

Critical Eye



Issue 11

Winter 2017

The Faculty of
Intensive Care Medicine

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Welcome



Dr John Butler
Clinical Editor

Welcome to the 11th edition of Critical Eye. Alongside updates on all the latest developments affecting the specialty there are a number of featured articles, some of which I have highlighted below.

Firstly however, I would like to acknowledge the significant achievements of our outgoing Dean, Dr Anna Batchelor. Anna has worked tirelessly, achieving a number of important objectives including the acceptance of the FICM into the Academy of Medical Royal Colleges. Reassuringly, she continues to be actively involved in many initiatives and her ongoing input is greatly appreciated by the FICM Board. Thanks to Anna and other members of the Board, we can look forward to a number of important publications in 2017.

Undoubtedly one of the most challenging areas of clinical ICM practice relates to the decision-making around the withdrawal of therapy. In his article, Dr Harvey provides an update from the JSC working party looking at the management of patients with potentially devastating brain injury. The remit of the group was to provide guidance on the early withdrawal of therapy from patients considered to have an unsurvivable brain injury in the Emergency Department. Publication of the full guidance is expected soon.

Dr Wallace outlines helpful suggestions for trainees approaching the final FFICM examination based on her own recent experience. Trainees and consultants will also benefit from the development of the new e-learning for Intensive Care Medicine (e-ICM) featured in this edition. In 2016 we saw the publication of the new Sepsis-3 definitions as well as the NICE clinical guideline on Sepsis: recognition and early management (NG51). In this interesting article Dr O'Flynn outlines the development of the NICE recommendations and how they relate to the development of Sepsis-3 and the qSOFA criteria.

I hope you enjoy the content and don't forget to book your place for the FICM annual meeting 'Hard cases or Bad Laws' on the 24th May.

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

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

Dean's Statement



Dr Carl Waldmann
Dean

This has been a busy last few weeks. It has been a true honour to be elected as Dean of our Faculty and I am a proud man.

Within one minute of my initiation ceremony my email inbox exponentially started to increase with every hour; I realised what big boots I was about to fill after Anna, Julian and Tim. They have really set the bar high. Anna deserves a well-earned rest though she is still heavily involved in many projects.

Her time on the Board was associated with several important developments of which two stand out; firstly the important step of welcoming the ACCPs into the Faculty and co-opting Carole Boulanger onto the Board. Secondly the membership of FICM onto the Academy of Medical Royal Colleges allowing us to contribute to many more initiatives.

I would particularly like to welcome the new members elected to the board, Drs Andy Ball, Danielle Bryden and Jack Parry-Jones. The amazingly talented Alison Pittard is the new Vice Dean and I know the future of the Faculty is in safe hands. At the last Board meeting I had the honour of presenting Helen Galley with Honorary Membership for her many years of high level research and commitment to our speciality.

Evolution of ICM

Now to the future. Some have likened the progress of ICM to climbing Everest.

In the 1970s the ICS was formed and since then we have seen the development of ICNARC, the Intensive Care foundation and the Intercollegiate Board for Training in Intensive Care Medicine. The Faculty was formed six years ago (I was at the

breakfast meeting where Judith Hulf managed to convince all the Presidents of the founding parent Royal Colleges to agree to the formation of FICM), and we now have evolved the ICM curriculum and syllabus and the FFICM exam is going from strength to strength.

One of Anna Batchelor's projects with Peter Nightingale has been to take on the writing the 3rd iteration of Comprehensive Critical Care first published in 2000 known as 'Critical Futures'. We look forward to this document being published which is based on the feedback of our Fellows and partner organisations in 2017.

Annual Meeting

Last July we were entertained by a first class meeting run by Colonel Henning and the Armed Services. I was gob-smacked by the extent and excellence of their work and it drove home to me why representation by the Armed Services is so important for the FICM. Next year we look forward to the Annual Meeting run by Danielle Bryden on Hard Cases or Bad Laws: A day of debate around contentious ethical aspects of ICM. As you all know there is a Legal and Ethical Policy Unit (LEPU) that reports into the Joint Standards Committee of the FICM and ICS; Chris Danbury has updated their work in this edition of Critical Eye.

National Adult Critical Care Data Group (NACCDG)

ICNARC has been important to the development of ICM through its case mix programme. We are now looking forward to continuing our work with ICNARC to further develop robust data collection to advise our future requirements. To this end,

the CRG and NHS England has requested that the Faculty of Intensive Care Medicine acts as Lead Stakeholder for the NACCDG, Chairing the group and providing support for the meetings. The FICM have agreed and have appointed Mike Grocott to Chair.

Standards

A huge thank- you to Simon Baudouin for his superb leadership with Standards. GPICS has been a great success. We welcome Peter MacNaughton who has recently taken over the reins. The success of this Joint Standards Committee has been one of many examples of how well the Faculty has worked with the ICS; long may this continue.

Work on GPICS Version 2 will begin in spring 2017. In addition our interdisciplinary work on the publication of a standard for the provision of maternity critical care services has resumed after a brief delay;

we thank Audrey Quinn for leading this and hope publication will be no later than mid-2017.

Smaller Units Advisory Group

Chris Thorpe has taken this important strand of work forward in the wake of concerns about how our Core Standards and GPICS were being applied in smaller and remote units. This group will be able to take forward recommendations for GPICS Version 2 with the JSC.

And Finally

I want to thank and congratulate Daniel Waeland, Anna Ripley and their staff for all the excellent support they give the Faculty; Alison and myself have been made extremely welcome and we hope that we can move the FICM further along its path; we are well past base camp but there is still a way to go the summit.

Photo credit: Crispin Hughes



Critical Futures



Dr Anna Batchelor
Project Lead

In the late 1990s intensive care hit crisis point. Patients were being transferred between hospitals for reasons unrelated to need and there were too few beds to meet demand. This was the trigger point for a step change in critical care services. Comprehensive Critical Care, published in 2000 introduced the concept of 'Critical care without walls', a service responding to the needs of critically ill patients throughout our hospitals. It recommended more ICU beds, opening HDU units, development of outreach teams and hospital wide critical care delivery groups. Aided by the accompanying £140million we have seen a dramatic change in care for the sickest patients in our hospitals.

The Faculty commissioned Dr Peter Nightingale, past President of both the Intensive Care Society and Royal College of Anaesthetists, to lead a project titled 'Critical Futures'. Almost 450 members of the ICM community responded to a questionnaire asking for their unprompted thoughts on critical care services. We are grateful to them for taking the time and caring enough about our specialty to want to influence its future and we aim to publish a report in 2017.

Some general themes are emerging from what is rather a lot of information. Although we have seen an increase in the number of trainees in ICM, we are a long way from being able to supply enough CCT holders and trainee staffing is also problematic. A particular stressor in smaller units is the need to provide a 7 day intensivists service with what may be an inadequate number of consultants. The place of consultants in anaesthesia as part of the ICM workforce solution attracts very polarised views, possibly related to local supply of intensivists and pragmatism. Many respondents suggest they are keen to train and/or recruit ACCPs to help

bridge the trainee gap. Nurse staffing is also a problem with some units unable to open funded beds because of recruitment difficulties. Overseas recruitment is a particularly popular strategy for doctors and nurses but this may become more difficult if immigration controls are increased.

Increased referrals particularly of older patients with multiple comorbidities and then difficulty discharging these patients is widespread. There is increasing pressure to make decisions about the value or not of critical care admission is seen as onerous and stressful by many. Increasing demand for admission after elective surgery has led to several innovative solutions including post-anaesthesia care units, or ring fenced ward based high care areas to avoid cancellation of surgery whilst preserving critical care beds for emergency cases.

Reconfiguration of services is viewed as inevitable but with views divided on whether this is desirable or not, variations on hub and spoke services, networked solutions, telemedicine and retrieval services are all considered. There is a strong view that district general hospitals are an important part of the service and referral of all acutely ill patients will devalue and undermine these hospitals. Comments include teaching hospital consultants should go and see how the other half live!

With the publication of the Sustainability and Transformation Plans we may see a rush of possibly hasty reconfiguration plans. It is concerning that, at a time when the critical care service is facing increasing demands in the face of insufficient staff to meet these demands costly and disruptive service changes may add to the problems critical care units are already facing.

Professional Standards



Dr Peter MacNaughton
Chair
FICM Professional Standards
Committee

This is my first report as Co-Chair of the Joint Standards Committee and I would like to thank my predecessor, Simon Baudouin, for his leadership and major contribution to the work of the committee. It is with some trepidation that I follow Simon but I look forward to the challenges ahead and hope to maintain the excellent work of the Committee.

Standards and guidelines need to be regularly reviewed to ensure that they remain based on the latest evidence. GPICS version 1.1 has now been published and includes some minor amendments. The planning for the first major revision of GPICS will begin in the spring of this year with a target publication date of July 2018. Like the first version, there will be a wide consultation process.

The ambition to gain NICE accreditation for JSC produced standards has been shelved as NICE will no longer accredit any external bodies. However, the JSC is committed to providing high quality, evidence based guidelines, with the publication of the ARDS guideline expected in the coming months and work starting on developing a delirium guideline. To support the introduction of the ARDS guideline, we are exploring a potential related short audit. The lack of an evidence base can make the production of clinically useful guidelines challenging. Guidance providing clinical recommendations based on a consensus of current best practice is an alternative approach. The JSC was made aware of significant variation in admission practice amongst ICUs for patients with perceived devastating brain injury. A working party of the JSC will be publishing a guidance document in the next few months to assist clinical decision-making and management of this patient group. More information can be found in Dan Harvey's article.

The National Safety Standards for Invasive Procedures (NatSSiPs) were published in September 2015 and are a set of high-level standards that should guide the development of local standards to cover all invasive procedures. They build on the experience of the WHO surgical safety checklist and cover all invasive procedures performed outside the operating theatre environment. Organisations should have reviewed their current local processes for invasive procedures and ensure that they are compliant with the new national standards by developing 'Local Safety Standards for Invasive Procedures' (LocSSiPs). To support the development of LocSSiPs, the JSC has developed examples of safety checklists for the common invasive procedures undertaken in the ICU that are available to download from the FICM website to be used or adapted locally as appropriate.

