



Critical Eye

Issue 3

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The Faculty of
Intensive Care Medicine

Welcome



Dr Graham Nimmo
Clinical Co-Editor

Welcome to the first edition of *Critical Eye* this year. You will find news and updates on all of our usual topics including the Faculty Board, trainee involvement, exams, recruitment and many others.

As you read through these I think that you will pick up the recurring theme that we are about people. The Dean concludes his comments with the statement that we 'focus remorselessly on improving the care we offer our patients and families' and the Vice Dean reports that two of the main themes for the Faculty Board from its first Away Day were 'improving care' and 'providing leadership'.

As we look forward to 2013 these principles provide us with encouragement and direction for a great year. Please contact us with any ideas and suggestions you may have for future editions of *Critical Eye*.



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Dean's Statement



Professor Julian Bion
Dean

We are now entering our third year as a primary specialty, providing an opportunity for a retrospective followed by a detailed look at the challenges and opportunities which lie ahead.

In January 2012 we held our first Faculty Day with an impressive line-up of speakers, and awarded three Fellowships by Election to Judith Hulf, Iain Ledingham and Sheila Willatts, individuals who have made profound contributions to Intensive Care Medicine through scientific research, professional development and education. In April we welcomed our first set of 52 trainees to the new ICM training programme at a highly effective two day recruitment round led by Tom Gallacher and Alison Pittard with our Regional Advisors and the West Midlands Deanery.

The FICM Training and Assessment Committee led by Simon Baudouin and the competency group by Anna Batchelor have ensured that the new programme is harmonised with our partner specialities in preparation for those trainees choosing Dual programmes of training. Academic training is a key area of interest; David Menon has produced a draft position paper with our other academic partners and which will be developed for presentation to the NIHR.

Nigel Webster and Andy Cohen now have the new FFICM examination in place, and we have appointed eight additional examiners from a very strong field of 38 – thereby regrettably disappointing 30 excellent colleagues, but as a profession something to be proud of at a time when many Colleges struggle to attract sufficient applicants.

Louie Plenderleith's group has chosen National Education for Scotland (NES) as the provider for our e-portfolio, and they have started work on the framework, content and functionalities. Guidance for revalidation in ICM is now in place thanks to the work and expertise of Tim Evans. The new COPMed Lead Postgraduate Dean for ICM is Michael Bannon, who brings with him expertise in academic training as well.

In the summer we welcomed to the Board our first members to be elected by the Fellowship, now numbering 1700. We held our first national workforce planning meeting in the autumn, and will be producing a preliminary report shortly. As part of workforce planning, a key ambition of the Faculty is to foster the development of Advanced Critical Care Practitioners by completing the development of a new curriculum for ACCPs (work led by Anna Batchelor and Graham Nimmo) and including ACCPs in the Faculty membership.

In addition to this work we have responded to 32 consultations, undertaken three invited external service reviews, and have substantially contributed to formulating the response to the CVVH supplies crisis during the late summer and the recent (and continuing)

winter crisis in paediatric ICU beds. The Faculty is represented on several important national initiatives, including the Royal College of Physicians' Future Hospital Commission and the Academy of Medical Royal Colleges' Standards for Consultant-Present Care.

We have bidden farewell to Peter Nightingale as chair of the Trustee Colleges, and have welcomed J-P van Besouw in his place, both of them highly effective advocates for our discipline. Throughout

the year we have benefitted from the outstanding administrative support and professionalism both of our own Faculty 'civil service' (Daniel, James, Anna, Andrea and Lorna) and of the Royal College of Anaesthetists as the governance college, and from the generosity of the RCoA and the RCP in supporting our activities.

Current preoccupations have focused on the place of ICM and of the Faculty in the reconfigured NHS. With the Intensive Care Society, our Joint Professional Standards Committee co-chaired by Carl Waldmann and Simon Baudouin has developed a preliminary set of national standards for Intensive Care Medicine. They are also considering how best to implement moderated reciprocal peer review as an instrument for quality improvement of training and service. These initiatives

“ What is the future for ICM at this time of organisational upheaval simultaneously in the Health Service and in health education combined with a national funding crisis? Fundamental as ICM is, we cannot be complacent ”

have provided important material for a Faculty-ICS working group chaired by Jane Eddleston and Bob Winter to develop guidance and performance standards for local commissioning of intensive care services, to help inform the work of Clinical Commissioning Groups, the coordination of care by Operational Delivery Networks, and whole-system integration by Strategic Clinical Networks. In a linked development, the Commissioning Board will be making appointments in January to national clinical director posts, one of which is for 'Emergency Preparedness and Intensive Care Medicine': the FICM is represented in this process.

