



CRITICAL EYE

Issue 14 | Summer 2018

Critical Futures
Update

Lifelong ICM

NHS England
PICM Review

ICM in
Sri Lanka

Recruitment
and Retention

BBC Hospital

The Faculty of
Intensive Care Medicine

CONTENTS

3 | Welcome

4 | Message from the Dean

6 | 2018 Annual Meeting Recap

7 | CRITICAL FUTURES

7 | End of Life Care and ICM

8 | Enhanced Care

10 | UK Critical Care Nursing Alliance

11 | BBC Hospital

13 | Paediatric Intensive Care & Specialised Surgery in Children Review

15 | CAREERS, RECRUITMENT AND WORKFORCE

16 | ICM Recruitment in 2018

17 | Reflecting on ST3 Offers

18 | FICM Workforce Census

20 | Women in Intensive Care Medicine

21 | Careers: Lifelong ICM

22 | Advanced Critical Care Practitioners

24 | PROFESSIONAL STANDARDS

25 | Legal and Ethical Policy Unit

26 | UPDATES

27 | Intensive Care Medicine in Sri Lanka

29 | Smaller and Specialist Units Advisory Group

30 | Getting It Right First Time

31 | National Adult Critical Care Data Group

32 | TRAINING AND ASSESSMENT

34 | Trainee Update

35 | e-ICM

36 | Regional Advisors

37 | FFICM Examination

39 | Membership Update

Please visit the News and Events section of the website for the latest news items at:

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

© Design and layout by The Faculty of Intensive Care Medicine

Cover photograph courtesy of ICCU, City Hospital Sunderland NHSFT

Clinical Editor

Dr John Butler

Managing Editors

Mr Daniel Waeland
Miss Natalie Bell

Administered & Designed by Mrs Dawn Evans

Dean

Dr Carl Waldmann

Vice Dean

Dr Alison Pittard



Dr John Butler
Clinical Editor

WELCOME

Welcome to the summer edition of Critical Eye.

In addition to the updates on all the latest ICM developments, we have a number of articles relating to some key strategic priorities in this edition.

Ms Janette Harper, Dr Liza Keating and Dr Peter Wilson give us an update on the Paediatric Critical Care and Specialised Surgery in Children Review and the subsequent next steps for this important piece of work. In 2016 NHS England (NHSE) set up a review of paediatric critical care services amidst concerns over the sustainability of the service with units predicted to reach near 100% capacity permanently by 2021. The review was set up as a collaborative work programme with expert stakeholders, including FICM, to develop services fit for the future. It is likely that this review will have implications for a number of units and further details can be found in the full article.

One of the key recommendations from Critical Futures was to explore the unmet need for patients who require ‘Level 1+’ Care. Currently, these patients are often managed in a Level 2 facility as their needs are too complex for ward care and consequently, a spectrum of perioperative care or specialty units have been set up where an enhanced level of care can be provided. With no national guidance in terms of service development and delivery, FICM has established a working party to ensure that delivery of care in these areas is both safe for patients and of the highest quality with an evidence-based strategy.

The annual FICM Consultant Workforce Census provides vital data so that we can continue to develop a picture of ICM consultant staffing demographics. In his article, Dr Parry-Jones gives us a run down on some provisional data including a crude indication of the numbers of ICM consultants required to fully cover GPICS requirements on a sustainable rota. The numbers of ICM consultants needed makes for very interesting reading but the good news for our colleagues currently in training is that we will need a lot more ICM trained consultants in the future.

We welcome any ideas for future articles including any comments on the new format of the newsletter. Please send your comments to contact@ficm.ac.uk.



@FICMNews

SAVE THE DATE
THURSDAY 13TH JUNE 2019
2019 FICM ANNUAL MEETING
END OF LIFE CARE



MESSAGE FROM THE DEAN

Dr Carl Waldmann

My article in this Critical Eye details what has been a very busy time for the Faculty.

CRITICAL CAPACITY

In March this year, the Guardian covered issues around Critical care bed capacity, highlighting *Critical Capacity*, a survey and subsequent report, that the FICM sent to its consultant members. It stated that 80% of consultants answering the survey reported the need to transfer patients for non-clinical reasons and 60% reported that their ICM service was being compromised for lack of nurses. A concern raised as a result of this survey was the divergence between what the doctors say they experienced on the ground and the bed capacity data released through NHS England. We took the results of this work through to a very productive meeting with NHS England in April.

MEETINGS

The Faculty has hosted several successful events this year; the Regional Advisors/Faculty Tutors/TPD day in March, the Annual Meeting 'Mind the Gap' in May and the ACCP Conference in June. You can read more about the Annual Meeting and the ACCP Conference in this issue.

DIPLOMATES DAY

Every year the FICM joins forces with the FPM and the RCoA and puts on a grand day at Westminster

Central Hall where in total we honour 400 of our trainees with the award of their fellowships. It is a day where the families of the successful candidates rightfully enjoy being proud day of their loved ones. I was so pleased to shake the hands of every one of our FFICM diplomates.



RECRUITMENT OFFERS

Diplomates day was fantastic until we received a phone call about a problem with the recently run RCP recruitment process which would have a huge knock-

on impact on our offers. Thankfully our trainees were eventually satisfactorily placed and given an assurance by HEE that nobody would be disadvantaged. I must congratulate Daniel Waeland on his superb handling of such a tricky situation over that bank holiday weekend and have to thank Liam Brennan, the RCoA President for all of his support. Following the events, Liam and I wrote jointly to HEE to register our concern and request involvement in any independent review so we could protect our trainees going forward.

AoMRC INTERACTION

The FICM has benefitted tremendously through our membership of the AoMRC. The Academy is now a much tighter organisation with all the Colleges and Faculties agreeing to work together on many projects. When I attended my Faculty of Medical Leadership and Management Leadership course prior to becoming Dean, I met with some politicians who told me that for politicians to meet with the Colleges was unnecessary as the government had their own advisors on health. Luckily, they now seem very happy to listen to us, and I was included in a delegation to meet the advisors at No 10 Downing Street, which proved extremely fruitful. We also met with the Shadow Health Minister Jonathan Ashworth and his team a few days later. The recent good news about Tier 2 Visas has been the result of these interactions. I hope engagement with the Royal Colleges and Faculties has both helped to encourage and inform the announcement of £20 billion investment into the NHS is welcome news.

UPDATE ON DEVELOPMENTS IN PAEDIATRIC SERVICES

In this edition of Critical Eye we discuss our recent interaction with NHSE and Peter Wilson on the question of capacity issues in our regional Paediatric Intensive Care Units. It was a reassuring meeting following significant concerns raised by our Board about the aims of this review. This is a detailed and long-term project, which will research in some considerable detail what support mechanisms can be established to protect paediatric patients. This will include any impact this will have on resource and training implications.

ESICM ELECTIONS

The recent elections for key positions in the European Society have just been announced. Three of our Fellows deserve special congratulations. Jules Wendon

has become the UK representative on the Society's Council, and Lui Forni has become the Society's Honorary Secretary. Both have recently been elected to the FICM Board. Maurizio Cecconi, who has recently moved from St George's Tooting to Italy, has been elected as President of the ESICM. This ensures the continuation of an excellent relationship between FICM and the ESICM at a crucial time when the UK prepares to leave the EU.



PROFESSOR JULIAN BION

The penultimate paragraph in my report concerns Professor Julian Bion. Julian was our first Dean, instrumental in getting the Faculty off to such an impressive start; but he will be the first to say (and I agree) that the success of the Faculty would not have been possible without the excellent support of Daniel Waeland and his colleagues in the office. Having been awarded the Gold Medal of FICM at the annual meeting this year, within a couple of weeks we heard the fantastic news that he was to receive an OBE. Well done Julian for everything you have done for the Faculty and for Intensive Care Medicine.

AND FINALLY ...

We will miss Anna Ripley and Susan Hall from the office but this will be only for shortish time whilst they go on maternity leave. We all wish you both well and look forward to your return.

MIND THE GAP

2018 FICM ANNUAL MEETING

Find out what you missed from our event organiser, Dr Alison Pittard

Our annual meeting this year, 'Mind the Gap', focussed on health and wellbeing and I think I can safely say from the formal feedback (and the ladies 'washbasin loo' talk) that it was highly successful. I do have to declare a conflict of interest as I was responsible for the programme but the buzz at the end of the day was palpable.

Finding a hobby that focusses the mind was an important theme for maintaining work-life balance. Caving at university combined with medical expertise led to involvement with the British Cave Rescue Council. A love of climbing led to scaling Everest and research in hypoxic conditions. Concentration, determination and commitment in competitive archery resulted, albeit via an unconventional pathway, in our third speaker becoming a consultant in ICM. An interesting debate on how to remain in full time ICM until retirement emphasised that everyone's balance is different and achieved in a variety of ways; finding that balance is essential for sustainability in any profession.

The mental health of our workforce is vital and we shouldn't need to be resilient in order to remain healthy and happy at work. We enter medicine to help patients but as the administrative burden increases so does the stress and, if left unchecked, can be a contributor to burnout. The best piece of advice was to assess the impact of any new policy on the mental health and wellbeing of staff. If this could be negative, then it should be modified or not implemented at all. Some resilience at organisational or team level is useful and we heard about systems that can help to create a positive working environment.

Some wonderful analogies were explored between the armed forces and ICM. The enemy is oneself and the environment, not our colleagues. During deployment, officers are 'brothers' looking out for each other, understanding the physical and mental stressors experienced. They have learned to be vulnerable and ask for help, supporting each other both on and off the field. We need to harness the power of our 'work family' because, to quote the Colonel, 'none of us is getting out of this alive!'

Our final speaker, a former BA pilot, talked us through the day his plane burst into flames on the runway during take off. His calm and efficient approach to this incident meant that the plane was evacuated with no loss of life. We tend not to be responsible for this many lives at once but the non-technical skills are very similar. Crew Resource Management, training for use in environments where human error can lead to devastating effects, focusses on communication skills, leadership and decision-making.

My initial anxiety as to the success, or otherwise, of the day very rapidly dissolved and I left London inspired and full of ideas. Thanks to all our speakers, all of you who attended, and Dawn for her superb organisational skills.



CRITICAL FUTURES

END OF LIFE CARE AND ICM

Dr Joe Cosgrove

Chair: FICM End of Life Working Party

The FICM End of Life Working Party (EoLWP) comprises medical and nursing representatives from within clinical and academic strands of Intensive Care and Perioperative Medicine plus external members representing patient groups, Palliative Care, the Royal Colleges of Physicians, Emergency Medicine, Surgery and NHS England. An extended stakeholder group (clinical and lay) will be invited to a meeting in autumn 2018 to discuss the working party's proposed outline for the guidance on delivering care at the end of life and how recommendations can be presented to health professionals and the public alike. It will also debate the training of clinical staff to enable improved skills and communications in presenting and discussing dilemmas faced by critical care teams when care at the end of life may have to be considered.

The final document will consist of an executive summary, a lay report and three detailed chapters that deal with the legal and ethical aspects of care plus guidance for best-practice. This will include difficult decision-making in acute environments and best-practice approaches to discussions in elective settings e.g. primary care, pre-assessment clinics or out-patient departments.

The first chapter highlights the dilemma between the duty to recognise when patients are dying and the concerns of potentially withdrawing or withholding life-saving treatments. It considers quantitative and qualitative aspects of care and gives an overview of the physical and psychological consequences of intensive care survival, debating how care can be advanced via clear legal and ethical frameworks. It also provides

insight into how critical care teams can deal with conflict and provides practical advice on delivering individualised care at the end of life. This latter component deals with physical and holistic aspects of care and practical matters such as step-down from intensive care and discharge home.

Dr Chris Bassford (University of Warwick) leads the work relating to difficult decisions in emergency situations. Poor decisions are associated with chaotic environments, misunderstandings about referrals, competing demands on clinical teams, poor communication plus limited confidence and experience in taking responsibility within the teams. Good decisions are, by definition, the antithesis of this. Evidence is emerging that collaborative discussions (patients, clinical teams and relatives) led by senior members of critical care teams can greatly improve clarity and effectiveness via information gathering, debating benefits and burdens and implementing the appropriate care with an ongoing review.