It is estimated that 1 in 10 patients in health care sustain harm that is potentially avoidable and which often highlight system errors that were not appreciated. By investigating these incidents, Trusts can identify the system errors and generate solutions to prevent future occurrences. Currently these lessons may not be shared widely and to improve wider patient safety, the Faculty is establishing a forum to share lessons from local safety incidents. A patient safety section of the FICM website has been introduced where learning from these incidents can be shared. I would encourage you to submit important safety lessons that have occurred in your own departments that have general relevance. A proforma for submitting anonymised summaries of adverse incidents and the learning arising is available to download. The safety section will also be used to cascade national safety alerts and a resource for other patient safety information including the LocSSiP checklists outlined above.

Devastating Brain Injury Working Party



Dr Dan Harvey
Chair
Devastating Brain Injury Working Party

The FICM and ICS Joint Standards Committee (JSC) exists to help develop clinical standards and ensure quality and safe practice. Whilst this includes synthesis of research into evidence based guidelines, it also includes publication of guidance in areas where the evidence base is less certain, but clear risks to either patients or professional practice exist. The concerns that resulted from the publication of Manara et al's recent paper in the Journal of the Intensive Care Society (JICS) is an example. In the interests of space I won't appraise the paper here, suffice to say that, if you have not read it, I strongly recommend you do so.

I am not alone in my opinion, JICS recently awarded the paper their annual prize in recognition of its impact. In summary it described a change in clinical practice in one geographical area, delaying the early withdrawal of therapy from patients considered to have unsurvivable brain injury in the emergency department. Perhaps unsurprisingly to some, the initial prognostication was correct in the vast majority of cases, but critically not all. Indeed Manara et al describe two patients in their initial cohort with good functional outcomes.

This is one area of clinical practice with a high clinical risk, and the implications of changes in practice may be significant. For example, it takes little imagination to see how changes in ICU admission criteria might be applied in other clinical areas, change family and staff expectations, or impact on unit and hospital quality metrics to name just a few concerns.

Areas such as this may benefit from the development of consensus statements from stakeholder organisations that take into account these widespread impacts. When the evidence base is weak, then we should at least be able to

clearly determine and summarise expert opinion and make it available to consultants on the front line. Such guidance can help ICU and ED clinicians establish consensus within their own organisations, marshal resources where necessary and ultimately protect patient safety. I would go further and claim (with admittedly little evidence) that the existence of such guidance may protect not only patients, but also their doctors from external criticism of decision making. Identifying a cohort of patients with certain criteria in common can help us measure the impact of changes in decision making, both positive and negative, for example the results from a similar area of practice have recently been published.

For this reason the FICM and ICS JSC set up a working party with members from a range of stakeholder professional organisations who have drafted guidance designed to protect patients and professionals when making these decisions. This is currently out for wider consultation with stakeholder organisations and is expected to be published in 2017. Such guidance should not replace individualised decision making by patients, their families and their doctors, but seek to ensure that barriers to making decisions in the patients best interests are recognised, challenged and removed.

We hope that Fellows will find the guidance useful, and that it will help to bring clarity and consensus to decisions that can be controversial. The JSC would be very keen to listen to feedback specifically on this guidance, but also more widely as to whether guidance within such areas of potential conflict and controversy is useful, and whether the process used to develop it is appropriate.

Legal and Ethical Policy Unit



Dr Chris Danbury
Chair
Legal and Ethical Policy Unit

DoLS continues to confuse people (including me). We have heard that the Court of Appeal has heard the case of F. This is a case regarding the death of patient with Down's Syndrome, who died on the ICU. The argument is whether F was "in state detention" at the time of her death, within the meaning of ss. 7(2)(a) and 48(1) and (2) of the *Coroners and Justice Act 2009* ("the CJA 2009").

The lower Court has ruled that she was not in state detention, but leave to appeal has been granted. The FICM and ICS have been granted permission to intervene at that stage, so the arguments of the profession will have a chance to be aired. The case was heard in December 2016 and we are not expecting an outcome to be delivered until February 2017.

The Law Commission continues with the review of DoLS, although whether there will be any parliamentary time for any proposed legislation is in doubt because of the aftermath of the Brexit Referendum. The Commission continue to say that they are looking for a solution that is not onerous on acute hospitals in general and ICM in particular.

Work on Alternative Dispute Resolution (Mediation) continues. The first workshop was held at the Royal College of Physicians in September and was highly rated. There is a second planned for March and will

be advertised shortly. The NHS Litigation Authority has recently tendered for organisations to provide mediation services for clinical claims. The successful groups have not been informed yet, but this is a very interesting development.

LEPU has been asked to prepare some guidance on Police Access to patients in Intensive Care. This is in an early phase, but we aim to look at a number of aspects, such as:

- the nature of injuries and obtaining photographs
- clinical information written (inc PMH) and reports
- blood specimens
- personal effects and access to them
- changes depending on the patient's role in any alleged crime
- who makes these decisions?
- what methodology should they use?
- how should any of these requests and decisions be documented?

If there are any comments on the scope of this work, please contact the secretariat.

Finally, the Faculty meeting next year is 'Hard Cases or Bad Laws?' I look forward to seeing you all there!

If you would like to contribute to Critical Eye we'd love to hear from you!
Please send any suggestions for articles, themes or responses to published articles to:

ficm@rcoa.ac.uk

NICE Guideline: Sepsis



Norma O'Flynn
Chief Operating Officer
NCGC

NICE have published a clinical guideline on Sepsis: recognition, diagnosis and early management ¹. When the guideline was scoped it was recognised that respected guidelines developed by the Surviving Sepsis Campaign were already in place for the critical care management of people with sepsis. The NICE guideline was developed therefore to compliment existing guidance and provide assistance on recognition and early management.

The guideline aimed to make recommendations up to the time critical care were involved whether via formal referral or discussion. While there are factors that make some people susceptible to sepsis, it is essentially a pathophysiological process that can present in any clinical setting. The NICE guideline was developed with a view to making recommendations relevant to all populations in all settings other than people already in critical care settings.

All NICE guidelines are developed using processes described in the NICE Guidelines manual ² which include the development of review protocols to answer clearly defined questions, systematic reviews of the literature and consideration of cost effectiveness. These processes allow the identification of gaps and uncertainties in the evidence and generation of research recommendations which can be prioritised to National Institute of Health Research (NIHR).

The evidence reviews are conducted by technical teams employed by NICE or teams commissioned by NICE to do this work. Guideline committees, specifically recruited to develop guidance on each topic, agree the protocols and develop recommendations using the evidence available and their experience. For the sepsis guideline

these included a varied group of professionals with expertise in general practice, ambulance service, nursing, adult and paediatric emergency medicine, adult and paediatric intensive care as well as lay members.

The aim of early recognition of sepsis is to identify people who have or who are developing a systemic response to infection that may be life-threatening and intervene as early as possible. The challenge is not to over investigate and over treat the vast majority of people with infection who do not have and will not develop sepsis. The NICE guideline includes an examination of the value of risk scores and of individual clinical parameters in diagnosing or predicting sepsis.

The evidence available was assessed using the GRADE criteria and, overall, was found to be of very low quality. Scores commonly used in hospital settings, such as NEWS, have not been validated in primary care and emergency care settings and studies would need to assess the practicality of using the scores in these settings. The committee considered that scores promote an assessment of a number of clinical parameters and their value may be in ensuring this is done systematically if there is suspicion of sepsis rather than recommending the use of a score in itself.

The committee developed risk assessment and management pathways for people at three risk levels; high risk, high to moderate risk and low risk. People in the high risk group are recommended for rapid transfer to hospital services with senior clinical decision maker involvement, antibiotics and fluids within one hour. The 'high to moderate' risk group includes

some people at risk of poor outcomes, patients in this group along with those in the 'low risk' group are recommended for assessment within a defined period but do not include immediate antibiotics and fluid. It provides a framework for the real-world assessment required to avoid treating high numbers of patients who have a non-sepsis diagnosis with broad spectrum antimicrobials.

The development timeline coincided with the release of Sepsis-3 'definitions'³ which were published towards the end of the process. While Sepsis-3 work provides narrative definitions of sepsis based on pathophysiological changes, there has been confusion about the place of qSOFA (quick Sepsis Related Organ Failure Assessment) in particular and how this may relate to the NICE guideline.

qSOFA, a set of simple criteria that could be easily used by clinicians at the bedside, was developed using a large US database including all medical encounters in the ED, hospital ward and ICU. A stepwise approach which identifies variables which improve the predictive ability of a model, was used to inform the qSOFA. The final qSOFA score included a systolic blood pressure of 100 mmHg or less, a respiratory rate of 22 breaths per minute or more, and an altered mental state defined as a Glasgow Coma Scale (GCS) score of 13 points or less.

In a second stage, the study authors sought to determine the optimal cut-off of the qSOFA for the prediction of hospital mortality. Using four additional databases 73%-90% of patients with a suspected infection had less than 2 qSOFA points. Those patients with a qSOFA score of 2 or 3 points accounted for 70% of deaths. The best identified cut-off was judged to be a qSOFA score of 2 points or more. The authors have clarified that qSOFA is not a definition of sepsis but is appropriate for use in risk assessment⁴. The nature of what management is appropriate is not defined.

The committee considered that the NICE guideline had to combine both risk assessment and the nature of early management. While recognising the significance of the work in developing qSOFA they did not consider that all people with a qSOFA score of 2 or more could or should be treated

urgently with intravenous antibiotics. Moreover a qSOFA score of 2 or 3 did not identify 30% of deaths. The criteria identified by Sepsis-3 are already included in the NICE recommendations with people with suspected septic shock in the high risk management pathway and all people fulfilling qSOFA criteria included in the high to moderate or high risk management pathways.

NICE guidelines are reviewed on a regular basis to ensure they are up to date. Further work and validation of scores including qSOFA can be expected to inform updates of the guideline.

1. *National Institute for Health and Care Excellence. Sepsis: recognition, diagnosis and early management. NICE guideline 51. London. National Institute for Health and Care Excellence, 2016. Available from: <https://www.nice.org.uk/guidance/ng51>*

2. *National Institute for Health and Care Excellence. Developing NICE guidelines: the manual. London. National Institute for Health and Care Excellence, 2014. Available from: <http://www.nice.org.uk/article/PMG20/chapter/1%20Introduction%20and%20overview>*

3. *Singer M, Deutschman CS, Seymour CW, Shankar-Hari M, Annane D, Bauer M et al. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA. 2016; 315(8):801-810*

4. *Seymour CW, Liu VX, Iwashyna TJ, Brunkhorst FM, Rea TD, Scherag A et al. Assessment of Clinical Criteria for Sepsis: For the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA. 2016; 315(8):762-774*

Smaller Units Advisory Group



Dr Chris Thorpe
Chair
Smaller Units Advisory Group

The group had their second meeting in November and several strands are coming together. We met with the Joint Standards Committee in December and discussed the opportunity to include of a chapter on smaller and rural units in the next version of GPICS, an approach that seems sensible. As I have previously mentioned in Critical Eye the SUAG have reviewed the GPICS document and in fact the majority of the document is helpful to units of all shapes and sizes. There are elements however that are not so easily met for some units, and focus will need to be brought on how to address these.