An important new development is the agreement we have reached with the Health Protection Agency to host a voluntary national surveillance and quality improvement programme for healthcare-acquired infections in adult, paediatric and neonatal intensive care, building on the work of the Matching Michigan collaboration. With the approval of the Department of Health, we have established a collaboration of professional organisations in intensive care, healthcare epidemiology, microbiology and infection prevention and control under the governance of the Health Protection Agency (HPA) and an oversight Board chaired by Professor Peter Wilson (UCL). We have called this collaboration the Infection in Critical Care Quality Improvement Programme (ICCQIP), and have launched the initiative with a short survey. Once the data collection tools have been developed, ICUs will be invited to participate, benchmarked reports will be provided to contributing ICUs, and aggregated data will be owned by the collaboration and available to our various constituencies.

What is the future for ICM at this time of organisational upheaval simultaneously in the Health Service and in health education combined with a national funding crisis? Fundamental as ICM is to the modern hospital, we cannot be complacent. We lack the

visibility of surgery, the volume of a medical specialty, the public profile of oncology, or the income of a primary contracting specialty. The Faculty Board therefore undertook an ICM-SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) early in the last year. Several themes emerged, all considerably easier to state than to implement. First, we must be proactive, not reactive. Second, quality care requires integration across the domains of research, clinical practice, education and the social sciences. Third, professional confidence requires a united voice across the various organisations involved in intensive care. From these perceptions it was a short step to the realisation that we needed to develop a national strategy for intensive care – building on the achievements of Comprehensive Critical Care in 2000 and the subsequent work of the Critical Care Stakeholder Forum. This strategic initiative has been named 'Collaborating for Quality'.

Collaborating for Quality has started with an independent process led by three Commissioners: Professor Sir John Temple (Chair), Dr Judith Hulf, and Professor Jon Cohen. We are very fortunate to have persuaded individuals of such standing to help the intensive care community in this way. They have taken evidence from the diverse organisations and groups involved in both adult and paediatric ICM to characterise their various remits, goals, ambitions, and challenges, with the intent of identifying opportunities for enhanced collaboration. We understand that the Commissioners' report will appear in the spring, and we expect and hope that it will challenge us all to develop a new national model for ICM for the future. We hope that as this work develops it will be supported by all our fellows and members. Whatever form this model takes, it must in the end engage all disciplines working in intensive care, create a confident and empowered workforce, and focus remorselessly on improving the care we offer to our patients and their families.



New FFICM Examiners being sworn in at the October 2012 Board meeting. *Left to Right:* Dr Simon Baudouin (Board member and FICMTAC Chair), Dr Carol Macmillan, Dr Shameer Gopal, Dr Ian Davies, Prof Julian Bion (Dean), Dr Jerome Cockings, Dr Mike Clapham, Dr Mark Carpenter, Dr Banwari Agarwal, Prof Timothy Evans (Vice Dean). *Photo credit:* Anna Ripley

FICM Board (not so far) Away Day



Professor Timothy Evans
Vice Dean

On 7th December 2012, members of the Faculty Board assembled at Goodenough College, which is almost a kilometre away from their usual meeting place at the Royal College of Anaesthetists (RCoA), with the aim of addressing issues thought to be of particular concern to the Fellowship and Membership of the Faculty. They were joined by Prof John Myburgh, current President of the Australian College of Intensive Care Medicine, and Dr J-P van Besouw, President of the RCoA; as well as Mr Kevin Storey (CEO, RCoA), Mr Keith Young (Lay Representative, FICMPSC), Ms Sharon Drake (RCoA Education Director), Mr Daniel Waeland (Head of the Faculty) and Mr James Goodwin (Faculty Supervisor).

The ice was broken during a session entitled 'The Functioning Board' during which members sought to identify what they saw as the primary function(s) of the Faculty. These were agreed as improving care, providing leadership and national advocacy, and overseeing the organisational governance of the Faculty.

There was a perceived need to define the remit of the Board and to separate core activities (such as the management of ICM training) from additional work streams; and to challenge and manage material emerging from sub-committees. Further engagement of Fellows and Members in FICM work was seen to be a priority, to be achieved in part via improved systems of regular communication.

