



CRITICAL EYE

Issue 16 | Summer 2019



GPICS V2

**AGEING
POPULATION**

ENHANCED CARE

**SOCIAL MEDIA AND
THE ICU**

**PATIENT FEEDBACK
FOR REVALIDATION**

**The Faculty of
Intensive Care Medicine**

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

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WELCOME

Welcome to the Summer edition of Critical Eye.

This month sees the launch of the second edition of the Guidelines for the Provision of Intensive Care Services (GPICS) document, a joint publication between the Faculty and our partners in the ICS. Revising this guidance has been a significant undertaking and it is appropriate to acknowledge the effort and commitment of the two co-editors, Peter Macnaughton and Stephen Webb, in producing this high quality document. The document is endorsed by 29 supporting organisations and specialist societies, and sets the benchmark for the planning, commissioning and delivery of adult critical care services in the UK. It is the standard against which local services will be reviewed by healthcare regulators. Fittingly, Dr Macnaughton provides an overview of the document in this edition.

The work of the Enhanced Care Working Party continues with a plan to publish a final document in early 2020. This document will provide recommendations for the development and delivery of 'Enhanced Care Services' and will incorporate perioperative care, enhanced maternal care and medical enhanced care units. It aims to promote safety, quality and equity of access for patients requiring enhanced care in hospital. Further details are provided in Dr Pittard's article.

Our annual meeting took place in June this year, entitled 'End of Life Matters.' The day focussed on the provision of 'End of Life Care' and thanks to the fantastic efforts of all the speakers it proved to be a great success. The emotive nature of the topic combined with the personal experiences relayed to the audience by several speakers led to an inspirational and interactive discussion. I hope that those of you who were able to attend enjoyed the day.

Finally, I wanted to pay tribute to Dr Carl Waldmann for all his tireless work over the last few years as Dean of the Faculty. Under his direction the Faculty has made great progress in improving the care provided to patients requiring Intensive Care treatment and in shaping the future of our speciality.

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



@FICMNews



MESSAGE FROM THE DEAN

Dr Carl Waldmann

This will be my last article for Critical Eye before I step down as Dean at the end of October.

I would like to say that it has been a privilege and a pleasure to have been allowed to have spent the last 3 years helping shape the future of our specialty. I cannot thank the staff of the Faculty led by Daniel Waeland enough for the amazing work they do. They are truly a magnificent team to work with. In addition, I have to say that I could not have asked for a better group of people representing our specialty to work with on the Board and in the various committees. Thank you also to all of our many role holders (from examiners to Regional Advisors), and of course to our members, who are the foundation of all we are able to do.

I will step down knowing the Faculty is in the safest of hands and that the specialty has the brightest of futures.

Working together

I have had many opportunities to meet the Presidents and Deans of the other Colleges and Faculties through the Academy of Medical Royal Colleges (AoMRC). Since the Faculty joined the AoMRC I have noticed how well the Colleges and Faculties are speaking with one voice through Carrie Macewan and Alistair Henderson. Many of the issues facing critical care are issues that face the whole NHS and there is considerable strength in teaming up to

provide guidance (i.e. The Reflective Practitioner) and champion causes.

The last meeting was held in Dublin at the Irish College of Surgeons. As well as meeting with our counterparts from Ireland, the visit was a great chance to see how the Republic of Ireland runs a medical college. The building is of 8 stories 4 below and 4 above ground level.

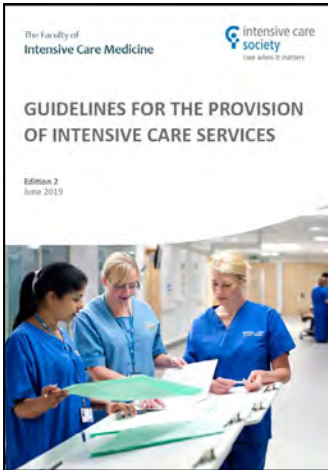
The Academy's work has given us the opportunity to meet regularly with the Secretary of State for Health and Social Care, firstly Jeremy Hunt and more recently with Matt Hancock.

Examination

The FFICM is moving from strength to strength and I would like to thank Andy Cohen for doing such an excellent job as chief examiner; he has recently stepped down and Vickie Robson has now replaced him with Jerome Cockings as her deputy. Congratulations to both. Vickie was previously the Deputy Chair of our Court of Examiners and Jerome has led the auditing side of the exam, so both come with a wealth of experience.

GPICS

By the time you read this, Version 2 of Guidelines for the Provision of Intensive Care Services (GPICS) will have been published by FICM and ICS. We hope



it will enable intensive care services in the UK to continue to move forward and ensure a quality standardised approach to our specialty. We have already liaised with the Care Quality Commission to ensure their visiting standards

remain up to date with Version 2.

Staffing

Future staffing for our specialty has been a hot topic. As described in our recent Dean's Digest, the Faculty has been contributing to a cross-specialty initiative on workforce in England. NHS Improvement is leading a workforce implementation plan in advance of potential funding from the government. The Academy of Medical Royal Colleges has become a central stakeholder in this process, and AoMRC members, including FICM, are being asked to contribute data, key messages and guidance as the work continues.

In Wales, we are also connected in with the ongoing critical care review commissioned by Vaughan Gething, who I had the pleasure of meeting at the Welsh Assembly.

We are still battling to help our ACCPs achieve recognition. We are proud of the growth of ACCPs and again the FICM hosted a sold out annual meeting at Churchill House on the 7 June. Jo-Anne Gilroy (an ACCP in London and the programme convenor) and Lucy Rowan (as event co-ordinator) should be congratulated on organising the event!

FICM and the other Faculties and Colleges are hoping to convince the Government of the need to look at the way pension rules are affecting our consultants and acting as a disincentive to work for longer.

Health Safety Investigation Branch (HSIB)

This organisation conducts independent investigations of patient safety concerns in NHS-funded care across

England. This branch works very much like the Air Accident Investigation Branch. The recommendations they make aim to improve healthcare systems and processes in order to reduce risk and improve safety. They have just released a report around a case of a deteriorating patient for which we were asked for feedback and we look forward to assisting them in any future investigation relevant to our specialty.

Critical Futures

Joe Cosgrove and Alison Pittard have done excellent jobs collating the work of their respective working parties on End-of-Life Care and Enhanced Care.

The End of Life has now been out for open consultation and was 'pre-launched' at the Annual Meeting on 13 June. The group are now busily working through the comments received to construct a final version due for September. The Enhanced Care work is now in early draft and will be going for stakeholder review also in September, with an open consultation to follow soon afterwards.

A multiprofessional and multidisciplinary group has been the backbone behind both projects, with the UK Critical Care Nursing Alliance, ICUsteps and the Royal College of Anaesthetists being key members in both groups, joined by many others. Read more in the relevant articles in this edition of Critical Eye.

Life after Critical Illness

Joel Meyer and Andy Slack co-chaired an excellent preliminary meeting at Churchill House in May on this important topic, demonstrating to strength of feeling and interest in this area. Life after critical illness was one of the 12 recommendations from Critical Futures and the Board has commissioned a new national project group on this area. I am pleased to say that the Board has kindly offered me the Chairmanship – as an active supporter of follow up since I can recall, this does mean a lot to me. I am even more pleased to say that Joel and Andy have agreed to be my deputy chairs. It will be great to continue to serve the Faculty, its members and our patients through this project.

A final thank you

I do hope you enjoy this addition of Critical Eye. I would like to thank John Butler for his continued hard work in producing Critical Eye. I hope also that it continues to suit your needs as members – do let us know what else you would like to see in the next edition.



CRITICAL FUTURES

END OF LIFE CARE AND ICM

Dr Joe Cosgrove

Chair: FICM End of Life Working Party

Expert stakeholders have now appraised the work of the FICM End of Life Working Party (EoLWP). By the time of this Critical Eye publication, comments and critiques from the open consultation will have been returned and reviewed for a final revision prior to publication. Since November 2018, weekly and at times daily discussions have led to a final format that will outline how the issues we face have evolved, how we use legal and ethical frameworks to weigh benefits and burdens of treatment and how effective end-of-life care is provided. The document also summarises how conflicts can arise, how they can be minimised and resolved, and how effective decision making can occur in acute settings and more controlled circumstances where advance care planning may be possible.

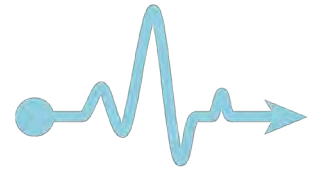
The section headings are:

- Foreword (from the Dean of the Faculty)
- Executive Summary outlining both the benefits and burdens of critical care survival, data relating to survival and how gaps in information can hinder effective evolution of care plans.
- Patient view from ICUsteps: This is aimed at setting the tone for clinical teams, patients and relatives to work together for effective care.
- Introduction (Twenty First Century Critical Care: Success and Dilemma, Intertwined): outlining dilemmas plus legal and ethical frameworks that can be applied to assist decision-making.
- The Provision of Care at the End of Life in Critical Care: a guide to the provision of physical and

holistic needs of patients near the end of their life on the critical care unit.

- Conflict, Confusion and Communication: a brief overview of how conflict can occur and what is available to minimise such situations including some clinical vignettes based on the experiences of the EoLWP.
- Clinical Decision-Making in Acute Situations: this explores the dilemmas that critical care teams are faced with when decisions relating to care and treatments have to be made in emergency situations over a short period of time. It focuses on three main decision-making models: the Warwick Model (Warwick University), End-of-Life Decision Making Climate Model (University of Ghent, Belgium) and the MORAL Balance Model (Nottingham University Hospitals).
- Advance Care Planning: this is the most extensive chapter of the document and is arguably the bedrock for future planning. It aims to encourage clinical teams to address concerns with patients and those close to them, before an acute decline occurs. It provides references to multiple resources and focuses on shared decision-making providing summaries of all forms of advance care planning documents currently used within the UK.

The final document will be published in short and long forms reflecting the above. The short form will consist of a brief prologue, key-points and recommendations followed by infographics for reference and easy to use guidance. The long-form includes the same information with added in-depth commentary related to the subject matter for each chapter. The date of eventual publication will be determined by endorsements from professional bodies and expert stakeholders but will be within the timeframe of the publication of complimentary guidance (currently also under consultation) from NICE (National Institute for Healthcare and Excellence), proposed for October 2019.



CRITICAL FUTURES

ENHANCED CARE

Dr Alison Pittard
Vice Dean

The Enhanced Care Working Party was established in 2018 in response to recommendation 4 of our Critical Futures initiative. Work on the project is going well: 3 meetings have been held so far and we hope to have the final document published by the end of 2019. Initially the focus was to gather information, via a survey, from organisations that already have enhanced care services in one form or another. We also held a small focus group session in February to obtain more detailed information about the drivers for change, service design and the impact of implementation. The majority of the feedback has been from perioperative services but there are some enhanced maternal care models and acute medicine high observation units that need to be considered.