Guidance on discussions in an elective setting is being led by Dr Douglas Black (Clinical Research Fellow, UCLH). The driving force for this has been perioperative death in high-risk surgical populations plus the medium to long-term consequences of survival to hospital discharge in the event of complications and a prolonged intensive care stay. Initial work is aimed at establishing the views of those providing perioperative care and exploring the role of Advance Care Planning in out-patient type settings. A process that could, in time, complement work such as, NHS England's (North East and Cumbria) Deciding Right initiative.

Initial work has been completed and we are currently on schedule to publish in late 2019/early 2020. In doing so, clinical staff, patients and those close to them will have an improved understanding of intensive care medicine and we will be better placed to provide individualised care at the end of life.



CRITICAL FUTURES

ENHANCED CARE

Dr Alison Pittard
Vice Dean

Critical Futures, published in November 2017, makes 12 recommendations based on the survey feedback we received from Fellows, Members and partner organisations. One of the recommendations was to explore the unmet need for patients who require 'Level 1+' Care.

“ FICM WILL COMMISSION A WORK

STREAM WITH OUR PARTNERS IN

PERIOPERATIVE MEDICINE AND SURGERY

TO EXPLORE A SET OF PROVISION

STANDARDS FOR LEVEL 1+ IN THE

POSTOPERATIVE SETTING, INCLUDING

MEDICAL WORKFORCE REQUIREMENTS.

There is real concern that as patients become older with more co-morbidities and require admission to hospital, either due to acute illness or to undergo complex surgery, they are managed in a Level 2 facility. They often do not meet the current criteria for admission but their needs are too complex for ward care. Some organisations, in an attempt to mobilise Level 2 beds, have developed services such as 24 hour recovery units, perioperative care or specialty units where an enhanced level of care can be provided.

There is no national guidance in terms of service development and delivery nor is there a competency

framework for those working in these areas. The FICM has established a working party to ensure that the delivery of care in these areas is both safe for patients and of the highest quality with an evidence based strategy for their development.

Initially the focus will be on the perioperative patient, a well defined group, with a variety of services already in existence.

The first meeting was in May with representatives from:

- Faculty of Intensive Care Medicine (*Lead organisation*) including ACCP representation
- Royal College of Anaesthetists, including Perioperative Medicine (POM)
- UK Critical Care Nursing Alliance
- British Anaesthetic and Recovery Nurses Association
- Intensive Care Society
- Clinical Reference Group for Adult Critical Care

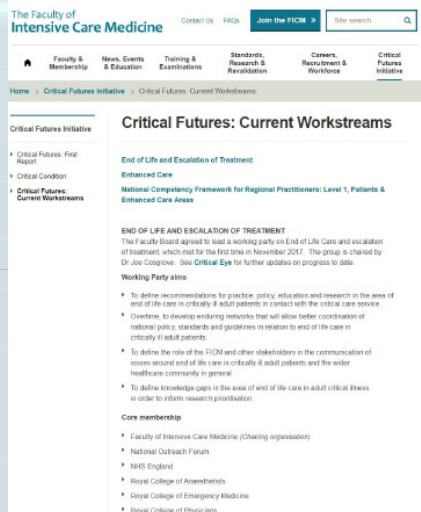
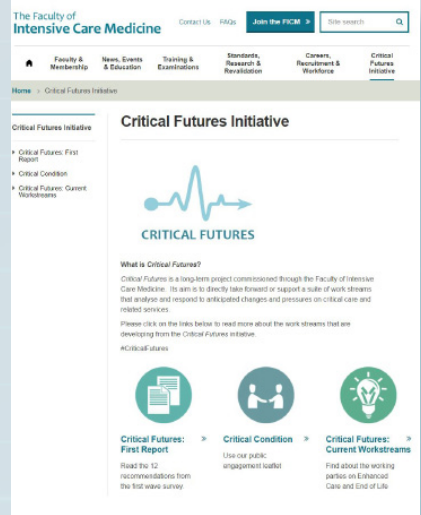
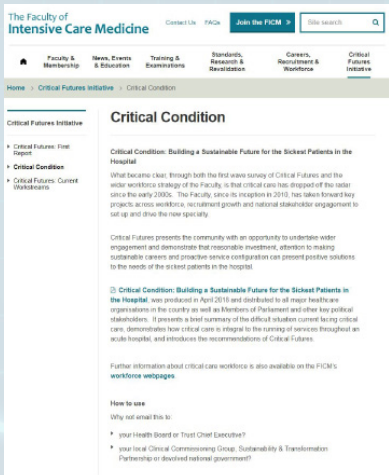
Having defined examples of best practice and developed some guidance, the current workstream will be expanded to cover 'Enhanced Care' in other areas e.g. obstetrics and medicine, with a revised core membership. Further consultation will be agreed with other key stakeholder groups (i.e. trainee doctors, the devolved nations, smaller and specialist units).

Between now and our next meeting in November we will circulate a questionnaire to 'Enhanced Care' / Level 1+ units already in existence and to regional perioperative medicine leads. We will also look at international examples and their quality indicators. With this information we will be in a better position to develop guidelines including admission/discharge criteria, appropriate interventions, initial and ongoing education and a clear escalation strategy.

Critical Futures webpages

The Critical Futures initiative now has a permanent home on our website. This resource currently includes the first Report, a breakdown of the recommendations, and information on working parties arising from the recommendations. It will be updated and grow over time as the initiative's work streams develop.

www.ficm.ac.uk/criticalfutures



Critical Condition

Over the last year of engagement with healthcare stakeholders and politicians, it has become clear that there is a lack of understanding about critical care. This is not just about its workforce issues, but how it interdigitates with other hospital services and how central it is to patient flow. In line with one of the recommendations from the Critical Engagements report, we have produced 'Critical Condition' to summarise key issues for a general audience.

www.ficm.ac.uk/critical-futures-initiative/critical-condition

UK CRITICAL CARE NURSING ALLIANCE (UKCCNA)

Mr Suman Shrestha

Chair: UKCCNA

The UK Critical Care Nursing Alliance (UKCCNA), established in 2013, provides a structured mechanism to facilitate collaborative working with all nationally recognised critical care nursing organisations across the UK. The aim of the UKCCNA is to be proactive and visionary about service requirements, providing quality assurance, enhancing the service, quality of care, patient experience and outcomes in critical care. The member organisations of the UKCCNA are the *Royal College of Nursing (Critical Care and Flight Nursing Forum)*, the *British Association of Critical Care Nurses*, the *Critical Care National Network Nurse Lead Forum (CC3N)*, the *National Outreach Forum*, the *Intensive Care Society* and the *Paediatric Intensive Care Society*.

Nursing, as a profession, is facing challenging times with the number of vacancies never higher than they are today. The Royal College of Nursing have highlighted that there are around 40,000 vacant posts in England alone and for the first time ever, the number of nurses leaving the profession outnumbers those entering it. Nursing within critical care is no exception to this trend. In a recent survey undertaken by the FICM, 62% of the critical care units stated that they are not able to recruit to their full critical care nursing complement and CC3N recently reported that an increasing number of units are seeking to recruit critical care nurses from overseas. This raises concerns regarding the potential impact on the nursing skill mix. The CC3N report on the critical care nursing workforce has highlighted that only 48.8% of nurses have a post registration critical care course and there is concern that, with the reduction of CPD funding, this is unlikely to improve. The development of the Advanced Critical Care Practitioner (ACCP) role has provided great opportunities for senior nurses to progress their career within the clinical setting, but it has also resulted in the loss of experienced nurses from nursing leadership and mentorship. It has therefore never been a better time for all the critical care nursing organisations to work together to develop this vital area of healthcare.

The UKCCNA develops a shared understanding of issues that affect critical care nursing at a local and national level, with a key focus on issues relating to training, education, workforce, standards and research. This provides a national platform for all critical care nursing organisations to identify, discuss and address issues of common concern, avoiding unnecessary duplication of projects and gaining a clear collaborative consensus.

The standards and specifications related to critical care nursing in GPCS (2015) were developed and agreed by the UKCCNA. The UKCCNA has also endorsed the National Competency Framework and Educational Standard for Adult Critical Care Nurses in order to standardise nursing competencies nationally. The UKCCNA recently conducted a systematic review of the evidence on measuring nursing workload and activity, identifying that there is a need for further research into this area. The group have begun work on a national research project, led by Professor Ruth Endacott, to review and develop an evidence-based model for the allocation of nurse staffing in ICU while evaluating impacts on patients, workforce and the organisation. This was raised as a priority for the critical care community in Critical Futures.

The UKCCNA is actively engaging and contributing to the broader multi-professional quality agenda for critical care services across the UK. It is part of the Critical Care Leadership Forum and is now well represented at various national critical care related forums such as the FICM End of Life Working Party, the National Adult Critical Care Data Group, and the UK Critical Care Research Forum. It endeavours to engage with all relevant stakeholders, be a strong leadership body and advocate for critical care nursing, so that the views of the critical care nurses are considered and their voices are heard at all times.

BBC HOSPITAL

Dr David Selwyn

Deputy Medical Director
Consultant in ICM & Anaesthesia
Nottingham University Hospitals NHS Trust

Ms Laura Skaife

Director of Communications & External
Relations
Nottingham University Hospitals NHS Trust

Usually when you hear that your hospital is going to be front-page news, you get that slight sinking feeling, as it is rarely a positive experience.

But for Nottingham University Hospitals NHS Trust (NUH) making the headlines for six weeks earlier this year was, as it turned out, a very positive experience. NUH was the 'hospital' featured in the third series of the award-winning BBC Two documentary series, *Hospital*. Broadcast over six weeks from March through to May this year, NUH staff and patients found themselves making local, national and international headlines, with each episode attracting an average of 2 million viewers.

As you might imagine, taking part in such a high profile and detailed documentary series was something that took a lot of time, effort and input to achieve. As we were about to find out, making 360 minutes of prime time TV is an all or nothing commitment. Before the documentary hit the screens, NUH staff were directly involved with the producers for around 12 months working together to bring the stories to the screen.

The ethos behind *Hospital* is to go behind the headlines and show a true picture of how NHS clinicians and managers interact to provide the best possible care to patients and their families. Label1, the production company who film *Hospital* for the BBC, worked with the Trust Board and senior leadership team initially, to reach agreement on taking part. Our reasons for going ahead were very closely aligned to what the producers were trying to achieve: To show the work of the talented and dedicated NHS staff who 24/7 provide the best possible care, under all circumstances. Staff engagement was a key factor in our decision-making process; we would never have been able to show 2 million people behind the scenes of NUH using other methods of communication. That said, as you would expect any Board to do, the NUH Trust Board

very carefully weighed up the risks of taking part in a documentary that would give cameras unprecedented access to our hospitals in the busiest and most pressured time of the year.

Filming took place over eight weeks in January and February with up to 30 production staff following staff and patients throughout the working week (24/7) across our two main hospitals sites. The producers assured us that we would very quickly forget that the cameras were there, and this was exactly what happened. The initial feeling of self-consciousness disappeared as it became clear that the focus was always on capturing what was happening, not getting in the way of what was happening. Though some of us continued to struggle to walk through doors on camera and not hold them open for the following camera crew. Force of habit!

We had very strict protocols agreed that meant filming would be stopped in the event it was compromising safe and effective care. Filming could only take place where the patients and relatives agreed in advance; there were a number of robust safeguards which meant that at any point patients or staff could change their mind. The producers worked closely with the clinicians responsible for the patient's care to ensure that filming was appropriate and sensitively managed.