The CQC has been visiting units around England as part of their hospital visits. Wales, Northern Ireland and Scotland have different arrangements; in Wales unit visits have begun through the Critical Care Delivery Group, a collection of clinicians, nurses and managers working under the auspices of the Welsh Government. Results from the CQC visits are freely available on the website; the summaries can be clicked on to give a decent overview but there is real meat in the full report.

Assessment against GPICS is only a portion of the report which is divided into 5 sections namely Caring, Responsive, Well led, Effective and Safe. These sections are scored as Excellent, Good, Requires improvement or Inadequate and are then combined to give an overall rating along the same scale. Out of 194 responses we had 15 outstanding, 112 good, 62 requires improvement and 5 inadequate. To reach an overall rating of 'requires improvement' at least two of the subcategories must be at that level or worse. Reading through some of the reports it is clear that there is a sticking point with some aspects of GPICS but in most there are additional reasons why a 'requires improvement' assessment is given.

The Nuffield Trust continues to provide a solid forum for rural and remote healthcare, and the latest meeting in London brought together clinicians, managers, nurses and politicians to discuss how to support and develop these essential services.

In Scotland one of our SUAG members, Catriona Barr from the Shetland Islands, has to deliver a critical care service for a population of just 23,000. The context of delivering a service in this geographically isolated hospital is clearly different to that of an urban hospital. Although most patients can be dealt with independently one of the integral parts of the solution is networked contact with larger mainland units. An interesting paper on this came out of the Dutch networks in 2015¹. Essentially all units in Holland were included in a revamp of critical care services. Units were separated into 3 sections according to size and staffing requirements, common QA processes were introduced and an annual report was required. Patients anticipated to be ventilated for >72hours in a Level 1 unit (the smallest) were to be discussed with a higher-level unit.

Following introduction of the system it was found that outcome measures were as good in smaller as they were in bigger units, with transfers at 4.2%. I like the way they went about it: introduction of robust common QA processes and increased communication seem obviously sensible. We also have the prospect of telemedicine raising its hand eagerly at the back of the class. Or perhaps the front. And I suspect this will be an integral part of networked critical care in the not too distant future.

1. The association between ICU level of care and mortality in the Netherlands. GH Kluge, S Brinkman et al. Intensive Care Medicine 2015; 41; 2: 304-311

National Adult Critical Care Data Group



Dr Jane Eddleston
Chair
NHS England National Adult Critical
Care Clinical Reference Group

In April 2016 NHS England re-commissioned the Clinical Reference Group (CRG) for Adult Critical Care. This reference group sits within NHS England's Trauma Programme of Care domain.

One of the workstreams generated by the CRG is the construction of and subsequent review of a National Dashboard for Adult Critical Care. Selection of the indicators for the dashboard has, for the past 3 years, been undertaken by the members of the CRG and the indicators have been uploaded from the ICNARC case mix programme on a quarterly basis. The exceptions have been two indicators which Trusts submit quarterly through the Specialised Services Quality Dashboards web portal. Clinical staff can gain access to their data through this portal, thereby permitting comparisons to be undertaken at local, network and national levels. The two indicators directly entered by trusts relate to patients undergoing elective surgery who have their surgery cancelled for lack of availability of a critical care bed on the day of surgery (ACC13a) and patients who have had their surgery cancelled more than once due to lack of a critical care bed (ACC13b).

The development of a National Dashboard is a major milestone for our specialty. It affords opportunities for ICM to maintain its high national profile. This is at a time when tremendous changes in service provision are anticipated consequent on the strategic transformation programmes being developed, as well as continuing the significant quality improvement work for which the professional bodies have worked collaboratively with the CRG over the past 3 years to deliver.

The CRG has recently commissioned a National Adult Critical Care Data Group (NACCDG).

The purpose of this group is to advise the CRG on the development, content and use of current and future national data within critical care to improve care, support research and drive change in processes and outcomes for critically ill patients. The NACCDG will provide advice on:

- the content of ICNARC's Case Mix Programme, including development of sub speciality datasets
- development of an operational dataset including a workforce dataset
- the content of the National Adult Critical Care Dashboard
- collaboration and data linkage between clinical datasets which have relevance to adult critical care
- identify opportunities for critical care data providers to increase efficiency including, methods of data collection, mode of data entry, methods of data management and design/content of National Audit reports.

The membership of the group will be drawn from NHS England, Critical Care Operational Delivery Networks, Public Health England, the Intensive Care National Audit and Research Centre (ICNARC), the Faculty of Intensive Care Medicine, the Intensive Care Society, the UK Critical Care Nursing Alliance, and the National Institute for Health Research Health Informatics Collaborative in Intensive Care Medicine. The lead stakeholder is the Faculty of Intensive Care Medicine and Professor Mike Grocott has been appointed to Chair the group.

In addition it is anticipated that the group will wish to co-opt other members for bespoke elements of work.

The North West School of ICM



Dr Sarah Clarke
Regional Advisor

Intensive Care Medicine training in the UK has made spectacular advances over the last 6 years since the GMC approved the standalone 5-year CCT programme. From 2012, trainees pursuing an ICM training programme also become eligible to apply for a second specialty training programme in the same locality, and the Dual CCT was born.

Things were also happening apace at regional level, and here in the North West we faced additional challenges. Historically, the region has been served by two Deaneries (Mersey and North West), with two completely separate administrations.

As our ICM programme grew and the numbers populating the matrix increased (balancing Consultant workforce planning and trainee numbers is a cause for constant debate and angst), we thought we were on top of things on our side of the M6, and our trainees and trainers were happy. Our focus was on the minutiae of Single and Dual Training (the reality is that each trainee has a bespoke programme, depending on their core training and experiences); we had monthly FFICM study days, post FFICM study days, interview preparation course, simulation courses, our DICM course evolved into a twice-yearly FFICM OSCE/SOE course, and there was close collaboration with ANWICU (Association of North West Intensive Care Units) for educational and research activities. Occasionally there were joint meetings with our friends in Mersey, mainly organised in collaboration with our Mersey counterpart AMICU (Associate of Mersey Intensive Care Units). Our STC members were certainly busy.

Then in Autumn 2014, we heard whisperings, mutterings from the administration. “Merger”, we

heard, “re-organisation, joining forces”. So we braced ourselves for the enormous challenge of two regions combining to create a ‘Super-LETB’. Health Education England North West was born in August 2015 overseeing postgraduate medical education and training for more than 7,000 hospital trainees, and nine Specialty Schools.

Now, some may consider that a forced marriage of two distinctly different regions, with very proud identities (and football teams) would be a stressful and turbulent process. However, we soon realised that though we had two ICM programmes, two STCs and two RAs, the reality was that there were far more similarities in our specialty than differences. From previous informal meetings with my counterpart in Mersey, Mark Hughes, we knew we had similar approaches, and we had regularly problem-shared and solved. Once our training committees were under the same Local Education Training Board, this became ever more straightforward and coordinated.

We found ourselves under the umbrella of the School of Anaesthesia, a convenient yet rather unsatisfactory placement. There remained work to do to further the specialty within Health Education England North West, and beyond. So began the next stage of our journey, to achieve and be recognised as a School. After all, the Faculty had established its own separate identity from the Royal College of Anaesthetists, after the RCoA had itself been emancipated from the Royal College of Surgeons. It seemed a natural progression, but we had to make the case.

In truth, there was a remarkable degree of support from every direction, even the LETB

from whom we would inevitably require funding. Our case for a School included the sheer size of the operation, with the trainee numbers totalling 88 on the two programmes, 22 training units, and 25 Faculty tutors. Administratively, more than 12 ARCP panels in one year, National Recruitment to 26 posts, 8 ICM training committee meetings, and representation at innumerable complementary specialty meetings: this was a serious headache for a support team in the School of Anaesthesia.

After some lobbying, to everyone's delight, we were granted School status in August 2016, following the successful appointments of a Head of School and two TPDs. The first School of ICM nationally.

The pros: improved administrative support, dedicated HEENW staff and School managers, strategic programme oversight, coordination of shared resources, and the 'cross-pollination' for

trainee experience/benefit. We have strengthened our ARCP processes and have sections on our new Anaesthesia & ICM website, www.MMAAC.uk. We continue our own 'patch' courses and study days as before, but with shared opportunities for trainees to attend across the School. This all contributes to robust quality training for ICM trainees in the North West.

The cons: I haven't yet come across any.

The great thing about the School of ICM in the North West is the retention of the individual quality programmes, with their own identities, fantastic collaboration with some super colleagues, and focussed, prioritised administrative support.

As per Aristotle: 'the whole is greater than sum of its parts'. Roll on the future.

Faculty Calendar 2017

February	27th	MEETING:	FICM Careers, Recruitment & Workforce Committee
March	6th	MEETING:	RA/FT/TPD Meeting
	10th	MEETING:	FICM/ICS Joint Standards Committee
	14th	MEETING:	FICM Training, Assessment & Quality Committee
May	3rd	MEETING:	FICM Board
	24th	EVENT:	FICM Annual Meeting
	25th	MEETING:	FICM/ICS Joint Standards Committee
June	9th	EVENT:	ACCP Conference
	19th	MEETING:	FICM Careers, Recruitment & Workforce Committee
	20th	MEETING:	FICM Training, Assessment & Quality Committee
July	12th	MEETING:	FICM Board

FFICM Examination Calendar 2017

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications not accepted before	Thursday 5th January 2017	Monday 10th April 2017
Closing date for Exam applications	Thursday 23rd February 2017	Thursday 1st June 2017
Examination Date	Tuesday 28th March & Wednesday 29th March 2017	11th July 2017
Examination Fees	Both: £570, OSCE: £315, SOE: £285	TBC

Spotlight on ICNARC



Mr Bob Nicholls
Chair

After a long career in health management and regulation, I was delighted to be appointed, early in 2016, as Chair of the Board of Management of the Intensive Care National Audit & Research Centre (ICNARC). Taking over from Dr Alasdair Short was a challenge; he had helped to establish ICNARC and had been its Chair for over 20 years bringing both a wealth of knowledge and experience in critical care. At the same time, three new clinical Trustees were recruited to the Board. Currently, we have ten Trustees who provide governance for ICNARC as an independent, charitable company limited by guarantee.