What is clear is that there is a huge diversity out there but no overarching governance structure. The current draft document, 'Enhanced Care Services: guidance on service development in acute care', focuses on this structure providing recommendations for development and delivery. It uses vignettes and case studies to highlight how individual organisations have addressed their local need. It also provides examples on the sorts of interventions and therapies that could be provided and how to ensure this is done in a safe way. Throughout the document there is an emphasis on avoidance of working in silos. Although these services may be managed on a daily basis by the perioperative team for example, working in partnership concentrating on team competence will be of most benefit to patients. Critical Care will have much to offer both during the development phase and in ensuring there is seamless flow of patients when escalation of care is required.

The current draft document focusses on the perioperative patient but includes vignettes on enhanced maternal care and medical HOBs (High Observation Bays). The latter will be addressed in more detail in a future guidance document that we are collaborating on with the Royal Colleges of Physicians. The overarching principles will be relevant to any area delivering enhanced care services but the landscape in terms of what is delivered, how it is delivered and by whom will vary. The recommendations we make fall into 7 categories: Governance, Service delivery, Protocols and procedures, Equipment, Workforce and support services, Education and training and Quality.

“THERE IS AN EMPHASIS ON AVOIDANCE OF WORKING IN SILOS...WORKING IN PARTNERSHIP CONCENTRATING ON TEAM COMPETENCE WILL BE OF MOST BENEFIT TO PATIENTS.

A summary of the survey data is included, as an appendix, for reference. It is hoped that the final document will prove useful to those wishing to establish enhanced care services as well as those already delivering them and will promote quality, safety and equity of access.

Following internal consultation of the draft document in June it will be reviewed by stakeholders at the Critical Care Leadership Forum in September and then circulated for formal external consultation. Hopefully there will not be too many amendments to make at this stage and we will remain on target to deliver the document by the end of the year.

END OF LIFE MATTERS: REVIEW OF FICM ANNUAL MEETING 2019

Dr John Butler
Event Lead

'How we, as a society, care for the dying is an indicator of how we care for all sick and vulnerable patients. Care of the dying is urgent care with only one opportunity to get it right to create a potential lasting memory for relatives and carers.'

Our annual meeting this year, 'End of Life Matters', focussed on End of Life Care and, thanks to the fantastic efforts of all of the speakers, it proved to be a great success. The emotive nature of the topic combined with the personal experiences relayed by several speakers (I would like to personally thank Sister Cath Applewhite for sharing her story) meant that there was barely a dry eye in the house! Fortunately, and thanks to our Vice Dean, additional tissues were made available throughout the morning.

The meeting was opened by the Dean and followed by Sister Applewhite's very personal story of how



Dr Carl Waldmann opening the day

#eolFICM

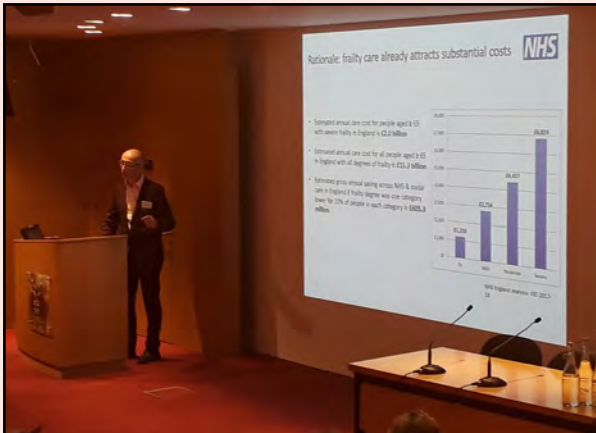
"The provision of end of life care on an intensive care unit is a vital skill set for all staff if they are to provide the best care for patients close to the end of their lives. For the best care, all involved must understand that life has philosophical as well as physiological components and individualised care is paramount."

Dr Joe Cosgrove
Chair, FICM End of Life Working Party

her mother sadly died on an ITU in Manchester. Sister Applewhite explained how things are on the 'other side of the bed space' and the lessons we can learn from relatives who have been through similar experiences. The key messages were about the importance of communication, information and honesty.

Joe Cosgrove, as Chair of the End of Life Working Group (EoLWP), presented an update on the progress of the group and gave an overview of the EoLWP Guidance document, due to be published in the autumn. Joe highlighted the importance of 'getting it right every time' when it comes to end of life care. He focused on ways in which we can improve our end of life care by addressing the physical, holistic, spiritual and religious needs of patients as well as the importance of providing effective communication to convey care and concern at all times.

Professor Martin Vernon, the National Clinical Director for Older People and Integration



Professor Martin Vernon giving his talk: Weak at the Knees!

gave a detailed overview of ageing and frailty. In England 1.8 million people live with frailty and more likely to live in deprived areas. As we are all aware severe frailty adversely impacts mortality in acute care. Martin outlined the national approach to reducing late crisis presentations to hospital and providing more community-based person centred care as a preventative measure.

When might it be considered unlawful to limit or withdraw end of life care? What is the UK legal framework for treating patients who don't have capacity? How do courts view treatment limitations and withdrawal decisions in ITU? These questions, in addition to several others, were addressed by Dr Beatty in her excellent overview of the Legal Aspect of End of Life Care. A series of case reviews demonstrated the importance of having a working knowledge of the current legislation.

Dr Chris Bassford gave a thought provoking talk on decision making in end-of-life care. He explored some of the concepts around shared decision making, incorporating ideas such as 'accountability for reasonableness' and factors associated with this. He communicated a series of models of decision making currently being utilised using assessment of evidence of the clinical situation, capacity and patients' wishes and values, through to reasoning and implementation. This was

followed by Professor Natalie Pattison who gave an update on the evidence base for end of life care and direction of travel for new areas of research and development.

The afternoon included talks related to 'discharging patients home to die' provided by Dr Donna Hall & Mr David Smith, followed by a 'Pathologists view on End of Life Care' by Dr Naomi Carter which was packed with anecdotal gems of learning.

'Is death always due to failure of a system or an individual?' Professor Mahesh Nirmalan, from Manchester, explored 'public engagement in end of life care issues.' He outlined an approach using arts and creative theatre to initiate debate and discussion about end of life care in partnership with a cultural organisation. A series of activities is due to be launched at the 'SICK! Festival' in Manchester in September 2019 (www.sickfestival.com) for those with an interest.

Appropriately the final session of the day was delivered by Mr Anthony Caffrey, a respected funeral director from Altrincham who gave us an amusing dialogue of his experiences, including a host of interesting requests for life's final journey.

#eolFICM

"Care and treatment are not necessarily interchangeable terms and phrases such as "withholding or withdrawing care" must be consigned to the dustbin for inappropriate medical phrases. Care must be constant regardless of changes in treatment."

Dr Joe Cosgrove
Chair, FICM End of Life Working Party

I think I can safely say from the formal feedback (and discussions in a local establishment afterwards) that it was highly successful day. I would like to thank all our speakers, all of you who attended, and Laura Owen for her superb organisational skills.



PROFESSIONAL AFFAIRS AND SAFETY

Dr Peter MacNaughton

Chair: Professional Affairs and Safety Committee

This is the first update that I have produced for some time that doesn't highlight the ongoing work by the committee in producing GPICS edition 2 as hopefully all are aware that it was published at the end of June! However GPICS related work doesn't now stop. The changes in GPICS 2 that influence the current documentation used by the Care Quality Commission (CQC) visiting teams have already been highlighted and fed back to the CQC.

A common question is what is new between edition 1 and 2 and is there a summary of the changes available? Unfortunately due to the wide-ranging changes it wasn't felt practical to simply produce a list of all the differences. However, the Faculty is working with the ICS and the National Critical Care Operational Delivery Network leads to produce an audit tool that will allow units to benchmark against the standards and recommendations in GPICS 2. In the longer term this could be used to obtain a national picture of the compliance with GPICS 2 that will provide important information for planning GPICS 3.

Another area of feedback from GPICS 2 was for more

guidance regarding airway care within critical care. Whilst comprehensive guidance was produced by the Difficult Airway Society in conjunction with the Faculty, ICS and RCoA for the management of tracheal intubation, there is a perceived need for guidance on other areas relating to airway care in ICU such as the management of extubation and what is needed to ensure that there is safe airway cover for patients in ICU who have been intubated. GPICS 2 has alluded to ACCPs providing airway skills, although advanced airway skills are not part of the FICM ACCP curriculum but seen as an extended level of practice and has been left to local units to define required training. We are currently scoping a project with the aim of producing comprehensive guidance for all aspects of airway management in ICU and would welcome any views on what this should cover.

Improving patient safety is very topical with NHS Improvement having just published their vision for the future with the publication of 'The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients' in July (<https://improvement.nhs.uk/resources/patient-safety-strategy/>). Our speciality

has been at the forefront of many patient safety initiatives and the Faculty is committed to using its resources where it can to enhance patient safety. One initiative that the committee has instigated is to work with NHS Improvement to review and share lessons from patient safety incidents in critical care that are reported through the National Reporting and Learning System database (NRLS). This aim of this project, which is being led by Prof Gary Mills, will be to include a safety bulletin within future editions of the Dean's Digest, our member newsletter.

Other areas of current work for the committee include Patient Feedback for revalidation led by Dr Peter Shirley and an ICU/ED interface project with

the RCEM with Dr Mike Spivey as our link and Dr Liza Keating as joint Chair. The joint FICM/ICS Guidance on the [Transfer of the Critically Ill patient](#) was published in May 2019. Thanks to all the members of the contributing group that was chaired by Dr Simon Whiteley for producing this excellent document.

Finally, I would like to thank all members of the committee for their ongoing work and commitment. We welcomed 4 new members earlier in the year: Dr Irfan Chaudry, Dr Peyton Davis, Dr Angela Lim and Dr Jamie Yarwood and I am delighted that my colleague on the Faculty Board, Dr Jeremy Cordingley, has taken on the role of deputy chair.

The Faculty of Intensive Care Medicine

Striking The Balance

Friday 27th September 2019

Talks include:

Succeeding as an introvert
Dealing with 'failure'
Leading with authenticity
Being an effective ally
Barriers to ICM Careers

Workshops include:

Mentor training
Know how to manage yourself
How do I... Speak, Write and Balance

Royal College of Anaesthetists, London
£195 (£140 Trainees)
CPD Credits Approved: 5



PUBLICATION OF GPICS 2

Dr Peter MacNaughton

Chair: Professional Affairs and Safety Committee

Thanks to all the hard work and commitment of all involved, we were delighted to launch the second edition of GPICS at the end of June. The project to revise and update the GPICS first edition (2015) began over 18 months ago and the publication is the result of a joint project between the Faculty and our partners in the Intensive Care Society. GPICS edition 2 is endorsed and supported by all the key critical care stakeholders and we are delighted to have grown from 19 to 29 endorsing and supporting organisations, covering the multiprofessional team, interacting services, specialist societies and the devolved nations.