To some extent, the success of this series of *Hospital* was not down to the careful research and planning; it was all about the timing. Filming started on the 2nd January when it was already becoming apparent that NUH, along with the rest of the NHS and social care, was experiencing a sustained period of unprecedented demand. This was the theme that ran throughout all six episodes. The stories that unfolded as a result were, in most cases, different to the ones that we and the producers had envisaged. On a personal note, this meant that areas like Critical Care gained a different

prominence than it probably would otherwise have done. Our role in managing patient flow and juggling elective and emergency demands featured strongly. On the whole I can only say that this was a positive outcome; *Hospital* was able to explore behind the scenes insights into not only our role as clinicians providing direct patient care, but also our role in leading, managing and often balancing the quality of care under the most challenging of circumstances.

palpable sense of pride as staff came into work on Wednesday morning, following the broadcast the night before. We laughed, we cried and we cheered as we saw colleagues in each episode; we all learned something new about NUH. One of my highlights was when a very established surgeon on our more elective hospital campus stopped me to explain how the programme had helped his appreciation of the impact of his ward work on the Emergency Department and patient flow.

“ONE OF MY HIGHLIGHTS WAS WHEN A VERY ESTABLISHED SURGEON ON OUR MORE ELECTIVE HOSPITAL CAMPUS STOPPED ME TO EXPLAIN HOW THE THE PROGRAMME HELPED HIS APPRECIATION OF THE IMPACT OF HIS WARD WORK ON THE EMERGENCY DERPARTMENT AND PATIENT FLOW.

As clinicians we were also involved in the editing and post production. We saw ‘draft’ episodes as they were ready and ensured that the collaboration between NUH and the series producers continued right through to the day of broadcast, and that scripts, voiceovers and commentary were accurate. This process was not about censoring or editing out what we felt the viewers should not see or what at times made uncomfortable viewing. It was about extending our duty of care to the patients and families featured, ensuring the patient stories and aspects highlighted were factual and balanced by providing technical and clinical input to ensure accuracy and clarity. I think this process is part of the reason why *Hospital* is so well respected and true to life.

The feedback from staff, patients, the local community and our health and social care partners as each episode was broadcast was just tremendous; it was overwhelmingly positive and the support for our staff and patients in each episode was unlike anything we have ever experienced before. People were stopped in the street, in the supermarket and even on the bus and thanked for the work they do. Our staff received ‘fan’ mail and we received presents from well-wishers for many of the patients who featured. There was a

Would we do the same thing again? I think the answer from NUH would be a resounding ‘yes’. For one thing, there are so many more stories to tell and so many services that were not able to be featured, but deserve to be. There are also some early signs that *Hospital* had a positive impact on our recruitment and retention; we had 150%

increase in clicks from Facebook recruitment posts to live jobs, over 20,000 visits to our new and dedicated recruitment pages on the Trust’s website and a significant increase in job applications during the broadcast period compared to the same period last year. We also have very clear evidence that NUH nursing retention is improving.

But overall my reason for saying ‘yes’ is because when we asked staff what they felt the impact of the series had been, 81% said it had created a better understanding of the NHS. That is the most important thing in the year we celebrate the 70th birthday of this country’s most precious institution.

Many months on, people are still talking about *Hospital*. That, surely, is a tribute to the quality of the programme, our fantastic patients and our exceptional staff.

PAEDIATRIC INTENSIVE CARE AND SPECIALISED SURGERY IN CHILDREN REVIEW

Ms Janette Harper

Head of Paediatric Intensive Care & Specialised Surgery in Children Review
NHS England

Dr Liza Keating

FICM Paediatric Intensive Care Representative

Dr Peter Wilson

Clinical Lead for Paediatric Intensive Care & Specialised Surgery in Children Review
NHS England

In 2016, NHS England (NHSE) set up a review of paediatric critical care services. Concerns had been raised over the sustainability of the service and the potential impacts from other enquiries such as the Congenital Heart Disease Review. The pressure on paediatric critical care services (PCC) is multiplying year on year due to increased life expectancy for patients with life-limiting conditions, greater use of technology to support life in these patients and the chronic staffing issues preventing additional beds being opened. NHSE's analysis shows that despite higher bed numbers, units are operating over their optimal capacity (85%) and are projected to reach near 100% capacity permanently by 2021. These high levels of capacity will severely limit their ability to respond to any surge in demand.

The development of a more sustainable model of care that reflects the changing needs of patients is clearly needed to avoid future crises and prevent children needing critical care support having to travel across the country to access this in times of surge. Services also need to develop to meet the changing needs of patients, some of whom will now survive into adulthood, and therefore will need to transition from paediatric to adult critical care services.

The review also covers Specialised Surgery in Children (SSIC) due to concerns over:

- increasing waiting lists for patients requiring elective surgery given a lack of capacity within paediatric intensive care services
- a deskilling of staff outside of specialised centres to undertake non-specialised activity, impacting on patient experience and potentially clinical outcomes for time-critical routine emergency interventions.

The review was set up as a collaborative work programme with expert stakeholders including the Faculty of Intensive Care Medicine, the Royal College of Anaesthetists, the Paediatric Intensive Care Society and the British Association of Paediatric Surgery (BAPS). Clinical data has been utilised to gain a full understanding of the issues behind the mounting pressure on PCC and SSIC thus creating a vision for future services that may ultimately resolve these issues. It is through this collaborative approach that the proposed networked model of care has been created, taking a system-wide approach to develop services fit for the future.

The data analysis identified unexplained variations across the country in:

- the rates of treatment of critically ill children and young people
- access and commissioning across paediatric critical care
- paediatric surgery
- ECMO
- critical care transport services

Significant pressures on workforces have been confirmed. Interestingly, all parties have noted the long-term strategic approach required to address workforce and training variation across all clinical services. There is still significant variation in the delivery of care across the country, which the review

has agreed will be at the forefront of their minds and NHSE is working with HEE and the professional bodies to develop workforce training and recruitment strategies for critical care and surgery.

Currently, there are a number of patients within PCC units whose level of care never exceeds high dependency but there is no HDU alternative. There are also a large number of patients who remain in the PCC units once their treatment has finished because they are unable to step down to more appropriate settings. The current set-up impacts on the patient and family experience as well as reducing capacity within PCC units. The review is not looking to move large cohorts of patients from PCC units to HDUs; instead, it is looking to develop services and models of care that meet individual patient needs.

The PCC/SSIC service review is now moving into the next phase. Having developed the case for change, the vision for services and the model of care for how to achieve this the focus now is on planning implementation. This will ensure that the necessary frameworks and supporting resources are in place to establish the model of care. Governance needs to be robust to ensure that clinicians, providers and parents feel safe and that risk is appropriately managed across a network.

NHSE is clear that this is a complex and multifaceted service area. The changes required to achieve the vision of more sustainable services, with patients cared for in the most appropriate environment, will not happen overnight. We envisage that the timescale for implementation will be over 3-5 years nationally, although some areas already working in a networked way may be able to move at a faster pace. For example, in some areas of the country there are already tried and tested approaches to the maintenance of paediatric critical care skills for the adult intensivist working outside of the tertiary paediatric centres. Consideration needs to be given to innovative workforce models and ensure there is access to funding for the training requirements across all staff groups.

New models of care are required for areas such as Long Term Ventilation (LTV), where patients need to be supported to move to community settings with greater engagement from the local district general hospital. It is

essential that we work with stakeholders to investigate different models. Currently there is huge variation across the country as to how these children and young people receive care. Local health economies can then adopt the most suitable model for their population and develop implementation plans to ensure the right resources and training are available.

NHSE are seeking to work with FICM on other key areas of the review. These are:

- Workforce and training strategies with HEE and the professional organisations
- Transition services, especially for patients with LTV needs
- Communication and engagement
- Development of governance frameworks to support the network delivery model
- Development of data sets to support networks to manage their activity

The important message that FICM has taken away from conversations so far with the review team is that this is not an attempt to make a swift and sudden change to services that will place further pressure on adult critical care. The implementation review will be methodical and careful, and entirely cognisant of the limitations on the ground.

The Paediatric Critical Care and Specialised Surgery in Children review remains a strategic priority for NHSE. Regional specialised commissioning teams are convening forums to develop the network footprints and cooperate with local stakeholders. This includes engagement with local commissioning structures such as STPs and ICOs/ACOs where these are in place.

Continuing collaboration with all stakeholders is essential to successfully achieve the vision for these services and ensure the sustainability to meet the changing needs of patients. If you would like to keep updated on the progress of the national review, please register as a CRG registered stakeholder at <https://bit.ly/zvtKnqz>.

If you have any comments or suggestions, please contact either contact@ficm.ac.uk or the national review on england.paedsreview@nhs.net, or via your regional Specialised Commissioning team.



CAREERS, RECRUITMENT AND WORKFORCE

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee

The committee is growing with Mike Duffy, Nitin Arora, Andrew Ratcliffe (Trainee Representative) and Rosie Baruah (WICM Chair) joining in the past 12 months; there's plenty of work for everyone to do.

We're focussing on developing resources that can be used locally or accessed directly from the Faculty website, as well as using the redesigned FICM Annual Workforce Census to identify topics that are 'bubbling under' and which we can work on in the coming year.

Check out Critical Engagements <https://bit.ly/2u3Ttff> that identifies the themes from the first six workforce engagements conducted to date and the Workforce Data Bank released in June <https://bit.ly/2Okqri7>. Key messages from both reports include the need to expand and widen the workforce and share information on successful ways this has been achieved.

We're using the careers work to focus on practical ways to promote interest in ICM. We're also intending it to widen the horizons of senior ICM trainees as to their choices of the type of consultant job they might want.

Recent examples include excellent pieces by Richard Gibbs and Mike Duffy on the personal benefits and professional opportunities afforded by working in ICM outside of a teaching hospital environment. Work is also ongoing on a new document, provisionally titled 'A Critical Foundation' designed to provide a resource of ways in which Foundation doctors can be exposed to ICM. Some Foundation trainee accounts are already on the website, so do please direct interested Foundation trainees to look them up.

We also recognise the need for developing mentoring and local networks to support individuals as they transition from training into permanent qualified roles, and as they develop their leadership and managerial capabilities. WICM has been tasked with developing this as a pilot, which if successful, we would aim to roll out to support the wider workforce.

If there is something you'd like us to investigate, let me or one of the Committee members know. <https://bit.ly/2KdeM1j>



ICM RECRUITMENT IN 2018

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee

'It was the best of times, it was the worst of times'
A Tale of Two Cities, Charles Dickens

Trainee contract negotiations have impacted on the number of people applying for specialist training for the past couple of years and it's perfectly understandable that some trainees will have made changes to their career decisions as a result of the uncertainty this brought. We mustn't however lose sight of the fact that this change in applicants was noticed across all specialties and ICM isn't unpopular as a career choice. Anyone who works with ACCS trainees knows of someone who's been converted into a career in ICM, having never previously considered it before their exposure to the high quality care, high quality training and MDT working that typifies an immersive ICM attachment.

2018 was a healthy year with increased numbers of applicants (274) booked to interview for 163 ICM training places. Digital scoring via iPads was introduced relatively painlessly, interviewers had once again been brilliant in giving their time and support and West Midlands HEE staff had run the process with astonishing efficiency; many interviewers commented on how straightforward the whole thing had been. It's also worth noting the benefits of single-centre recruitment for applicants. We've worked hard to make the process as fair and transparent as we can, recognising the difference in training stages and backgrounds of applicants. There is an independent quality assurance process with lay and trainee observers; all of whom noted how fair the interviews appear to be and the high levels of interviewer professionalism.

The overall calibre of applicants was extremely high and it was invigorating to feel that the future of the speciality was in safe hands. 32 candidates with a declared medical background (19.6% of successful applicants) had accepted a place to train in ICM

with overall training backgrounds consistent with previous years' figures. My Twitter timeline was a happy place with tweets from trainees celebrating their offers, delighted to be joining the ICM 'family'.

At 4pm on the Friday before the first May Bank Holiday weekend, I took a phone call from Daniel Waeland, informing me of the problems with medical recruitment. Doubt over accuracy had crept into the RCP ranking process which meant that HEE decided to withdraw all medical offers including those for ICM as they felt there was sufficient overlap to potentially impact our candidates. Nothing had gone wrong in ICM recruitment or our offers process but HEE had already made the decision and there was no going back. Dismay, frustration, resignation; these words pretty much summed up the first part of that phone call for me. But what could we actually do at that point?