ICNARC was established in 1994 to promote improvements in the organisation and practice of critical care in the UK, through a broad programme of audit and research. To achieve this, ICNARC collaborates closely with many other organisations, employs around 30 staff and is led by the Chief Executive and the Director of Scientific and Strategic Development.

The ICNARC Clinical Trials Unit (CTU) is fully registered by the UK Clinical Research Collaboration (UKCRC). Within the CTU, and in collaboration with many clinical and non-clinical co-investigators, ICNARC conducts a broad portfolio of research, applying both quantitative and qualitative methods. In addition to externally-funded research, ICNARC also undertakes internally-funded analyses of the national clinical audit databases with the objective of informing policy and practice.

ICNARC has established and continues to develop three, major, national clinical audits, two addressing adult critical care (the Case Mix Programme - CMP and the Irish National Intensive Care Unit Audit - INICUA) and one, in collaboration with the Resuscitation

Council (UK), addressing in-hospital cardiac arrest (the National Cardiac Arrest Audit - NCAA). All of the audits have high coverage and, for each, ICNARC provides quarterly cumulative comparative risk-adjusted reports to participants, plus opportunities to request and obtain additional data analyses, and for individuals from participating sites to attend training events and annual conferences.

ICNARC promotes improvement through routine comparative reporting at local, regional and national levels. At the local level, quality indicators have been included in regular quarterly reporting from the CMP since 2004. Since 2007, regional reports comparing quality indicators for units across critical care networks have been produced. In 2011/12 and following participants' agreement, ICNARC released online its first CMP Annual Quality Report providing publicly identifiable results.

ICNARC's work has been pivotal in underpinning other major national audits and guidelines, including 'Critical to success' (Audit Commission, 1999), 'Comprehensive Critical Care' (Department of Health, 2000) and 'Recognition of and response to acute illness in adults in hospital' (NICE Clinical Guideline 50, 2007).

The Board has recently agreed strategic priorities for 2017-2019. ICNARC's priorities for this period include achievement of a year-on-year balanced budget, a reduction in operational costs, a major IT upgrade for the CMP platform, retention of UKCRC CTU registration, development of succession planning, continued working with key stakeholders to support ICNARC's aim to improve critical care, and the outcomes and experiences of critical care, for patients and for those who care for them. For further information please visit: www.icnarc.org

Critical Care Leadership Forum

In May and June 2016, the Critical Care Leadership Forum elected a new Chair and Deputy Chair to succeed Professor Julian Bion (as Chair) and Dr Anna Batchelor (as Deputy Chair).

Dr Anna Batchelor: CCLF Chair

Dr Anna Batchelor graduated from Sheffield University before training in Anaesthesia and Intensive Care Medicine in Sheffield, Leicester and Newcastle. She is currently working as an anaesthetist and intensivist at the Royal Victoria Infirmary, Newcastle spending 50% of time in each specialty. Dr Batchelor is a Past President of the ICS and until November 2016, was Dean of the Faculty of Intensive Care Medicine.

Dr Batchelor led the production of the new curriculum for ICM and the ICM component of the anaesthesia curriculum. She also led the production of the Department of Health Competence Framework for Advanced Critical Care Practitioners (ACCPs) and helped develop their FICM curriculum.

Dr Batchelor believes that successful Critical Care requires a team; the CCLF is an opportunity for the members of the team to come together to discuss and shape the future of our specialty by sharing ideas and expertise across the team members. The forthcoming reduction in the membership of the Critical Care Reference Group will mean the CCLF can become an even more valuable forum. Our specialty faces challenges with a growing need for our services in the face of limited workforce and funding and Dr Batchelor intends to look at new approaches to service delivery believing the Leadership Forum can play a valuable role in exploring and developing these models.

Colonel Jeremy Henning: CCLF Deputy Chair

Colonel Jeremy Henning gained his medical degrees from the University of Wales in 1991, after which he commissioned into the Royal Army Medical Corps and served as a General Duties Medical Officer in Germany with a UN operation in Bosnia. After this he started anaesthetic training at Queen Elizabeth Hospital, Woolwich; before moving to Royal Hospital Haslar when the former closed. He developed an early interest in intensive care medicine and spent the next years training in Wessex and the South West, eventually gaining a CCT in 2003. He undertook a Fellowship in Adelaide working on the Airborne Intensive Care Unit.

He now practises at James Cook University Hospital, Middlesbrough although, as he continues to serve, he has undertaken many operational tours, including Iraq, Afghanistan, Kosovo and Sierra Leone. His major interests lie in trauma care and ethics, but recent deployments have also interested him in infectious diseases. He has an active research portfolio looking at hypovolaemic shock using a healthy volunteer model of blood loss. He was appointed the first Defence Consultant Advisor (the clinical lead in Defence) for Intensive Care earlier this year, and also serves as an Honorary Senior Lecturer at the University of Teesside and Royal Centre for Defence Medicine.

He was elected Deputy Chair of the Critical Care Leadership Forum in June 2016. He aims to use this post to ensure that all those involved in the care of this group of patients have a full voice in all aspects of their care, from national initiatives to local standards. He sees that the Forum should have a very powerful voice as it is probably unique with representation from the whole multi-disciplinary team, which has to be developed.

Training and Assessment



Dr Alison Pittard
Vice Dean

All we seem to hear about is the state of medical training, low trainee morale and the manpower crisis! But when speaking to trainees, they say they actually enjoy what they do so we need to build on this to ensure our curriculum and training remains relevant.

We are considering a number of changes based on feedback and, along with new standards to be published by the GMC in the spring, will result in a major curriculum update. The Case Summaries are a hangover from the Diploma exam, incorporated to provide an opportunity for academic writing. We plan to remove these but in the meantime they are required to complete each year of training. It is likely we will phase them out to coincide with completion of the current Stage each trainee is in. To maintain academic writing opportunities we will replace Audit with Quality Improvement. These are longer term projects so rather than completion in full, a summary and reflection on the experience will also be expected although the details are still being agreed. Finally we are still unable to include ultrasound and Echo as mandatory requirements in the curriculum as there are insufficient trainers to make this universally deliverable. Please read Danny Bryden's RA Update for more information We will revisit this in two years' time using feedback from the RA annual report. Our new look curriculum will still have a similar content but be more outcome based with a reduced assessment load.

Another exciting development sees us working with the ICS to recognise some of the sessions at future State of the Art meeting as suitable for training purposes. We have been asking trainees, via Jamie Plumb our Trainee Representative on the committee, which areas of the curriculum are particularly difficult to access. For future meetings these topics could be specifically targeted, including the use of simulation,

but also we aim to look at the programme in general and those sessions that have appropriate content will be mapped to the curriculum. A small trial was undertaken for the December meeting and we hope to build on this.

The Academy of Medical Royal Colleges is taking the current manpower crisis seriously and has established a working party to look at improving trainee working lives. There are a number of work streams including a pilot in Emergency Medicine to broaden the opportunity for flexible training. The effect of this on recruitment and retention will be monitored to help inform future policy. Another area of concern is the cost of training and how this varies between specialties. A huge amount of work has been undertaken to establish, in each specialty, the total cost to trainees taking into account the duration of training, mandatory courses, exam fees and average pass rates. This will be accessible via an online resource hosted by the Academy making the cost of training in every specialty easy to find. Trainees will be able to input information such as periods of LTFT working, number of exam attempts etc and see what the total cost over the duration of the programme will be.

These are challenging but exciting times; I took up my role as Vice Dean in November and am sad to say, having been involved in training for almost 20 years, this is my last article as Chair of the Committee. I have handed over to Dr Tom Gallagher, who has a fantastic track record in this field and many of you will know Tom through his role as National Recruitment lead. I am confident the Committee is in safe hands and hope that you continue to engage with us so we can be proactive in maintaining the relevance of our curriculum. I will miss it all immensely and thank you for all your support.

Trainee Update



Dr Jamie Plumb
Trainee Representative

If we've learned anything from 2016 it's that elections are no longer predictable. In many ways the political climate is as uncertain as any of us have ever known. I'm pleased to say that recent Faculty elections have been far less controversial and I'm sure that all trainees who know Carl will know that he will do the Faculty proud and that Anna's boots (or heels) will not be too difficult to fill as he steers the Faculty as Dean. Richard Gould becomes the Trainee Representative Elect and I take over the role of Trainee Representative from Ian. I'd like to take this opportunity to thank Ian for his hard work and direction in what the role entails.

It genuinely is a privilege to be a member of the Faculty in the capacity of the Trainee Representative. My overriding impression is that we have a Board of committed consultants

who genuinely want to improve training in our speciality.

We've faced a difficult period over the last 12 months and some new ICM trainees will transition onto new contracts when these come into effect for new ST3s next year. It is difficult to know exactly how this will affect training and rostering but there is little doubt that this period will have significantly affected and shaped us all.

Next year will see the start of an important curriculum review and it has been interesting to speak to many of you about your ideas, and at times frustrations, with the current edition.

As ever, I do genuinely want to hear from you and take seriously any issues locally or nationally that you feel need raising at board level.

In November 2016, Dr Richard Gould was elected as the next FICM Trainee Representative. Richard will succeed Dr Plumb in January 2018.

Richard Gould is a dual ICM and Anaesthesia trainee based in West Yorkshire. After graduating from Manchester, Richard completed his house jobs in Stoke-on-Trent. These included a placement on ICU that confirmed his enjoyment for the specialty. Richard moved to Yorkshire for SHO training, and was one of the first year appointed to the ACCS programme.

Richard stayed in the region and obtained his NTN in Anaesthesia and ICM. Currently, he is midway through Stage 2 training whilst also completing higher anaesthesia modules. His interests include point-of-care ultrasound and the use of technology for teaching. He is also involved in undergraduate education and is a trainee representative on the STC.

Outside of work, most of his time is spent with his wife and two young children, although given the opportunity he is always keen to indulge in his hobbies of photography and astronomy.



