is for a college that is a trusted and authoritative professional organisation, that is bold enough to recognise opportunity and work differently, more sustainably and as a more inclusive, global organisation. For many of us, our professional identity in the ICM team may not be the same as it was 12 years ago, partly due to the changing demographics of the ICM workforce, and also due to the impact of the pandemic and the way healthcare is changing. It's time to be progressive and explore how a move to becoming a college gives us the ability to create an organisation that reflects those working in ICM now and in the future. For some, your professional identity and vision may not be the same as those around you. We need to hear from all of you to ensure that we keep our desire for inclusivity at the heart of planning.

The Faculty is still focused on the basics of our current functions namely training, workforce (continuing a multifaceted approach to recruitment, retention and supported working) and professional standards (including recently starting work on GPICS v3). We also know that some of you would like more from us. If we are to achieve this now, as well as in the future, we need to hear from you. We will be aiming to engage directly with as many of you as we can through as many channels as possible as we outline the detail of our engagement.

Involvement

We do not expect the formation of a new college to be a quick process which is why we are not presently putting an exact timeframe on this work. However, after our initial process of engagement, we hope to have a clearer idea of your aspirations which will help inform a likely timeframe and how we continue to involve you as we develop along this road. In the interim, contact@ficm.ac.uk will bring you directly to us and the Board.

Jack Parry Jones our new Vice Dean, the Board and I are all here to listen: we ask that you tell us your needs and vision as we start to outline the many futures and identities we could have working in a College of ICM.

Message from the Vice Dean

Dr Jack Parry-Jones
FICM Vice Dean

It is an honour to write as Vice Dean, and a real pleasure to support Danny Bryden as our new Dean. I feel very fortunate to have worked with Danny in the Faculty and we both feel very fortunate to work with the Faculty Team and Faculty Board. The public statement of our intent to evolve from a Faculty to a College, sets us on a journey as a Board, as a specialty and as individuals.

In 2004 I wrote an editorial entitled 'Anaesthetist or Intensivist'[1]. I made a case for separating anaesthesia from critical care; that Intensive Care Medicine had reached specialty status where it should stand alone.

I argued the complexity of critical care necessitated a separate specialty and that appropriate training in intensive care was more important than base specialty. In response, some implied I was naive and impatient whilst one explicitly stated it was my personal insecurities that led to these views. Luckily, at that time social media did not exist.

Greater autonomy

In a typically kind and supportive reply, Professor Mervyn Singer[2] wrote "Dr Parry-Jones makes an impassioned and cogent plea for a clear distinction to be made between anaesthesia and the nascent specialty of intensive care. It was not that long ago that anaesthetists strove for greater autonomy from the Royal College of Surgeons (under whose auspices they fell as a faculty) in order to achieve more credibility, influence and an enhanced status."

He went on: "with professionalism comes trust and respect, and the specialist tag."

Professor Singer advocated for patience and to allow our deeds as intensivists, as well as our thoughts, behaviours and words, to speak for themselves. During the pandemic our deeds spoke for themselves.

The ensuing years since 2004 have allowed our thoughts, behaviours and words to be more cognisant of where we have come from, as well as where we want to go. I learned, albeit slowly, that independence as a specialty is more a process than an outcome. That process continues now with more urgency but it will take time.

A home for all

Intensive care in the UK has changed a lot since 2004, not least the birth of the Faculty of Intensive Care Medicine in 2010 and single, dual and triple CCTs and Certificate of Eligibility for Specialist Registration (CESR). It is worth remembering the UK Intensive Care Society is over five decades old.

Where before the Royal College of Anaesthetists was seen by most

FICM Board members, October 2022

practising in intensive care as their 'home' college, that is no longer the case.

Those with single, dual or triple accreditation, but without anaesthesia now need to feel that they equally will have a 'home' college; a college where feeling at home is governed by people's recognised training, not by their 'other' specialty.

The complexities of critical care continue to increase. It is our patient's needs that should primarily govern who cares for them, how we train them, and how we subsequently self-identify.

Support and recognition

The COVID-19 pandemic has led many more, outside the environs of intensive care to believe that Intensive Care Medicine is sufficiently professionalised, trusted and respected for us to seek College status. It is especially gratifying to have the support and recognition from the Royal College of Anaesthesia.

COVID-19 truly demonstrated where our closest friends are — in anaesthesia, infectious diseases, respiratory, emergency, and acute medicine. Our ability to manage during the pandemic was enhanced immeasurably by these friendships. A UK College of Intensive Care Medicine status does not lessen those bonds but seeks to build on them.

Becoming a college will give the specialty the necessary credibility, influence and status to build on the foundations laid by intensivists over decades. It is my pleasure as Vice Dean to continue their work.

References

1. Anaesthetist or Intensivist. Parry-Jones AJD. *Hospital Medicine*, Editorial. September 2004, Vol 65, no 9.
2. Anaesthetist or Intensivist: continued debate. *Hospital Medicine*, October 2004. Vol 65, no 10.

Your New FICM Board Members

Shashi Chandrashekaraiah

I qualified from Mysore University, India in 2001 and moved to the UK in 2003 with a keen interest to pursue a career in Intensive Care Medicine(ICM).

I am a Consultant in Anaesthesia and ICM at Lancashire Teaching Hospitals NHS Trust (LTHTR) since 2015 after completing training in the Northwest. I have been Associate Director for Postgraduate Medical Education at LTHTR since April 2022.

I have been the Royal college of Anaesthesia/ Faculty of intensive care MTI lead since 2019 and a member of the RCOA MTI leadership group. I have been a member of FICM's Careers, Recruitment and Workforce Committee since 2019 and amember of the FICM Training, Assessment and Quality committee since 2021. I am the FICM CESR lead and a RCOA CESR assessor since 2022.

Special interests: Ultrasound and ICU beyond walls; Workforce development and developing support systems for career progression of locally employed doctors; Simulation based human factors and communications skills training.

Dhruv Parekh

I am a Consultant in Intensive Care and Respiratory Medicine at the University Hospitals Birmingham NHS Foundation Trust and Associate Professor at the University of Birmingham. I graduated from Bart's and the London Medical School, completing clinical training in London and higher specialist training in Intensive Care Medicine, Respiratory and Internal Medicine in the West Midlands.

I am currently a Faculty Tutor at University Hospitals Birmingham NHS Trust and co-Education lead of our large department. Regionally I am the Integrated Academic Training Lead for ICM, Acute and Respiratory Medicine and have led the successful growth of our ACF and ACL programme. I sit on the ICM and Respiratory Training committees and the School of Anaesthesia Board. I am the Deputy Lead of the Birmingham Acute Care Research Collaborative integrating research between the NHS and academia. Nationally I sit on the BTS Critical Care Advisory Group. As Programme Director of the Birmingham NIHR/Wellcome Clinical Research Facility and Deputy Theme Lead of the cross-cutting Acute Care Research Collaborative within the Birmingham Health Partnership I oversee a breadth of academic and industry led research.

I am immensely honoured to have been elected to the FICM Board. I am passionate about representing the diverse voice of our critical care community and to ensure research, education, innovation and well-being is embedded in practice to future proof the specialty for our patients and members. Outside of medicine I am the proud father of three children, governor of our local school and enjoy travelling and experiencing new cultures.

Pete Hersey

I am the clinical lead for critical care in South Tyneside and Sunderland. My clinical work is split over two sites, working between a large general ICU and one of the country's smallest units. I also deliver anaesthesia, but that role is diminishing as time goes by.

My first involvement with FICM was as a Faculty Tutor, subsequently becoming the deputy clinical lead for the e-portfolio. I worked to improve the 'old portfolio' before helping to develop the Lifelong Learning Platform and prepare it for launch.

In 2016 I was appointed by the Faculty to work with Health Education England to create the e-ICM programme. I then formed the Education Sub-Committee, which oversees the educational strategy of the Faculty and produces regular content under the banner of FICMLearning. I joined the Training Assessment and Quality Committee in 2019, and in 2021 I was delighted to be awarded a Faculty Commendation.

Working with the Faculty has allowed me to make a positive difference to the specialty, something I plan to continue whilst a member of the Board.

Matt Williams

I have been a Consultant in Critical Care and Anaesthesia at Portsmouth Hospitals University NHS Trust since 2005, following medical school at Bristol University and postgraduate specialist training in the South West and Wessex regions that included overseas posts at the Alfred in Melbourne, Australia and at the University of Michigan. My professional interests are in medical education, ethics, and patient safety.

I have previously been Faculty Tutor, Clinical Lead for Organ Donation and the Clinical Lead for Simulation at Portsmouth Hospitals. I have been a FFICM examiner since 2014, as an OSCE sub-group member with an interest in the Simulation station. From 2016, I have been the Regional Advisor for Wessex, and more recently FICM's Deputy Lead and then Lead Regional Advisor during which terms I organised three TLAM meetings and sat on the TAQ committee. The terms have coincided with the pandemic and being the FICM's lead for the transition to the 2021 ICM curriculum. Whilst testing and turbulent times, it has been enlightening and a privilege to have been in these positions, working closely with key FICM personnel and the stakeholders we interact with to help coordinate the specialty's response and to keep ICM specialist training on track.

I am delighted, humbled and honoured to have been elected to the FICM Board. I aim to embrace and respond to the challenges and opportunities that the specialty of ICM faces, now and in the future.

Humanising Critical Care and Improving Recovery

Developing and Delivering Critical Care Rehabilitation Garden Service at University Hospitals North Midlands (UHNM)

Lucy Powell
Rehabilitation Coordinator

Stephanie Hagger-Knight
Advanced Physiotherapist

Jo Steele
Rehabilitation Coordinator

Dr Ramprasad Matsa
Clinical Lead, Critical Care
Corresponding Author

Background and Purpose

Evidence suggests fresh air and natural daylight improves recovery[1] and promotes rehabilitation. Patients in the Critical Care Unit [CCU] can become deprived of this basic need. Moreover, lack of natural light affects multitude of factors including mood, circadian rhythm[2], disorientation etc all of which can lead to delirium. In turn, this can impact upon patients' engagement in rehabilitation process and eventually delays recovery. Therefore, it is important to provide such daylight therapy if possible and if it is safe.

The Royal Stoke CCU had access to a small outdoor area (service yard). This area was utilised for provision of daylight therapy as a pilot project. Although this is less than ideal, the patients and their family liked rehabilitation with natural light and fresh air. The feedback collected from the patients felt that the outdoor area had improved their mood and increased motivation to participate in the rehabilitation process. This warranted the need to formalise the process of delivering outdoor rehabilitation on a regular basis. However, the area in question is a service area and hence not always available and can sometime invade privacy and dignity.

Therefore, we developed a dedicated outdoor area to deliver critical care rehabilitation that has natural sunlight, greenery and at the same time has shelter from bad weather and space for the family and is safe. This article highlights our experience on successful development and delivery of Royal Stoke Critical Care Rehabilitation Garden service to humanise critical care and to improve recovery.

Developing the Critical Care Rehabilitation Garden

Concept and Design

A multidisciplinary project team that included critical care rehab team, former patients and their families was formed. This team led the design process to ensure that the facility would be fit for purpose and would provide an ambience to aid the patients' recovery process. Key factors such as patient safety, location and functionality were given an utmost importance.

Table 1
Factors to consider whilst designing the Rebah Garden
Level non-slip surface Raised beds Integrated seating Sensory lighting Sensory planting Shelter Heating Medical gases & electrical ports Provision for Crash Trolley Provision for emergency airway kit Communication devices for emergency Privacy Secure access Long-term sustainability Low maintenance

The design of the facility was rigorously explored through information gathering that included entry and exit points, bed and wheelchair accessibility, weather proofing [shelter and heating facilities], a multi-zone design, communication provisions for safety netting, seating area for the families, and interesting sensory planting (Table 1).