The first edition of GPICS was a landmark publication that built on the earlier *Core Standards for Intensive Care Units* (2013). GPICS has become the definitive reference source for the planning, commissioning and delivery of Adult Critical Care Services in the UK. Many units have found the standards and recommendations within GPICS invaluable in developing successful business cases to enhance their local services and improve patient care. GPICS has also been used as the benchmark by which local services are peer reviewed and assessed by healthcare regulators, such as the Care Quality Commission (CQC).

In undertaking GPICS edition 2, we consulted widely, both with the key stakeholder organisations and through an open public survey. This resulted in significant changes to the planned content of GPICS. We also changed the balance of the authors ensuring they were more representative of the wider critical care community in terms of size of unit and geography.

All chapters have been subject to extensive peer review and collaboration between the Faculty, the ICS and stakeholder organisations. The draft document was open for public consultation that produced nearly 600 individual items of feedback.

They were all carefully reviewed and much of the constructive feedback was incorporated into the final version.

The standards from the first edition have not been changed unless there has been new evidence presented, or widespread professional views expressed, to justify modification. The second edition focuses on service delivery, quality and safety with less emphasis on specific clinical practice guidelines. Individual chapters relating to the provision of support for each of the main organ systems have replaced the previous clinical sections. Any relevant, high quality, evidence based guidelines produced by other professional bodies are signposted within these chapters. A number of new chapters relating to service delivery, including capacity management, focused ultrasound and serious infection outbreak have been added. There is also a new chapter addressing the particular issues for remote and rural units that provides guidance for ensuring a sustainable solution to maintaining a high quality service within this challenging environment.

The role of a document such as GPICS, is to improve the standards of care that critically ill patients receive and to reduce geographical variation. GPICS is written to assist and support units in developing their services in order that patient care is of the highest quality. For every unit, there will be some aspects of GPICS that are not currently met and we hope that units will use these gaps as a driver and focus of where to develop and enhance their local service for the benefit of patient care.

I would like to thank all the authors and the Faculty secretariat for their hard work and commitment in producing such a high quality document. A special note and thanks must go to my co-editor, Stephen Webb, and Dawn Tillbrook-Evans as the Faculty Co-ordinator.



PATIENT FEEDBACK FOR GMC REVALIDATION AND INTENSIVE CARE

Dr Peter Shirley

FICM Professional Affairs and Safety Committee

GMC revalidation for doctors was introduced in 2012. The patient feedback element of this has created discussion for doctors who don't have standard patient contacts in a clinic or standard ward setting.

The current GMC guidance is fairly prescriptive in relation to patient feedback¹:

- *At least once in each revalidation cycle you must collect, reflect on and discuss feedback from patients about their experience of you as their doctor.*
- *If you do not have patients you should collect feedback from others to whom you provide medical services. If you believe you can't collect such feedback, then you must agree with your responsible officer that you do not need to.*
- *Those asked to give you feedback must be chosen from across your whole scope of practice.*
- *You should use standard questionnaires that have been validated and are independently administered to maintain objectivity and anonymity. You must agree any alternative approaches with your responsible officer.*
- *You should not personally select those asked to give feedback about you, and you should make sure the method used for collecting feedback allows responses to be obtained from a representative sample.*
- *You must reflect on what the feedback means for your current and future practice, and discuss it at your appraisal.*

FICM has stated previously² that agreement has been reached with the GMC that individual patient

feedback to intensive care doctors should not be mandatory and that other material may be used in lieu.

As part of the work of the FICM Professional Affairs and Safety Committee, a short survey was conducted in late 2018 to get a sense of the situation across the country with regard to the experience of consultants gathering patient feedback. Although the response rate was low (n=38) some consistent themes emerged from this.



21 of 38 respondents said they were required by their Trust / Health Board to collect feedback for patients in intensive care. 27 of 38 stated that they were not able to use other material in lieu of patient feedback. The majority of these were patients in level 2 areas with some in level 3 environments. Some with anaesthetic practice reported just approaching patients that they had previously anaesthetised.

22 of 38 respondents cited difficulties with collecting feedback for intensive care patients and 20 felt it was not reflective of their practice.

The numbers of completed feedback forms required by reporting officers ranged from a minimum of 10 up to 34. The GMC do not specify a minimum number.

16 respondents felt the feedback was not of use to themselves or their appraiser as part of the appraisal process. From other comments received there was a clear indication of frustration in the requirement to do this. Comments such as 'inappropriate' and 'pointless' were entered as responses to opinions regarding gathering this feedback. Of the 25 respondents who entered an open ended response, none were positive as to their experience of this process.

All of this raises the question as to the validity of this element of revalidation. From the survey, it seems that the majority were required to collect feedback which was not felt to be necessarily informing the appraisal process. There is a clear danger of just 'ticking a box'. Given the time constraints on all clinicians it doesn't seem on the face of it a good use of time if the end result isn't actually beneficial or supporting the revalidation process. The GMC has the aims of patient feedback³:

- *To understand what your patients and others think about the care and services you provide.*
- *To help you identify areas of strength and development, and highlight changes you can make to improve the care or services you provide.*
- *To evaluate whether changes you have made to your practice in light of earlier feedback have had a positive impact.*

It is not at all clear from the survey conducted that these aims are being met; I suspect they aren't.

The GMC have opened a consultation for both the doctors and the public about patient feedback. This is an opportunity to have some input into this process. The link is provided as part of the reference list below. I would urge everyone to individually take part in this consultation. The FICMPAS Committee has made a submission based on the survey results.

References:

1. <https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation/your-supporting-information---feedback-from-patients-or-those-to-whom-you-provide-medical-services>
2. <https://www.ficm.ac.uk/sites/default/files/Guidance%20on%20Revalidation%20in%20ICM%20Ed.3%202014.pdf>
3. https://www.gmc-uk.org/about/get-involved/consultations/consultation-on-changes-to-our-revalidation-requirements-for-patient-feedback?utm_source=shortlink&utm_medium=social&utm_campaign=patient_feedback_2019&utm_content=feedbackyourway#doctors



ACCP CONFERENCE

The 2020 ACCP Conference is being held on Thursday 4th June 2020 at The Education Centre, Royal Victoria Infirmary, Newcastle.

The programme and online booking will be available at the end of the year. We hope to see many of you there!

FICM AND RCEM - JOINT FRAMEWORK FOR BETTER COLLABORATION

Dr Liza Keating

Project chair

Critical care services have seen a 4-5 per cent year on year increase in growth as reported by multiple data sources. In parallel with these statistics, emergency department (ED) attendances continue to rise and in 2017-18 23.8 million people presented to the ED in England¹. Although seasonal variation exists the number of patients admitted to hospital from the ED has continued to rise. The persistent year on year increase in ED attendances has resulted in patients waiting even longer in the ED to be seen². It is recognised that departmental crowding has been associated with rising mortality figures³.

It is increasingly apparent that both EM and ICM are under mounting pressure. Last winter RCEM and FICM issued a joint position statement. In the face of the ever-increasing challenge of complexity and demand, safety concerns were raised in the context of the extraordinary pressures placed on both services⁴. Both the College and the Faculty, cognisant of the need to focus on the delivery of care to critically ill patients, committed to collaborate on a national framework to outline best practice between emergency medicine and the critical care team. The aim of this project is to deliver better outcomes for the care of the critically ill patient in the ED.

In spring 2019 a working group, with representation from across both emergency medicine and critical care, was established to achieve this objective. The intention is to pull together best practice for this group using specific examples of exemplary care from across the country supported by the evidence. The document will attempt to reach a consensus on staffing levels, training and skill maintenance with respect to the care of this patient group. Reference will be made to previous work by other organisations. Through the identification of processes common to both teams, the brief is

to include recommendations on equipment where appropriate.

Key performance indicators are already available for conditions known to benefit from the timely delivery of evidence based targeted ED interventions. This list includes well-defined conditions that commonly present to ED including: traumatic brain injury, stroke and patients undergoing emergency abdominal surgery. However this ambitious framework needs a broader overview of the ED population. It mandates the recognition of undifferentiated critically ill patients within the ED. The framework will attempt to agree outcomes for this at times complex group.

A list of stakeholders has been identified with further discussion due at our next meeting. The document will be circulated for consultation prior to publication later this year. If you are interested in this project and would like further information on any aspect please get in touch.

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LEGAL AND ETHICAL POLICY UNIT

Dr Chris Danbury

Chair: Legal and Ethical Policy Unit

Acting ‘In the Best Interests’ or ‘Determining Best Interests.’

The FICM Annual Meeting: End of Life Matters was on the 13th June this year. Dr Joe Cosgrove, the Chair of the FICM End of Life Working Party, gave us an insight into the upcoming guidance *Care at the End of Life: A guide to best practice, discussions and decision-making in and around critical care*.

This is a hugely important piece of work and I commend it to everyone. It is particularly important in patients who cannot consent for themselves. The Mental Capacity Act came into force in 2007, so it is now almost 12 years old. Over that time, we have learned about best interests, and it is now an integral part of critical care culture.

We talk about acting in the patient’s best interests, but what do we mean by this? How do we know what those best interests are, and what steps have we taken to determine the best interests. The recent British Medical Association / Royal College of Physicians [Guidance to support doctors making decisions about CANH for adults who lack capacity in England and Wales](#) goes a long way to answering this question. Although this document is aimed primarily at decisions about Clinically Assisted Nutrition and Hydration (CANH), the decision making process is equally applicable to other critical care treatment decisions.

During the case of Re Y last year, the Supreme Court was asked if there was a distinction between CANH and any other forms of life-sustaining treatment. The Court did not answer, and so I infer (although happy to be corrected) that there is no legal distinction between CANH and any other form of life-sustaining treatment. Thus, the guidance on decision-making and the flowchart can be used to help us determine what the best

interests of our patients actually are.

We as clinicians understand the medicine, the people who are close to our patient, who knew them prior to their admission to critical care are well placed to understand them as an individual. We are obligated by the Mental Capacity Act to consult with those with an interest in our patient’s welfare, so I find it useful to have a flowchart to help me through that process. The final point here is we are decision makers. This sounds like a strange thing to say, but in a recent (non-critical care) case, the doctors involved held themselves to be neutral in a decision. This cannot be right, as we have to be able to justify that any treatment we start (or continue) is in the best interests of our incapacitous patients.