Well, what happened subsequently was a huge effort to support the trainees who had accepted offers. Regional Advisors, local trainers and the Faculty secretariat were galvanised into action, reassuring, providing advice and clarifying individual positions. Weekend email exchanges and phone calls confirmed facts, as well as obtaining assurances that ICM trainees would not end up disadvantaged. Twitter timelines moved through anger and uncertainty to relief and praise for the support offered by ICM trainers and the Faculty.

'Not making a drama out of a crisis' might be a good description of ICM but also perfectly describes how the situation was handled by everyone within the ICM community. There are many of you who have played your own part in supporting trainees over that long weekend and the subsequent days; our recruitment rate for 2018 (87%) is healthy as a result. I thank every one of you.



REFLECTING ON ST3 OFFERS

Mr Daniel Waeland
Head of the FICM

It was about 4.30pm on Friday, fresh from another successful Diplomates Day when I received the call from HEE. An unfortunate human error at the RCP recruitment office had resulted in issues in the final ranking spreadsheet used to allocate ST3 offers. There were doctors who should have received an offer that currently had not meaning that all of their offers would need to be reset in order to allow the Oriel system to fairly redistribute new offers. One of the immense benefits of ICM training is its flexible entry, welcoming trainees from all routes of ACCS, Core Medical and Core Anaesthetic Training. Unfortunately, on this occasion, as we offer to a number of doctors from a core medical background, our offers would also need to be reset to allow Oriel to undertake its automatic processes.

The first step was to brief all those who needed urgently to know: Carl (as Dean), Alison (as Vice Dean), Danny (as CRW Chair), Mark and Sarah (as the Lead and Deputy RAs). Then of course send emails out to lead trainers, Board and Committee members. What struck me most (and remains I admit the reason I've stayed working with the FICM so long) is that all of their worries and concerns were not about how this would reflect upon the FICM. It was all about the doctors caught up in this. The uncertainty it placed them all in, the decisions they may already have made to leave homes (and schools, and utility contracts, and gym memberships, and all the other ties we have, big and small). Lying ahead was an evening of keeping in touch with those impacted, through the FICM inbox and Twitter DMs. Alison, Danny, Mark and Sarah, as established tweeters, rallied to the cause.

HEE continued to be supportive. During a Saturday morning call, we reached an agreement that we could confirm publically that no doctor would be disadvantaged as a result of a change in offers. This was the reassurance we had sought and meant we knew

we could protect our applicants. A weekend followed of close contact with HEE, our National Recruitment Office housed in HE West Midlands, the RCP, and, most importantly, the ICM applicants directly affected by this.

There followed a fortnight of daily teleconferences between the FICM, HEE, the RCP, the Royal College of Radiologists (as Medical Oncology offers had also been affected) and the BMA, so we were all in the loop and could ensure that any information released was appropriate. On 10 May, the offers went out afresh, and a fortnight of offers, re-offers and recycling took place. The percentage of those receiving the same offers crept upwards 90%, 97%, 99% ...

Finally, we heard what we had all been hoping for since that first Friday: 100% of our applicants had received the same offer.

The FICM and the RCoA have written to HEE to request they are part of any independent review of RCP processes. It is important to say that this is not meant as a criticism of the RCP, who have managed an incredibly complex series of national recruitments for years without issue. However, we have an obligation to ensure we are doing everything we can to protect ICM applicants in future. This has also allowed us a new avenue to discuss with HEE about how the Oriel system could be improved to allow both parts of a dual programme to be accepted in the same recruitment round. This is something we have been pursuing for years, so I remain hopeful there may be an unforeseen silver lining to this whole problem when the central system comes up for renewal in 2020.

I hope some of the doctors who joined ICM this year are reading this. Welcome to the specialty and I hope this has confirmed what you always suspected – ICM is a team specialty where everyone looks out for everyone else. As Twitter rightly said: #ICMrules!



FICM WORKFORCE CENSUS

Dr Jack Parry Jones

Workforce Lead

“A pathological need to be needed.”

Census respondent 2018

The FICM Workforce Census conducted for 2017/2018 is closed, and the data return is now being looked at in more depth. We received 887 responses back from those eligible to respond (2278) giving us a response of 39%.

Table 1. FICM Census data 2017/2018 returns

Total sent	2278
Undelivered	11
Completed	877
Partial Response	98
No Response	1292

The response rate was improved by a lot of hard work from the Faculty team chasing up responses. A full census report will be released later this year through the Faculty, when we’ve had a chance to thoroughly analyse the data.

This year, we also included a separate ‘wellbeing section’. Completing the section was voluntary, but the vast majority (90%) of you who completed the main census also completed these additional questions and we’d like to thank you very much for your time and effort. This data will be analysed by a team including Dr Julie Highfield, a consultant clinical psychologist, with an additional plan to follow up with some of you in more depth for a number of years as part of a longer-term study. We hope that this will prove valuable in aiding recruitment to the specialty. Equally important, we need to retain those of you who are already in the specialty but thinking of reducing your critical care workload, or entirely stopping critical care pre-retirement. We need to see and understand what really motivates people to go into Intensive Care

Medicine, and then stay in the specialty. We also need to share this information, whilst working on those factors within our control, to improve job satisfaction. This is, of course, crucial to staffing critical care units when the annual number of trained intensivists is still significantly fewer than the annual number of posts that require filling. Demand well outstrips supply.

Out of curiosity, I selected a breakdown of what respondents said they enjoy most about their jobs in ICM. Some of the additional comments predominantly included teaching, but also ‘more respect than anaesthesia’ and ‘better control of one’s own time’. My favourite response however was ‘a pathological need to be needed’. I’m not sure about this as an advertisement for critical care medicine consultant posts, but for honesty and insight it couldn’t be bettered.

Table 2. Breakdown of 887 responses to what Faculty Member responders enjoy most about their jobs.

Variable and challenging case mix	86%
Working as part of a multi-disciplinary team	75%
Feeling like you make a real difference to the care of the patients and relatives	67%
Supportive colleagues	67%
Research	18%
Other	3%

The Faculty Careers, Recruitment, and Workforce Committee (CRW) are aware that there is understandable disquiet, particularly from some of our FICM trainees, that they are competing for critical care consultant posts with those who do not have a CCT in critical care, or without equivalent training, or additional time spent working in critical care, or a critical care examination. I, and others share these concerns. We also understand however that when we

look at census data there are those working in some units (particularly smaller units) who really struggle to recruit ICM consultants to a stand-alone ICM rota. Consultants on the rota then suffer significant stress and strain to themselves, and their family, of working a high frequency night and weekend rota which can prove intolerable. There is then huge temptation to appoint consultants with less experience to make the rota sustainable. Those with a CCT in ICM should not worry as they really do stand out. Their consultant job opportunities to go wherever they want are so good when the demand for them is so high (see Table 3 below). This is especially true as the requirement for critical care expansion becomes ever more apparent and ever clearer to our political and financial masters. Whilst the speciality is still developing and growing, the absolute key issue for patients and their relatives is “will I, or my relative, be receiving a good and safe standard of care”. The General Provision of Intensive Care Services (GPICS V2) seeks to address these concerns, and of course includes a section on medical staffing of units.

“THOSE WITH A CCT IN ICM SHOULD NOT WORRY AS THEY REALLY DO STAND OUT. THEIR CONSULTANT JOB OPPORTUNITIES TO GO WHEREVER THEY WANT ARE SO GOOD WHEN THE DEMAND FOR THEM IS SO HIGH

Table 3 gives a crude indication of the numbers of ICM consultants required to fully cover GPICS requirements on a sustainable rota. The numbers don't include Scotland which would take the number up to close to 4000 as a minimum. We currently have around 600 FICM registered trainees in post, at all stages in their training, across the U.K. Sadly, mapping demand is not an exact science but it's safe to say we need a lot more ICM trained consultants (These data derive from the Case Mix Programme Database. The Case Mix Programme is the national, comparative audit of patient outcomes from adult critical care coordinated by the Intensive Care National Audit & Research Centre (ICNARC). For more information on the representativeness and quality of these data, please contact ICNARC.

The census for 2018/19 will include the same main backbone of census questions so that we can continue to develop a picture of ICM consultant staffing demographics. The wellbeing section will be replaced by questions on Fatigue and the Ageing Intensivist.

I would urge you again to please fill it out when it arrives in your inbox. To those of you who responded this year, thank you again. It is much appreciated. To those out there with a pathological need to be needed don't worry, you are still loved, wanted, and needed.

Table 3. Breakdown of critical care units in England and Wales based unit size with critical care consultant cover requirement based on GPICS requirement of day consultant: patient ratio of 1:8 on a 1 in 8 on-call.

Number of beds on unit	Number of units with that bed number in England & Wales	Consultants required to meet 1:15 patient ratio (nights) on a 1:8 person minimum rota
0-4	6	6 x 8 = 48
5-8	51	51 x 8 = 408
9-16	108	108 x 2 x 8 = 1728
17-25	32	32 x 3 x 8 = 768
>25	17	17 x 4 x 8 = 544
TOTAL	214	3496 ICM Consultants



WOMEN IN INTENSIVE CARE MEDICINE

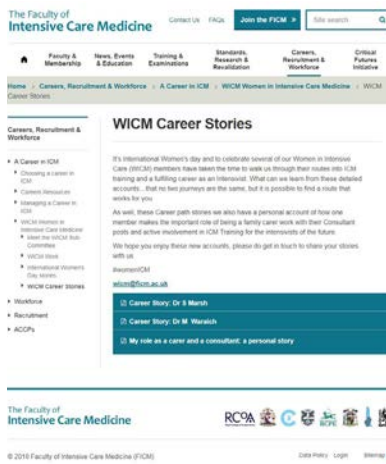
Dr Rosaleen Baruah
Chair: WICM Sub-Committee

The WICM Sub-Committee are delighted to be able to announce that the first **WICM Annual Meeting: Critical Care Without Ceilings** will be held on the 6th February 2019 at the RCoA building in London. The morning will be made up of talks on topics like ‘Succeeding as an Introvert’, ‘Leading with Authenticity’, and ‘Setting Boundaries and Role Conflict’. The afternoon will divide the group into two streams; one will undergo mentor training in preparation for setting up the WICM Mentor Network, and the other will take part in workshops with topics such as ‘Negotiating and Influencing Skills’. The day will end with a group discussion and facilitated networking session. All are welcome, male and female.

The **WICM Mentor Network** will ‘go live’ after the one-day meeting. This will create a UK-wide network of mentors and mentees. WICM will be monitoring the progress of each mentor/mentee pairing to evaluate the success of the project.

The **WICM Emerging Leadership (WICMEL) Programme** will be a one-year programme for three female consultant-level Fellows of the Faculty. There will be no upper age limit as there is for some College leadership programmes; we believe that a female consultant can be most productive later in her consultant career and career paths need to follow varying trajectories. The programme will be funded to allow the WICMELs to attend Board and Committee meetings at the Faculty, backed up with mentoring from a Board member who will help them set and achieve leadership development goals. It’s likely we will advertise for this in Spring 2019 for an autumn 2019 start.

We now have a number of **career stories** on the FICM website; this would be good to share with trainees considering choosing ICM. <https://bit.ly/2jaXSEO>



Women in ICM are currently underrepresented in medical leadership and research roles. WICM would like to set up **WICM leadership/management and research networks** for female intensivists. The hope would be that these networks will help connect and support women who currently hold such a role or are interested in developing in this direction. If this sounds like something you are interested in and are willing to help set up such network, let us know. We will discuss these networks in greater depth at the February meeting and if we can identify a leadership and a research lead before this, that would be ideal.

Finally, we are keen to start **Regional WICM Networks**. These would basically be a group of intensivists, trainee, consultant and non-consultant career grades, who meet up over dinner to discuss all things related to being a woman in ICM. We envisage these evenings as laidback and fun, but also as a source of support and networking for women in ICM. As ever, if you have ideas or comments about the projects WICM is developing, please let us know via email at wicm@ficm.ac.uk.