Additionally, staff wellbeing is a huge part of the team culture on our CCU, and consideration was given to enable staff to access the garden for quiet reflection and wellbeing when needed. The project was kindly supported by generous funding from UHNM Charity. The project team also raised funds through charity events.

Setting up the service: operational delivery

Staff and training

MDT staffing model for transfer of the patients to the garden area and the provision of therapy was developed taking into consideration the acuity of the patient. The model included the availability of the ACCPs, on-call medic etc. The guidance from ICS for transfer of the patients[3] was adopted and impetus was placed on safety.

The training for the staff involved was organised. Carefully planned scenario-based training were developed by a specialist simulation expert within the critical team. The simulation training included airway emergencies, evacuation of the patients during emergency situations etc. Multiple such training was delivered until the team were competent to transfer such patients.

Equipment

Equipment needs were identified and to prevent conflict with routine clinical transfers (MRI/CT/theatre) additional equipment was purchased. This included transfer trolley, airway and safety equipment, oxygen cylinders,

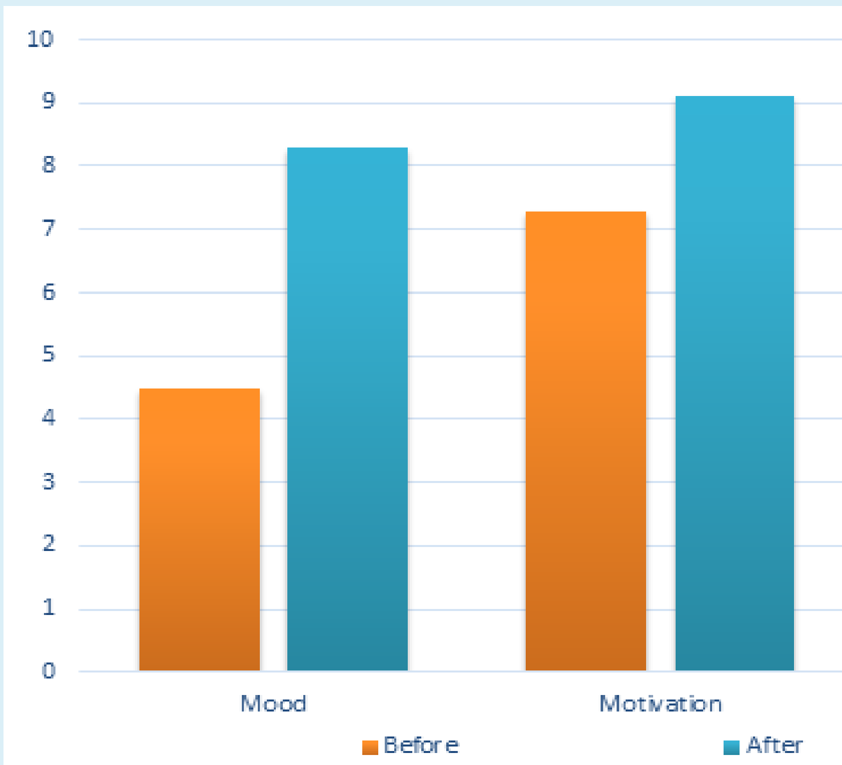
designated portable phones and team contact details. Moreover the special chairs and mobility aids were also included in the equipment list.

Governance, patient selection and administration

Strict governance process was adhered. Standard Operating Procedures for patient selection, transfer and recording of the adverse events was developed. Data collection tools were devised that included tracking of patient acuity, length of critical care stay, proposed therapeutic benefit [e.g., delirium, low mood etc.] and duration of visit. Indicators of effectiveness were identified and collected including goal achievements, garden activities and patient satisfaction. To regulate and optimise the use of the garden, an electronic booking procedure was developed, and the process was shared with therapy team. The data was further used to assess the effectiveness of such therapy and the objectivate the use of garden space.

Figure 2. *Patient feedback*

Figure 1. *Mean improvements in mood and motivation before and after Garden therapy*



The Results

The project "Humanisation of Critical Care" has demonstrated a clear benefit from the patient's perspective. This also provided the family members of the patients to interact and engage in the therapy activities of their loved ones, and they found such service very useful. The preliminary data is shown in the (Figure 1).

The qualitative feedback collected so far has been positive (Figure 2). The Garden area has also been used for the critical care staff wellbeing. There were no untoward events so far.

The Challenges

Logistical Delays

Project delays are inevitable, in our case contributed to by a global pandemic, but by strict management and adhering to realistic timelines, deadlines can still be met. Close collaboration between the project management team and clinicians is fundamental to identifying issues and solutions that may not have been foreseen and could derail the project.

Enabling staff to maximise therapeutic potential

Following on from this, enabling staff to have the right skills to ensure the most patients could benefit from a garden visit was of paramount importance. Early identification of team knowledge and skills gaps is essential to allow appropriate education strategies to be devised and implemented. At UHNM, we benefit from an established clinical simulation suite, and this provides an excellent opportunity for team members to develop

appropriate transfer and airway skills to support safe patient garden visits.

Under-utilisation is a possible risk given the acuity of the patient group, and careful planning and stakeholder involvement during the conceptualisation phase is crucial to ensure the space is functional and can support a range of therapeutic interventions. By incorporating distinct zones into the design, it enables more than one patient to access the garden at any one time and can provide confidential spaces for staff or relatives for quiet reflection.

Funding

Development of a strong proposal needs to balance service user feedback, research evidence and powerful testimonies to allow the decision makers to understand the positive impact that your project will have for this vulnerable patient group. For our project, we worked closely with the Trust communication team to use a variety of visual media to demonstrate the importance of the project which we were informed had a considerable impact in the success of our application.

Conclusion

Accomplishing the mammoth task of developing and delivering the critical care rehabilitation garden service from its inception, is due to the sheer dedication and hard work of all the members project team including the patients and their families. The UHNM Critical Care Rehab team are extremely proud and pleased with the fantastic rehabilitation garden now available to our patients, families and staff. There has been an overwhelmingly positive response to the garden and regular feedback is sought to determine our next steps in developing the space even further. Work is ongoing to maximize the number of patients that can benefit from the garden including CCU step-down patients and patients on different care pathways within the hospital. The future is to conduct research to address the true effectiveness of critical care garden in terms of hard outcomes such as cognitive improvement to make this project more rigorous. This would indeed make this project sustainable.

Acknowledgements

- The UHNM Charity for their generous contribution in funding this project
- All the fundraisers including the staff, friends and family that helped in funding this project
- Patients and their families for having participated in this project including design, and their feedback without which this project would not have happened
- Our Matrons Sr Barrington and Sr Bogucki for their support.

References

1. Park et al; The effects of natural daylight on length of hospital stay; Environ Health Insights 2018; 12
2. R Castro et al: The eff ect of light on critical illness; Critical Care 2011, 15:218
3. Intensive Care Society: Guidance for: The transfer of critically ill adults to an outdoor space during end of life care, August 2022

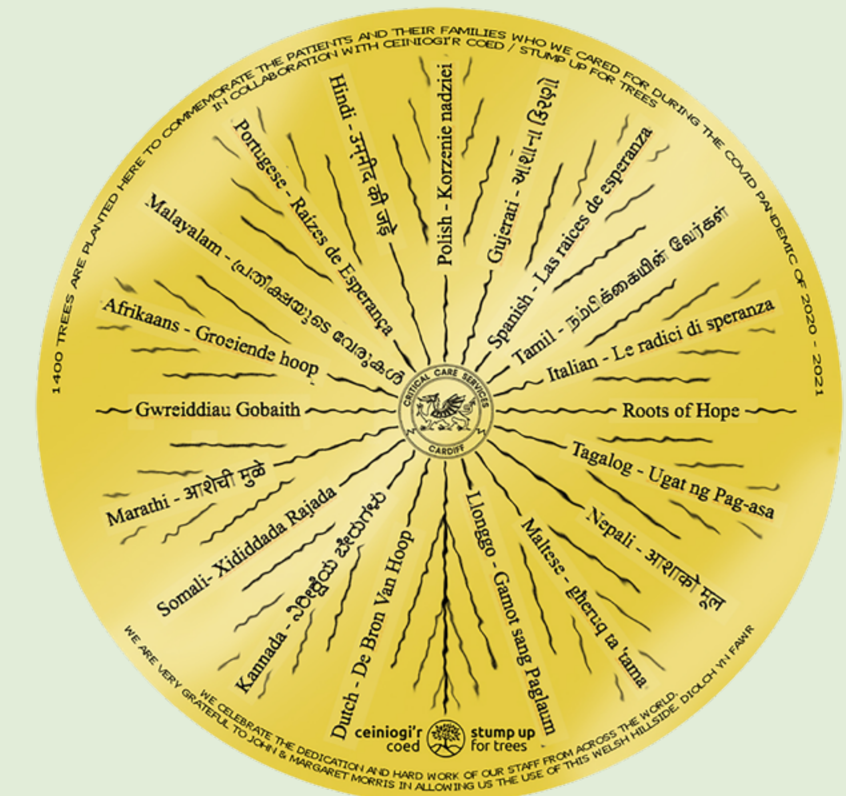
Gwreiddiau Gobaith
Roots of Hope

Dr Jack Parry-Jones

Dr Heather Baid

It's hopeless, what difference can I possibly make to the unfolding environmental catastrophe?

During a critical care follow-up clinic pre COVID-19 I was struck by the sharp contrast in outlook of two patients with similarly severe, residual effects of critical illness. Despite disabilities, one had a bright outlook and was supporting people he deemed less fortunate. The other was caught up in themselves and could not escape the loss of function imposed by their recent critical illness. In conversation, our clinical psychologist advised I read *Man's Search For Meaning* (Victor Frankl, 1946). Frankl's central hypothesis is that it is meaning in our lives that gives us the mental and physical strength to withstand the harsh vicissitudes of life; few being more harsh than a Nazi concentration camp.



I often think of Frankl's book. Some people survive, even flourish despite their critical illness and ongoing limitations. During the pandemic, when at a loss in how to get through the repetition of pandemic cycles I thought more purpose outside of critical care would be good. In addition, there was trying to recognise our critical care staff, particularly younger ones across the multidisciplinary team. From this sprang the idea of planting a memorial wood for patients and relatives that would also commemorate our staff. The wood is named 'Gwreiddiau Gobaith' (Roots of Hope). The critical care directorate raised over £5,000 and planted over 1,500 trees. Some relatives of patients also planted commemorative trees for their loved ones. Our critical care department employs people from across the world with over 21 languages spoken. 'Roots of Hope' has been translated into their first languages, representing them and the gratitude of the critical care department for everyone's unparalleled contribution to the critically ill in Cardiff. Raising money and planting tress provided a focus for hope that things can get better outside of a pandemic, but it also provided a renewed focus for our Green ICU group which has also cleaned rivers, beaches and the hospital site.

You don't need to be the perfect climate conservationist; a love of our natural world and a belief that acting together to improve our environments is enough. A healthy environment is good for our mental and physical health. It is good for our families' and our communities' health. Critical care units need to do their part; to reduce their carbon footprint, improve energy efficiency, and reduce waste. We can also help increase biodiversity on land, air and water by improving those natural habitats. Putting it more bluntly — climate change is a medical emergency. It affects our patient's physical and mental health, it affects our staffs physical and mental health and even more so, it will increasingly affect our children's mental and physical health. As healthcare professionals we have a duty to promote sustainable practices and living. For the Faculty we need to get involved more with our partner organisations. It sits clearly within our own strategic primary aim of improving care for patients and relatives.

What can critical care units practically do?