The Faculty has endorsed the BMA/RCP guidance, which has been extremely popular with thousands of downloads. I understand that the BMA intend to produce a more general decision making framework in the near future. I look forward to its publication and the help it will bring to all of us to ensure that we get it right every time.



SOCIAL MEDIA IN THE ICU - AN ETHICO-LEGAL PERSPECTIVE

Dr Rosie Baruah

Legal and Ethical Policy Unit

A case history

A woman has been violently assaulted and is admitted to the ICU. Her ex-partner is now sought by the police. She has a number of injuries and is unable to take part in discussions or consent to any sharing of her information. Believing it to be in her best interests, relatives are updated on her condition by the ICU team. An apparently well-meaning relative posts the story of her injuries and treatment on ICU on several social media platforms in an attempt to enable members of the public to locate the alleged assailant. This story is picked up by newspapers nationally, accompanied by photos from the social media feeds of the relative. When the ICU team found out, the relatives were asked not to take photos and to consider carefully what was posted as it was breaking confidentiality.

A changing landscape

Over the last ten years, social media has become an increasingly important part of all our lives, whether we willingly engage with it or not. In the ICU, families may rely on social media to communicate with wider friends and family and this may include sharing of confidential information and images of the patient. Without appropriate use of privacy settings, images and updates can be shared widely across the globe in a very short space of time, without the patient ever having consented to sharing this information.

Being a patient in ICU is associated with longstanding psychological morbidity in a sizeable proportion of patients and having one's privacy violated in this way could be a contributory factor. From a legal perspective, Article 8 of the European Convention on Human Rights (ECHR) enshrines the right to respect for private and family life. Distributing private images and details of a patient who lacks capacity to consent to such distribution may be seen as a violation of this right. The ECHR is more concerned with the acts of states on the rights of

citizens rather than the acts of individual citizens, and so it is very unlikely that this legislation could be used to prevent use of social media by families. Many devices now automatically store login details for websites and apps, and it is possible for family members to login and post material to the patient's own social media feeds on their behalf. Whilst this may be done with benevolent intent, unless the patient had given explicit consent for this to happen, including giving admin rights to those posting, they may be in violation of the Computer Misuse Act (1990). This Act renders it a criminal offence to gain unauthorised access to a computer and cause it to perform any function with intent to secure access to any programme or data held in that, or any computer. Accessing a mobile device or computer in order to modify content on a social media webpage or app could fall under the provisions of the Act. It is possible, although very unlikely, that a patient who has recovered from their critical illness could seek prosecution of a family member who had accessed and posted on their social media feed without such explicit authorisation.

It is not clear what we, as critical care clinicians, can do to prevent the privacy of our patients being violated via social media. Most organisational social media policies do not include guidelines for families of patients without decision making capacity using social media to distribute information about their illness. Perhaps all we can do is discuss with families the potential longer-term implications of such breaches of privacy.

LEPU is keen to hear from any intensivists who have been involved in a situation similar to that described in the case history – does your organisation's social media policy adequately capture the complexity of social media use in the ICU by family members? Do you feel explicit guidance in this area would be useful? Contact@ficm.ac.uk.

GUEST ARTICLE



Ageing Population: How fit are you for frailty?

Professor Martin J Vernon
National Clinical Director for Older People

Martin qualified as a medical doctor in 1988 in Manchester. He trained as a Geriatrician and General Internal Physician in the North West and London before becoming an NHS Consultant in Manchester in 1999 where he continues to practice medicine. He has a MA in Medical Ethics and Law from King's College London and continues to teach these subjects.

Martin has held many senior NHS leadership roles including Clinical, Divisional and Associate Medical Director. He has been Clinical Champion for older people and integrated care in Greater Manchester and British Geriatrics Society Champion for End of Life Care. He was also a standing member of the NICE Indicators Committee.

Martin teaches Ethics and Law at Salford University and was appointed as Visiting Professor at the University of Chester in 2016.

In 2016 he was appointed National Clinical Director for Older People at NHS England and Improvement. He has led multiple national workstreams including development of the NHS Long Term Plan Ageing Well Programme published in 2019.

AGEING POPULATION - HOW FIT ARE YOU FOR FRAILITY?



Professor Martin J Vernon
National Clinical Director for Older People

As we edge into the 21st century, we must not forget 20th century NHS history¹. To continue delivering high quality care for all those in need, a 20th century model of health care largely based around disease must modernise to support people in their communities to both live and plan for their futures². Of all evolved health and care systems, the NHS in England may be currently the best placed to do this through the Long-Term Plan published in 2019³.

Why is this important? World economic development has influenced hugely the spread of successful modern health care, with global disease burden shifting from communicable (infectious) to non-communicable disease. One obvious result is that human beings in the main live longer with the older population growing at about 3% annually. In 2017, 13% of the world population or around 962 million people, were aged 60 or over⁴. By 2030 this is projected to be 1.4 billion and 2 billion by 2050.

At 25%, Europe has the greatest proportion of its population aged 60 or over. Those aged over 80 years are projected to increase from over 5% in 2016 to nearly 13% by 2080. Their absolute number is expected to more than double, rising to 66 million by 2080⁵. In England, average life expectancy at birth has now reached 79 years for males and 83 years for females⁶. One in 5 of all new-born boys and a third of all girls can expect to live to be centenarians⁷.

However there has been a price to pay for these additional life years. Healthy life expectancy (the number of years lived in good health) while also increasing, has not kept pace and is now only 63

for males and 64 for females. Since the start of this century, life expectancy has increased by more years than healthy life expectancy and therefore the number of years lived in poor health has also increased: 16 years for males and 19 years for females.

Health systems must now adapt to the reality that greater numbers of people are surviving to later life with multiple long-term health conditions (multimorbidity) and increased levels of social care need. This is creating significant challenges for governments, health and social care systems around the world.

Many clinicians must also understand and adapt their practice to these realities. One in four adults



now lives with multimorbidity: half of older people have 3 or more long-term conditions⁸. These include physical and mental health conditions, on-going conditions such as learning disability, symptom complexes such as chronic pain, sensory impairments such as sight or hearing loss, or alcohol and substance misuse⁹. The most frequent patterns of multi-morbidity include osteoarthritis together with cardiovascular and/or metabolic disorders such as diabetes¹⁰. The prevalence of multi-morbidity has a significant positive association with lower socioeconomic status¹¹ so where and how you live really matters to your health and wellbeing and to how you will utilise health services. This makes a difference to the way health systems need to be organised locally.

Where does frailty fit into this? As a characterisation of problematic ageing, frailty provides us with a workable means of identifying key population segments with similar vulnerabilities towards whom specific health interventions can be targeted and planned for. In 2017 NHS England defined frailty as a long-term condition characterised by lost biological reserves across multiple systems and associated vulnerability to decompensation after a stressor event¹². This is intended to help routine frailty identification, particularly important when an older person with this vulnerability becomes acutely unwell, sustains injury or is planned to receive a new a healthcare intervention.

Importantly frailty is not just about being old: 20% people aged over 90 are estimated to remain fit and ageing well¹³. But as with multimorbidity, frailty is particularly associated with where and how you live¹⁴. Furthermore, the consequences of living with frailty for people at any age are potentially significant. More specifically a person aged 65 or over with severe frailty, when compared to their same age peer could have up to five times the risk of in-year death, permanent entry into a care home or requiring hospital admission¹⁵. Even 'mild' frailty doubles these risks.

Proactively identifying the presence of frailty can help care professionals to assess and plan with a person, through shared decision making, to optimise their experience and outcomes from both planned and un-planned health care events. This requires a series of important changes to the

way we organise health care by moving away from purely disease-based care models towards those which include an understanding of functional ability.

The first of these changes has already occurred. In 2017/18 England became the first developed health economy in the world to systematically identify frailty in General Practice using electronic health care record data¹⁶. To be clear this is about proactive population health management, not screening. Population segmentation in this way helps to target direct assessment on individuals to diagnose and risk stratify for important outcomes using validated tools.

“ HEALTH SYSTEMS MUST NOW ADAPT TO THE REALITY THAT GREATER NUMBERS OF PEOPLE ARE SURVIVING TO LATER LIFE WITH MULTIPLE LONG-TERM HEALTH CONDITIONS

This has now begun to help tackle the health and care challenges posed by population ageing while continuing to deliver high quality care: a key NHS priority. In 2019 NHS England & Improvement announced a new national programme focused on Ageing Well¹⁷ as part of the £4.5billion NHS Long Term plan commitment to primary and community services. Integrated care models that support older people with frailty, rely on primary, acute, community, social care and voluntary sector providers to collaborate and join up their work. Acute health providers have become more specialised and efficient but are under increasing pressure throughout the year. This has led in turn to pressures when managing patient flow particularly for those with complex conditions and significant ongoing care and support needs, many of whom are older people.

The NHS Ageing Well programme and associated commissioning tools¹⁸ set out an evidence-based

framework of care for older people with frailty to be delivered nationally¹⁹. This focuses on delivering integrated personalised care in communities and addresses the needs of older people with three inter-related service models centred on clearly identifiable population groups:

1. Community multidisciplinary teams -targeting older people with moderate frailty, people whose annual risk of urgent care utilisation, death and care home admission is 3 times that of an older person of the same age who is fit. This group are considered to be the most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.
2. Urgent Community Response—crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.
3. Enhanced health in care homes – and ensuring a consistent offer on this across England.

The intention is to support commissioners and providers of acute and community health services, social care and the voluntary sector to work together, turning what is currently urgent care into planned care for key groups of vulnerable older people. Everyone now has a key role to play in getting health and care systems fit for frailty.

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CAREERS, RECRUITMENT AND WORKFORCE

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee (FICMRW)

“Without data you’re just another person with an opinion”

W. Edwards Demming

This year’s Faculty Census has just closed with our highest ever response rate: thank you to those of you who completed it. So what are we going to do with the information? The short answer is more analysis and wider dissemination of results.

Whenever we meet with national bodies like the Departments of Health, the GMC etc. we need to have good data to identify and confirm our assertions.

In March I was at an Academy of Medical Royal Colleges meeting with Baroness Dido Harding and Julian Hartley who are leading the national workforce implementation element of the NHS Long Term Plan. The initial focus is on nursing and midwifery provision nationally, but they want more granular data from the Colleges/Faculties as they are aware that provision of service has great local

variation. Going forward we will be able to show what’s happening in ICM provision locally from the Workforce Engagement events and can also profile the workforce from Census data.