CAREERS: LIFELONG ICM

Dr Daniele Bryden

Chair: Careers, Recruitment & Workforce Committee

The Faculty, through the work of CRW, is trying to develop a modern approach to a careers strategy, considering those working in Intensive Care from their 'Recruitment to Retirement'.

Workforce Wellbeing

In all high impact, acute specialties, the spectre of burnout is raised, often based on simple surveys and without accompanying tangible solutions. Workforce wellbeing is complex, a lifelong issue and covers elements of professional and personal life. It is not fixed. We all know of other acute specialties that have been damaged by association: "I wouldn't do X specialty, it is awful and everyone is miserable" is a description the Faculty is determined to avoid for ICM. Our careers focus is to support the existing workforce and encourage new entrants; negative associations without solutions positively damage the specialty.

Solutions include learning lessons from others, whether your colleagues, other professions (as our Mind the Gap event demonstrated) or from wellbeing professionals. We are engaging with the Management Advisory Service to get some basic content available on resilience training. Others aspects include job planning, where the Regional Advisors get involved in 150 consultant Advisory Appointment Committees a year, nudging and pushing job descriptions to be more accommodating and sustainable. It is also learning from existing rotas and using those to discuss local change.

The whole profession can benefit from WICM initiatives which include flexible working, mentoring and helping leaders emerge who are happy in their work-life balance. Our 2018 census included a number of questions on wellbeing. This is not a one-off study - the validated questions were chosen to focus on your positive and negative attitudes to working in ICM. It is being used to indicate future areas of activity for the Faculty and to follow up with people from the same cohort to learn from their life changes and experiences.

Finally, wellbeing partly depends on our workforce. Growing the number of trainees, ACCPs, and working with a national healthcare stakeholders (DHSC, NHSE, home nation governments) to raise critical care's profile are all part of the solution to this.

Exposure

The hidden gem of any good careers strategy is ensuring that future intensivists have early exposure to our complex and rewarding specialty. A spark of interest, great role models and experience of our supportive teams, can turn someone who may have only considered surgery or general practice so far, into an inspired intensivist. I know of so many careers up and down the UK that have been started this way.

Our work last year with the RCoA and FPM on developing an undergraduate framework and our work this year building an easy guide to making best use of ICM in Foundation programmes, will help with gaining exposure for our specialty. The work of TAQ and its predecessors in ensuring ICM is part of ACCS, CAT and now the new core Internal Medicine curriculum, means we should be getting even more windows of experience. Finally, in higher training, it is making the most of the GMC's new and more open outcome-based standards to redesign our curriculum and make it more sustainable and more flexible. You can read more on this in Tom's article.

Information

In September, we will launch membership for medical students, foundation and core doctors to help bring them more up to date and useful information about the specialty and hopefully ensure the spark of their initial interest continues throughout training. We are developing career resources that can be used, by you, to hold local tasters and careers events rather than relying on a traditional, single London based event which doesn't reflect what is happening in your individual training schemes.

Is there more you want us to do? Would you like to get involved? We would love to hear from you.

ADVANCED CRITICAL CARE PRACTITIONERS



Ms Carole Boulanger

Co-Chair: ACCP Sub-Committee



Dr Simon Gardner

Co-Chair: ACCP Sub-Committee

We would have liked to have been reporting the outcome of the MAP (Medical Associated Professionals) consultation aiming towards ACCP regulation as a profession. However, the outcome has been delayed due to the appointment of a new Secretary of State for Health and Social Care. It has already announced that Physician Associates (PAs) will be regulated and we are delighted for this group; we hope the consultation reflects the requirements of the ACCPs, PA(A)s and SCPs. There are ongoing implications for the accessible pool of professionals able to enter ACCP training who would meet the requirements to join the FICM. There are several competing views and considerable debate on whether ACCPs are MAPs or could be called ACPs (Advanced Clinical Practitioners). Non-medical prescribing remains a core skill for ACCPs; those who cannot prescribe cannot become a FICM ACCP Member. Achieving MAP status and separate regulation would be the most expedient route to ensure our ODP colleagues can join paramedics as ACCP trainees eligible to prescribe and fulfil the full capacity of the role.

During the debate, the Faculty ACCP Sub-Committee continue to work to ensure that ACCP training is standardised according to the FICM ACCP curriculum across the UK that sets a clear standard for the role in clinical practice led by clinicians. A key priority for

the group is to ensure that there is no dilution of the academic, knowledge, skills and competencies achieved during the two-year supernumerary period of training. The FICM associated ACCP role has become accepted by clinicians and is known to provide safe, high quality care and a clearly recognised standard.

The recently published ACCP specification aims to assist organisations in developing the ACCP role as an integral and permanent part of their workforce and to do so with effective planning and communication across their organisation: <https://bit.ly/2L2GWkh>. It is with some concern that we have received reports of UK healthcare organisations who have failed to effectively negotiate and contractualise ACCP training at a Trust Board level. As a direct result, these programmes have been halted part way through, resulting in huge logistical upheaval and financial loss for the trainees involved. We strongly recommend that Trust Boards follow the advice on the Faculty website when setting up a programme, to take advantage of the wealth of experience held in this regard. Training ACCPs brings with it high resource implications in terms of cost and personal commitment from trainees and trainers, both of which deserve careful planning and forethought.

The National Association of ACCPs, with support from the Faculty, have been able to negotiate MDDUS indemnity cover specifically for FICM associated ACCPs. Up to this point, ACCPs had to consider generic indemnity that failed to accurately reflect our clinical practice and was priced at exorbitant annual rates. The MDDUS provide ACCP specific indemnity for FICM associated ACCPs, at a third of the cost of other providers for generic cover.

And in other news, Health Education England have funded the production of an information film about the ACCP role and how it functions in clinical practice <https://bit.ly/2KhUVhA>.

2018 ACCP CONFERENCE

We are fresh from our 6th National ACCP conference hosted this year by Royal Stoke University Hospital, led by Dr Ram Matsa and the Stoke ACCPs. We are pleased to report that the event was once again sold out and oversubscribed. We are very grateful to the Royal Stoke and their ACCPs for making us so welcome and for their help and support throughout.



It was good to hear about regional networks that the trainee and trained ACCP community have developed to provide CPD activities, peer support and networking opportunities. These are highly active on social media and provide an active forum for discussion and support.

SAVE THE DATE

The 2019 FICM ACCP conference will
be held on

FRIDAY 7TH JUNE

at the Royal College of
Anaesthetists building, London

If you have any suggestions for the
programme please get in touch at
contact@ficm.ac.uk



PROFESSIONAL STANDARDS

Dr Peter Macnaughton

FICM Chair: Joint Standards Committee

The main focus of the Joint Standards Committee (JSC) over recent months has been GPICS V2. This is a considerable piece of work that is progressing well with a number of changes compared to GPICS V1.

The Committee agreed to move away from using GPICS as a source of clinical practice guidance and to focus on service delivery, quality and safety. As a result, some of the current clinical chapters will not appear in GPICS V2 although relevant clinical guidelines will be signposted in the document. A number of new chapters relating to service delivery including capacity management, point of care ultrasound and serious infection outbreak have been commissioned. Individual chapters relating to the provision of support for each of the main organ systems will replace the existing clinical sections within GPICS V1.

Drafts for all the planned chapters have been produced and reviewed by members of the Committee and following final sign off of each chapter, there will be an extensive consultation process: first with key stakeholders and then an open public consultation prior to final publication, which is expected to be early in 2019. I am very grateful for the considerable work and

time that all the authors and reviewers have dedicated to this project to date. Also I must express my sincere gratitude to the hard work and expertise of Dawn in the FICM secretariat who is making sure we are on track.

The FICM/ICS ARDS guidelines have now been published and are available on the Faculty's website to download <https://bit.ly/2tZJ1DG>. This has been an immense piece of work that was undertaken using GRADE methodology and I would like to thank all those involved including the co-chairs Professor Mark Griffiths and Dr Simon Baudouin. The two recommendations with the strongest supporting evidence are the use of protective ventilation with low tidal volume in all patients and prone ventilation in those with moderate and severe ARDS. These are interventions that all units can provide and should audit to assess their compliance. Plans for a national audit of ventilator practice are being explored. A survey of prone ventilation was commissioned by the Committee earlier this year; the results are being analysed with a plan to produce guidance on management of the prone patient, which should support the greater use of the intervention.



LEGAL AND ETHICAL POLICY UNIT

Dr Chris Danbury

Chair: Legal and Ethical Policy Unit

I'm delighted that since the last Critical Eye, the Government has accepted the Law Commission's proposals regarding DoLS, in principle, and this will be legislated when time allows. The LEPU 'Guidance for police access to ICU patients' is entering its final draft and should be released in the autumn. The FICM and ICS will be publishing GPICS V2 later this year and I'm pleased to say that a legal chapter will be included.

LEPU intervened, on behalf of FICM and the ICS, in the case of Re Y. The issue to be decided: "Is it mandatory to bring before the court the withdrawal of Clinically Assisted Nutrition and Hydration ('CANH') from a patient who has a prolonged disorder of consciousness ('PDOC'), in circumstances where the clinical team and the family are agreed that it is not in the patient's best interests that he continues to receive that treatment?" One of the questions asked of the Supreme Court is whether CANH is any different to any other form of treatment, and if so how to tell the difference. At the time of writing, we are still waiting for the decision. If anyone else wants to watch the case, they can view the Supreme Court on catch-up TV <https://bit.ly/2sZClax>

Mediation continues to develop, with NHS Resolution reporting that over 200 cases have been mediated with a success rate of >75%. LEPU is aware of a number of cases involving disagreements regarding best interests that have been successfully mediated. There has been a recent conference involving senior members of the judiciary (present in a personal capacity), senior lawyers and decision makers from medical defence bodies (public and private). The conclusion of the conference is that mediation and other forms of ADR have a place in resolving disputes.

Finally, you should have seen details of the review by Dame Clare Marx of Gross Negligence Manslaughter, homicide and how they relate to clinical practice. She

is calling for views and will be hosting four workshops (two in Manchester and two in London) so can I urge all readers to contribute to what is likely to be a once in a generation review of this area of law. You can find more details about the workshops here: <https://bit.ly/2MMgijQ>

PATIENT SAFETY INCIDENTS

Dr Peter Macnaughton

Co-Chair: Joint Standards Committee

The Faculty was asked to contribute to the reply to a coroner's regulation 28 letter that was sent to the RCoA following the death of a patient in an ICU as the result of air embolism from a central line. The lessons from the incident are summarised in a report available on the Faculty's website: <https://bit.ly/2LAPtfg> and highlight the need for all staff to be vigilant in ensuring that the unused ends of a central line are occluded appropriately and to the risk in using a line that does not include an occluding clamp. The JSC had already been approached and agreed to commission national guidance on the management of air embolism and this report is a timely reminder of the dangers of this avoidable complication. As previously highlighted, the Faculty is keen to provide a conduit to share learning from adverse incidents and I would encourage you to submit any lessons that you may have from local incidents that would be of general interest using the form available on the website: <https://bit.ly/2AnnsTi>



UPDATES

1

Intensive Care Medicine in Sri Lanka

2

Smaller and Specialist Units Advisory Group

3

Getting it Right First Time

4

National Adult Critical Care Data Group



INTENSIVE CARE MEDICINE IN SRI LANKA

Dr Alison Pittard
Vice Dean

In January, The College of Anaesthesiologists and Intensivists of Sri Lanka invited me to their 34th Annual Congress. It is a country I have always wanted to visit so didn't hesitate to accept their offer to be Guest of Honour. Having booked leave and flights, I then found out not only did they want me to give a couple of lectures, but I was expected to deliver a formal address at the inauguration ceremony. Time to take the holiday clothes back out of the suitcase! The secretary for scientific affairs, Dr Loranthi Samarasinghe, appeared to organise just about everything and anyone who has been involved in similar situations will appreciate the stress that must have been involved.