1. Collaboration

One of the great things about improving the environment are

the people involved. In south Wales we collaborated with a local charity StumpUpforTrees (https://stumpupfortrees.org). I would strongly recommend joining up with experienced environmental groups. You may have access to NHS land that can be planted, but for us it made better sense to work with a charity who had available land but needed people — planters.

The land we planted was unproductive farm land that could be better utilised as new woodland using native trees; thus restoring a welsh hillside to how it was 100 years ago. We raised enough money to plant 1500 trees with a plan to continue to plant further areas. Another charity to consider is the Centre for Sustainable Healthcare which includes the NHS Forest project as part of its Green Space for Health Programme. NHS Forest encourages biodiversity and engagement with nature at healthcare sites — see link below.

2. Set up a regular Green ICU meeting

Seek representation from your own NHS procurement, NHS estates, nursing, pharmacy, management and medicine. Our own Green Group is still at the start of a journey that seeks to improve energy efficiency and waste management; to purchase smarter, to deliver cleaner, greener care and improve biodiversity without impacting on care standards for patients. For example: we have instigated more energy efficient lighting (light emitting diode bulbs) and automatic switches where appropriate through the directorate. This saves considerable amounts of energy and expense. We have investigated our use and expenditure on non-sterile gloves. Our annual cost in a 36 bedded unit is now around £300,000 which reflects a huge increase in use during the pandemic and inflationary costs — vulture capitalism. The evidence for using these gloves in many healthcare settings is poor.

With education we hope to significantly reduce our use and therefore cost and waste. Our initiative is based on the 'Gloves off campaign' from Great Ormond Street Hospital. Their work predates the COVID pandemic. Better environmental practices need not be more expensive; in fact, they can save departments significant amounts of money and be more environmentally sustainable.

3. Get involved in a National Group

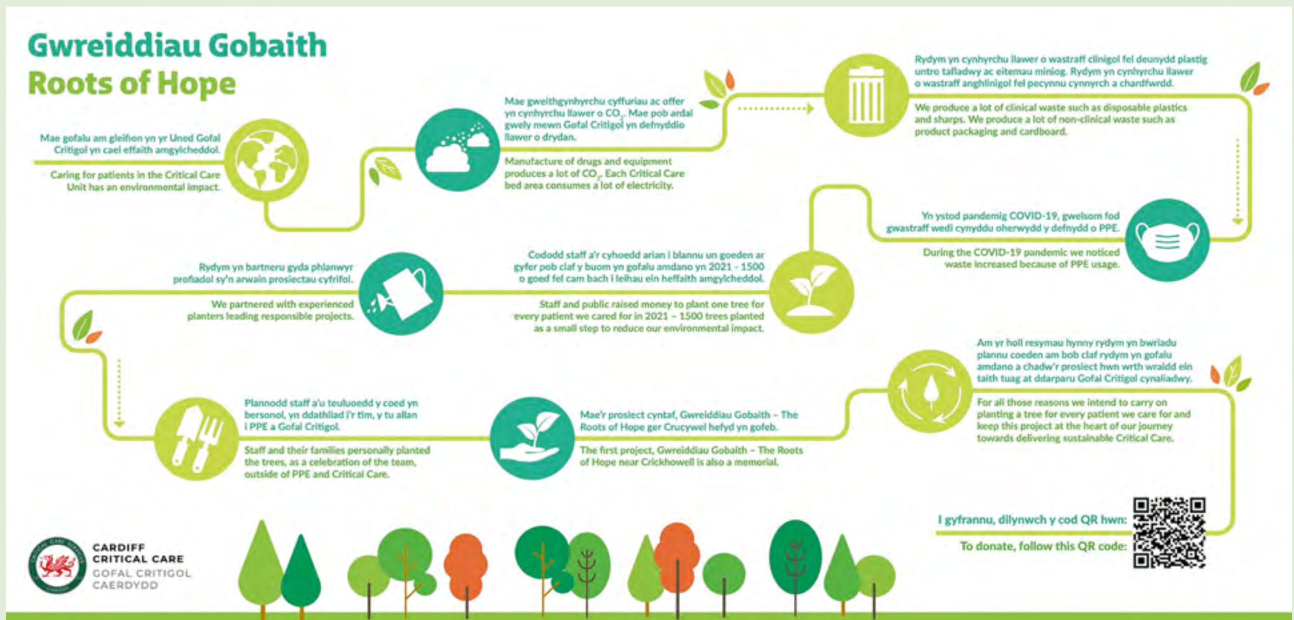
The Intensive Care Society (ICS) set up a Sustainability Group in 2021. It sought broad representation, recognising that we all face an ecological disaster that won't itself recognise human boundaries. The group is eclectic; ranging from those with expert knowledge, Professor Hugh Montgomery, Dr Richard Hixson, Dr Heather Baid and Rosie Cervera-Jackson to those keen amateurs like me, representing the Faculty of Intensive Care Medicine, with a wish to try and help bring about change. You can request membership of this group through the ICS — see link below. Climate change is a medical emergency. It affects our patient's physical and mental health, and as healthcare professionals we therefore have a duty to promote sustainable practices and living. The Faculty needs to get involved more because it therefore sits clearly within our strategic aim of continuing to improve care for patients and relatives.

Critical Care Susnet was set up in July 2022. It sits within the Centre for Sustainable Healthcare and is endorsed by BACCN and ICS. You can register for free to post on the blog site to ask questions, share examples of your own sustainability projects and learn from others. The Critical Care Susnet also hosts bimonthly sharing hours which are free on Zoom as an opportunity for informal discussion, invited speakers to focus in on particular topics and supporting each other to collectively improve the environmental footprint of ICUs. See link below.

4. Integrate sustainability into quality improvement

The SusQI model provides a structured, practical approach to improving quality healthcare using a sustainability lens. The SusQI framework helps clinicians to link together clinical, financial, environmental and social outcomes as a result of quality improvement changes. The Centre for Sustainable Healthcare have a dedicated SusQI website (see below) which contains free templates, resources and an educator pack.

Seek out how the SusQI model can be used by students and staff already undertaking audits as part of their course/job for routine quality improvement projects. While considering resourcing implications of a SusQI project, seek advice and involve procurement, estates and waste



management teams and use a multi-disciplinary approach within the critical care team.

5. Disseminate your sustainability projects

If you have completed a sustainability project, why not share this with others to help the critical care community to learn from your initiative and maintain hope that it is possible for ICUs to become more sustainable. The Intensive Care Society's State of the Art Conference (27-29 June 2023) has an environmental sustainability category for ePosters and oral presentations.

The British Association of Critical Care Nurses will also include a sustainability abstract option for its next national conference (11-12 September 2023). Also consider publishing your sustainability quality improvement project in a journal article using the SusQI model in the 'rationale' section of the SQUIRE framework — see link below.

The hillside we planted looks out onto an escarpment behind which lie the coal and steel works of the Welsh valleys. In the 1940s, it is thought Tolkien used this view as the basis for Mordor but the dust from the closed mines has now settled, the steam has gone and the steel works's fires lie cold.

The critical care community need to grow the green grass of sustainable critical care. We all need meaning in our lives and what better way than working together for our environment. We believe we can together make a difference in our homes and in our work places. We can reduce our environmental impact, reduce our carbon footprint and waste at work and return our industrial heritage sites to nature and biodiversity. But we need hope and the belief to do so.

Links

1. NHS Forest https://nhsforest.org
2. 'Gloves off Campaign' https://www.gosh.nhs.uk/news/gloves-are-off
3. ICS Sustainability Group https://ics.ac.uk/membership/sustainability.html
4. Centre for Sustainable Healthcare https://sustainablehealthcare.org.uk
5. Critical Care Susnet https://networks.sustainablehealthcare.org.uk/network/critical-care-susnet
6. SusQI https://www.susqi.org
7. Intensive Care Society State of the Art conference abstract categories https://ics.ac.uk/soa23/present-your-work/eposters-and-oral-presentations.html
8. British Association of Critical Care Nurses national conference https://www.baccn.org/conference/future-conferences
9. SQUIRE framework (Standards for QUality Improvement Reporting Excellence) http://squire-statement.org

CRITICAL EYE *Spotlight:*

Medical Support Worker (MSW) Role in Critical Care

Dr Rachel Saunders
ST7 Royal Devon and Exeter Hospital

The Special Skills Year is an opportunity for single specialty ICM trainees to explore other facets of Intensive Care. I successfully applied for the Faculty of Medical Leadership and Management (FMLM) regional Clinical Fellowship and undertook a secondment with the North West AHP and Nursing workforce team. They, amongst other roles, are experts in international medical workforce recruitment.

The FMLM programme lectures and workshops, combined with the expertise and experience gained through the secondment, enabled me to run a Medical Support Worker (MSW) programme for refugees and asylum seekers across the Northwest. These are some of the lessons I have learned.

Current pathway to GMC registration as an International Medical Graduate

International Medical Graduates (IMGs) who are living in the UK have to navigate a difficult path to gain GMC registration and enter the NHS. The process begins with a language examination (OET or IELTs); once passed, the doctors are eligible for PLAB 1 (a written exam) and subsequently PLAB 2 (an OSCE exam) before being suitable for a GMC licence application. Completion can take two to three years; during this time, many doctors are unable to use their skills, experience, and knowledge. Options for gaining experience in the NHS include unpaid clinical attachments and work shadowing opportunities; however, these placements ceased during the COVID-19 pandemic.

What is the Medical Support Worker (MSW) role?

"Without this opportunity, I would not be able to go back to my career, as MSW is a great opportunity. It was a huge step to take, as I have to leave my family." (MSW feedback)

The Medical Support Worker (MSW) role was coined during the COVID-19 pandemic to provide IMGs with clinical experience. In recent years, the role has been likened to that of a physician's associate, aiding with diagnosing and managing patients in primary and secondary care. MSWs can undertake a range of essential and routine tasks under the supervision of the health care practitioner in charge of the clinical area. Still, they cannot practice independently or undertake tasks that require registration (prescribing and ordering chest x-rays).

IMGs are eligible for the MSW role after passing the IELTs or OET language examination, with a GMC-recognised medical qualification, post-graduate experience working as a doctor for at least one year, and working rights within the UK. Typically, the role is for 12 months, and the salary is at the lower Band 6 Agenda for Change pay scale for 37.5 hours per week. Hospitals can recruit doctors directly into the role or engage with the National MSW programme, which provides salary support for hospitals and recruits every year (for more information, please see https://www.england.nhs.uk/coronavirus/returning-clinicians/medical-support-workers).

"Financially, I am secured now that I can pay for my study and exams without asking for help or support" (MSW feedback)

How the MSW role can benefit Critical Care

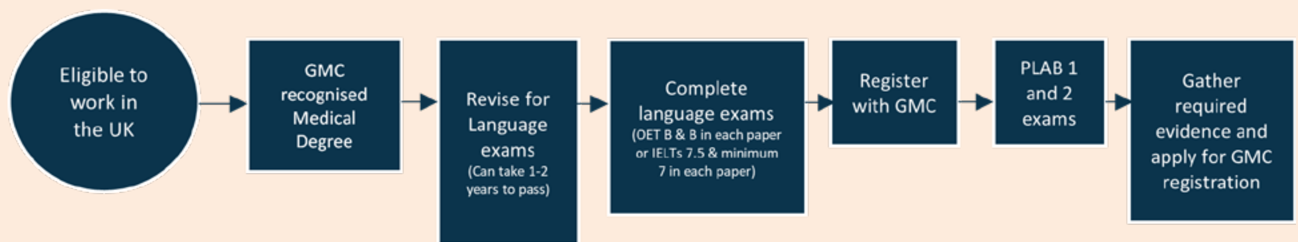
The short-term benefits to Critical Care departments are seen through the hybrid role that MSWs can adopt; helping with nursing and medical tasks. Furthermore, the Critical Care environment is ideal for MSWs as most trainee practice is supervised; therefore, the perceived burden posed by MSW supervision is minimal.