Engagement with the workforce is an important part of the committee’s work, and we plan to increase our outputs in terms of reports, meetings and academic publications. *A Critical Foundation* will be released in the autumn, to provide a resource showcasing how Foundation doctors can be incorporated into the ICM team and giving you information when you make a case for new posts. We start next on a much bigger piece of work looking at the ICM workforce including operational aspects of workforce standards and sustainability. Last year’s optional census data on wellbeing has also been accepted for journal publication and will provide some interesting comment on portrayal of working in ICM and the risks of burnout.

The census isn’t a sterile survey: the data is vital to the specialty.



ICM NATIONAL RECRUITMENT

Dr Tim Meekings

Careers, Recruitment and Workforce Committee

National ICM Recruitment took place from 12th-15th March this year, hosted by Health Education England working across the West Midlands at The Hawthorns in West Bromwich. As the heavy rain on the first day passed, broken clouds and even some sunshine saw a total of 281 candidates interviewed over the four days, applying for 164 posts across Scotland, England, Wales and Northern Ireland.

The interview process has evolved over the last few years and now consists of four face-to-face panel stations and one written exercise station. The panel stations include a clinical scenario station (20 minutes preparation followed by 10 minute interview), a presentation station (10 minutes preparation followed by 10 minute interview) and a task prioritisation station (10 minutes preparation followed by 10 minute interview). The final panel station is the portfolio assessment station – in this station the first ten minutes is spent verifying a previously submitted self-assessment score of the candidate's portfolio; this is then followed by ten minutes of questions further exploring the candidate's portfolio. The written exercise station is conducted under examination conditions and is designed to assess the candidate's ability to constructively reflect on a previous experience, and

demonstrate experiential learning from this.

The panel stations and the written exercise are all scored independently by two consultant intensivists; this means that each candidate will have been seen and assessed independently by 10 different consultant assessors during the day, to ensure each candidate has a fair opportunity to demonstrate their strengths and suitability for further training in ICM. To quality assure the process, across the four days of interviewing a team of consultant assessors with previous experience of interviewing visited each station in turn, observing the interview process and assessing the performance of the interviewers. A lay observer was also present during the interviewing, to observe the process and ensure it was fair and objective. Feedback on the interview process was collected from the assessors, the quality assurance team, lay observers and, crucially, from the candidates themselves. All this feedback will be used to further enhance and streamline the process in future years.

National Recruitment Selection Methodology training has been provided by the Faculty every year in the months leading up to the national recruitment round, to ensure every consultant

assessor has the opportunity to attend and learn more about the theory behind selection and the specific process used for National ICM Recruitment – this includes seeing samples of the panel stations in action with the opportunity to see examples of different performances by a candidate, subject to my limited acting skills ...

There has been some concern voiced by candidates, Educational Supervisors and Faculty Tutors about the self-assessment scoring of their portfolios when applying for ICM training. The self-assessment matrix



is freely available on the ICM national recruitment office website and is composed of ten different domains, including academic qualifications and achievements, teaching skills and also achievements outside medicine to name just a few. A total of 54 marks are available for this self assessment and it is important to point out that the majority of candidates only score well in a few of the domains, as it is very difficult to score highly across all the domains. This has left candidates with the impression that they are submitting a weak application, due to a perceived low self-assessment score for their portfolio. It should be borne in mind that the portfolio self-assessment score accounts for a maximum of 54 marks in a total of 400 available across the five stations – so any perceived weakness in the portfolio self assessment should be possible

“THE SELF-ASSESSMENT MATRIX IS FREELY AVAILABLE ON THE ICM NATIONAL RECRUITMENT OFFICE WEBSITE AND IS COMPOSED OF TEN DIFFERENT DOMAINS

to make up for in the other four stations. During this year's recruitment, the mean score for the portfolio self assessment this year was 31 out of 54 (mode 27, median 31). Further analysis of the data from this year reveals that 22 candidates who scored 20 marks or fewer in their portfolio self assessment still achieved an overall score for the day that would make them appointable.

For potential applicants for ICM recruitment in 2020, there is more information available on the ICM national recruitment office website (icmno.wm.hee.nhs.uk). This includes lots of information for the 2019 process, much of which is unlikely to change significantly for 2020 – there is a downloadable applicant guide, a detailed scoring matrix for portfolio



self assessment and a list of FAQs. The annual recruitment process usually starts with an application window around January/February, with the interviews normally held sometime in March/April.

For potential consultant assessors – we would value your support! Look out for an email with more details about the 2020 round towards the end of this year, asking for your help. The National Recruitment Selection Methodology Training day offered by the Faculty to provide specific training for assessors for ICM recruitment is due to be held on 25th February 2020 – all assessors new to ICM recruitment would be well advised to attend. Assessors can choose to attend as many or as few days of the recruitment round as they are able to. As well as being an interesting and informative experience, it also offers the opportunity to renew old acquaintances and make some new ones. Finally, attending National ICM Recruitment as an interviewer also offers the chance to meet the next generation of our ICM training workforce on one of the early steps of their journey.





WORKFORCE ENGAGEMENT: THAMES VALLEY CENSUS

Dr Jack Parry Jones
Workforce Lead

Are we born to be Intensivists, or are we the moulded product of strange forces experienced over time in the critical care environment? It is most likely of course that we are a product of both; a spark of interest into an enquiring receptive mind, then youthful enthusiasm and training at the coal face. That spark of interest might be a special patient, research, or an inspirational role model in the unit but most commonly I suspect it is a feeling of fitting in to the team. A feeling of being comfortable in our working environment, being looked after, and ultimately belonging there. It is difficult to define what makes some units such fertile grounds for recruiting to our specialty but some definitely are. These are not necessarily where consultants end up working but mangrove swamps before some go out into the deep blue.

We need, as a specialty to encourage the creation of those sparks of interest in medical students, and the cross specialty trainees that come to us. There is potentially something for nearly everyone in critical care which is, after all is said and done, truly the very best bits of general medicine; diagnostic conundrums, novel treatments, basic sciences and humanity, often in its darkest hour but paradoxically often at its most endearing. For some there is

also modern technology, if that is what grabs your interest. For me over time it is increasingly the follow up of patients following their discharge from critical care.

There are amongst you some truly inspirational role models in critical care. These are however,

**“ ARE WE BORN TO BE
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CARE ENVIRONMENT?”**

by definition, few and far between. What really strikes me regularly is how many people in critical care work so hard, often altruistically, to improve care for patients, to showcase the specialty, and to train future Intensivists. Too often this is still in the absence of additional resource, and with little help, or understanding from the organisations we work in.

The Faculty Workforce review of the Thames Deanery in May really demonstrated this. The Faculty were wonderfully looked after in a lovely revived lido, but more important, it became clear over the course of the day how much effort and success is being made by individuals in the region to tailor training to individual trainee's needs, and to try and deliver the best



possible critical care. The day was a very positive one. There were, as ever, lessons learnt by the Faculty team, and we hope lessons learnt by the region from each other and from the Faculty team. A full report will be produced in due course to go with the previous workforce reviews which are all available on the Faculty website. The Faculty team really hope that these in-detail reviews of a region's workforce and their future workforce requirements are useful for planning and securing resources. At the very least it should be useful for the key players in a region to get together, network, and review the progress that has been made, and plan for where it hasn't and needs to be. Our next



Faculty workforce review is due in November in Wessex. It's not a competition, but the Thames deanery lunch was incredible – I'm just saying!



Lastly we must also do all we can not to dampen that youthful enthusiasm but let it flourish and grow. Maintaining people in the specialty is as important as them entering it, and to do this we must look after our own. The Intensive Care Society Wellbeing day in May was a good demonstration in how far our specialty has got in this regard. There is always more we can do. I was struck by the how many women there were on the day compared to men. Despite significant improvement, the critical care consultant workforce is still predominantly male but you wouldn't have known this. So – come on fellow men, we need to do more than just pay lip service to our own wellbeing, that of our immediate colleagues, and that of the whole multidisciplinary team. The retention of our trainees, and our consultant colleagues within the specialty is absolutely crucial to the future, and should not rest only with female colleagues. We should be breaking down these stereotypes.

If you are interested in helping to showcase the specialty in your area, you don't have to start with a blank page! The Faculty's Careers, Recruitment & Workforce Committee has developed a pack for anyone arranging careers evenings to engage and network with the local medical workforce.

The pack includes a series of lectures (with notes), handouts and an organiser's guide. Access the pack here: <https://www.ficm.ac.uk/careers-hub/virtual-careers-evening>

ADVANCED CRITICAL CARE PRACTITIONERS



Ms Carole Boulanger

Co-Chair: ACCP Sub-Committee



Dr Simon Gardner

Co-Chair: ACCP Sub-Committee

We recently held our 7th National ACCP conference hosted by FICM and were pleased to again have sold out with a waiting list. It was a very popular programme coordinated with the help of Jo-Anne Gilroy from the London ACCP network. We were pleased once again to have Carl Waldman as Dean not only open the conference but also stay and enjoy the sessions and interact with the ACCP group. We had posters from regional networks about activities and good opportunities to share and collaborate.

The FICM ACCP Sub-Committee has expanded in numbers – we have four new elected members: two ICU consultant and two ACCPs. This considerably increases our capacity to engage with all the national activity around advanced practice and reduce the time for application reviews for FICM membership. We have a steady increase in FICM ACCP Members (152) and the number of trainee ACCPs registered with the Faculty.

Whilst the landscape around advanced practice nationally is changing significantly as it evolves the challenge of whether we as ACCPs are MAPs (Medically Associated Professionals) or ACPs (Advanced Clinical Practitioners) remains under debate and not clear. It was debated at our conference – it is key we in the ACCP SC for FICM ensure we are acting on the consensus opinion of the ACCP community. There are

strong opinions and rationale on both sides which are important to hear to inform direction going forwards. Granted the MAP route would circumnavigate the issues around non medical prescribing statutes and allow our OPD colleagues and others to enter training to the level of the national curriculum. The ACP route offers existing regulators and has increased engagement from the NMC on the matter of advanced practice. What was clear from the conference and discussions was that we are clear what an ACCP is, the curriculum, knowledge, skills and competency standards required. That group identity is really important going forwards to avoid dilution of the role which has been well accepted in clinical practice as part of a workforce solution for ICU. We will continue to engage both with our members and the national agenda and active contribution and communication are key. It is gratifying how well the FICM ACCP curriculum and CPD/appraisal documents are received in the national arena and viewed as something of a benchmark.

We have been looking forwards to hub and spoke academic and clinical training in recognition of the resource implications of training and support gaining competencies. Also to help meet some of the challenges of providing care in smaller ICUs. As the ACCP SC we are working towards a proposal for the FICM Board of accreditation of university programme provision to ensure a consistent quality standard across the UK.