Issues relating to the workforce and career pathways were debated. It was agreed that more data is required to inform workforce planning, and that the commissioning perspective (provided via the new national Clinical Reference Groups) would be vital in informing this. Gaining information from overseas (e.g. Australia and New Zealand which have reached saturation for consultants and now have trainee unemployment) would be useful, as would an assessment of the role of Advanced Critical Care Practitioners (ACCPs). Feminisation of the workforce will likely be a key issue in future years.

A presentation on recruitment and training led to a discussion concerning the redefinition of traditional 'models' of education following the introduction of a single, 'standalone' CCT in ICM. It was felt that in the short to

medium term, the distinction between single and dual CCT holders was of less significance than establishing the principle that doctors should be trained and fully committed to ICM duties when rostered to do so. The changing face of the NHS is likely to influence training needs, as networked 'hub-and-spoke' hospitals work together and the concept of an acute care 'continuum' is developed.

Academic Intensive Care Medicine is seen to be a crucial area for the Faculty to support and develop, external agencies being more likely to accommodate and recognise the needs of specialties backed by a solid evidence base. Raising awareness and developing a research strategy are seen to be key drivers, whilst ensuring core competencies are acquired by all ICM trainees. The Board feels strongly that effective research will drive quality improvement.

The history of the 'Collaborating for Quality' initiative was presented. Led by Professor Sir John Temple, Dr Judith Hulf and

Professor Jonathan Cohen, the commission will submit a final report in February-March 2013 having taken evidence from 11 professional UK bodies involved in ICM.

A presentation was given on national and international engagement and led to an explanation of the new systems of commissioning. Clinical Reference Groups (CRGs) will be responsible for commissioning and the Faculty Board should provide leadership on the 'products' our specialty provides, such that standards which the Faculty/ICS joint Professional Standards Committee delivers can be employed for commissioning purposes. CRGs view critical care as high risk and high cost, rendering the interpretive role of Operational Delivery Networks (formerly CCNs) vital in bringing a common standard to purchasers and providers.

Those present were enthused by what they had discussed, recognising that a great deal of work needs to be done to develop the specialty, its practitioners and the Board itself. 2013 will bring further challenges amongst which more NHS reorganisation, the Francis Report and the Shape of Training Review loom large. If nothing else, they provide ample material for next year's Away Day. These and other issues will be discussed at the Faculty Day on 1st March. Make sure you are there to contribute.

“Academic Intensive Care Medicine is seen to be a crucial area for the Faculty to support and develop”

Professional Standards



Dr Carl Waldmann
FICMPSC Chair



Dr Chris Danbury
ICSSQ Deputy Chair

The standards committees of the Faculty and of the Intensive Care Society (ICS) have now met jointly for the third time; this has proven to be a very successful collaboration. It is alternately Chaired by Dr Waldmann (on behalf of the Faculty) and Dr Danbury (on behalf of the ICS). The following are issues that have been addressed by the joint committee:

National Minimum Standards for Critical Care: The FICM and ICS have jointly commissioned this document as an update of the ICS 1997 Standards for Intensive Care. The writing group is chaired jointly by Dr Tim Gould for FICM and Dr Chris Danbury for the ICS. We hope the document will be ready for publication later this year. It is intended as a reference point for the commissioning and monitoring of critical care services.

Revalidation: Prof Tim Evans has updated the FICM guidance on revalidation to comply with current national requirements. Prof Evans represents the ICM community on the joint RCoA/FICM/FPM Revalidation Committee.

Diagnosis of Brain Stem Death: Dr Dale Gardiner has presented two very useful forms on the documentation of brain stem death. The longer form may be useful in teaching around this subject. He has written a helpful editorial in *JICS* on the need for two sets of tests to confirm the diagnosis of brain stem death.

Lack of Paediatric Intensive Care Beds: A recent outbreak of RSV has resulted in concerns at the lack of PICU beds. Negotiations between FICM/ICS/PICS resulted in a consensus statement to cope with the shortfall in PICU beds. It is suggested that adult ICUs help with older children with advice and support from their colleagues in PICU.

Resuscitation Standards: Prof Gavin Perkins reported that he had contributed to the Resuscitation Council (UK) Council on behalf of the Faculty. As a result, FICM and the ICS have endorsed the document.

Advanced haemodynamic monitoring: The RCoA Professional Standards Committee have asked for advice concerning procurement and use of Cardio-Q devices for the use in enhanced recovery.

Critical Incident Reporting: Dr Tony Thomas has done a great deal of in-depth work locally in the North West on critical incident reporting. He would like to roll this out nationally, and the FICM and the ICS fully support this intention. Sources of funding are being explored.