"It is amazing to work in the speciality that I am passionate about" (MSW feedback)

Examples of the workforce support an MSW can provide include:

- **Clinical support** through the documentation of ward rounds, examining patients, taking and documenting observations, updating microbiology results, completing daily reviews, assisting with critical care outreach, and preliminary assessments of referred or unwell patients.
- **Practical support** through turning and mobilising patients, cannulation, phlebotomy, taking blood cultures, setting up CPAP and hiflow, proning patients, and invasive procedures within their skill set, for instance, insertion of CVC lines, intubation, chest drains, etc.
- **Educational support** through journal clubs, departmental teaching, participation in audit and QIP, and data collection for research projects.

In the long-term, MSWs who gain GMC registration can feed into national training programmes, regional staff grade positions, associate specialty vacancies, and clinical fellowship roles. Many critical care units across the country are struggling to staff departments, and these recruitment difficulties are often heightened in district general hospitals and geographically isolated regions. Strategic hiring



of MSWs with the experience to meet the hospital's workforce needs once GMC registered, is a cost-effective and efficient way of addressing these difficulties.

Considerations for Clinical Directors and Lead Clinicians

"Still not everyone is aware about what exactly the role is" (MSW Feedback)

- **Ensure your department understands the role of an MSW.** This will help the MSW feel appreciated and included. The MSWs can only practice within the limitations of the GMC, so staff must understand which tasks MSWs should be allocated. Posters help explain MSW roles to staff, patients, and family members.

- **Interview prospective MSWs.** Ensure the prospective MSW's experience meets both your expectations and the need of the department. For example, in some countries, the role of a consultant can be more managerial and less practical, so ask about their previous day-to-day role as a clinician, what they can do and what skills may need refreshing.

- **Consider hiring a couple of MSWs.** MSWs work 37.5 hours per week. More than one MSW may be required to provide clinical cover and support over a week. The MSWs will undoubtedly benefit from peers providing valued psychological and social support.

"I sometimes feel not welcomed..." (MSW Feedback)

- **Involve third-party organisations and charities.** If you are thinking of directly recruiting MSWs, consider approaching the charity RefuAid, who supports a large pool of asylum seekers, refugees, and IMGs. Other regional organisations include REACHE, RAGU, Bridges, WARD, and the Lincolnshire refugee doctor project.

- **Align the MSWs expectations with your own.** Many MSWs have not worked in the NHS before, so time will need to be spent familiarising themselves with the UK system. Initial practice will be at a different level than the level of trainees, and therefore expectations need to be managed. The role of the MSW may be new to some IMGs, so discuss the expected responsibilities, tasks, and daily activities, especially if adopting the hybrid position. Assess which skills may need refreshing or development, and explore the knowledge and skills MSWs have which could enhance the unit or your practice.

- **Invest in your MSW.** Allocate a clinical supervisor who has time to spend in the initial months. MSW can obtain a Horus ePortfolio for meetings, documenting their clinical progress and feedback. Encouraging involvement in audit, QI, research, and teaching is beneficial to both parties. IMGs can begin completing appropriate parts of their CREST competencies during their MSW role, which will be helpful if considering transitioning into fellowship or trust grades roles. Finally, consider the allocation of study leave for exams.

"... this role provides me with an NHS experience, it also makes me more confident and update my skills and information." (MSW Feedback)

- **Clinical governance and support considerations.** MSWs can gain medical indemnity through MPS and are covered under the NHS resolution Clinical Negligence scheme. Line managers should handle complaints and concerns by following hospital organisational procedures. The BMA provides a 24-hour counselling service for refugee doctors and their families.

"This has had a huge impact, financially I can pay for my courses and study. Nothing will stop me." (MSW Feedback)

Education Sub-Committee

Dr Sarah Marsh
ESC Chair

The Education Subcommittee (ESC) is now entering its fourth year, and with that heralded the end of term for Dr Pete Hersey as the inaugural chair. Pete has overseen the creation of the committee and the development of FICMLearning, the home of educational output for the faculty produced by the ESC members. His commitment and enthusiasm for this venture will be missed and we thank him enormously for his contribution.

Dr David Melia will take on my role of Deputy Chair as I take on the baton as Chair to continue the work and I would like to take this opportunity to refresh what you may or may not know about the ESC and FICMLearning.

An introduction to FICMLearning

The aim of FICMLearning is to provide a hub for regular educational outputs from the Faculty and to signpost to other external useful resources, courses and events that intensive care staff would find helpful.

FICMLearning can be accessed through the FICM website, www.ficm.ac.uk/ficmlearning and is found on the top bar of the landing page. From here you can access the content produced by the Faculty which includes blogs, podcasts, the Case of the Month (COTM), Midnight Laws, simulation resources and webinars from previous FICM events. There is also a calendar of intensive care related events being held around the country — do get in touch if you would like to publish your event on this calendar. E-ICM is also signposted to from here.

Blogs — Content lead Dr Gilly Fleming

A blog is published once a month and allows the opportunity for some free writing based upon a topic of interest related to ICM. Topics have included blogs relating to training, for example how to pass the FFICM, Trainee Anaesthetists and Intensivists in Education and Recruitment and adapting teaching in response to the pandemic, blogs relating to the service including environmental sustainability in the ICU, clinical informatics and how to establish a follow up service as well as more focused clinical topics such as patient management following a volcanic explosion, Max and Kiera's law and even vancomycin. You can find them on the website or through twitter (@FICMNEWS) and will hopefully provide you with a light but insightful glimpse into ICM.

Dr Chris Allen has now left the ESC to focus on new projects and we'd like to thank him for his contribution as one of the blog content leads over the last 3 years.

Podcasts — Content leads Dr Gareth Thomas and Dr Rik Bell

Dr Martin Huntley and Dr James Sira have handed over the podcast mantle to Gareth and Rik — again huge thanks for their hard work in getting the podcasts off the ground and for making some really thought-provoking and valuable material.

The podcasts are free to listen to and can be accessed via the FICMLearning page as well as from Apple podcasts or Spotify (search FICMLearning). The podcasts have delivered discussions related to themes as well as to prescribed clinical topics. These include 'Knowing your team' (featuring dieticians, occupational therapists,

pharmacists, nursing staff, ACCPs, physiotherapists, and psychologists), 'The Coroner' (with medical examiners, a coroner, how to prepare for inquest), 'Simulation' (detailing how to get started, importance of debriefing and how to use it to improve patient outcomes) and 'Decision making' (discussing good practice in decision making, moral balance and futility as a framework for decision making). The podcast also features clinical topics with field experts such as ARDS and ECMO, renal replacement therapy, and frailty. The downloads from the podcasts exceed 1000 per month so thank you to all the listeners out there.

If there are topics you'd like to hear about or contribute to, please let us know.

Case Of The Month — Content leads, Dr Kyle Gibson and Dr Ramprasad Matsa

The Case of the Month is one of the most popular streams from FICMlearning and centres around a clinical case featuring a short history, followed by a succinct overview of a specific condition. The COTM is designed to be easy to read, and to provide bite-size learning on the go. Recent topics have included toxic shock syndrome, brain death, and right heart failure. The COTM is published monthly and aims to provide learning bursts that cover topics from across the curriculum. We're always looking for authors to come forward to take on a topic so please get in touch if this is something you'd like to contribute to.

Simulation — Content lead Dr David Melia

In the last two decades the use of simulation in healthcare has mushroomed. Its use in Intensive Care Medicine has accelerated, with both in-situ simulation and high-fidelity, high-technology courses becoming more commonplace.

In the summer we launched our new Simulation resource area within FICMLearning (featured in the previous edition of *Critical Eye*). Within this resource are documents relating to getting simulation started, how to debrief, templates on which to develop scenarios as well as links to external resources that may be helpful. In addition, new scenarios are added bimonthly that are ready to go or can be adapted as needed to make getting simulation going as easy as possible. This resource is by no means a complete package, but the start of something that we can grow as a Faculty. We hope to curate rather than create this resource, as we know there is so much phenomenal simulation occurring across the UK . Hopefully in time this will become your one-stop shop for all your simulation needs.

If you would like to share your simulation experiences or scenarios with the wider audience on here please get in touch.

e-ICM — Content lead Sonya Stone

e-ICM is a joint venture between the FICM and e-Learning for Healthcare (e-LfH) and provided by Health Education England. The programme was launched in August 2016 and provides nine modules of resources including e-learning sessions, links to open access review articles and guidelines.

Registration is free to all NHS staff members, students and those with OpenAthens accounts. It features over 700 sessions, mapped to the curriculum. New sessions are

continually being produced and published including 'Induction of anaesthesia in the critical care unit', 'Care of the collapsed pregnant patient' and one to look out for coming soon 'Ultrasound use on the intensive care unit'.

A number of learning paths have also been produced — these are essentially a bundle of sessions aimed to house relevant information for a specific purpose and includes 'New to ICU' (directed at personnel just starting out in intensive care medicine including ACCS and Core Anaesthesia doctors in training), 'Hard to reach areas of the curriculum' (aimed at higher level doctors in training) including sessions on the management of burns, tracheostomy insertion and mechanical assist devices, as well as sessions put together that address the 'Step Competency Framework' (Levels 1-3). A new learning path for ACCPs is also currently in production.

Annual meeting

This year's annual meeting was held virtually in May and was titled 'Fit for the Future'. The focus of this meeting was looking to the horizon for Intensive Care Medicine and included lectures on 'Environmental Sustainability in Intensive Care' (Dr Heather Baid), 'Generational Intelligence' (Dr Toni Brunning) and using 'Artificial Intelligence in the ICU' (Drs Post and Marshall). We also had frank and open discussions about the longevity of a career in ICM (Dr Joe Cosgrove) as well as developing a portfolio career (Dr Chris Danbury). The '10 clinical trials we need to do over the next 10 years' (Dr Charlotte Summers) created a lot of debate and ideas, as did 'POCUS — five applications that you didn't know you needed' (Dr Marcus Peck). Experiences of creating a sustainable workforce (Dr Sanjay Wijayatilake) and the vision for the development of critical care (Prof Ramani Moonesinghe) rounded off what was a thought provoking and inspiring day.

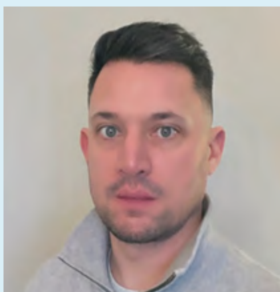
Prep course

The FFICM exam preparatory course was held in person this autumn for the first time since the pandemic started. In response to feedback entry to the two day event was widened to improve accessibility for candidates, with Day 1 (hot topic lectures) open to all, recorded and available to access after the day. A tier system was in place again which allowed candidates to access material online only, attend in person plus online access to lectures and mock questions, and finally full access including to the mock exam on Day 2. This enabled over 70 candidates to access the course and a model that we will work to improve upon going forward. The next FFICM Prep Course will take place over two days. 27 February 2023 will be an online lecture day, followed by an in-person mock OSCE and SOE day on 7 March 2023.

Survey

Now that the ESC is well established and in the aftermath of the pandemic the FICM would like to undertake a review of our current educational workstreams and events programme. A survey has been complied and will be sent out to you in due course to assess what you find useful and what you don't, and what you would like to see being produced and delivered in the future including for events. Without your input we cannot reflect on past work and improve going forward so please do take a moment to respond to the survey and help shape the future of FICM's educational outputs.