There is now almost universal cover across the UK of regional ACCP network groups. These are proving to be highly effective at providing local CPD, peer support activity and communication network. These have developed and ensure there is local coordination and an opportunity to share good practice. Having local networks communicating effectively by social media and other means ensures a strong voice for ACCPs and allows us to come together as groups. We are coordinating contacts and activities on these regional groups on the NAACCP webpage hosted by FICM. We would ask that any activities being held are sent into the faculty office to be posted on this page - some ACCPs have been attending other regional activities that sharing of experience other than just a the national conference is invaluable.



WOMEN IN INTENSIVE CARE

Dr Rosie Baruah

Chair: WICM

The Women in Intensive Care Medicine (WICM) group continues its work to promote ICM as a specialty for all.

Our newest project, unveiled in early May, is the Emerging Leaders Fellowship. This fellowship programme is the result of a lot of hard work from Manni Waraich, one of the WICM Sub-Committee members. There will be 4 places in the first Fellowship programme intake, recruiting this summer for an early autumn start. The programme was open to female Fellows or Members of the Faculty who hold consultant or SAS posts. Women at any stage of their career could apply, and we were particularly keen to hear from women who feel they hadn't yet fulfilled their leadership potential. Fellows will be matched with a mentor from within the Faculty Board, will attend meetings of Faculty committees of their choice, and complete a leadership project with the Fellowship group. To help more formal leadership development, Fellows will be funded to complete an Open University certificate in leadership skills. On completion of the Fellowship, Fellows will have acquired skills including effective chairing and leading meetings, communication and networking skills and effective time management and goal setting.

We have organised a one-day meeting, "Striking the Balance," which will be held at Red Lion Square on 27th September. This CPD accredited meeting has been organised by WICM committee member Sarah Marsh and is aimed at anyone working in ICM, and will cover all the 'soft skills' which often prove to be the most challenging part of the job. Talks include subjects such as "Succeeding as an Introvert", "Being an Ally" and "Dealing with Failure". We will provide training in mentoring skills, and hold workshops on management skills based on your personal management style, chairing meetings and speaking in public, dealing with the risk of burnout and how writing can help you develop as a person and as an intensivist. The full programme can be found [here](#). It will be a

fantastic day for anyone who works in ICU and related specialties and we look forward to seeing you there!
<https://www.ficm.ac.uk/ficm-events/wicm>

Returning to work after a career break can be a real professional challenge, regardless of the reason you have had to take time out; maternity or parental leave, research or illness. WICM member Roisin Haslett is setting up a working group to draft Return to Work guidelines for the Faculty to help both clinical line managers and individual doctors plan a return to work after any prolonged absence. We hope to have this important piece of work completed by the end of the year.

“ THE WOMEN IN INTENSIVE CARE MEDICINE GROUP CONTINUES IT'S WORK TO PROMOTE ICM AS A SPECIALTY FOR ALL

Finally, the WICM group has a monthly blog here: <https://www.ficm.ac.uk/wicm-women-intensive-care-medicine/wicm-blog>. We really hope you take the chance to have a look at it. We have published blogs by WICM members and the wider ICM community on a wide variety of subjects – this would be a good resource to point doctors in training who may be interested in a career in ICM. We also have an active Twitter feed @WomenICM which is definitely worth a follow!

As ever we are keen to hear what you think about WICM's projects – you can get hold of us at wicm@ficm.ac.uk.



UPDATES

1

Supporting ACCEA Applications

2

**Smaller and Specialist Units
Advisory Group - Remote Working**

3

**National Adult Critical Care
Data Group**



SUPPORTING ACCEA APPLICATIONS

Professor Gary Mills
Chair: ACCEA Advisory Group

There was an impressive array of applications for citations in the recent round. Writing an ACCEA application is difficult, because space is limited and competition is high. Providing evidence of the important roles and contributions that each applicant has undertaken, in a form that is understandable by those from other specialties and by lay members, needs careful thought.

Deciding whether to apply used to be straightforward. Unfortunately, we now have seen applicants withdrawing, because of the implications of tapered personal allowances and tax on pensions. This is a complex area, that for many will need financial planning advice; to determine whether winning an award is worthwhile, or whether attempts should be delayed, because of pension related taxation. How best to determine if or when to apply may also be affected by the timing of key features on applicants CVs.

The consequences of these tax bills for consultant involvement in developing the specialty are potentially very serious, as this affects life-style choices, based on the available evidence. These are often very long-term plans.

Although yearly financial decisions are understandably difficult, it is important to make these before applying for support, because late withdrawal may mean that another candidate is not supported with a citation, when they could have been.

The future for ACCEA awards is likely to be complex, but for those who want to apply, a thought-through and well written application that follows the guidance and clearly explains the applicant's contributions is vital. We wait to see the outcomes of this year's round in the hope that the future pension tax arrangements will change, however unlikely that may seem.

FFICM EXAM CALENDAR July 2019 - June 2020

	FICM MCQ Examination	FICM OSCE/SOE Examination	
Applications & fees not accepted before	Monday 7th October 2019	Monday 8th July 2019	Monday 6th January 2020
Closing date for Exam applications	Thursday 21st November 2019	Thursday 29th August 2019	Thursday 20th February 2020
Examination Date	Tuesday 7th January 2020	Tuesday 15th & Wednesday 16th October 2019	Tuesday 21st and Wednesday 22 April 2020
Examination Fees	£485	Both: £600, OSCE: £340, SOE: £305	Both £600, OSCE £340, SOE 305



SSUAG UPDATE - REMOTE WORKING

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

How invested are we when it comes to patients in other hospitals? We are all human beings. It is easier to be involved when you are personally responsible for the patient in front of you. Once you are separated from that personal contact, it is natural to not have that same feeling of ownership. It is however possible to still provide a great service, but one of the difficulties is to ensure that everyone is singing from the same hymn sheet – both those in the referring centre and those in the receiving centre.

One of the ways in which human interaction improves is if you know the person personally. This means that the phone call is between two colleagues who are familiar with each other and this naturally feels easier. Another important aspect is the provision of a robust infrastructure. This ideally incorporates up to date information on the patient's condition which can be easily accessed. There is an increasing interest in ways in which we can improve this aspect, and providing services remotely is gaining traction in a number of areas in medicine.

How close are we to having a service model which incorporates telemedicine in critical care? The truth is in the UK we are a long way away. An interesting paper that has recently come out from Christopher Farmer in the USA (in press) details the infrastructure needed to provide a telemedicine service¹. It provides alarming reading. The costs are enormous, and the need for staff to run the centre is likely to be prohibitive at a time when we struggle to fill our current vacancies. There are also practical aspects in the United Kingdom of which a major issue is where does the responsibility lie?

Farmer asks direct questions: does the presumed benefit justify the high cost (perhaps \$3 - \$5 million per 100 beds just for the eICU system, with staffing and other aspects extra). He also points out that

if instituted the model will vary - as usual one size does not fit all.

So are there alternatives? At a basic level we already have collaboration across units: scans are sent digitally between linked centres: the cardiothoracic units and neurointensive care units are experts at making remote clinical decisions on patients out with their hospital, but within their catchment area. This is usually based on telephone conversations alongside any imaging or results available. Perhaps upscaling this type of interaction might be a start. Clinical information systems are a lot cheaper to implement, and can provide information that may be of use across a wider scale than just the individual unit. GPICS V2 has a section on clinical information systems written by Dunn, Lympny and Szakmany which helps to clarify the use of these systems.

Although communication between units is available, it is in its infancy. A USA style of telemedicine provision seems out of reach for us at the moment but there are simpler options. Exploring whether these achievable steps would be helpful would seem to be a sensible approach to help improve links between units within the same network.

1. Important administrative aspects of critical care telemedicine programmes. J S Farmer; Critical Care Clinics 2019 <https://doi.org/10.1016/j.ccc.2019.02.001>



NATIONAL ADULT CRITICAL CARE DATA GROUP

Dr Lui Forni

National Adult Critical Care Data Group

Despite the great strides that the National Adult Critical Care Data Group (NACCDG) has made, Professor Mike Grocott has decided to hand over the reins following his recent election as Vice President of the Royal College of Anaesthetists. Hence I now find myself basking in his reflected glory before taking over the stewardship in September. In all seriousness, Mike has done a terrific job and I know he will be sorely missed. Over the past few months there have been several developments worth noting. Firstly, under the guidance of Dr Tim Gould, the Data Working Group, consisting of Professor Duncan Young, Dr Tamas Szakmany, Dr Alain Vuylsteke, Dr Steve Harris and Dr Nazir Lone held their first meeting supported by FICM. Discussions centred on the current status of healthcare systems in the UK (of which there were surprisingly few) as well as debate as to the data wished for, particularly that over and above that supplied to the case mix programme. The group discussed scalability and felt that although data from multiple databases can be standardised a better long-term strategy may be to store data in a data lake and pull out subsets of data as and when required. Although this would have enormous benefits for critical care in the UK it is a huge undertaking and would require support from the ICM community. Although some way off I am sure we can all see the potential benefits so watch this space!

A possible purpose for the group could be to set minimum standards of how data should be defined,

similar to the Apache HTTP Server standards in the U.S., so that all providers have to submit data in a specific format, which may accelerate the process. The 3-year CRG cycle ended at the end of March with changes implemented to the membership and we look forward to working closely with the future members. NHS England reported that the AAC specification will go to CPAG in early February for approval and that discussions have now taken place with the pricing team. Looking to the future, a move away from fixed tariffs is expected which may improve efficiency and quality without pushing the inflation price up. Options being considered include a locked contract arrangement for a large conurbation or a set number of beds for each unit. There are added costs for a higher level of HRGs, which needs to be discussed with the pricing team.

Our colleagues at ICNARC will be rolling out a new product for the IT platform which will be rolled out over the coming year hopefully leading to increased efficiency of processing of data. They also stressed that ICNARC continue to discuss with NHS Digital regarding the current difficulties with data linkage and also linking with the National Emergency Laparotomy Audit (NELA) which will be a significant step in the right direction. These are certainly exciting times for data husbandry within our specialty, which hopefully will translate into patient benefits. I will of course keep you informed!





TRAINING AND ASSESSMENT

Dr Tom Gallacher

Chair: Training, Assessment & Quality Committee (FICMTAQ)

Our recently conducted trainee Focus Groups demonstrated that commitment to a career in ICM was strong from all trainees interviewed. The feedback demonstrated almost no support for the uptake of ICM as a post CCT credential in preference to the current dual training programme. Factors that produced a negative impact on current work life balance, such as extending training rotations or lack of support for training, were factors considered likely to have a negative impact on trainees continuing in ICM training. Trainees wanted flexibility within training programmes in relation to hours worked as well as opportunities for additional experience.