The College formed in 1971 and the Faculty of Intensive Care Medicine was inaugurated in 2010, the same year as our own Faculty was established. I was surprised at the similarities in our history, the obstacles we faced and the training programmes that have been established. The only real difference appears to be the catalyst for creating Intensive Care Units; in the UK it was tetanus in the 1950s, in Sri Lanka it was the commencement of open heart surgery in 1968. This means that the development of Intensive Care Medicine in Sri Lanka is a little behind the UK however, considering there was civil war between 1983 and 2009, progress in the specialty has been impressive.

Arriving in Colombo early in the morning was amazing; the air was warm, the sky blue and the tweeting of birds made me feel like I was in paradise. Once at the hotel, preparation began for my address at that evening's inauguration ceremony. Sri Lanka is considered the home of the pure Theravada form of Buddhism and the religion, as it is generally practiced, is full of ceremonies and rituals. I wasn't sure exactly what to expect but was greeted by the President Elect of the College, Dr Ramya Amarasena, presented with flowers and then processed, fully gowned with council members, into the room. I felt like the Queen. Once seated there was a

very colourful display of some of the rituals performed to bestow good luck on the conference. I delivered my address and could then relax and enjoy the rest of the evening. As 2018 is the 100th anniversary of women being given the right to vote I chose to focus my talk on women in medicine. I was preaching to the converted as Dr Samitha Jayawickrama, General Secretary, pointed out the numerous female council members sitting on the front row! Having processioned out at the end I was approached by so many people from all over the world wanting to discuss their training. I was made to feel so welcome and retired to bed with a huge sigh of relief.



The following morning I rose bright and early. Colombo was hot and sticky and my walk to the conference produced blisters that accompanied me for the rest of my stay. The meeting, titled 'Paving the way for best outcomes in Anaesthesia, Critical Care and Pain Management', was managed with military precision and opened at 07:30. Anyone who knows me will understand how difficult it was to cope without my usual caffeine boost.

The Chief Guest, Dr Jeremy Langton, former RCoA Vice President, gave the first plenary lecture followed by my own on the History of Intensive Care Medicine in the UK. The main programme ran over two days with parallel sessions focusing on Anaesthesia or Intensive Care as well as workshops the week before and some continuing afterwards. The international faculty delivered a varied and extremely interesting programme with sessions on obstetric critical care, beyond critical care including my second lecture on outreach, ethical issues and end of life care, expertly delivered by Dr Joe Cosgrove (FICM End of Life Working Party Chair), and a free paper competition. Sri Lanka does not have outreach services at the moment so my focus was around early recognition and intervention. This seemed to go down well judging by the questions.

The conference banquet was held on the first evening. As Guest of Honour, I was seated at the top table, another nerve wracking experience. However, I am delighted to say that it was a most enjoyable evening followed by dancing, where I was told I danced like a Sri Lankan; I took that as a compliment. I have never been in so much demand!

Having travelled all that way I decided to take a few days holiday to explore the country. A train to Kandy, arriving at sunset, was the most amazing journey. A tent with a view on a tea plantation was incredible and visiting a tea factory gave a wonderful insight into the amount of manual labour that goes in to making our morning cuppa. The next stop was Dambulla where a wonderful Sri Lankan drove us in his tuk tuk to show us the sights and waited patiently as we climbed Lion Rock in Sigiriya. The view from the top was breathtaking. The final night was spent in Negombo Beach with time to reflect on a very hectic week.

Despite the civil war having ended so recently, the locals have tried to put the troubles behind them. Sri Lanka is a wonderful country; I felt extremely safe and the people are so friendly. They will do their utmost to help, give advice and generally show interest. It is steeped in history and I could only experience such a small part of it. I will definitely return and spend more time there. I would like to thank the Sri Lankan College and Faculty for their hospitality and commend them on their successful congress.





SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

The three chapters for GPICS V2 on remote and rural, cardiothoracic and neurocritical care units have been submitted. Next up is editorial adjustment and review, and hopefully the new version will be out in January 2019. I thought it might be useful at this point to go over some aspects of the remote and rural chapter. It is not, in the end, anything to do with smaller units vs big units. In fact, there has been a bit of a change over the last 10 years anyway, and a vague atmosphere of mutual acceptance and support has gently crept into the specialty.

“ SOLUTIONS SUCH AS CROSS-SITE WORKING ARE MORE FEASIBLE FOR HOSPITALS IN CLOSE PROXIMITY ... NETWORKED SOLUTIONS SUCH AS TELEMEDICINE AND VIDEO LINKAGE ARE AREAS THAT NEED STRONGER DEVELOPMENT, AND COULD PROVIDE A KEY FOR BETTER INTEGRATION ACROSS A REGION.

One of the elements of difficulty for smaller remote hospitals is maintenance of competencies for critical care staff. Staff may be required to look after all age groups, from neonates to adults, and may be required to look after them for a prolonged period of time. Furthermore, some conditions may occur very infrequently and keeping knowledge and skills up to speed is crucial to providing safe care to their population. Solutions such as cross-site working are more feasible for hospitals in close proximity, and periodic attachments to larger units may be more appropriate. Networked solutions such as telemedicine and video-linkage are areas that need stronger development, and could provide a key for better integration across a region.

Transfer services are an integral part of the system, not an add-on. For example, there can be difficulties

in getting prompt attention for time critical transfers if the ambulances are overloaded. In our region, ST elevation MIs are not regarded as a priority by the ambulance service once through the doors of ED (they are now in a place of safety) and therefore getting onward transfer to our PCI centre is not necessarily straightforward. In smaller hospitals, transfers also deplete essential staff and systems need to ensure that this is minimised.

Lastly, sustainability of the service is an important part of future planning. Elements of the new chapter explore this area in the context of staffing and support in smaller hospitals. Inevitably, the link with the wider services in the hospital is an essential part of this, and work is ongoing to explore acute services more holistically such as the acute medicine take. Trainees vary in where they see themselves in the future; while some want a big hospital or urban area, others want a rural lifestyle. Talking to our trainees, we have a very substantial group that want to stay in the area and inevitably they graduate to general practice that allows them to stay local, both for training and their eventual permanent job, buy a house and get on with their lives. Can we offer this sort of stability to our trainees? It's difficult. Clearly they need to have rotation as part of their training but perhaps we can look at improving the lifestyle for those wanting to base themselves in one area. I have had foundation trainees who love ICM (and are very good) who have said their ideal job is GP/ICM in our area. It would be interesting to explore the possibilities. I suspect this is an extra cohort and would swell the potential numbers of ICM clinicians but, I can't see an easy way to develop this. Although some parts would be excellent, I'm not entirely sure of the skill mix. Perhaps in the first instance, we should increase rotations to remote and rural areas for those interested, and in the meantime explore innovative solutions.



GETTING IT RIGHT FIRST TIME

Dr Anna Batchelor
ICM Clinical Lead

So after a few months of data dredging, head scratching and various moments of panic we are close to finalising our data packs. We have done three pilot visits to test drive the packs and I'd like to say special thanks to the folk at Bristol Royal Infirmary, James Cook and North Tees hospitals for their generous welcome, engagement and thoughtful feedback.

The GIRFT data team (Matt Colmar, Caroline Beadle and I) are meeting up with David Harrison and Kathy Rowan at ICNARC to finalise things. By the magic of having people who know their stuff, buttons will be pressed (or more likely computer terminals sweated over) and over the next month data packs will be generated for every unit in England. Caroline (the Project Manager for our work stream) will be contacting hospitals to book in deep-dive visits where we get to sit down with you and discuss your data. This is an opportunity for you to provide us with the context for the data and detail about how your unit and hospital works. It is already clear that there is huge variation with how we get the job done, all driven by history, facilities, evolution, staffing, geography etc so there is almost not a 'British Standard Critical Care Unit'. These visits are not to judge you, they are an opportunity for you to benchmark yourselves against other units over the metrics we have chosen and see where you excel or have areas where you can learn from others.

When Caroline books visits we would like you to invite as many people from the unit as possible; consultants, matrons, allied health professionals, and key individuals from the Trust including Chief Executive, Medical Director and Finance Director. In order for you to use this data to the maximum you need active engagement, not only from your team, but also from the senior management team so they understand what your issues are. We will bring Caroline and myself, often Matt (our data guru) and members of the team at ICNARC will try to attend some meetings. Collecting,

reporting and discussing data is only the first stage of the GIRFT process so an implementation team (more later) will also join us on the day.

What information can tell us that we don't know? Cancellations of major elective surgery are obviously important but there is, as yet, no standardised method of reporting this. There are cancellations on the day, or in anticipation of no bed, or patients are admitted and slotted in when bed comes available. What is the best approach?

Outcome data in ICM is pretty much limited to dead or alive. There is no nationally collected quality of outcomes data, which, for me is a major drawback in our otherwise pretty comprehensive datasets. Do you have any you can share with us? How do you think we should be collecting it?

You need to tell us what is missing and what you would have liked us to have asked/answered. This will be useful for two major reasons, the first is that GIRFT is not a once and for all process and needs to feed into on going data collection, quality improvement and reduction in unnecessary variation. The second is the specialty, through the National Adult Critical Care Data Group chaired by Professor Mike Grocott (FICM) is leading a review of what data we should be collecting in the future through ICNARC.

After the visits, we produce a report for your unit and together with the GIRFT writing team we then produce a national report. The seven regional implementation teams then take our recommendations and work with hospitals and Trusts to implement those recommendations. I'm really looking forward to meeting so many people at the 'coal face' of critical care and together lets work to make our specialty and the care we offer patients the best it can be.

NATIONAL ADULT CRITICAL CARE DATA GROUP (NACCDG)

Dr Tim Gould

ICNARC Representative: NACCDG

The National Critical Care Clinical Reference Group (CRG), set up in 2013, provides one of the key forums for the specialty to interact with the National Specialist Commissioners for NHS England. The four meetings a year attempt to address and influence key issues around commissioning, standards, quality and patient safety within our intensive care units. As the NHS becomes more 'data rich' year on year 'metrics' become the 'new' surrogate outcome measures for commissioners and the public.

It became clear to the members of the CRG that a subgroup was needed with specific expertise related to data collection, analysis and interpretation. In 2016 the National Adult Critical Care Data Group (NACCDG) was set up, Chaired and hosted by the Faculty, with Professor Mike Grocott as the first Chair. Membership is from groups that collect data about Critical Care in the UK (ICNARC, ICCQIP, GIRFT) together with key stakeholders from NIHR, BACCN, Public Health England, the Critical Care Networks, (ICS), Patient Groups and Commissioners.

The work of the NACCDG is a combination of review and understanding of current data sources, together with future proofing existing data collection and consideration of future needs.

The group has undertaken a review of the multiple dashboards that display Critical Care Data in the public domain, Healthcare Quality Improvement Project (HQIP), NHS Choices, Care Quality Commission (CQC), Methods and ICNARC quarterly and annual reports. Although the presentation is often bespoke according to the organisation, there must be reconciliation of the data, particularly when the majority comes from the ICNARC data set.

ICNARC, a significant stakeholder, is well underway with the development of a new software platform to transition the current database and in parallel introduce the next modified version of the ICNARC dataset.

A workstream has commenced to understand the future trajectory whereby more units have a Clinical Information System (CIS). Unfortunately due to the number of key providers (Phillips, iMDsoft, GE, Drager, EPIC, Cerner) as well as local bespoke systems, there are no national/international standards that allow these systems to easily share data. This is even true for the same provider in multiple units as the database becomes unique, dependent on the local configuration. Ultimately the specialty and NHS England may need to commission, build and manage a data warehouse, where data can be sent from the multiple units but stored in a single dataset. The problem is how to collect a metric, e.g. Tidal Volume from each CIS, when there may be several labels/codes in use defining Tidal volume (e.g. Vt, Vtexp, Vte, TV, TVol, Tidal Volume). Do we want Vt or would mls/kg be simpler? We at least want to calculate this, but then how do we measure or collect weight IBW (which algorithm?) v Actual? And so it goes on. You see the problem!

This becomes an extremely important piece of work for the future, but will require stamina from all those involved. However, if it can be achieved the ideal would be real time downloads, real time analysis, real time dashboards and alerts fed back seamlessly, as opposed to a dashboard showing performance six months ago. Is it too late to mandate a national/international configuration on the industry? How could we achieve this?