Trainee Research in Intensive Care (TRIC) Network: the past, the present, the future



Dr Brian Johnstone
ICM Trainee

The Trainee Research in Intensive Care (TRIC) Network was launched at the UK Critical Care Research Group meeting in June 2019. Originally known as the National Audit and Research Cooperative of Trainees in Intensive Care (NARCoTIC), our mission remains the same: to facilitate and inspire audit, quality improvement and research among intensive care medicine trainees and ICM-affiliated clinicians.

Whilst trainee-led research networks are not new, the TRIC network is the first network specifically representing Intensive Care Medicine (ICM) trainees and allied health professionals. The multiple routes of entry into ICM from medicine, emergency medicine and anaesthesia means that ICM trainees are ideally placed to conduct audits and research across the acute specialties, with potential for significant and far-reaching impacts on patient care and outcomes.

The pandemic

The first study to be run by the TRIC Network is a multi-centre longitudinal observational study assessing the Psychological Impact of COVID on ICU survivors (PIM-COVID). PIM-COVID was devised by trainees before being developed with clinical psychologists and ICUSteps. The TRIC network were fortunate to be awarded funding through the Intensive Care Society New Investigator Award, in addition to a charitable contribution from the Mersey School of Anaesthesia. Trainees have led the study, both in the central team with a trainee Chief Investigator and at sites with Trainee PIs, and for some trainees the study has facilitated their inaugural experience of clinical research. Study participants have answered questionnaires assessing for anxiety, depression and trauma symptoms at 3, 6 and/or 12 months after leaving intensive care. We have also collected data to assess whether there are demographic, clinical, physical and/or psychosocial predictors of psychological distress. Fifty-two sites have contributed to the study in England, Northern Ireland, Scotland and Wales. Over 1,600 patients were recruited with over 2,000 responses to questionnaires in total. We are now in the process of closing sites before we move into the data analysis phase of the study. We look forward to presenting the results at the Intensive Care Society's State of the Art meeting in June 2023. For updates about the PIM-COVID study you can follow @pim_covid on Twitter or visit the study website www.pim-covid.com.

The TRIC Network has contributed to several other studies. The COVID-19 Emergency Response Assessment a Professional Study (C.E.R.A) investigated psychological distress experienced by frontline doctors during the COVID-19 pandemic. The TRIC Network worked alongside RAFT, TERN and PERIUK to help promote and disseminate the survey throughout the UK. The study found that >50% of frontline acute doctors reported psychological stress during the early stages of the pandemic and has since been published in the *Emergency Medicine Journal*[1] and the *British Journal of Anaesthesia*.[2] We also collaborated with colleagues across the UK to conduct the 'ICU visiting and family communication during the COVID-19 pandemic' study. This was a national study involving 134 ICUs that characterised the significant changes in how units communicated with families during the pandemic and was published in *JICS*.[3]

After the pandemic

Ongoing collaborative work includes the NIHR funded EXTEND trial, a study investigating the use of long-term antibiotics in complicated abdominal infection. Members of the TRIC Network committee sit on the Trial Management Group and are working to build engagement from critical care trainees across the UK. This trial is registered with the NIHR Associate PI scheme and provides an excellent opportunity for trainees to become formally involved in research.

TRIC Network representatives are also involved with the NIHR funded AIRWAYS3 study, a multi-centre, randomised trial investigating the use of supraglottic airways vs endotracheal intubation in intrahospital cardiac arrest. This trial has commenced recruitment at pilot sites and its findings will provide intensivists with vital data to help guide airway management during cardiac arrest. Further details on both ongoing trials and the Associate PI scheme can be found on the TRIC Network website.

Future of the TRIC Network

With the PIM-COVID study coming to an end, we are very happy to announce that we will now be accepting proposals for the TRIC Network's next national project. Applications are open to all intensive care trainees who have an audit, research project, quality improvement project or service evaluation that they feel could be launched on a national scale. This is a brilliant opportunity for trainees to lead a national project of their own inception with the support of our well-established trainee network. Application forms can be found on our website: www.tricnetwork.co.uk; and via email: tricnetwork@gmail.com.

In an exciting collaboration with the Intensive Care Society, the TRIC Network will be hosting a session on trainee intensive

care research at the UK's largest intensive care conference, State of the Art 2023. Short-listed applicants for our next national project will have the opportunity to present their proposed project in a head-to-head fashion during the session, and the winning project will be voted for by those in attendance and selected by an expert judging panel. This is an excellent opportunity to promote trainee intensive care audit and research on a national platform and highlight the value trainees bring the research landscape.

Getting involved

Earlier this year we revamped our website with an easy to use interface making it accessible on both desktop and mobile platforms. Here you can meet the team, get involved with projects, and subscribe for updates. Integrating research and clinical work can be challenging. We have been creating ways to expand our community and connect both trainees and ICM-affiliated clinicians involved or interested in research. We recently hosted our first 'listening event' in collaboration with FICM representatives. This was an informative evening allowing academic trainees to share their experiences and have their voices heard. In addition, we have recently launched the TRIC Network Forum, which can be found through our website, to help build our community and share ideas. Please check it out!

References

1. Roberts T, Daniels J, Hulme W, et al. Psychological distress during the acceleration phase of the COVID-19 pandemic: a survey of doctors practising in emergency medicine, anaesthesia and intensive care medicine in the UK and Ireland. Emerg Med J 2021;38(6):450-59. doi: 10.1136/emermed-2020-210438 [published Online First: 2021/04/10]
2. Roberts T, Hirst R, Sammut-Powell C, et al. Psychological distress and trauma during the COVID-19 pandemic: survey of doctors practising anaesthesia, intensive care medicine, and emergency medicine in the United Kingdom and Republic of Ireland. Br J Anaesth 2021;127(2):e78-e80. doi: 10.1016/j.bja.2021.05.017 [published Online First: 2021/06/29]
3. Boulton AJ, Jordan H, Adams CE, et al. Intensive care unit visiting and family communication during the COVID-19 pandemic: A UK survey. J Intensive Care Soc 2022;23(3):293-96. doi: 10.1177/17511437211007779 [published Online First: 2022/08/30]

Trainee Representatives

Dr Cat Felderhof
FICM Lead Trainee Representative

My two-year tenure is finishing, and I finally have a hard earned dual CCT firmly in my grasp so it is time for Matt to step up to the Lead Rep role — a role which I know he will perform expertly and admirably.

My time as FICM rep has been challenging, enjoyable, eye-opening and educational, it has helped me to gain a clearer view of the direction of travel for us as a specialty. If you had asked me two years ago how I felt about the recent announcement regarding the Faculty pursuing College status, if I'm honest, my response might have involved an ambivalent shrug of the shoulders. Having spent the last couple of years experiencing first-hand, the trials and tribulations faced by those organising training, by continuing to plough through my final stages of training and getting to grips with life as a consultant, I am increasingly persuaded of the benefits of becoming a completely independent specialty. Being able to advocate for ourselves will benefit our ability to staff units and allow us to be more autonomous with our finances. Recently, in Scotland we saw a significant increase in training numbers for the coming year (thanks to the immense hard work by the FICM RAs for Scotland, together with the Scottish Critical Care Delivery Group) and I believe those involved would credit an increasing level of independence as a specialty as helping to facilitate this.

The StR Sub-Committee continues to flourish, it will always be the voice of the new generation of intensivists and I will have an immense sense of pride whilst watching their achievements from a distance. Thank you for allowing me to have this opportunity as StR representative.

Dr Matt Rowe
FICM Lead Trainee Representative

As we look to the new year and to welcoming a new Deputy Trainee Representative, I want to again thank Cat for her enormous contribution to the FICM Board during her tenure. I have no doubt that she will continue to do amazing work in support of our specialty. Over the coming months, the StR Sub-Committee will be looking to appoint new ICM/emergency medicine and IMG representatives. It will also be moving forward on a number of projects focused on improving the quality of training for all ICM trainees across the UK. The coming year will mark the first direct trainee involvement at a Training and Leadership Annual Meeting (TLAM) of the regional advisors in February. We will also be looking at ways in which we can improve communication and shared opportunities between regions and trainee networks. This will include looking at how we can increase the number and quality of SSY opportunities available to single specialty trainees. Finally, as ICM evolves, so too does the diversity of its workforce. To this end I hope to use my year as Lead Trainee Representative to support trainees in forging a high quality, pragmatic and rewarding training pathway with real-world job opportunities at the end of it. As we begin our exciting journey towards independent college status, the voice of our future consultant body will be critical in shaping a college that best serves the interests of our patients and our profession.

FFICM Examinations

Dr Victoria Robson
Chair of Examiners

The nineteenth sitting of FFICM took place in June and October 2022. This exam has now been running twice a year for 10 years (with one gap due to the COVID pandemic). Candidate numbers have increased from approximately 60 in 2013 to over 220 at the Spring 22 sitting. The first candidates were mainly trainees on the old Joint CCT programme, for whom the exam was optional.

Most are now single or dual CCT trainees (the exam is a mandatory part of their training programme), with a smaller number of candidates in non-training grades. The standard of the exam is set at the end of Stage 2 training (1 year from CCT) and includes questions from all parts of the Stage 1 and Stage 2 training curriculum.

Multiple choice

The multiple choice exam continues to run virtually on the TestReach platform. The change from multi true/false questions to single best answer questions has been completed. Questions with a long stem, often containing a clinical scenario are awarded 2 marks whereas those with a short stem (mainly used to test factual knowledge eg applied basic sciences) are 1 mark. The pass rate was 69%.

Oral components

In order to accommodate the increased candidate numbers and to enable larger numbers of candidates to have the same questions (which assists with analysis of question performance) we now run simultaneous exams on two floors in the RCoA building. 122 candidates sat the Structured Oral Examination (SOE). Of these 79% passed. 132 sat the Objective Structured Clinical Examination (OSCE), of which 63% passed, giving an overall pass rate for the oral exam of 61%.

Candidate resources

The candidate resources section of the FICM website has been expanded recently (https://www.ficm.ac.uk/trainingexamsexaminations/resources-for-candidates). This includes guidance on ECG, radiology and simulation questions. Since publishing the guidance, examiners have noticed an increase in the proportion of candidates who are systematic in their interpretation of ECG and radiology images, and so score better marks on these questions. The resources section also contains the exam syllabus, a number of example questions for all parts of the exam, and videos demonstrating 'good' and 'borderline' candidate performances in SOE and OSCE questions.

Visitors

A number of visitors (up to six per day) were present to observe the oral components. These are ICU consultants, often Faculty Tutors, and they commented on the neutral and fair behaviour of all examiners and the appropriate standard of the questions. They noted some candidates appeared to be very well prepared and some less so. The visitors felt that observing the exam would help them in preparing future candidates. A lay visitor is also present at some exams; he/she is usually particularly interested in observing candidates in the OSCE communication station.

Thank you

My thanks, as always, go to the examiners and also to the RCoA exams department for their hard work in administering this exam.

Regional Advisor Update

Dr Matt Williams
Lead ICM Regional Advisor

The writing of this piece comes at the time of a baton change. As of mid October, I have demitted as Wessex and FICM's Lead Regional Advisor, with Drs James Doyle and Andrew Sharman taking over the respective reins. I am pleased to be able to have the chance to pen some reflections from the last two years.

As you can probably imagine, it was already busy enough when I took over from Sarah Clarke in the autumn of 2020, and I can safely say it only got busier! The Lead RA provides clinician input to advice sought from the FICM secretariat, leadership and support to the other regional advisors, sits on the FICMTAQ committee and has a co-opted presence at the FICM Board meetings. The impact of the pandemic on training progression and the implementation of the new curriculum provided even more need for input. But it was very much a team effort involving the fabulous, exceptionally hardworking FICM secretariat, the senior members of FICMTAQ and the Deputy Lead RA to help guide the ship through the, at times, quite stormy waters.