The Faculty are addressing these issues by working closely with the Academy of Medical Royal Colleges (AoMRC), Health Education England (HEE) and the General Medical Council (GMC) on joint collaborative initiatives focused on improving the working lives and work-life balance of doctors in training. Initiatives have included the development of portfolio career posts, study leave reform and enhanced mechanisms for supported return to training as well as a pilot on extending access to less than full time training to a wider

pool of trainees. In addition, we have representation on the AoMRC group responsible for producing new guidance to facilitate increased flexibility in training. The flexibility framework is expected to be submitted to the GMC in the second half of 2019.

To improve our education provision the Faculty have formed an Education Sub-Committee comprising consultants - led by Chair Dr Peter Hersey - and trainee members. They will be responsible for organising educational courses and events as well as producing new e-learning (including e-ICM) materials. We will build an education website which will include our e-ICM modules and will work towards producing and hosting our own podcasts and blogs.

Members of the TAQ Committee conducted an internal review (utilising the e-portfolio system) of the ARCP documents and outcomes for a random selection of trainees. The purpose of this exercise was to assess and ensure consistency in the assessments. None of the portfolio reviews gave any cause for concern and the reviewers agreed with the ARCP panel's decision in all cases.



CURRICULUM RE-WRITE

Dr Tom Gallacher

Chair: FICM Training, Assessment and Quality Committee

In January 2019 the Faculty received conditional approval for our Purpose Statement from the General Medical Council. The approval is subject to the Faculty clarifying some minor issues with the GMC and we are now pushing ahead with our full curriculum rewrite with a view to submitting this to the GMC's Curriculum Approvals Group in April 2020.

All 14 ICM High Level Learning Outcomes (HiLLOs) have been agreed and mapped from the existing ICM syllabus to the new curriculum. Although we are required to rewrite the curriculum to comply with the new standards, there has been no change in the overall skills and competencies required to become a specialist in Intensive Care Medicine.

All syllabus elements from the current curriculum will be included in at least one of our new HiLLOs. This is to ensure that the standards and competencies required at present to become a specialist practitioner in Intensive Care Medicine are mirrored in their entirety in the new curriculum.

The HiLLOs for medicine and anaesthesia have been compiled in close collaboration with the Joint Royal College of Physicians Training Board and the Royal College of Anaesthetists, whilst our contribution to the Acute Care Common Stem curriculum rewrite has also included work with the Royal College of Emergency Medicine. The Faculty and all of our partner Colleges have been mindful to write those elements of our curriculum which will be accessed by all specialties in such a way that trainees will be able to transfer the capabilities gained in any specialty training placement in its entirety to any of the other specialties. This will maximise the opportunity for flexibility in careers as well as standardising the training requirements of all trainees regardless of base specialty when they undertake a placement in a specialty other than their own. This should make it easier for trainers to understand the learning needs of their trainees –

including those from other specialties - since these will be largely identical and will help futureproof our new curriculum. The latter is achieved by maintaining our partner specialties' capabilities as HiLLOs in their own right. This means that in the event that a partner specialty changes their curriculum we would only be required to change the relevant HiLLO and not have to re-write the entire curriculum as would be the case if we integrated the partner specialty capabilities throughout the curriculum as a whole.

One of the requirements to have our new curriculum approved by the GMC's Curriculum Oversight Group – the first phase of the approvals process - was to consider whether ICM would be suitable as a credential of another specialty when the GMC's Credentialing Framework is introduced. Since the new framework has not yet been implemented, this took the form of a discussion paper. To inform the discussion paper, and to gauge demand for such a credential, the Faculty conducted a series of trainee focus groups across 5 training regions and involving a total of 29 trainees. Trainees interviewed were in all stages of ICM training and included those from dual programmes as well as single ICM CCT and less than full time trainees.

From the discussions in our Focus Groups we found almost no support for ICM as a post CCT credential as an alternative to the current dual training programme. It was felt this would devalue the specialty and there would be little motivation for undergoing further training via a post CCT credential in ICM when consultant posts in partner specialties are available.

We therefore continue to focus on completing our assessment strategy for the new curriculum and have begun stakeholder consultations as well as developing educational materials aimed at facilitating the introduction of the new curriculum which we hope will be in August 2021. Look out in Dean's Digest and on the FICM website for opportunities to input.



e-PORTFOLIO

Dr Andy Gratrix
e-Portfolio Lead

It's been a little while since you have had any news regarding the e-portfolio. That's not to say we haven't been busy behind the scenes working hard towards the future and in particular exploring the options for a new e-portfolio provider.

As you may remember from the last update, the Faculty agreed the need to explore alternate options to the NES (NHS Education for Scotland) e-Portfolio system. Whilst we had hoped to move to version three of NES a while ago, the decision of a number of colleges to leave NES has meant this will no longer be an option.

In the last update we had said that we had been in discussion with Nomensa, the Royal College of Anaesthetists' new e-Portfolio provider, and continued discussions with Fry IT, who provide the portfolio for the Royal College of Radiologists and the Royal College of Paediatrics and Child Health. Following this update Nomensa revised its initial costings. Workshops were subsequently held in March with both providers to view and discuss options and functionality of each system to try and inform a decision of which to provider to move forward with.

A day was spent with each provider. The group consisted of the members of the e-Portfolio Sub-Committee, trainers, trainees and FICM staff, and other interested parties from the RCoA. Each provider was invited to demonstrate their portfolio both as an overview and to demonstrate specific tasks that are presently undertaken in the portfolio. This was in order to demonstrate the workings and functionality of their system and to answer specific questions posed by the group on the day. Prior to the workshops we had produced a list of questions and potential problems that we had previously encountered which we used as a specification template and this was put to both providers to help

inform our opinions and a future potential decision. At the end of each day further discussion occurred within the group to summarise the day's events and openly discuss our thoughts and opinions.

Both days were extremely productive and have left us with a tremendous amount of information to process. We now have other questions and queries that need to be answered which are presently being worked through. It is quite clear that both systems are able to deliver the functionality we are looking for, however, in different ways – both systems have advantages and disadvantages. However, functionality is not the only consideration. Finance is significant and there is a difference in total costs and a different costing model. The future proofing of the system and the risk of going with either provider in terms of data, wider IT support / integration and longevity all have to be considered. The partner situation with RCoA is significant and has to be taken into account also.

So, where next? We still have further queries and questions as a result of the workshop days that we are working with the providers to answer. A final report will have to go through the e-Portfolio Sub-Committee, TAQ, FICM Board and the boards in the RCoA that manage technology and finances before a final decision can be made. Watch this space!





FFICM EXAMINATION

Dr Victoria Robson
Chair, Court of Examiners

The final FFICM examination had its first sitting in 2013, and has been held twice a year since then. It forms an integral part of the assessment strategy of the stand-alone ICM CCT programme, and is mandatory for all single and dual ICM trainees prior to entry into stage 3 training. The questions are set, revised and examined by a Board of 60 examiners, who are also responsible for the standard setting. They are well-supported by FICM Department and by the Examinations Department of the RCoA. I have been an examiner since its inception, recently deputy chair and now have just taken over as chair of the Court of Examiners, following the retirement of Dr Andy Cohen. Under Andy's leadership the exam has grown and flourished into the well-respected badge of honour it is today within the Intensive Care community.

At the most recent sitting of the FFICM MCQ paper (March 2019), 106 candidates presented for the exam of which 84% passed. The MCQ pass mark was 66.89%. The MCQ paper has gradually changed over time from consisting of only true-false multiple choice questions, to an increasing number of single best answer (SBA) questions, at the request of GMC (who oversee all postgraduate medical examinations).

The OSCE and SOE are held over two days in London, and are face-to-face examinations conducted by examiners. 116 candidates attended the March 2019 sitting of the OSCE and SOE. 21 had passed one component previously. 60% passed the exam overall and were awarded the FFICM. Looking at the individual components, 69% of the 104 candidates sitting the OSCE passed this component, and 70% of 107 sitting the SOE passed that component. A prize is awarded for performance at the highest level in all parts.

The standard is set at the end of stage 2 training, and the examination aims to test as wide a range of the ICM CCT stage 1 and 2 curriculum as possible, including aspects of professionalism and relevant practical skills where possible. To this end both high

fidelity simulation and communication stations (often involving actors) have been used since the first sitting.

After each examination sitting the Chair writes a report, often highlighting curriculum areas where a number of candidates have had significant difficulty. Some themes recur, such as applied basic sciences and the structured approach to reporting x-rays and ECGs.

Examiners, and the exams department, strive to make the exam as fair as possible. All newly-appointed examiners receive induction training and established examiners continue to have regular training (including exam-specific equality and diversity training). Examination conduct is audited both by visitors and examiners and examiners receive feedback on their performance at exams appraisal. Each of the questions is written, then revised and scrutinised by a number of examiners before being included in an examination, and then regularly revised, using statistics available of the performance of the questions. The pass mark for each component is set by the relevant subgroup of examiners using validated standard setting statistics. A considerable part of an examiner's role is in the design and revision of questions and standard setting. Results are all double-checked.

And the future? The move to increase the proportion of SBA questions in the MCQ paper will continue: from January 2019 the paper will contain 50% single best answer questions.

Numbers of candidates presenting for the face-to-face component has gradually increased, and it is likely that this will need to be held over 3 days in the near future, as examiners are very keen to have sufficient capacity for all appropriate applicants at the sitting of their choice. The question banks will continue to be revised and expanded, to reflect changes in both the curriculum and ICM practice. And we hope candidates will present themselves well-prepared, so the pass rate will be as high as possible!



e-ICM AND THE EDUCATION SUB COMMITTEE

Dr Peter Hersey

Chair: FICM Education Sub Committee

The development of e-ICM is ongoing; some of it visible and some very much behind the scenes. The key bits of interest are summarised in the sections below.

Launch of three learning paths - Learning paths are a new development within e-ICM. They are essentially an easy way to find the most useful sessions on a particular topic. We have launched two 'Introduction to ICM' paths (one for ACCS trainees and another for core anaesthesia trainees), and a third learning path that highlights those sessions covering the 'hard to reach' areas of the curriculum. All the paths have been mapped to items on the relevant curricula, and they can be found at the bottom of the e-ICM main menu page. More paths will follow so do keep checking the e-ICM webpage.

Deletion of module 7 - Module 7 was the basic sciences module; a huge carbon copy of content available in e-Learning Anaesthesia. Usage figures highlighted that this module was not really being accessed, and there was no scope for us to provide any development of it. We therefore took the decision to remove the module from e-ICM. Hopefully it will not be missed, but you can still access all sessions via e-LA if you need to.