Dr Pete Hersey
Clinical Lead

e-ICM (www.e-icm.org.uk) is a programme of approximately 700 learning sessions within the e-Learning for Health (e-LfH) platform. Whilst produced by the FICM, funding has come directly from the Department of Health after our successful bid and access to the programme is free for anyone within the NHS.

e-ICM has been produced to cover the syllabus for training in ICM, but it will not just be of interest to those in training; there's plenty there for Consultants too. We would also encourage you to make your Nursing, Physiotherapy, Dietetics etc. colleagues aware of this resource.

The sessions and resources within e-ICM take a variety of forms. Most are the kind of interactive e-learning sessions you will be used to if you've used e-Learning Anaesthesia (e-LA), but there are also review articles and links to relevant guidelines. As well as producing our own content, we have made use of relevant content from 23 other programmes within e-LfH.

A useful feature of e-ICM is that activity is recorded. For trainee users of the e-portfolio, we are in the process of building a feature whereby activity will be recorded automatically in the portfolio itself and available to link to the curriculum. We hope to launch this soon, and will send out instructions and more information when it is available. For all other users, learning activity is automatically recorded within the e-LfH system, and reports can be produced very easily as evidence of CPD activity for appraisal.

The structure of e-ICM is one that you will hopefully find intuitive.



Dr Sarah Marsh
Deputy Clinical Lead

Module 1

Identical to the first module of e-LA, it is written for a trainee undertaking their first 6 months of training in anaesthesia.

Module 2

An overview of the general aspects of clinical intensive care medicine that are not specific to a particular disease or patient group, for example organ support and transfer medicine.

Module 3

The spectrum of diseases that present to a critical care unit. A wide variety of pathologies are presented, classified by medical and surgical specialty.

Module 4

This details the prevention and treatment of infectious disease within intensive care medicine. This module also covers the common causative pathogens encountered in intensive care medicine.

Module 5

This is concerned with the management of trauma and traumatic injuries.

Module 6

A practical overview of common procedures within critical care. It also includes resources to aid in the interpretation of commonly requested investigations, including imaging studies. Monitoring is also included in this module.

Module 7

A basic science module, mirroring e-LA in the same way as module 1.

Module 8

This module concerns patient safety. Critical incidents and emergency situations are covered, plus safety in blood transfusion, prescribing and procedures. Safety in the critical care environment is also discussed.

Module 9

Introduces the non-clinical aspects of intensive care medicine.

Module 10

A self-assessment module, providing relevant MCQs that will be useful for anyone preparing for an exam or wanting to test their knowledge.

If you have any questions or suggestions about the project, please contact Susan Hall (shall@rcoa.ac.uk).

The production of e-ICM has been a team effort. The project was made easier by being able to learn from the experiences of e-LA and we are grateful to Ed Hammond for his input. We have also worked closely with Ali Hall (editor for the e-LA ICM module), as well as Jamie Strachan (RCOA Technology Fellow and ICM trainee). We currently have several authors and editors who are busy producing more content, and our thanks particularly go to them. Faculty support has been provided by Jyoti Chand and Daniel Waeland. The project lead is Nick Cleary and the lead instructional designer Lynne Perry.

Consultations: Summary FICM Responses

NHS Blood and Transplant: Guidance on the microbiological safety of human organs, tissues and cells used in transplantation.

September 2016

The guidance is primarily aimed at Specialist Nurses–Organ Donation and the transplantation community rather than intensivists, whose role is mainly to identify and refer potential donors. The content seems very comprehensive and clear in its guidance, although the Committee does not feel fully qualified to comment on them. The guidance will provide a useful reference for intensivists when discussing donor suitability with their SN-OD, although the final decision regarding this will always lie with the transplant surgeons and physicians.

The guidance needs to be made accessible to all involved in organ donation and transplantation via the websites of their professional organisations.

While SaBTO is an acronym well recognised in the transplant community, the Committee suspects that it is not in the intensive care community, and perhaps the document should not use this when trying to convey its content.

NICE: Rehabilitation after Critical Illness - Topic Overview

December 2016

The FICM and ICS welcome the development of the quality standard based on CG83. The FICM and ICS believe the main area of work should be on the development of measures to monitor and maintain compliance with the Clinical Guideline. We do not expect that the guideline needs to change much however, steps need to be taken to ensure that it is implemented effectively and universally.

NICE Quality Standard: Care of the dying adult in the last days of life

October 2016

Recognition at ward level about end of life seems to be often delegated to intensive care and, in some of these situations, admission to an ICU is not appropriate. The decision to escalate to intensive care cannot be made by a referring team without discussion with the intensive care consultant and it is never a decision made by the relatives. Palliative admission to ICU is sometimes appropriate but again this needs very careful discussion. The FICM and ICS believe this could be better reflected in the document.



Dr Jonathan Goodall
Careers Lead

In the summer edition of Critical Eye, I described how the FICM was working on a new approach to supporting careers in ICM. Since then, we have been developing our career strategy and this was submitted to the Board in November 2016. A summary of the strategy can be found below.

Key Requirements for FICM Careers

The FICM Recruitment, Quality and Careers Subcommittee has been considering several fundamental questions:

- How can we ensure that we attract the suitably motivated medical students and core trainees into the specialty, and do so in numbers required to meet workforce needs?
- How do we support colleagues during ‘pivotal periods’, such as the transition from trainee to consultant?
- What can we do to help colleagues balance the challenges of working longer and harder in times of fewer resources, and in less certain circumstances?
- How do we provide appropriate support for those responsible for providing the support required by other?

As a result of these discussions, four priorities (‘key areas’) were identified. Career support for these priorities will be developed over the coming year.

The 4 ‘Key Areas’ of FICM Careers 2017

1. Support during recruitment and training of ICM professionals.

- Supporting effective recruitment into the specialty by provision of information for medical students, foundation and core trainees about careers in ICM
- Supporting and expanding recruitment of ACCPs into the specialty by providing information for prospective ACCPs about careers in ICM
- Helping trainees make effective and appropriate career choices during training in ICM
- Developing support structures, mentorship and guidance for non-consultant career grade doctors in ICM

2. Support during transition to a permanent post in ICM

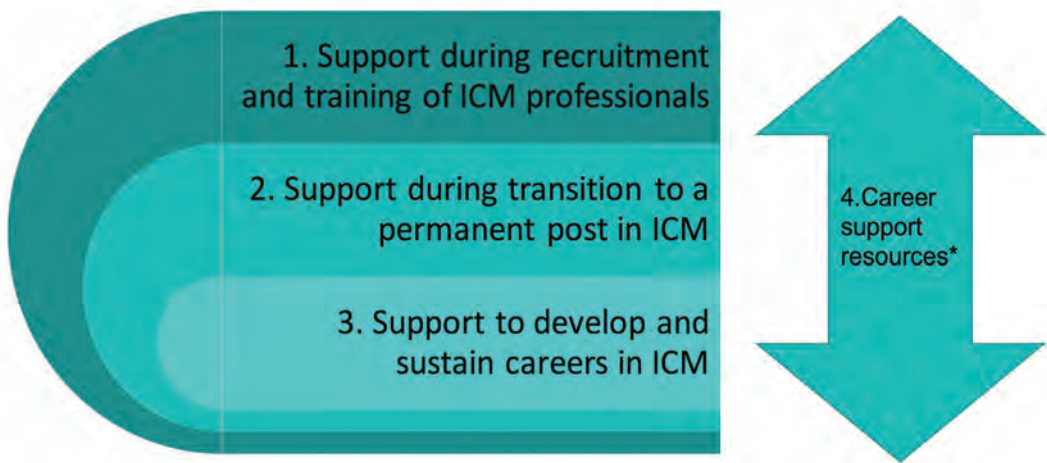
- Recognising that transition to a permanent post (for example a consultant post) is a potentially stressful time which requires induction and support from others
- Developing support and mentorship structures for newly appointed ICM consultants
- Developing support and mentorship structures for newly appointed ACCPs

3. Support to develop and sustain careers in ICM

- Strategies to reduce and manage burnout and stress in ICM professionals
- Examining new ways of working in intensive care, sharing ideas to reduce 'burnout' and ways to better sustain a career in ICM

4. Guidance for those providing advice and support for others at all the above stages

- Provision of resources and advice for those giving career support to trainees
- Provision of resources and advice for those giving career support to consultants and ACCPs
- Ideas, materials, resources for other aspects of career guidance and support



FICM Career Strategy

**An essential part of the strategy is to provide resources, information and training for those who are providing career support*

Delivering FICM Careers: How will it be achieved?

This is an exciting time for FICM Careers. The structure of Faculty committees has recently been refined, and the FICM Careers will now be delivered by the newly formed 'Careers, Recruitment and Workforce Committee'.

Our objectives include the development of the FICM Careers webpage into an effective resource for each of the four 'Key Areas' described above. These resources will begin to appear on the website early in 2017. If there are any aspects of careers support you feel need addressing and would like us to include in our initiatives, please let us know!

Simulation



Dr Andrew Jacques
Faculty Tutor

Medical simulation is now well established as a discipline. Too often though, it is not directly transferrable to 'real life' as it is conducted in a remote location, using different equipment and with individuals who do not normally work together. This reduces the potential benefits to be gained. Point of care simulation may prove more effective at revealing latent hazards, knowledge gaps in providers and improving team performance.(1)

Local practice at Royal Berkshire ICU

We have been conducting multi-disciplinary team (MDT) simulation at point of care, in the intensive care unit for just over two years. What started as ad-hoc sessions are now established as a twice monthly integral part of the education programme.



We use a range of scenarios covering both frequent events for improving team performance and familiarity (e.g. intubation of a patient, management of new onset AF), and more infrequent events for improving confidence in managing emergencies (e.g. displaced tracheostomy, preparation of a patient onto our trolley for time critical transfer). Increasingly we are producing scenarios in response to local clinical incidents. This led to a scenario being

designed on managing a patient with a cuff leak requiring emergency re-intubation.

The fidelity of the sessions is moderately high using a manikin that can undergo basic and advanced airway manoeuvres including tracheostomies and defibrillation. We secure arterial and central lines to the manikin and run the drugs and fluids given into a collection reservoir via intravenous tubing. Physiological variables are displayed on a tablet which replicates our monitors in appearance and is

controlled remotely by a mobile simulation tablet with adjustments being made in accordance with participants' interventions and the scenario 'storyboard'.