New curriculum

In the last two years, we have seen the COVID derogations and guidance allow for continuing training progression, the 2021 curriculum implemented reasonably smoothly, the placement of an extra 100 NTNs in August 2020 and the gradual increase in NTNs (and continuing necessary workstream), continuous improvements in the website materials and the communication streams to and from the Faculty. The raft of guidance of documents uploaded to the website and the engagement events have helped the implementation of the new curriculum.

The surveys of ICM StRs and RAs in the summer, together with a decrease in enquiries, suggest that the curriculum is bedding down. Change is difficult, but perhaps getting it over and done with rather than staging will be easier in the long run. As we write in our report to the GMC, the curriculum is a work of continuous improvements. I know that those in FICMTAQ want to hear, and look for, constructive things to improve. With the receding of the pandemic, the cognitive bandwidth to ensure information is relayed clearly is more and more to the fore of this group. The formation of the StR Sub-Committee is already significantly helping with communication, and the input to workstreams; engaging the Intensivists of the future in shaping the specialty's development is so important. Further work is happening in the Faculty, with RAs input, on ensuring advice is consistent on CCT and CESR pathways to training, and gathering workforce data. Both are key to addressing the well described workforce gaps facing Critical Care services.

Thank you

I leave the roles with a slight tinge of sadness, but I know that they are in very good hands. I wish Andrew all the very best in his tenure as Lead RA. I have very much enjoyed and feel privileged to have held these roles. I'd like to thank all those involved in delivering ICM training across the UK, and particularly my RA colleagues. We have come a very long way in a short period, and I am honoured to continue playing a part in further developing our specialty having been elected to the FICM Board.

Training, Assessment and Quality (FICMTAQ)

Dr Sarah Clarke
TAQ Co-Chair

By the time you read this, we will be 18 months into the new curriculum and the LLP. While none of us particularly likes change, I hope you share my opinion that overall it has been a change for the better. We now have an outcomes-based curriculum, which describes what our Intensivists of today and the future look like.

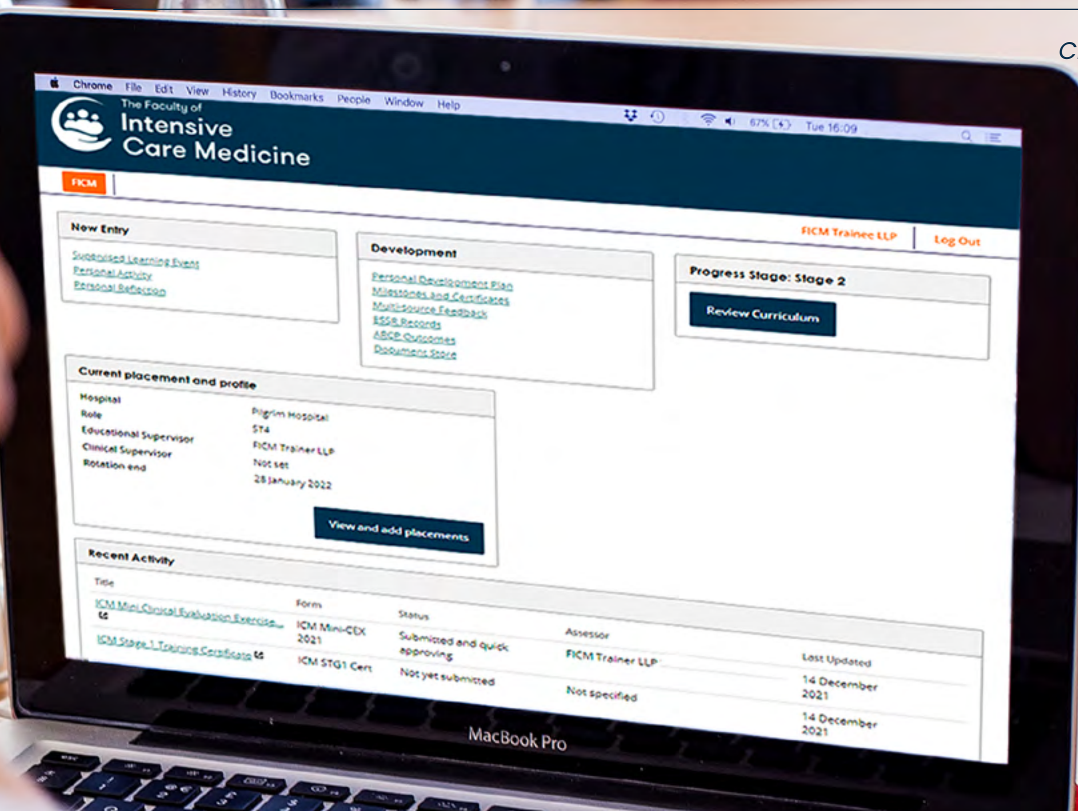
Out are the tick boxes, and in are the pieces of evidence which demonstrate the knowledge, skills and experience of that Intensivist with a CCT in ICM. Over 1,000 trainees are now on the 2021 CCT programme.

New guidance

From the initial flurry of transition guidance and 'How to use the LLP' webinars, we have spent the last few months developing further guidance on:

- Writing ES reports and ARCPs[1]
- Recognising training undertaken outside of core training programmes[2]
- Overseas training and OOPs[3]
- Educational development time[4]
- Guidance for Training Units[5]
- Less than full time training[6]
- Academic training in ICM[7]

It is heartening to hear that curricular and portfolio enquiries to the Faculty have been diminishing over the last few months, though we remain ever



attentive to suggestions, glitches and issues (llp@ficm.ac.uk or contact@ficm.ac.uk). As with any change, feedback and evaluation is very important, and we seek it actively through various channels, including the trainee survey and trainee/trainer engagement. We must also submit our evaluation to the GMC, so your views are needed and appreciated.

Please also seek out the guidance documents on the Triple CCTs in ICM and the Physician specialties.[8] This has been a monumental collaborative project between the Physician Colleges, FICM and all involved parties. My sincere thanks to Chris Thorpe, outgoing Chair of FICMTAQ for his dedication and determination to see this through to fruition. We are delighted to be able to continue to welcome the medical specialties to join Intensive Care Medicine training in a Triple CCT. Diversity in training and experience is our strength.

Another big focus of work of late has been to address inequalities and differential attainment of certain groups of our intensive care doctors, to create a more fair training culture. My gratitude to Liza Keating and her work with the GMC in taking us on this vital and necessary journey.

New members

We welcome two new members to TAQ: Dr Dhruv Parekh who is the new FICM Academic Training Lead, and Dr Shashi Chandrashekaraiah who has succeeded me as FICM CESR Lead. They bring their wealth of resources to TAQ and I'm sure will strengthen our capabilities to best serve our trainees, CESR applicants and trainers. Finally, a big round of applause to Chris Thorpe, who has led TAQ through the launch of the new curriculum and has been a shining beacon of fairness, pragmatism and trainee advocacy. Thanks Chris!

References

1. https://www.ficm.ac.uk/sites/ficm/files/documents/2022-12/FICM%20Guide%20for%20ARCP%20and%20ESSR%20Preparation%202022.pdf
2. https://www.ficm.ac.uk/documents/guidance-on-cesrcp-to-cct/what-is-cesrcp
3. https://www.ficm.ac.uk/trainingexamstrainees/overseas-or-out-of-programme-training
4. https://www.ficm.ac.uk/trainingexamstrainees/educational-development-time
5. https://www.ficm.ac.uk/documents/guidance-for-training-units/introduction
6. https://www.ficm.ac.uk/trainingexamstrainees/less-than-fulltime-training
7. https://www.ficm.ac.uk/trainingexams/academic-training-in-icm
8. https://www.ficm.ac.uk/dual-triple-ccts

Careers, Recruitment and Workforce (FICMCRW)

Dr Jack Parry-Jones
FICMCRW Chair

This is my last piece for *Critical Eye* as chair of Careers, Recruitment and Workforce (CRW). I am very pleased that Matt Williams has agreed to take on the Chair's role. Matt will be very ably assisted by the leads from each section: in Careers by Ascanio Tridente and Ken McGratten, in Recruitment by Tim Meekings and in due course Liz Thomas, and in Workforce by Richard Porter.

CRW also functions as the lead committee for matters involving Pharmacy represented by Richard Bourne, for ACCPs represented by Carole Boulanger, for Women in Intensive Care Medicine represented by Liz Thomas, for International Medical Graduates (IMGs) and CESR process by Shashi Chandrashekaraiah, and for Specialist Doctors represented by Manish Pandey.

Share your experiences

I feel extremely fortunate to have worked with such a group of individuals including the Faculty team. An enormous amount of work has been done in each section. I recommend looking at the FICM website: www.ficm.ac.uk/careers-workforce. There is a standing call for updating the Careers section; we need your own experiences in your ICM careers so please consider submitting them. In particular, it is very useful to hear from a wide selection of people at different stages in their careers. This allows other people to see where others have gone through similar paths and provide learning and avoidance of some obstacles. It is also very useful to see and share how people's job plans work in relation to weekend working, on-call, annualised sessions etc.

The 2023 recruitment timeline is out. This is important to applicants as well as those supporting and guiding them through the process. CRW, led by Ascanio published a paper on Differential Attainment in recruitment: https://pubmed.ncbi.nlm.nih.gov/36089594/. We hope the data and publication provides some reassurance that we take this very seriously, and enough to dedicate significant resources to this in terms of time, energy and finance. We are not complacent and further scrutiny across whole ICM careers, from start to finish remains necessary.

Recruitment annually examines its processes and further evidence of this will become available in due course. We hope this continues to provide reassurances that the recruitment process is in excellent hands and is open, transparent and fair.

Critical Staffing

The Faculty also published the final section of the three part series 'Critical staffing' – Returning to Work. The hope is that this will support individuals returning to work for whatever reason as well as provide departments and senior hospital management with a guide as to what should be available to maximise successful returns to the critical care workplace: www.ficm.ac.uk/careersworkforceworkforce/critical-staffing.

Lastly, we have a new Lead Dean for Intensive Care Medicine, Dr Jo Szram, who takes over from Michael Bannon; so a fond farewell and thank you to Michael and a very warm welcome to Jo from the Faculty and CRW. We look forward to working together.

ICM Recruitment Update

Dr Tim Meekings
Recruitment Lead

The 2023 national ICM recruitment round is now well underway, with applications having originally opened in mid-November 2022. By the end of February 2023, the verification of the portfolio self-assessment will be complete and this will allow all applicants to be ranked to facilitate shortlisting for interview.

Successful applicants will then be invited to attend an online interview; these will commence at the end of March. The portfolio self-assessment matrix has been updated for this year's process in response to feedback on previous years from applicants and following guidance from Health Education England which applies to all specialty recruitment processes.

Online interviews

For this year's online interview process, the Qpercom platform has had a purpose-built upgrade to enable us to offer a multi-station interview. This has already been used in other specialties and further enhancements made in response to real-world testing. This will enable us to provide a three station interview, with a pair of different interviewers in each station. One of the stations will be a clinical scenario based around the assessment and initial management of a critically ill patient. Some initial written background information will be provided to the candidate prior to entering the station and meeting the interviewers, who will then start with an opening question. Some additional information (e.g. a blood result or x-ray report) may be provided during the station, with the candidate asked to discuss this result and how it might impact their management of the patient.

Another station will consist of a task prioritisation exercise. Again, the candidate will be supplied with a list of tasks before entering the station to review and decide what further information they would need and how they might prioritise addressing the tasks they have been given. Upon entering the station, the interviewers will then further explore the candidate's understanding and their ability to plan how to manage the tasks presented.