Revision of content - In order to have launched e-ICM within the timeframe and budget available we have shared (borrowed!) much content from other programmes within e-LFH. Whilst this has served us well, it has also left us with some sessions that we would like to update but cannot, and some areas where the content is not quite as specific or streamlined as we would like. The ongoing overhaul of ICM content in e-LA is helpful in this regard, but we are aware of more areas in need of a refresh. Where at all possible we are updating sessions, but if that is not possible the new content will be produced in due course.

New sessions - Having been successful in a bid for further funding from Health Education England, we

have been able to begin work on some more new sessions. This will increase the amount of content in e-ICM that has been commissioned by the Faculty, and therefore written to our specifications and standards. The next ones to watch out for will be two sessions covering maternal critical care (replacing the vast majority of what is already in place on that topic) and sessions on decision making around admission to critical care. There is more in development and still plenty to do, so if you are interested in authoring please do let us know.

Nursing engagement - We are about to start work on ensuring e-ICM is as useful as possible for our nursing colleagues. This will undoubtedly involve production of some new content and the creation of more learning paths, but also a fair bit of publicity. We will work with the nursing organisations and, once ready, we would also like to ask for your help to get the word out.

Change of oversight - The Faculty has just formed the *Education Sub Committee* (ESC), which will report to the Training, Assessment and Quality Committee (TAQ). The purpose of this new sub-committee is to co-ordinate and develop the education and CPD functions of the Faculty, and to act as a hub for easy access to educational resources. As part of that, the ESC will look after e-ICM and its future direction. Having recently appointed the group's membership, the first meeting was held in June. We will keep you updated, but whilst it may all seem a bit quiet at first please have faith that there is already work going on!

As always, my thanks to everyone involved with e-ICM, particularly Sarah Marsh as deputy lead (and deputy chair of the new ESC) and our authors and editors. There is plenty of scope for getting involved with education at the Faculty, so if you are interested or think you might be, please get in touch. We would also welcome your suggestions for work you would like to see the ESC undertake.



FFICM PREP COURSE MARCH 2019

Dr Sarah Marsh
FFICM Prep Course Lead

The 5th sitting of the FFICM Exam Preparatory Course was held this spring, and was the first to be held in London at Churchill House.

The course is a 2-day affair organised by FICM that is aimed at trainees who are about to sit the SOE/OSCE part of the FFICM exam. It has been held once a year in Leeds since 2015 and has been increasingly oversubscribed ever since, leading to the course being commissioned to run biannually from 2019. FICM HQ was the natural choice to be the home of the newly launched spring sitting, with the autumn leg continuing to be based in Yorkshire.

The event is split into 2 distinct parts; day 1 consists of small group tutorials and “hot topic” lectures. The topics covered are wide ranging and in part reflect previous exam questions, with this sitting including discussions on maternal critical care, liver disease in the ICU and skin conditions. Eleven experts in intensive care medicine as well as radiology, paediatrics and cardiology, delivered these interactive sessions. The calibre of speakers was absolutely fantastic and we are very grateful for the time and effort they took into preparing such excellent presentations.

Day 2 aims to replicate the real exam day as closely as possible, with a morning filled with OSCEs and an afternoon of SOEs. Consultant involvement is key in terms of the execution of day 2 and with 16 stations in total per round, we require at least 20 consultants to help examine on the day. This year with the new location, a new cohort of examiners was needed and we were able to secure the required number quickly due to the fantastic response we had to the request, with thanks going to the London TPD, Gary Wares, and the Regional Advisors for their help in spreading the call to arms across the southeast.

Each course can accommodate 32 candidates. Over the last 5 years, the cohort of candidates on the course has altered as would be expected. The number of candidates who are dual training in ICM with anaesthesia has reduced over this time (76% in 2015 to 60% this sitting), with an increase in candidates who are in training in ICM with other acute specialities including emergency, acute and renal medicine, as well as sole ICM trainees attending. Thirty candidates went on to sit the exam with 60% passing both components. Furthermore, 71% passed the OSCE section overall and 69% passed the SOE. These figures compare very favourably with the results of the exam as a whole.

In response to detailed and overwhelmingly positive feedback from both the candidates and the examiners, the lectures, tutorials and questions have been adapted over the years to reflect current learning needs as well as the evolving style of the exam. Radiology and cardiology (including ECGs) sessions have remained, as these continue to be mentioned in the FICM Examination Report¹ as areas requiring improvement. New sessions as well as new questions are commissioned for each course to keep the content current, up to date and relevant.

Our aim is that the course will give the candidates a real sense of what to expect on the day of the exam itself, as well as setting the bar for the level and depth of knowledge required. Despite being an intensive course to prepare for and deliver, it is a most enjoyable few days. It contributes to our own professional development as faculty, as well as fostering the opportunity to network with colleagues from around the country. And of course none of this could be done without the help and support of the faculty (Dr Jane Howard, Dr Paul McConnell, Dr Tim Wenham, Dr Sharon Moss and Dr Steve Lobaz), the examiners and speakers, as well as the FICM team – all of which I thank enormously.

TRAINEE UPDATE



Dr Andrew Ratcliffe

Lead FICM Trainee Representative



Dr Richard Benson

Deputy FICM Trainee Representative

Changes are afoot! Not only is summer on the horizon, bringing with it the annual frenzy of final assessments, completion of projects and preparation for ARCPs, but August also welcomes our new colleagues taking up training posts and bids farewell and good luck to those trainees who have successfully completed training to take up consultant posts around the country. It is a busy and daunting time for all. To ease this transition process, the Faculty has produced a number of guidelines and checklists to ensure you are ready for the next step in your careers. For those of you new to our specialty, a guide to training, assessments and how to make the most of your training can be found [here](#) and to those approaching ARCPs, we remind you of the “[Guidance on Competency Sign Off](#)” document on the website. After listening to your feedback, we are also pleased to signpost those trainees nearing CCT to a [new section of the website](#) dedicated to ensuring you are prepared for your final sign off. This section has been further supplemented by an article in the latest edition of [Trainee Eye](#) that outlines some top tips for completion of training.

The Training, Assessment and Quality (TAQ) Committee are working hard to develop the new curriculum and e-Portfolio. This complex process involves collaboration with multiple stakeholders and partner specialties to ensure not only that our training produces consultants ready to meet the demands

of our future critical care patients but also, for those undertaking Dual Training, enables trainees to develop the relevant competencies in their partner specialty. All specialties are currently undergoing curriculum rewrites, the first to be published being the new IMT curriculum. Many of you have expressed concerns regarding how this will impact future Dual training with the Joint Royal Colleges of Physicians Training Board (JRCPTB) medical specialties. Please be assured that the Faculty and JRCPTB are fully behind maintaining the future of these training programmes. Now that ICM has its High Level Learning Outcomes (HILLOs) in draft, the next few months will be spent working with the GMC to find a way forward. Further information can be found on the [Faculty website](#).

Following the January Board meeting, Richard attended the GMC/NHSI roundtable discussion on the mental health of doctors and medical students. It is acknowledged that whilst health and wellbeing programmes are good to see, we need to get to the base of the problem. Integral to this is the need to improve hygiene factors such as rest, study facilities and our working practices. One of the best ways to ensure this is by yearly audit through the GMC survey and it has been excellent to see that access to study and rest facilities were included in the 2019 survey. The focus of the AAGBI, FICM and RCoA work as part of the Fight Fatigue programme, and the BMA's new charter, has helped raise the importance of this area across the NHS. We sincerely hope that this can be a vehicle for positive change. One of the other groups that we sit on is the Academy of Medical Royal Colleges Trainee Doctor Group. There has been a significant concern raised about the process of credentialing with a feeling that the credentialing framework, as presented for consultation, is incredibly broad, indistinct, and as such without clearly defined limitations to its scope.

We see our roles as representing the trainee voice to the Faculty. As such, we want to hear from you. Whilst we certainly won't have all the answers we will do our utmost to answer any queries and bring your thoughts to the Faculty. You can contact Andrew or Richard via email andy.ratcliffe@doctors.org.uk and Richard.p.benson@gmail.com or via Twitter (@RPBensonICM).



SPOTLIGHT ON TRAINING: THAMES VALLEY

Dr Ian Rechner

Past Regional Advisor

Thames Valley boasts the second largest ICM programme in the UK. Education has always been paramount in its international reputation with the dreaming spires of Oxford at its heart but the region also has a broad economic base with industries including motor manufacturing, publishing and a large number of information technology and science-based businesses. 2.5 million people are served by the five main NHS trusts within the region: Milton Keynes in the north, Reading in the South, Stoke Mandeville in the East, Wexham Park (Frimley Healthcare) in the South East and Oxford in the centre.

Training Variety

Thames Valley punches above its weight. Despite being the smallest deanery in England, in terms of population and number of hospitals, the 2018 GMC survey contained two of the regions' hospitals in the top 10 for ICM training. There are currently 60 doctors on the ICM programme with a healthy mix of single and dual trainees. Both Acute Medicine and Emergency Medicine are well represented within this group.

Thames Valley has established a collaborative, professorial led ICM academic training programme with NIHR funding. This has enabled studies to be run within the individual regional ICUs with 15% of the regions' trainees being in academic posts. The Kadoorie Centre provides an excellent training facility for the ICM programme through its exam based teaching, guiding the trainees on their journey to specialisation.

ICM Training Programme

All the region's hospitals are large enough to provide a good case mix of critically unwell patients. There is a trainee driven move towards simulation, improving teamwork and a multi-disciplinary focus on patient delivered care. All these are helping

in development of the trainee for when they become a consultant. Stage 1 training is delivered throughout the region, stage 2 is carried out in Oxford where there are paediatric, neurosurgical and cardiothoracic Intensive Care departments. Specialist skills modules to date have been echocardiography, simulation, teaching and quality improvement programmes. Stage 3 is split over six months between Oxford and one of the other hospitals in the region.

The Oxford Regional Intensive Care Society (ORICS) meets twice a year. Here the specialist trainee committee liaises with three trainee representatives to move the programme forward ensuring ARCPs are a seamless process and that the training meets the trainees needs. Further information is available at <https://www.oxfordicm.co.uk/>.

Consultant Numbers and the Future

From next year the programme will produce about 10 consultants annually. Historically, many of these specialists choose to stay within Thames Valley, continuing the collaborative approach that has been nurtured during their training in region.

Within the region we have trainees driving change in areas such as: women in Intensive Care Medicine, part time working, behaviour and well-being. Improvements in these areas will steer the implementation of the GPICS 2 standards required of all Critical Care Units and continue to modernise the NHS.

Finally

"I have met and trained with some truly exceptional young people. They are motivated, collaborative, enthusiastic and working with them just makes you enjoy your job so much more."

The Faculty of
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