In the medium term we should aspire to better data linkage between ICNARC, ICCQIP, NELA, National Mortality data etc. Discussions are ongoing as to how to improve the current links.

Finally, Anna Bachelor as Clinical Lead for GIRFT (Critical Care) is also a member of the group and we have worked with Anna to help advise/access some of our separate data sources. In particular ICNARC and GIRFT have formed a close working relationship to generate the unit reports. You will all start to see in the next few months.



TRAINING AND ASSESSMENT

Dr Tom Gallacher

Chair: Training, Assessment and Quality Committee

The major focus at present for the Training, Assessment and Quality Committee is the rewriting of the Intensive Care Medicine curriculum to comply with the General Medical Council's new requirements.

At the time of writing, the Faculty have had their first meeting with the GMC Curriculum Oversight Group (COG), which now encompasses the Shape of Training Initiative. The COG primarily examines the Faculty's purpose statement, which expresses why we need ICM specialists and their role in delivering modern healthcare in the UK. They also ensure that the proposed curriculum meets with the requirements of the Shape of Training Review in its content, design and duration. Our meeting though was primarily factored around workforce and recruitment, and we are generating a new detailed report and presentation for them to discuss at a second meeting in September.

Both defending the specialty's position and completely reviewing the curriculum are complex, demanding and resource-intensive projects and we are working alongside, and enlisting the help of, our partner

Colleges. A lot of work is required in the preparatory phase to establish the overall format before the more detailed curriculum can be written. It is very important that we adhere to the necessary standards, where we are required to rewrite the curriculum based on high-level outcomes and to reduce the burden of assessment significantly. It is also imperative that as a relatively new specialty we remain focused on the prime aim of our curriculum during its re-structuring: To develop doctors capable of caring for the very sickest patients in the hospital across a diverse range of clinical environments and to maintain the current high standard of our training programme output and its contribution to the future consultant workforce.

“IT IS IMPERATIVE THAT, AS A RELATIVELY NEW SPECIALTY, WE REMAIN FOCUSED ON THE PRIME AIM OF OUR CURRICULUM DURING ITS RE-STRUCTURING: TO DEVELOP DOCTORS CAPABLE OF CARING FOR THE VERY SICKEST PATIENTS IN THE HOSPITAL ... AND TO MAINTAIN THE CURRENT HIGH STANDARD OF OUR TRAINING PROGRAMME OUPUT AND ITS CONTRIBUTION TO THE FUTURE CONSULTANT WORKFORCE.

We will need to ensure that all elements of the CoBaTrICE competencies are enshrined in the new curriculum since these competencies have European-wide consensus on their validity. Should we decide to add to or remove any of the existing CoBaTrICE

competencies we will have to justify this to the GMC's Curriculum Assessment Group in due course. In contrast, our current assessment framework will require significant re-structuring to reduce the burden of assessment and return the focus of training back towards learning rather than a complex process of acquiring evidence to support such learning. This is a change which has long been called for by doctors in training and trainers alike and something we wanted to tackle in our first major curriculum rewrite.

“WHEN WE CIRCULATE THE INTENDED CURRICULUM FOR CONSULTATION WE WANT TO ENSURE THAT WE HAVE TAKEN ACCOUNT OF ALL STAKEHOLDER COMMENTS AND FOR THIS REASON, AS WELL AS THE OPPORTUNITY TO INFLUENCE THE FORMAT AND CONTENT, I WOULD ENCOURAGE YOU TO TAKE PART.

To date two curricula have been approved by the GMC, the Joint Royal College of Physicians Training Board's Internal Medicine curriculum and the Royal College of Paediatrics and Child Health's Progress curriculum. These two have very different approaches in their formatting and the Curriculum Working Party are considering both. We have close links with both Colleges for advice as we progress with our own curriculum developments and we will have the first iteration of our own proposed new curriculum structure ready for presentation to the full TAQ Committee in the autumn. Afterwards we will be seeking the views of all stakeholders including all members, doctors in training, Postgraduate Deans, NHS Employers and patients amongst many others. When we circulate the intended curriculum for consultation we want to ensure that we have taken account of all stakeholder' comments and for this reason, as well as the opportunity to influence the format and content of the new curriculum, I would encourage you to take part.

The GMC have reviewed the process for approving new training sites and Faculties and Colleges will no longer approve sites on their behalf. The Postgraduate Dean, on the advice of the relevant Head of School, will now apply directly to the GMC for new site approvals and the appropriate College or Faculty will be informed of any new site approval by the Postgraduate Dean's

office. The Faculty were keen to maintain local input into such approvals by the Regional Advisor and Training Programme Director so a pro-forma has been agreed that will be sent to any Regional Advisor affected by a new site approval. Should they have any issues with the approval, they can inform the Faculty who will review the approval and take any action necessary.

NHS Education Scotland (NES) who support our current e-Portfolio platform have undergone an organisational change resulting in a change to the support of NES version 2 that we currently use.

It will continue to be supported until 2020 however, like many other Colleges, the Faculty have taken this opportunity to review their e-portfolio arrangements and we hope this will be a prudent opportunity to integrate our new curriculum requirements with whichever provider we ultimately appoint. Currently, we are considering our options and with the

Royal College of Anaesthetists implementing their new Lifelong Learning Platform (LLP) from this August, there would be obvious benefits to any new provider's system being compatible with the LLP. The proposals will be considered by the e-Portfolio Sub-Committee in the first instance who will recommend their preferred option to TAQ and this will then be passed to the Board for final ratification in the autumn.

The new Internal Medicine curriculum, which will replace the current Core Medical Training curriculum in 2019, includes an ICM module. The Faculty worked closely with JRCPTB on the content of this module and ensured that trainees undertaking ICM training were fully integrated into the ICM team, in particular that they had the opportunity to gain out of hours experience in ICM. Everyone will be well aware that the hospital environment feels and operates very differently out of hours and one of the aims of the ICM placement is to prepare the physician trainees to act as the lead for 'unselected' take in their IM 3 year. We recognise that this will produce significant logistical problems in its implementation in some regions and we continue to work closely with JRCPTB, the Deans and the GMC to overcome these difficulties. However, there are considerable benefits in terms of exposing physician doctors in training to our specialty that makes this change important to achieve.



TRAINEE UPDATE

Dr Richard Gould
Lead Trainee Representative

With summer upon us and the annual cycle of ARCPs, exams and new rotations beginning to filter through to us, this time of year is often fraught with finalising the last few assessments, QIPs and seemingly mountains of paperwork. It therefore seems an opportune moment to reflect on how far we have come as a Faculty in attempts to streamline some of these processes and provide some useful reminders of where you can access key information. We also want to address some of the myths and 'half-truths' that sometimes ruminate between us trainees.

The 'Guidance on Competency Sign off in Intensive Care Medicine' (<https://bit.ly/2LsaKnv>) produced at the end of last year provides trainees and trainers with examples of how curriculum outcomes can be achieved without the need for assessments becoming didactic 'tick box' exercises. This, in conjunction with the Curriculum, Assessment and Training page (<https://bit.ly/2u13CME>) of the Faculty website, has attempted to simply and demystify some of the more complex aspects of the sign off process.

We would encourage you all to take advantage of e-ICM: <https://bit.ly/2cWvuSb>. A huge amount of work goes into this programme; there are regularly updated, new tutorials that have been specifically designed to cover some of the more challenging curriculum outcomes. These can, of course, be used as evidence on your e-Portfolio.

We also occasionally hear grumblings of how courses and study days are too 'London centric', watch this space for plans to improve accessibility to such courses and the possibility of video conferencing of key topics and lectures.

The Faculty's curriculum review group continues to meet regularly. There have been many meetings with the GMC and others to advise on how a new

curriculum should look and work. The ambition is still to write and submit the new programme by the end of 2019. Despite being over a year away, this is still a tight timeframe to complete the work. One of the most important tasks will be getting input and opinion from trainees and trainers, and expect to hear from us later this year.

August also sees us welcome our new ST3 colleagues into the critical care fold. We would like to extend our gratitude for their patience and understanding over the fiasco surrounding their recruitment this year. We appreciate that this will have caused great distress to many of our new colleagues, for which we can only apologise. Nevertheless, we are very pleased to finally offer our warmest congratulations to you all on joining FICM and this great specialty. You can read more about this in the recruitment articles in this issue.

Dual ICM training may, at times, seem tough; an extra set of exams, e-Portfolio assessments and a slightly longer training pathway than a single specialty. We are proud of the supportive and cohesive reputation that ICM has developed over the recent years. Our senior colleagues provide some of the most engaging learning environments in which to acquire the knowledge and skills necessary for us to develop as clinicians. As a result of this few trainees, once registered, leave our specialty to pursue other careers. This is a great testimony to the hard work being carried out both locally by your own ICM teams and within the Faculty that is striving to improve trainees working lives. We hope you enjoy your time as an ICM trainee and wish you every success in the future.

Should you wish to raise any questions, concerns or have any ideas for future projects, please do not hesitate to get in touch with one of us and we will endeavour to help as best we can.



e-ICM

Dr Pete Hersey
Clinical Lead

e-ICM celebrates its second birthday in August 2018. Having introduced the programme in the Winter 2017 issue, the time seemed about right to report back on what's been happening and to remind you it's still there! As a brief recap, e-ICM is an online programme of over 700 sessions embedded within the e-Learning for Healthcare (e-LfH) project. There's a whole host of other programmes within e-LfH, the ones you are probably most familiar with are e-Pain and e-Learning Anaesthesia. The sessions are arranged into 10 modules, and are either traditional e-learning sessions, links to guidelines or review articles (of which the majority come from BJA Education). Module 10 is a self-assessment module, essentially a large bank of MCQs.

The first 18 months of usage data (August 2016 – February 2018) has given us a useful insight into how the programme is being used. Without going into too much detail, the headlines are:

- Over the first 18 months the programme recorded 51,001 session launches, and engagement by 3,331 distinct active users.
- Each month consistently sees about 150-200 new users engaging with the programme.
- The average user launches approximately 9 sessions per month and spends about 4 hours engaged with the programme.
- 36% of users are specialty doctors in ICM, anaesthesia, acute medicine or emergency medicine. Only 6% of users are consultants, and 8% nurses (the system cannot currently identify someone as an ACCP so there is no data on that as yet).
- Feedback left on completion of the sessions is reassuringly positive.

Since we launched, the main piece of work has been the production of further content. The authors and editors involved with that have produced sessions of fantastic quality and interest, so I would really

encourage you to look at those. That work is nearly complete, and whilst there are no immediate plans to produce any more we are really grateful to still have the details of further volunteers.

As far as the immediate future goes, we will be keeping an eye out for the re-write that the RCoA have started for their ICM content in e-LA. The implications for e-ICM are a little up in the air but should be to our advantage. There's a lot of co-operation between the various programmes within e-LfH; without it, e-ICM would never have gotten off the ground.

Another task is to finally resolve some long-standing technical issues with uploading articles from BJA Education to the programme. It's been one of those problems that we have confidently cracked on several occasions! The time delay between online publication and availability via e-ICM will hopefully be in the region of 6 weeks maximum once it's up and running. Even if you don't use e-ICM for anything else, it will soon be the easiest way to search the ICM relevant BJA Education back catalogue.

A feature that we know trainee users value is the ability to map activity within the programme to the curriculum within the e-portfolio. We are hoping, through imminent changes to the e-Portfolio, to be able to make the link even easier and more useful.

The last item on the 'to-do list' is to find out how our ACCP colleagues, particularly those in training, interact with e-ICM. This will unfortunately probably mean a survey!

My thanks once again to all the team involved with e-ICM, but particularly to the authors and editors of the new content. If you have any questions about the programme or ideas for developments you would like to see, please get in touch via contact@ficm.ac.uk.



REGIONAL ADVISORS

Dr Mark Carpenter
Lead Regional Advisor

Recruiting and retaining trainees is an important part of what we do as a Faculty. In this social media age the recent RCP ST3 recruitment issue has been at the forefront of my Twitter feed, but retention of trainees within ICM training has been an issue that we have been looking at following some concerns from RAs and trainee reps.