Plans for the third station are still being made at the time of writing, but this is likely to be a more open format, to allow an assessment to be made of the candidate's commitment and suitability to ICM as a specialty. This will also be an opportunity for the candidate to highlight some of the strengths of their portfolio. The online interview carousel means that the although the order of the stations may vary from candidate to candidate, the questions asked and scoring matrices used by the interviewers will be the same for every candidate during that session.

High quality workforce

We anticipate that the opportunity to be assessed during the online interview process by three different pairs of interviewers across three separate stations will ensure that each candidate is given a good opportunity to demonstrate their strengths and suitability for joining the ICM training pathway. Through this process, we are confident we will continue to recruit and train the high quality workforce that we need for our specialty to continue to be successful both now and into the future.

FICM Census 2022

Dr Richard Porter
Census Lead

In 2022, the Careers, Recruitment and Workforce Committee surveyed the clinical leads within Intensive Care across the United Kingdom to ascertain current working patterns and to assist with workforce planning. We received a total of 151 responses from clinical leads.

Geographical variation

Table 1 demonstrates the geographical variation of responses. A total of 147 units provided data on call frequencies. This ranged between 1 in 4 to 1 in 21. Figure 1 demonstrates the relative frequency of the on-call frequency. A total of 149 units provided data on consultant rota gaps with 88 units (59%) reporting gaps.

Figure 2 demonstrates the frequency at which the number of gaps occurs (range is 0 to 8). 145 units responded regarding whether there is a fixed age to be allowed off the on-call rota. 119 (82%) did not have a fixed age. The range for the remaining units was 50 to 65 years as demonstrated in Table 2.

Wellbeing

In terms of wellbeing commitment 76 out of 146 respondents (53%) felt the trust commitment to wellbeing is sufficient. The table below demonstrates whether *Critical Staffing: A best practice framework* has been read and useful.

Working patterns

This census demonstrates a significant variation in working patterns across the UK in terms of both frequency of ICU commitment and practice to help manage the older consultant in the workplace. Less than 20% of ICU's allow for on-call commitments to be dropped once a set age is reached. More than half of the respondents did not feel the commitment by their trust to wellbeing was sufficient.

The challenges in delivering consultant rotas remains visible with the majority of units demonstrating gaps in consultant staffing. Although most respondents have not read the framework – of the 40 that did 33 (83%) felt it was helpful. We would urge those who have not yet read the Critical Staffing series to do so: https://www.ficm.ac.uk/careersworkforceworkforce/critical-staffing.

Further census analysis will be available in future editions of *Critical Eye*.

Table 1. *Geographical location of ICUs*

Please select the region/nation your unit is based in:	**Freq.**	**Percent**
North West England (including Mersey)	20	13.25
Scotland	15	9.93
Kent, Surrey, Sussex (KSS)	13	8.61
East of England	10	6.62
London (North East and Central)	10	6.62
West Midlands	10	6.62
London (South)	9	5.96
North East England and North Cumbria	9	5.96
South West Peninsula	8	5.3
Thames Valley	8	5.3
Yorkshire & the Humber	8	5.3
East Midlands	7	4.64
London (North West)	6	3.97
Severn	6	3.97
Wessex	5	3.31
Wales	4	2.65
Northern Ireland	2	1.32
Isle of Man / Channel Islands	1	0.66

Figure 1. *On call frequency*

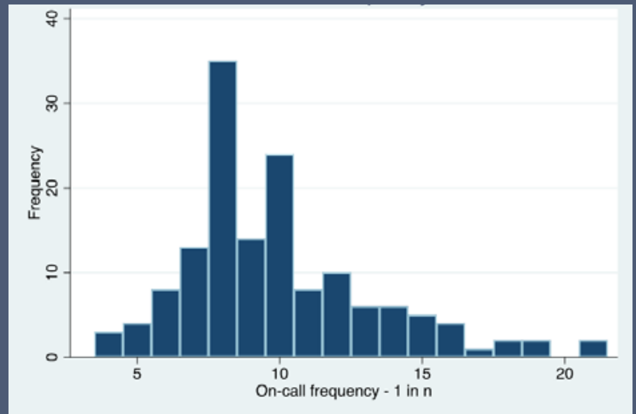


Figure 2. *Consultant rota gaps*

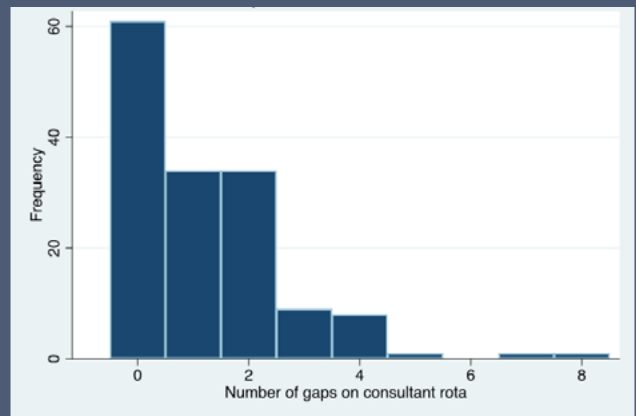


Table 2. *Age at which consultants can come off on-call rota.*

Do you have an age that consultants can choose to come off the on-call rota?	**Freq.**	**Percent**
No set age has been determined	119	82
50 - 55	13	9
56 - 60	12	8
60 - 65	1	1

Table 3. *Critical Staffing — read status*

Do you think the recently published Critical Staffing: A best practice framework is useful?	**Freq.**	**Percent**
Have not read it - but plan to do so	65	51
Have not read it - did not feel it would be useful	3	2
Have not read it - unaware of existence	19	15
No	7	6
Yes	33	26

Women in Intensive Care Medicine (WICM)

Dr Liz Thomas
WICM Chair

Women in ICM (WICM) continues to be an active subcommittee promoting ICM as a career for all, but with an aim to increase the number of female ICM consultants. The committee meets four times per year, with multiple active work-streams running in between.

Our last meeting was an 'away day' — held early November 2022. Sadly we had to meet online due to travel problems on the back of the rail strikes, however we had a very productive day, reviewing all the work WICM has completed over the past five years since its foundation and planning for the future.

Striking the Balance

Striking the Balance, our annual event, ran in October and was face-to-face at Churchill House. We had a whole

day of lectures, workshops and networking and the feedback was excellent. We were also delighted to welcome several award winners to receive their awards in person — congratulations to all! You can see photos of two of our award winners just over the page.

FICM Thrive

FICM Thrive, the mentoring scheme run by FICM and hosted by WICM has turned one, and the first pairings have completed their year. Feedback has been good and we are always looking for new mentors.

There will soon be an online form to aid registration. Consultants in the first five years of their posts are welcome to apply to have a mentor assigned. Mentors to date have found it very rewarding.

The Wider WICM Group (WWG) has over 100 members now. We are keen to use the group to help on our workstreams, connect like-minded ICM professionals and expand the promotion of ICM as a career for all. If you would like to join our wider group please drop an email to wicm@ficm.ac.uk and we will add you to the team.

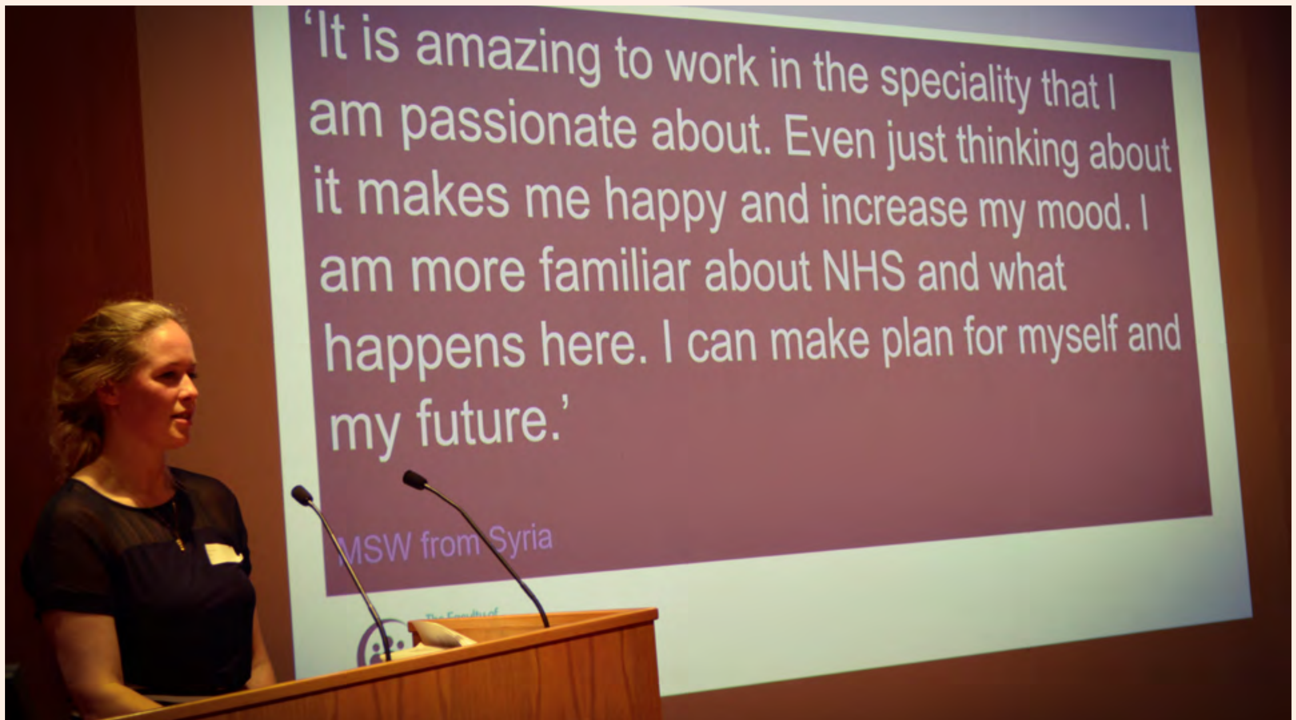
The WICMEL (Women in ICM Emerging Leadership) scheme is going really well. The second cohort have completed their year long programme and we had a final event gathering both the first and second cohorts together. We aim to run the WICMEL programme every other year, so we will be advertising for the next cohort in due course.

Join the committee

One of our trainee reps, Dr Hannah Potter, has finished her three year term and also is now a consultant. Therefore we have a vacancy for trainee rep. The post will soon be advertised so keep your eyes peeled. Thank you to Dr Potter and Dr Haslett who has also recently completed her term.

We remain active on social media (@WomenICM) and blogs. Dr Mishti Oberoi has taken over as social media lead. We are always keen to have volunteers to blog for WICM — anything is considered, clinical and non-clinical.

Striking the Balance 2022: Award Winners



Winner of the Making a Difference Award, Dr Rachel Saunders presenting on the MSW programme.

Dr Danny Bryden presenting Dr Alicia Waite with her FICM-NIHR Early Career Clinician 2022 Award.

Smaller & Specialist Units Advisory Group (SSUAG)

Dr Chris Thorpe
SSUAG Chair

One of the biggest issues that we have in staffing small units still remains the medical workforce. There are two aspects of this: the consultant workforce and resident or trainee workforce.

Firstly, the consultant workforce. Unfortunately they are still not enough trainees coming through to staff all the posts available. Some solutions, such as cross-site working, can help but cannot provide a complete solution. Therefore we still need consultants from other specialties to help deliver the service. Recent guidance has provided governance ideas on how to implement this.

Another consideration is that even if we do have enough trainees coming through, there may still be difficulties in staffing some units. Trainees often want to stay where they have trained because of a variety of reasons. The solutions are not straightforward, but placement of trainees across these units at least exposes them to a variety of units, and moving forward this is an essential part of long-term workforce planning.