Prior to the session we run a brief familiarisation for the medical and

nursing staff participating in the scenario. Faculty comprises of an ICM consultant and nurse practice educator who lead the scenario and operate the tablet. The debrief is conducted jointly by the nursing and medical facilitator. The debrief is held as a learning conversation and focuses on the three domains of knowledge, skills and human factors. A learning summary is established at the end of the debrief and feedback collected from participants using an online survey tool.

Challenges to implementation

The key intervention in moving from ad-hoc with variable engagement to a regular programme was forming a simulation working group with representation from medical and nursing staff. The scenarios occur in our weekly academic teaching day so there are always sufficient junior doctors to participate and their time is protected with the two clinical consultants on shift holding the emergency bleeps. Advance planning of the sessions has allowed additional nursing staff to be rostered and ensures there is always true MDT involvement with at least two nurses attending.

Conscious patients and family members in surrounding bed spaces are counselled before the simulation that a training scenario is being conducted. We have had only one family member find being in proximity to the simulation distressing. Further time was spent with them explaining the purpose of the training and apologising for any additional distress caused.

We have taken a variety of approaches to the use of equipment and drugs over the two years. This is still in evolution. Our current approach is to use equipment from the unit in order to test the system. This approach has revealed latent weaknesses, such as lack of knowledge where the nearest airway trolley was for part of our unit which is geographically separate from the main unit. With regards to drugs we are using real drugs with the exception of controlled drugs due to the legal complexities involved with their use.

Again, using real drugs revealed latent weaknesses such as unawareness of where mannitol was stored resulting in a significant delay in administration.



Using dedicated simulation-only equipment risks not 'stressing' the system and revealing potential areas of weakness. There is also the additional risk of simulation equipment being used on actual patients. Using standard ICU equipment has obvious cost implications and the potential for patient safety issues with failure to restock following the scenario. There is a significant time commitment in preparing prior to the simulation and in returning the unit to order afterwards. Leaving the bedspace unfit for a patient admission does not facilitate engagement from colleagues and compromises patient safety.

In-situ simulation is still relatively new and therefore engagement is currently high. The challenge will be to maintain it. One way to ensure this is for staff to see the benefits it delivers. To this end we are producing a bimonthly newsletter with the first edition due out in December 2016. It will highlight what we are doing, why we are doing it and summarises the learning that has come from the scenarios in the previous two months.

References: *Patterson MD, Blike GT, Nadkarni VM. In Situ Simulation: Challenges and Results. In: Henriksen K, Battles JB, Keyes MA, et al., editors. Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 3: Performance and Tools). Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Aug. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK43682/>*

Photographs provided by the Medical Photography Department at the Royal Berkshire Hospital

Recruitment

The Faculty would like to thank those of you involved in the 2016 recruitment round. There were 15% fewer applications than in 2016 however, 90% of posts were filled and the number of ICM posts available has more than doubled since 2012. A breakdown of the 2016 data can be found below:

Total Posts Available	158
Filled	142

STAGE	NUMBER
Applied	255
After longlisting	251
Attended interview	228
Appointable	195

FUTURE TRAINING INTENTION	%
Dual ICM with Anaesthetics	65.5%
Dual ICM with Medicine	21.5%
Dual ICM with Emergency	7.5%
Remain Single	5.5%

The 2017 National Recruitment round will begin on 25th January 2017 and will, as in previous years, be run by the West Midlands Deanery. The full timeline can be found below:

- **Wednesday 25th January:** Advert released
- **Wednesday 1st February:** Applications open
- **Wednesday 22nd February:** Applications close
- **Tuesday 7th March:** Interviewers training day

Interviews will be held in Birmingham on:

- **Tuesday 21st March**
- **Wednesday 22nd March**
- **Thursday 23rd March**

If you are interested in becoming an interviewer for 2017, please contact Susan Hall, FICM Co-ordinator at shall@rcoa.ac.uk. If you are unavailable this year but are interested in 2018, please look out for requests via the Faculty communications.

Workforce

The Faculty's 2016 Consultant Workforce census closed on 1st July with a response rate of 38%; over 5% lower than the previous year. Information collected by the census is key to helping us develop our strategy to ensure there is a well-trained clinical ICM workforce able to provide a high quality service to patients whenever and wherever is required.

Following three years of detailed census questions required to give us a range of data sources, the Faculty will now move to a cycle of much shorter annual censuses with less frequent detailed censuses as required. The data will concentrate on information that is likely to change annually and/or of consistent interest to the national bodies we liaise with on workforce issues. This census should now take less than ten minutes to complete for those doing so as an individual and only slightly longer for those providing data for their overall unit.

The 2017 Census will be sent to all Fellows at the end of February. We would also like to include consultants not affiliated with the Faculty and would request that if you are aware of a colleague practicing ICM who has not received this survey to contact us at ficm@rcoa.ac.uk so that we can provide them with log in details.

We would like to thank those of you who have completed the census in previous years. The FICM Workforce Advisory Group is in the process of combining all of the data from the 2014, 2015 and 2016 censuses into a full report which will be published later this year.

The Faculty has now undertaken four Regional Workforce Engagement Meetings in Wales, the West Midlands, Scotland and Yorkshire. We will be running our next meeting in the North West in March 2017. The full report for the Wales and West Midlands meeting is now available on the FICM website. The reports for Scotland and Yorkshire are expected in early 2017. If you would like the Faculty to undertake an engagement meeting in your region or you would like further information, please do get in touch.

Regional Workforce Engagements: Scotland



Dr Brian Cook
Chair
Scottish Critical Care Delivery Group

Critical Care underpins our ability to support major elective surgery and acute services across the NHS. With this in mind, the demographic projections of demand and workforce supply can make for some anxious reading. The Centre for Workforce Intelligence (CfWI) report in 2015, predicted up to a 100% increase in demand for Anaesthetic and ICM CCT holders in England by 2033. Data from the Scottish Intensive Care Society Audit Group (SICSAG) is consistent with the experience south of the border that demand is rising as predicted: total Level 2 and Level 3 patient days have increased by 13% over the last 6 years largely driven by a 5% per annum increase in level 2. Of some immediate concern is that in the FICM UK Census 2015, 24% of consultants who responded plan to drop ICM sessions.

One of the main pressures from GPICS is a requirement to split Anaesthetic and ICM rotas at Consultant level. This may be challenging in smaller hospitals and Scotland has a number of these. Scotland may have to find alternatives due to our geographic realities and political necessities. Lack of trained ICM Consultants will inevitably deplete resources from Anaesthetic departments while demand is also increasing for Anaesthetists.

With this background, I was delighted to accept the Faculty's support to help organise the 3rd Regional Workforce Engagement meeting in Scotland. The attendance was excellent with the majority of Scottish hospitals being represented and supported by the Regional Adviser network led by Carol Murdoch and the Faculty's travelling team. This was a constructive day which set out to look at current gaps in rota and service provision, ICM workforce morale, workforce solutions and training numbers to sustain the future.

At time of writing this article, we are still in draft phase of producing a report from the day, but some clear messages are evident. Expectations of critical care delivery remain high and there are very close working and shared service relationships with Anaesthetic departments in Scotland. ICM training in Scotland is heavily dependent on Dual appointments with Anaesthetics and this is not a sustainable position. Whilst the UK average of new post to population has dropped, the ratio in Scotland has risen from 1:355k in 2015 to 1:590k in 2016. Advanced Critical Care Practitioners (ACCPs) are a successful workforce solution in Scotland but used inconsistently.

What's in it for us? This report will bring together information in one place which has never been available before in Scotland. That is a national picture of our specialty which can inform strategic decisions for the next decade. It could also be used to give clinical staff in smaller hospitals where GPICS is unachievable, planned support at a national level and help to sustain small rural units where we have no alternative.

We also learned that a workforce engagement meeting requires service clinical managers, regional educational advisers and the Faculty to all organise together. Local unit and hospital knowledge is central to success and the faculty have the standard methodology to keep this consistent.

Finally, the day reminded us that the ICM clinical community in Scotland is small but very well formed. As the NHS becomes increasingly diverse across the UK nations, we must continue collaboration toward solutions for a sustainable future aligned to the same professional standards.

Advanced Critical Care Practitioners



Ms Carole Boulanger
Co-Chair ACCP Advisory
Group



Dr Simon Gardner
Co-Chair ACCP Advisory
Group

Last year was a busy year for the ACCP Advisory Group. Dr Simon Gardner became the new Co-Chair and we welcomed two new members; Helen Singh, an ACCP working in Edinburgh and Ram Matsa, an ICM consultant working in Stoke.

At present, ACCPs must maintain their primary professional registration with either the Nursing and Midwifery Council (for those with a nursing background) or Health and Care Professionals Council (for those from physiotherapy) and complete their respective processes for revalidation. However, many of the responsibilities of the qualified ACCP lie within what might be traditionally described as a medical remit and supervision for ACCPs lies solely with their Clinical Lead and Consultants in Critical Care. This created a clear need for ACCP appraisals to reflect the clinical requirement of their role as well as address the specific requirements of their NMC or HCPC revalidation. With this in mind, the ACCP Advisory Group developed and published a comprehensive CPD and Appraisal Pathway, allowing qualified ACCPs to plan, institute, maintain and evidence their ongoing clinical, academic, and professional learning. The Pathway can be found on the FICM website.

The Faculty and National Association of Advanced Critical Care Practitioners continue to receive queries from HEIs and units wanting to set up a training programme. The Advisory Group are currently piloting an ACCP Programme Specification to help those units ensure they meet the requirements of the curriculum and ensure their ACCPs are eligible to apply for FICM Associate Membership when qualified.

Representatives from the ACCP Advisory Group (on behalf of FICM), are engaged in an ongoing process

with Health Education England (HEE), who are exploring the possibility of creating an entirely new and independent form of advanced level healthcare professional under the overarching title of Medical Associate Professionals. It is understood that this new “hybrid” specialist profession would require clearly identified training, education and governance pathways alongside a detailed professional registration system that would be overseen by an officially appointed regulator (such as the GMC).

Whilst these national developments have the potential to register and protect the ACCP role via separate regulation, they also have the potential to generate defined national level funding streams for ACCP training and revalidation. FICM Associate Membership as an ACCP will remain integral to this process, as a clearly defined quality standard of academic and clinical practice.