RECRUITMENT

As RAs, in conjunction with our colleagues from HEE and the devolved nations, recruitment is an important part of what we do. Getting the correct doctors into our specialty at the start of their training is in many ways as important as how we train them afterwards. This year the RCP ST3 crisis has brought a few issues to the fore with recruitment.

Since ICM became a single specialty in 2012 we have run national recruitment in Birmingham. The process has been outlined previously, with multiple stations, trained assessors, thorough quality assurance and lay representatives. It is hard work for assessors, a bit of a trek for many candidates and to be honest we have struggled to get the timing perfect on a couple of occasions. This year we introduced electronic scoring for the first time to help reduce human error.

The advantages of national recruitment are myriad and in the aftermath of the RCP crisis there were many calls for the abandonment of national recruitment. Just as with attrition rates, I think it is important that we remember where we came from and try not to look at what we had with rose-tinted spectacles when it really wasn't that good. Before national recruitment, recruitment to specialties was done locally with less QA. Bias was not intentional I am sure, but local candidates were potentially advantaged, trainees had to travel to different regions to be interviewed on numerous occasions and then had to play the "shall I accept this offer" game, knowing that accepting then

rejecting an offer was seen as 'bad form' to say the least. With national recruitment I think we have a fairer, more transparent system and have recruited some excellent colleagues during the process.

RETENTION

Retention of trainees after recruitment is clearly important. It is not good for a specialty to see trainees leave and so it was with some concern that trainee reps and a number of RAs came to me, initially in 2015, saying that they thought we had a problem with retention.

ICM training now is a very different beast to what it was 'in my day' or even when I first became a trainer. In those days of joint training we appointed people to the joint scheme late in their training, who had often done a significant amount of critical care before appointment and had (just about) passed all of their postgraduate exams. Training was short and there was no compulsory exam. We now appoint early into a full CCT training scheme and life events (good or bad) are more likely. Our training scheme is now more rigorous and involves a compulsory exam (good for our specialty and patients but, an extra burden on trainees).

We have conducted two surveys looking at trainee retention. There is very little published data on this and informal discussions with other Colleges/Faculties would suggest that very few of them look at or keep this data (RCOG report 30% of trainees do not complete training). Both surveys revealed that around 5% of trainees entering ICM training do not complete training for some reason. Re-assuringly the reasons for leaving are varied and are much more likely to be related to a revision of career plans after a life event than due to an issue with ICM training itself. We will keep this under constant review. As always please get in touch if you wish to discuss anything (related to this article or otherwise) @mcarpenter1967.



FFICM EXAMINATION

Dr Andy Cohen

Chair, Court of Examiners

In the past when contributing to Critical Eye articles on the exam I have provided a statistical analysis of the way the FFICM is performing. This was relevant information about a new exam but is less so now the exam is more established and predictable. For those interested in numbers the data are published in the Chair's report after each sitting and can be found here: <https://bit.ly/2OqmQiV>

The exam is currently taken in several parts. There is a machine marked test, comprising of Multiple True/False questions and Single Best Answer questions, each July and January. The oral components of the exam consist of a structured oral exam and a clinical OSCE taken in October and April. Not all candidates who pass the machine marked test choose to proceed to the oral exam immediately afterwards. Some candidates who take the oral exam fail a single component and then have to present themselves to retake the second component at a later stage. This means that not all candidates progress through the exam following the same path.

By this time next year I will have overseen my last FFICM exam; I will be handing over to a new Chair having served my term. I have spent more than 20 years as a postgraduate examiner, initially for the FRCA, then the DICM and finally the FFICM. I took over as Chair of the FFICM exam from Prof Nigel Webster, who oversaw the creation of the FFICM, and have seen it develop into an established component of training in intensive care medicine.

This might be an appropriate time to look at what might happen to our exam in the future. Many clinicians have no involvement in postgraduate exams but will have experienced watching their teenage children taking GCSEs and A-Levels. They will note that exams have changed from when they were at school, they may even think exams have become easier. I would suggest that

this is not the case, what has happened is they have changed. Educationalists will tell us that they recognise different ways of learning. Some learners respond to reading and writing, some respond to the use of visual material such as graphs and diagrams, others respond by performing practical procedures and some like to listen and speak as aids to learning. It might be that changes in examining techniques from when you were at school may now suit your style better, it does not mean they are easier. If you really think they are easier take a look at science A-Level papers. Not only are they difficult, but a lot of the material seems to have been invented, certainly since I was at school.

So how will the FFICM develop? Please consider the following comments to be the musings of an old examiner not an indication of Faculty policy. Assessment of critical care training will continue to include an exam as an important component. Eventually, there will be a demand for a Primary exam. I am sure this will initially be a machine marked test but it may not include Multiple True/False questions. Multiple True/False questions are good at testing factual knowledge but we should be interested in more than this. The GMC tends to favour alternative methods of assessment. Those unfamiliar with modern college exams might be surprised to see pages of facts such as normal values being made available to candidates while taking an exam. Similarly, many would be surprised at the sophistication of electronic devices that can be taken into some GCSE/A-Level maths papers. Students might call them calculators, but they can perform statistical analyses very much faster than the Commodore PET I used for this purpose when I was a Lecturer in Anaesthesia.

At some stage 'Open Book' exams could be introduced where the candidate is allowed access to reference material. To generations told to vilify those sneaking material into the exam room, how

can we come to terms with giving the candidates books to read in the middle of an exam? Then again, which good doctor would fail to use reference material to help with the diagnosis and treatment of a patient? Testing a candidate's ability to perform in the presence of reference material seems quite legitimate to me. To pass the exam, candidates have to understand how to use the resource efficiently and they will have insufficient time to plough the whole way through a complete textbook. This is not really different to the common practice of allowing undergraduates access to the BNF when prescribing for simulated patients in their final exams.

questions unaided by others, but it is likely that developments in IT will help the way we examine in the future.

Returning to more traditional topics, I can confirm that candidates still need to concentrate on the areas I regularly highlight in my Chair's reports. It is interesting to note that we can inform candidates of some questions in advance and performance will be unaffected. Take the ECG station in the OSCE for example, I have noted in a number of my reports that some candidates seem to have forgotten how to read an ECG in a structured way. While performance at this station remains poor it will be used again in future exams. Another guaranteed area to be examined in the OSCE is interpreting images where some material will come from normal patients. Candidates will be expected to have a structured approach to how they interpret images unless asked something direct such as 'what is the most obvious abnormality you can see?'. It is pleasing to see that some candidates are preparing better for the OSCE simulator and communication stations but there remain many who are not.

Examining takes a significant amount of time. We appreciate the contribution in time and effort made by examiners and we hope that departments will support consultants in this commitment. The FICM is in the process of appointing new examiners and will announce the names of successful candidates later this year. The exam could not run as efficiently as it does without the hard working exams department functioning in the background. I would like to thank both the exams department and examiner colleagues for their efforts over the last year and for the support I have received over many years. My time as Chair of the Court of examiners has been both challenging and rewarding. I wish everyone all the best in the future development of the FFICM exam.

“ EXAMINING TAKES A SIGNIFICANT AMOUNT OF TIME. WE APPRECIATE THE CONTRIBUTION IN TIME AND EFFORT MADE BY EXAMINERS AND WE HOPE THAT DEPARTMENTS WILL SUPPORT CONSULTANTS IN THIS COMMITMENT

Open book examinations not only have potential benefits in their own right but could also open up the possibility that candidates could sit written papers outside the college, maybe even sit individualised online papers in their own home, allowing them to have access to whatever resource material they wish. There are challenges to face before we would embark upon this sort of practice, such as having a way of ensuring we know the identity of the person sitting the paper and that they are answering the

FFICM Examination Calendar 2018

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications & fees not accepted before	Monday 16th July	Monday 15th October
Closing date for Exam applications	Thursday 6th September	Thursday 22nd November
Examination Date	Tuesday 16th & Wednesday 17th October	Tuesday 8th January 2019
Examination Fees	Both: £585, OSCE: £335, SOE: £300	£475

MEMBERSHIP UPDATE

FELLOWS

Andrew Achilleos
Kenneth Adegoke
Parvathprasad Annamalai
Yogasundaram Arunan
Christopher Beet
Kathryn Bennett
Victoria Bennett
Nicholas Bolton
John Bramwell
Anna Briggs
Sanjeet Chana
Fiona Christie
Samantha Clayton
Laura Cooper
Roger Davies
Nishita Desai
Pareksh Dhruv
Ahmed El Haddad
Deedy Elmissiry
Rebecca Frank
Grainne Gallagher
Benjamin Garfield
Atul Garg
Kyle Gibson
Stephen Glover
Mihaela Gresoiu
Christopher Hall
David Hall
Daniel Harper
Richard Hodgson
Julian Howes
Anwar ul Huda
Wasimul Huda
Richard Hunt
Musarat Hussain
Simon Illott
Helen Jones
Timothy Jones
Vaughan Jones
Omar Jundi
Shamir Karmali
Scott Kemp
Wael Khalaf

Asad Khan
Aidan Kingwill
Martin Knight
Shaun Paul
Christiane Kubitzek
Simon Lampden
Andrew Laurie
Peter Lax
Rebecca Lewis
Dagan Lonsdale
Louise Ma
Jonathan Mackenney
Nadia Mahmood
Paul Mallett
Claire McCue
Christopher McGovern
Sachin Mehta
Patricia Mills
Gary Misselbrook
Aditi Modi
Philip Molyneaux
Dominic Moor
Anushka Mudalige
Smitangshu Mukherjee
Michael Munro
James Napier
Andrew Nash
Alexander Parker
Chinmay Patvardhan
Skylar Paulich
Mark Peters
Elizabeth Potter
Adrian Proffitt
Kay Protheroe
Judith Ramsay
David Rees
Keith Ritchie
Anthony Rostron
Elham Safar
Barnaby Scrace
Arun Sengottaiyan
Ayush Sinha
Matthew Smith

Jagdish Sokhi
Enrico Sorrentino
Susan Stevenson
Helen Surgenor
Joel Swindin
Nicholas Talbot
Matthew Taylor
Nicholas Truman
Timothy Tufnell Barrett
Phillip Ward
James Watchorn
Deborah Webster
Chamene Welhengama
Francois Wessels
Nia Wright
Thomas Wright

ASSOCIATE FELLOWS

Audrey Chambers
Mohammed Dessoky
James Johnston
Pulak Paul
Aneta Sowinska
Andrew Topping

MEMBERS

Jane Benedict
Kakusanda Ganegedara
Ahmed Hassanin
Udesch Perera

ASSOCIATE MEMBERS

Tracey Heron
Hannah Maitland
Liam McHugh
Helen McMillan
Stephen Roberts
Alexandria Scott
Jennifer Spence
Terry Stenhouse
Michael Wright

STATE OF THE ART MEETING 2018

QEII CENTRE – LONDON – 10-12 DECEMBER

WORLDWIDE VIEW BEDSIDE DELIVERY



search: Intensive Care Society



follow us: @ICS_updates



search: Intensive Care Society



www.soa.ics.ac.uk

Contact us

020 7280 4350 / info@ics.ac.uk / www.ics.ac.uk

Click here to book your place

We have a fantastic line up of events this autumn.

Book now to save your place. **Enjoy summer!**

Monday	10.09.18	Microbiology
Friday	14.09.18	Legal and Ethical
Tuesday	18.09.18	FFICM Prep
Wednesday	19.09.18	ICS and RSM: Get into Critical Care Research
Friday	21.09.18	ARDS Symposium
Monday	24.09.18	Bronchoscopy
Tuesday	09.10.18	Wellbeing
Thursday	25.10.18	CUSIC

Connect
with us on
social media



The Faculty of
Intensive Care Medicine

Churchill House | 35 Red Lion Square | London | WC1R 4SG
tel 020 7092 1688 | email contact@ficm.ac.uk

www.ficm.ac.uk

@FICMNews