Resident workforce

Secondly, the resident workforce has received a huge boost with the development of ACCPs. This group can train locally, and importantly usually stay in the area once qualified. Unlike rotating trainees they are a permanent addition to the ICM team and can be worth their weight in gold. The second aspect of resident staffing is to beef up training for less experienced doctors, such as IMT and Foundation docs. A great workforce can be developed, and almost always the trainees at this level really get a great deal out of ICM.

Centralisation of services

On a separate note, there has been a publication looking at centralisation of ED services. It shows that outcomes were worse. This aspect of healthcare planning has always been brought forward as a panacea for both quality and finance, but as we have previously documented, evidence for centralisation is limited to a small number of specialties, and cannot be extrapolated to all care. This paper serves as a good reminder to us in ICM as well.

Thank you

Lastly, this is my last SSUAG update, as I have stepped down as chair. Thanks to all who have supported us. The smaller units in particular have a much stronger voice now and that is down to the enthusiastic support of the Faculty who had the vision to support the development of the group at a time when the only voice was that of larger units.

Hwyl Fawr!

Critical Care Pharmacists

Dr Greg Barton
Pharmacy Sub-Committee Chair

In the summer of 2022, the Pharmacy Sub-Committee (PSC) conducted a survey of the current pharmacy membership to take stock of the work done to date and to give the opportunity to influence the future direction of pharmacy within FICM. Nearly all respondents stated that the primary reasons for joining FICM were so that pharmacy could be supported by the "national influence" and "political voice" that FICM wield.

Pharmacy Membership Survey

The PSC hope that moving forward the planned greater integration of pharmacists into the FICM workstreams will mean that not only will we be able to benefit from this UK-wide platform but also positively contribute FICM's outputs.

Three outstanding areas of importance to the pharmacy membership are around credentialling, mentorship — mentoring others and being mentored themselves — and workforce planning. These are all within the gift of the FICMPSC to influence. The soon to be launched Royal Pharmaceutical Society (RPS)/United Kingdom Clinical Pharmacy Association (UKCPA)/ FICM Advanced Specialist Critical Care Pharmacist Curriculum will provide a framework to be credentialled against, one that ties in with the rest of the RPS pharmacist career pathway. This is vital as it is not a dead end or blind alley, and pharmacists will be able to use it on their way to consultant pharmacist posts. Where FICM can support this process is through providing examiners for the credentialling process, pharmacist mentors and coaches for those going through the process building their eportfolios and then ongoing support to develop pharmacists into consultant-level practitioners.

A final note on the survey. Picking up on the universal interest in mentorship, the PSC plans to approach existing FICM pharmacy members to offer short one-off coaching sessions to new pharmacist members as a member benefit. This simple intervention should be both highly beneficial and attract pharmacist who are not currently members to join.

RPS/ UKCPA/FICM Advanced Specialist Critical Care Pharmacist Curriculum

On the subject of the curriculum, this should hopefully be out in the early spring with an accompanying assessment process. As alluded to above, it will fit after the RPS post-registration Foundation curriculum, alongside the Advanced Core curriculum and pre- the Consultant pharmacist curriculum, making one clearly described career pathway.

The Advanced curriculum focuses on the specialist capabilities required to be a pharmacist operating at the entry level to advanced pharmacy practice. Core will not only cover the generic advanced clinical capabilities but also generic Leadership, Education and Research at this level.

Finally, watch this space...

As opportunities arise to join groups and new workstreams, we will be reaching out to the pharmacist membership to identify appropriate pharmacist members to represent the profession. Examples of potential areas include medicines safety and the FICM *Safety Bulletin*, Education and Research. We also plan to advertise for mew committee futures in the near future.

Advanced Critical Care Practitioners (ACCPs)

Carole Boulanger
ACCP Subcommittee Co-Chair

The FICM ACCP Subcommittee said goodbye to Simon Gardner, Co-Chair, who stepped down at our last meeting in September after being with the committee since before its inception (which preceded the formation of FICM itself). We are pleased to welcome Dr Gregor McNeil from Edinburgh as Co-Chair, carrying on the development of the role.

The committee would like to thank Simon for all his hard work, persistence and wisdom supporting the ACCP role so far. We wish him all the best in his next endeavours.

Central funding

This reporting period has seen the first HEE central funding to support ACCP training ever since the role's inception. This has provided £100k per trainee ACCP towards salary costs and dedicated funded educational supervision time. This coupled with the capacity to use the apprenticeship levy to cover academic costs has created a great deal of opportunity for trusts to start or expand their ACCP training programmes. Unfortunately, this funding offer was only for England, however we hope that the devolved nations follow suit with a similar funding offer. We were delighted as a committee that HEE chose to use the FICM standards and requirements as the governance arrangements for the funding hence all those receiving HEE accelerated funding will be being trained to FICM standards with FICM membership as an ACCP as a key output. This reinforces the Faculty position on scope and standards of training. What has been clear is the importance of a clear strategy for ACCPs as part of individual ICUs workforce plan. Also highlighting the importance of preparation of the training environment for units new to the role and the time and planning this requires. Of course, there are no guarantees that this offer will be repeated in England, however it does herald an increased awareness of the role and its value in critical care when looking at central funding. What is clear is short-, medium- and long-term planning for how ACCPs might fit into your ICU workforce is key to being able to take best advantage of any funding offers which may be short notice during these times.

We continue to review increasing numbers of FICM ACCP membership applications with the trained ACCP pool expanding across the whole of the UK. FICM membership continues to be viewed as a surrogate for independent regulation as an ACCP being commensurate with a core knowledge, skills, competencies and behaviour set.

Curriculum review

An update to the FICM ACCP curriculum is due out for consultation shortly. This reflects the changes with our new alignment with the centre for Advanced practice and feedback from ACCPs, educational supervisors and university providers. Please engage with the consultation. Your feedback on this is much appreciated so the curriculum reflects the view of the ACCP community and their supervising teams. The FICM ACCP Sub-Committee will be working on active engagement with ACCPs trained and in training with the exciting news of aiming to progress towards college status.

Professional Affairs and Safety (FICMPAS)

Dr Dale Gardiner
FICMPAS Chair

It's my honour and privilege to take over from Dr Pete Macnaughton as Chair of FICMPAS. I have thoroughly appreciated having the chance to observe Pete's leadership since I joined PAS a year ago. We have also seen other members move on, and I want to thank Dr Jeremy Cordingley, Dr Chris Bassford and Dr Peter Shirley. A change in membership is a moment for stocktake. What is FICMPAS and how can we make things better for intensive care, our patients and families?

Our terms of reference say we, 'will be concerned with quality improvement matters that arise within the FICM, with particular reference to clinical effectiveness, clinical guideline development, continuing professional development (CPD) and the integration of any such areas into the revalidation process.' So pretty broad!

Safety

FICMPAS's broad remit has not stopped some excellent outputs. Probably the two most known to me when I joined the Committee, though I hadn't appreciated FICMPAS's role, is the regular *Safety Incidents in Critical Care* (Safety Bulletin) and GPICS. Prof Gary Mills has led the Safety Bulletin since December 2020. It's a powerful (sometimes scary) resource which has required Gary to trawl through hundreds of NHS England/ NHS Improvement DATIX incidents looking for patterns and themes to share with us all. Though Gary's term of service on FICM Board and FICMPAS has completed, he is kindly staying on to hand over the Safety Bulletin to new FICM Board Member, Dr Peter Hersey.

GPICS

Another large project of FICMPAS is GPICS. As Chair of FICMPAS I will be working with Dr Paul Dean from the ICS as lead editors for GPICS v3. I'll have more to update in the future but, as you would appreciate, this is a major undertaking for which we will need a broad editorial team.

Legal and Ethical

A subcommittee of FICMPAS is the Legal, Ethical and Policy Unit (LEPU). You may be most familiar with LEPU's work with their excellent Midnight Laws. Another powerful (sometimes scary) resource. I am sensing a pattern here. Dr Chris Danbury was the long-time chair of LEPU but has handed over the leadership to FICM Board Member Dr Monika Beatty. Given recent legal challenges concerning intensive care I am very glad we have LEPU's wisdom and expertise so readily available.

None of the work of FICMPAS would be possible without FICM's administration team and the wide representation the other members of the committee bring. I can't highlight everyone on the Committee but for this update I would like to recognise Dr Angela Lim (Trainee Representative) and the co-opted members of the Committee: Ms Deborah Mayo (ICU Steps), Drs Mark Blunt and Mike Carraretto (National Networks' Medical Leads Group), Ms Debbi Scotting (NHS Improvement) and Dr Marlies Ostermann who is replacing Dr Paul Dean (Intensive Care Society Standards Committee).

Get involved

For FICMPAS to do its job effectively we need clear goals and broad membership. At our next Committee meeting we will be discussing both. There will be a call for new Committee membership soon. If the above update has interested you, that person might be you!

Safety Incidents in Critical Care

Prof Gary Mills
FICM Safety Lead

The *Safety Incidents in Critical Care* bulletin is now on its sixth edition. It is hoped with the advent of the approaching national 'Learn From Patient Safety Events (LFPSE)' service from NHS England, our ability to search for and analyse incidents will improve. We also hope to expand to include more data from all four nations and wider expertise to our already existing medical, allied health professional and NHSE group.

In the last *Critical Eye* we talked about preparing a campaign to raise awareness about certain incidents that have appeared across the bulletins since 2020, some of which have major safety implications. We will be releasing a new supplement on *Recurring Incidents: Safety in Critical Care*, covering the last three years. It groups and summarises the experience of recurring incidents, in an attempt to focus awareness in one package and, potentially, to eventually reduce their frequency.

Recurring incidents

As part of this campaign, we will be producing a series of posters focusing on individual common recurring incidents, which we hope will be displayed in departments to highlight risks and good practice. You may even see these on a toilet door or in appropriate areas in the critical care unit soon!

The aim is that the messages in the posters are clear, memorable and linked. They will hopefully be supported by other forms of communication such as blogs to emphasise what we can do that helps avoid safety incidents i.e. the 'what goes well and why' Safety 2 approach, as well as the 'what goes wrong and why' Safety 1 viewpoint and an emphasis eventually in GPICS v3.

Importance for patients

From a personal perspective I have spent the last four years creating and writing the Safety Bulletin , the recurring incidents work/supplement and developing the role of FICM Safety Lead, as well as the multidisciplinary editorial group that goes with it.

None of this would have been possible without the editorial group's hard work, support and advice; including Dr Pete McNaughton (former FICMPAS Chair) and Dale Gardiner (current FICMPAS Chair), together with Dawn Tillbrook-Evans and Anna Ripley in the FICM office. I will soon be passing this role over to Dr Peter Hersey. Pete is an incredibly able medical educator and intensivist from Sunderland, who I am looking forward to working with on the seventh bulletin as we hand over. Pete will bring many innovations to this area which has real importance for patients over the coming years.

Hidden causes

Finally, it's important to remember that the latent cause of many incidents lies hidden, often for years before an event happens. So, there may still be time to intervene and find the safe ways of working.

Thank you

Thank you for reading the Safety Bulletin, and if you haven't been, you should! The *Safety Incidents in Critical Care* Safety Bulletin can be accessed via: https://www.ficm.ac.uk/standardssafetyguidelines/safety.

Safety Incidents in Critical Care

January 2023 | Issue 6

Suitability for transfer is an important consideration, but so is a recognition that deterioration can occur. Transferring teams should have access to suitable equipment, drugs and monitoring, as well as sufficient training to reduce these risks and to provide an adequate handover.

The sixth issue of the *Safety Incidents in Critical Care Bulletin* is out now, summarising NHSE/I-sourced data on critical care incidents classified as moderate or severe in patients above the age of two in a more digestible and readily available form for doctors, nurses and AHPs working in critical care.

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

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