HEE are currently undertaking a curriculum mapping exercise to examine the academic components of the training pathways for ACCPs, Physician’s Assistants (Anaesthesia), Physician’s Associates and Surgical Care Practitioners. The aim is to initially identify any areas of commonality between the curricula. It is theoretically possible that in the future there may be scope for some combined elements of training and education for these separate clinical roles. It is important to note however, that whilst there are clear similarities there are also fundamental differences which we need to protect. For example, Non-medical Prescribing provides the role with independent practitioner status which is not the case for all practitioners. The Advisory Group are actively engaged in this process at all levels.

5th ANNUAL ACCP CONFERENCE

Friday 9th June 2017

Royal College of Anaesthetists, London

Cost: £45

Workshops will include:

- Platelets, platelet function & monitoring
- Advanced ventilation troubleshooting
- Social media as an educational tool

Lectures will include:

- Renal Replacement Therapy
- Legal & Ethical Issues
- FICE: Pros & Cons

Abstracts are invited from trained ACCPs or ACCPs in training on any of the following areas:

Clinical | Audit | Quality Improvement | Education | Research | Patient Safety

ACCPs will be given the opportunity to present their abstracts to the rest of the delegates. Further information can be found on the FICM website.

Booking and abstract information can be found at:
www.ficm.ac.uk/ficm-events/accp-conference

Please note: this programme is subject to change

Regional Advisors



Dr Daniele Bryden
Lead Regional Advisor

What defines being an appropriately skilled ICM doctor? The answer appears pretty straightforward for trainees; there is a curriculum and the annual ARCP process to define progress in training, so that an individual can be assessed as trained. Job done. Except we all know that many trainees are trying to develop skills and expertise in areas outside the curriculum which they hope will add to their future careers. That is currently the case with formalised training in echo and ultrasound which many trainees are pursuing with a considerable degree of enthusiasm, often in their free time, through the FICE and CUSIC systems.

At the September Regional Advisors' (RA) meeting we discussed whether the current curriculum and particularly the assessment system adequately reflects the stages of training and whether the time is right to formalise echo training from its current 'add on' status. Marcus Peck from the ICS provided an overview of the current numbers and location of FICE mentors nationally and RAs reviewed facilities within their individual regions. CUSIC is some considerable way behind in terms of numbers and locations at present.

Huge progress has been made nationally in terms of the number of trainers who can provide echo mentoring through FICE, but those mentors are also giving up their free time to support the growth of training. In addition there are still a small number of regions who are struggling in terms of hardware, number of trainers and locations to support the training. Putting echo training into the curriculum now would potentially overburden those trainers and break the fragile ecosystem. Interestingly, the RAs also felt it important to recognise that by putting echo into the curriculum at this stage, we're removing an important degree of choice from trainees as to how they might want to develop their

own careers. Not every trainee wishes to pursue FICE and not everyone is convinced that FICE skills are essential for an intensive care consultant (as one of the incompletely trained, I'm relieved that I'm not being put out to grass quite yet!). ICM is a broad congregation of expertise and we should recognise that some trainees and future consultants will prefer to devote time to other areas of professional development that is equally of value to patients.

The RAs' hope is that trainee enthusiasm will be converted into a greater number of new consultants who can support other trainees in the future. The time may yet come when it is right to include echo skills in the curriculum but not yet. We will relook at this in two or three years as we are keen to ensure that the small number of areas currently behind with growth, have been facilitated to improve their training provision in the interim.

The greatest concern with the existing curriculum relates to Stage 2 and the burden of assessments. Mark Carpenter is leading on collating the RA and FT view as to what needs further reconsideration when the next curriculum rewrite takes place. The GMC's review of its standards for curricula and assessments has great potential to encourage a different sort of ICM curriculum rewrite, one that could radically change the infamous '99 competencies' in Stage 1. The RAs would welcome that.

This is my last report as Lead RA. It has been an absolute pleasure to work with a fantastic group of RAs and I extend my very best wishes to my successor. My thanks to those of you who voted for me to join the FICM Board. I've got a bigger constituency of individuals who have put their trust in me now and it's time for me to step up to the plate.

Spotlight on East Midlands



Dr Som Sarkar
Regional Advisor

The East Midlands is one of the largest regions encompassing five counties with 11 ICUs delivering training. Trainees tend to 'rotate' around the central teaching Trusts in Leicester (South) or Nottingham (North). We are proud to offer high quality broad based training across a diverse population with differing health needs. The variety of hospitals include acute general hospitals admitting all comers to specialist hospitals focussing on cancer and elective care. Specific specialities available include training at the ECMO centre at Glenfield Hospital, Leicester (CESAR trial), Echocardiography at Derby, Neurosciences and the largest Major Trauma Centre based at QMC, Nottingham as well as active research programmes at both Universities of Nottingham and Leicester.

All of our trainees have thus far chosen to train in dual programmes. Whilst the majority are partnered in Anaesthesia, a recent local survey showed an increasing number of Medical and Emergency Medical trainees, wishing to train in ICM. We also have academic ICM trainees based in the Universities of Leicester and Nottingham.

Stage 1 is delivered in most of the hospitals in the region, primarily in the peripheral hospitals. Stage 2 is delivered in the teaching bases Cardiac/ECMO (Glenfield, Leicester), Neuroscience (QMC, Nottingham), Paediatrics (Leicester or Nottingham). For single CCT ICM trainees, the Special Skills Year may be taken in a range of disciplines including Research, Trauma, Neurocritical care, Cardiothoracic/ECMO or Prehospital care. Dual CCT programmes are adapted to deliver individual trainee requirements which currently include Medicine (Acute, Renal, Respiratory), Emergency Medicine and Anaesthesia.

Currently, Stage 3 is delivered in primarily in Leicester, Nottingham and Derby. However, we will be including more peripheral hospitals over the coming years to accommodate the growing number of trainees. Placements in both teaching and peripheral hospitals are flexible to ensure breadth of senior pre-Consultant experience, with an increasing focus on management and service/quality improvement training.

There is an established regional teaching programme, which offers support for the FFICM examination as well as excellent preparation for life as an ICM consultant. In addition, individual ICUs deliver in house teaching. The region is supported by focused and progressive Faculty Tutors in each ICU. With all of the ICUs accredited for Stage 1 training there is flexibility for trainees joining us. We have an active STC which incorporates significant Trainee representation across the region, to shape and evolve our programme.

Living and working in the East Midlands combines the best of the outdoors with city life. Whether you enjoy sports live performing arts or rural outdoor pursuit, there is something for everyone. The cost of living is more favourable than other parts of England, whilst being well connected by rail, road and air. The East Midlands featured twice in the top ten areas to live in the last Halifax Quality of Life Survey from 2015.

With the projected workforce shortages over the next 10 years, we are expanding our training entrants to nine in 2017 with a view to increasing this in due course. Job prospects are good given the variety and number of hospitals, leading to a demand for more Consultant delivered and directed Critical Care. If you are interested in training with us, feel free to visit and get in touch with either myself or my TPD colleague, Dr Alex Keeshan at Leicester.

A Trainee's Guide to Approaching the Final FFICM



Dr Fiona Wallace
ICM Trainee

The new single specialty training programme in 2012 was a hugely important milestone in the development of our specialty. While it is clearly right that the new curriculum is accompanied by a rigorous exam, to test standards of which we can all be proud, this does mean an additional hurdle for ICM trainees to clear. I will share some tips that I hope will be useful to those still to sit the exam. Before I start, I must make clear that the following advice is my personal opinion and aimed firmly at passing the exam. It is not about becoming an excellent ICM doctor, although I would like to think there is some overlap.

I prepared for the multiple choice and single best answer paper by practicing lots and lots of MCQs and SBAs. FFICM MCQ and SBA books are increasingly available. Personally I recommend 'Intensive Care MCQs' by Benington et al. and 'Critical Care MCQs' by Lobaz et al. I also subscribed to Crit-IQ, an Australian website with lots of questions, data interpretation and other helpful exam preparation resources. There is 20% discount available for ICS members. 'Data interpretation in critical care medicine' by Venkatesh et al. is slightly terrifying but very useful for both the written paper and the OSCE.

If you have passed the written component, you have almost all the knowledge needed to pass the OSCE and SOE. Being good at vivas is a skill, which can, and for most people must, be learnt. Practice speaking out loud, explaining concepts and responding to questions, under pressure, while smiling and trying your best to charm your examiners. Spending your study time reading Oh's Intensive Care Manual cover to cover is, in my opinion, avoidance behaviour. I would strongly advise starting early, rather than leaving it until you feel your knowledge is 'up to scratch'. I practiced regularly with two friends who

were sitting the same exam as me, a more senior trainee who had recently passed the exam and lots of obliging consultants. I also attended to the North West and Oxford FFICM courses, both of which were excellent and provided practice under pressure in a more formal setting.

The exam is intended to be passed by someone achieving the standard of a doctor in training who is familiar with the syllabus and has done the necessary bookwork. However, I would suggest being strategic rather than relying solely on the syllabus to guide you. The Chairman's reports and lists of previously asked topics are freely available and essential reading.

The OSCE focuses on data interpretation. It appears that ICM trainees struggle with chest radiograph and ECG interpretation; there is therefore an emphasis on these key skills. I found 'Radiology for anaesthesia and intensive care' by Hopkins et al. very helpful and dusted off my copy of 'The ECG made easy'. Steve Mathieu's 'Hot topics in ICM' presentation, which is available on the Pincer course website, summarises important trials and guidelines. Do not attempt to read every ICM-related study, read this.

I would highly recommend taking some time off before each component of the exam: minimise your work related stress and get to London in good time. Speak to your educational supervisor and rotamaster early.

The day itself passes very quickly. Try and appear calm, smile, and keep moving forward. Do not let one bad station put you off. Overall I felt it was a very fair exam; the range of topics were appropriately broad and there were no esoteric questions or 'difficult examiners'. Good luck!



2017 FICM ANNUAL MEETING

Hard Cases or Bad Laws?

Wednesday 24th May 2017

Royal College of Anaesthetists, London

Registration fee: £170 (£90 for trainees and nurses)

Join us for the Faculty's 5th Annual Meeting, this year centred on the theme of legal and ethical issues within Intensive Care Medicine. The event promises to be a day of lively debate on contentious areas of ICM practice. Lectures will include:

- There is nothing left to discuss: A Coroner's view on whether ICM has fixed all of its ethical and legal problems
- When lawyers become involved in ICU care
- Did the theory reflect the practice? Caring for a patient when the court of protection is involved
- Supervision: Who is responsible?
- Donation practices can be unethical
- Can ICU care be uneconomic?
- Can ICU care be futile?
- Can we justify using ICU care to manage the end of life?
- Panel discussion: how not to get sued!

Register online at: www.ficm.ac.uk/ficm-events/ficm-annual-meeting



The Faculty of
Intensive Care Medicine

Choosing Wisely



Dr John Butler
FICM Board Member

Choosing Wisely started as a clinician-led initiative in the USA and is now being taken up in a number of countries across the world. The aim is to promote conversations between doctors and patients by helping patients to choose care that is supported by evidence, free from harm and truly necessary. The campaign is part of a global initiative to reduce over-medicalisation. The question of inappropriate clinical interventions has been an issue for some time with a range of organisations raising concerns (www.bmj.com/too-much-medicine). The Choosing Wisely Campaign also believes that there is evidence of a considerable volume of inappropriate clinical interventions resulting in sub-optimal care for patients. By working alongside similar initiatives, it encourages both doctors and patients to discuss the value of treatments and to raise awareness of treatments, tests and procedures whose value should be questioned. In the USA, there are now over 450 recommendations for procedures or treatments.

Early in 2014, the Royal College of Physicians London, who had been approached by the USA/Canadian Choosing Wisely Campaigns, suggested the Academy of Medical Royal Colleges should take forward discussions as this is a cross-specialty issue. In June 2014, the Academy was represented at a conference bringing together clinicians from a wide variety of countries with an interest in Choosing Wisely initiatives. The campaign gained real traction amongst a wide range of stakeholders including NHS England, NICE and the Department of Health. The Welsh government also launched its 'Prudent Healthcare Initiative' which aligned closely with Choosing Wisely. NHS England confirmed its support for the Academy taking the lead role in taking this forward on a partnership basis. With guidance and support from the Academy national organisations representing

medical specialists were asked to identify tests or procedures commonly used in clinical practice, whose necessity should be questioned and discussed. There was general agreement that if this initiative was to gain real momentum then it had to be recognised as being led by clinicians and patient groups themselves rather than the health system or Government.

Colleges and Faculties were asked to produce a list of the top five recommendations for their specialty with input from patient groups. It was explicit that the chosen recommendations should be relevant to the specialty, have an impact on the NHS, be evidence based, actively involve patients and be measurable and implementable. All recommendations were reviewed by the Choosing Wisely Steering group to make sure they followed the set principles and process before being adopted as Choosing Wisely Recommendations. The programme steering group, Chaired by Professor Dame Sue Bailey (Chair of the Academy), comprised of representatives from the Colleges, Faculties, patient groups, the Coalition for Collaborative Care, NHS England, NICE, NHS Confederation, a representative from Wales, and the BMJ.

The Academy launched the campaign in October 2016 with a list of 40 treatments and procedures drawn up by experts from eleven UK medical specialities as well as patient groups and NICE. At the heart of the campaign is a call to both doctors and patients to have a fully informed conversation about the risks and benefits of treatments and procedures. The current UK list of recommendations is likely to be added to annually. Further information including the recommendations from FICM and ICS can be found at www.choosingwisely.co.uk.

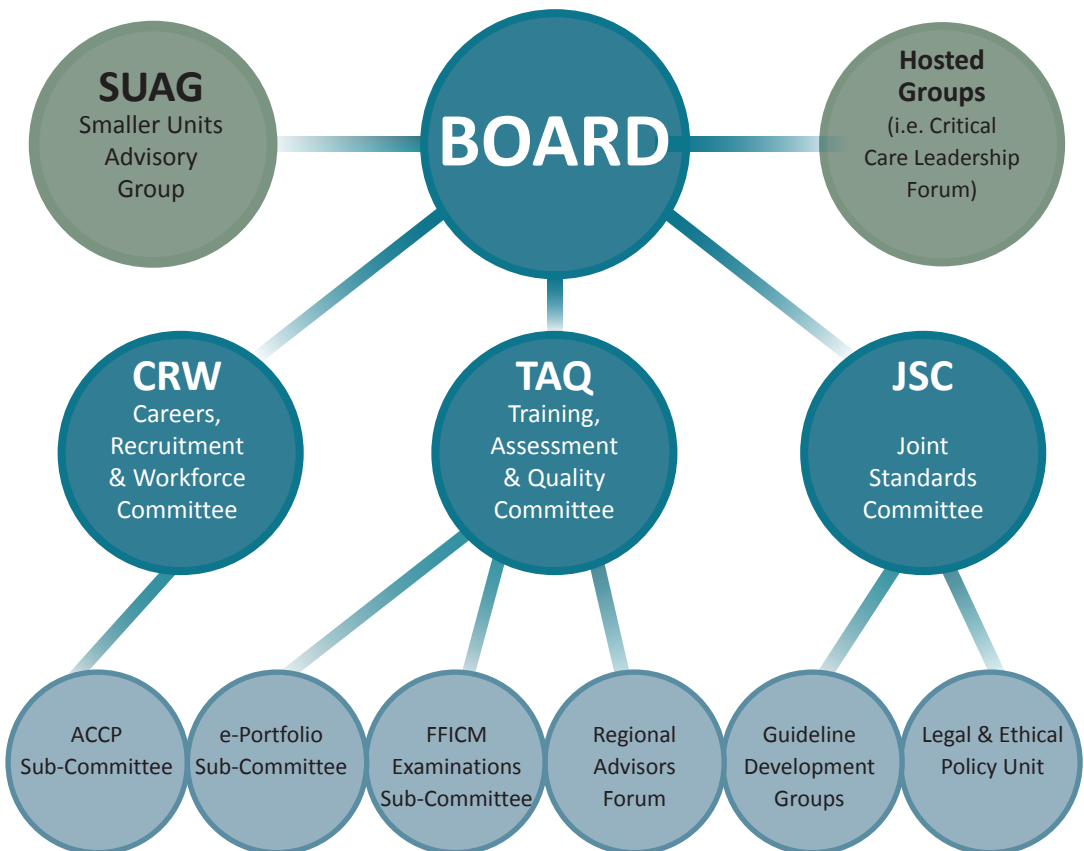
Faculty Restructure



Mr Daniel Waeland
Head of the FICM

The swearing in of a new Dean and Vice Dean brings with it a reshuffle of Board member roles and responsibilities. This has allowed us to undergo a small restructure of our committees and groups to be better prepared for the next three years of the Faculty work plan.

The new structure will see three standing committees reporting to the Faculty Board, each with their own sub-committee structure. Please see below for an organogram of the new structure. Visit the FICM website here www.ficm.ac.uk/committees-faculty for a full breakdown of the membership and responsibilities of each group.



FICM and NIHR Clinical Research Award

Manon Dark
Student Journalist
City, University of London

Winners of the first joint FICM/NIHR Clinical Research Network (CRN) awards received their honours in December 2016, demonstrating outstanding leadership and excellence in research delivery from NHS consultants and trainees in Intensive Care Medicine.

Dr Stephen Wright, at Newcastle University's Freeman Hospital, won the consultant award. Dr James Plumb, ST6 at University Hospital Southampton NHS Foundation Trust, won the trainee's prize.

Daniel Waeland, Head of the FICM said: "The high standard of critical care services is made possible by the quality research conducted in the field by, among others, our consultant and trainee doctors. The Faculty of Intensive Care Medicine is delighted to work with the NIHR to fund these two research awards to help recognise such achievements."

The awards were presented during the Intensive Care Society State of the Art Meeting. Applicants included trainees, junior consultants and established colleagues practicing NHS Intensive Care Medicine throughout the UK. Joanne Ashcroft, NIHR Assistant Specialty Cluster Lead and member of the judging panel said: "The applications we received for these inaugural awards were inspiring to read. They clearly demonstrate the dedication of the Critical Care research workforce. The strong leadership the applicants displayed is vital in helping the specialty to deliver complex studies for patient benefit."

Professor Stephen Smye, NIHR Clinical Research Network Specialty Cluster Lead and awards panel member said the applicants "described some really outstanding examples of excellent clinical research leadership, with impact extending beyond critical care to the wider clinical research community and NHS. Effective clinical research leadership is central to the next 10 years of NIHR as it continues to embed research in the NHS for the benefit of patients."

Established in April 2006, the National Institute of Health Research (NIHR) is a UK government body funded by the Department of Health to produce research programmes that benefit NHS patients in England. The NIHR function under the slogan "improving the health and wealth of the nation through research", by supporting individuals, facilities and research projects.

Professor Paul Dark, NIHR CRN National Specialty Lead for Critical Care and Chair of the Judging Panel said: "Following the great success of these inaugural prizes, we look forward to developing the awards scheme further in partnership with the FICM and encourage NHS colleagues to consider applying in 2017."

Details of the 2017 FICM and NIHR Clinical Research Awards application window will be published later this year.

Look out for announcements on the FICM and NIHR websites:

www.ficm.ac.uk/news-events-education/news/ficmnihr-research-awards

<http://bit.ly/RCoA-FCIMawards>


**National Institute for
Health Research**

CORE TOPICS SEMINARS 2017



5 Core Topics seminars relevant to intensivists as well as trainees



An opportunity to update your knowledge on a wide range of core topics.

1st Mar	Sepsis/Infection
20th Apr	Gastrointestinal Issues/Ethics
16th Jun	Liver/Obstetrics
5th Oct	Renal/Cardiology
1st Nov	Trauma

For more information on seminars or membership please get in touch

web: www.ics.ac.uk
email: info@ics.ac.uk

Edinburgh Radiology Course for ICM

Thursday 23rd & Friday 24th February 2017

Edinburgh Training and Conference Centre, St Mary's Street, Edinburgh

Course fee: £400



Topics Include:

- Basic Principles of Radiology
- Indications & Limitations of Different Imaging Modalities
- Interpretation of CXR & AXR including tubes & lines, CT Chest & Abdomen/ Pelvis including venous & arterial phase and angiography
- CT Head & C-Spine including Neuro-Interventional Radiology, Pan CT Trauma including common injuries & fractures.

REGISTER YOUR PLACE NOW!

For more information and to register online please visit:

www.epay.ed.ac.uk/conferences-events/college-of-medicine-and-veterinary-medicine/school-of-clinical-sciences/division-of-clinical-and-surgical-sciences/edinburgh-radiology-course-for-icm

OR

Contact Dawn Campbell: **Email:** dawn.campbell@ed.ac.uk **Tel:** 0131 242 6395



This meeting has been approved for
10 CPD credits by the Royal College
of Anaesthetists





The Faculty of
Intensive Care Medicine

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