Podcasts in Critical Care: Dr Segun Olusanya and Dr James Day have presented the use of podcasts in Intensive Care Medicine. They have received full support by the committee and are releasing their first podcast for the January edition of *JICS*.

Revalidation moves from development to implementation

Professor Timothy Evans, Vice Dean

In July 2012 the General Medical Council (GMC) wrote to all Responsible Officers (ROs) enclosing a list of doctors for whom they felt the RO was responsible in terms of managing revalidation. These were speculative in nature, encompassing clinicians of all grades whom the Council felt might name the relevant organisation as the Designated Body (DB) through which they would revalidate. Consequently, ROs were permitted eight days to accept or reject those identified. The group of medical staff (consultants and other grades excepting Deanery trainees) accepted by a given DB should by now have been allocated by their RO revalidation dates between April 2013 and March 2016.

In so doing, DBs are restricted as to the numbers of staff that can be put forward in any single year (20%, 40%, 40% for 2013-14, 2014-15, 2015-16 respectively). Whilst staff would obviously need to demonstrate compliance with the GMC-specified minima, DBs are also mandated to ensure an even 'spread' of consultants and other grades are proposed for each year; and that these vary by specialty and seniority. Some authorities have suggested that medical managers and others with administrative responsibility; especially those overseeing the appraisal process, should be put forward early on. However, the first group of doctors to be revalidated are ROs, who in London at least must complete the process by December 2012. The Faculty will provide (with the Royal College of Anaesthetists and Faculty of Pain Medicine) a helpline accessible to Trusts and to Fellows who are, for whatever reason, having difficulty navigating the revalidation maze.



Mr Don Liu and Mr Chris Kennedy
RCoA Revalidation and CPD team

A helpdesk has been jointly set up by the RCoA and Faculties of Intensive Care Medicine and Pain Medicine to provide advice on revalidation. The helpdesk is intended for Fellows and Members as well as their appraisers and responsible officers.

We already receive a number of revalidation-related enquiries which can be categorised into the following areas:

- The revalidation process
- Return to work, doctors working overseas, independent practice, locum work
- Issues arising from appraisal
- Appraisal process, scope of practice
- Continuing professional development (CPD)
- The CPD Matrix, CPD credits, personal development plans
- Review of clinical practice
- Clinical audit, outcome data, case reviews and significant events
- Feedback on clinical practice
- Colleague, patient and teaching feedback, complaints and compliments
- Performance concerns
- Performance issues, probity, health, remediation

Enquiries relating to the generic processes underpinning revalidation are usually dealt with by the helpdesk staff, making reference to appropriate General Medical Council and departments of health guidance and regulations when responding to these enquiries.

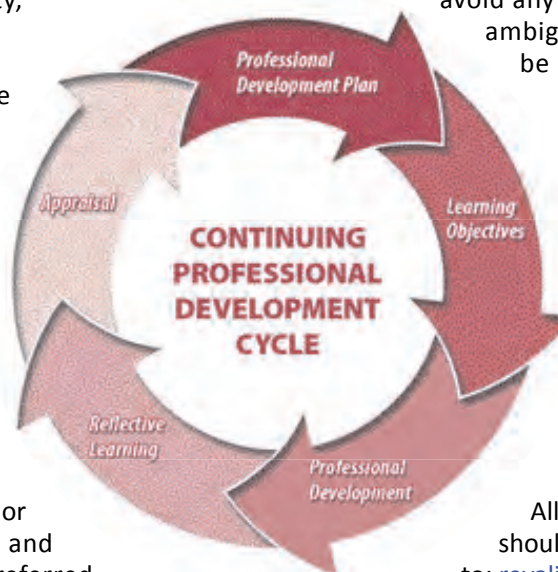
Revalidation Specialty Advisors

Those questions regarding or seeking clarification on clinical and specialty standards will be referred to a team of senior clinicians appointed as Revalidation Specialty Advisors for the RCoA and Faculties. The team represents a wide range of clinical expertise and has undergone training to provide informed and impartial advice.

No doubt the expertise of the Specialty Advisors will be called upon in providing informed advice on problematic issues which could arise from appraisal and revalidation processes, including concerns about a doctor's performance, professional practice or clinical skills. In these cases the College and Faculties will be a valuable source of information in helping appraisers and responsible officers, particularly those not practising in anaesthesia, intensive care or pain medicine, to fully consider these concerns.

It is worth remembering that the College and Faculties cannot become directly involved in the decision-making process regarding a revalidation recommendation (i.e. instructing a responsible officer to recommend or not recommend a doctor for revalidation). However we can provide advice and inform the responsible officer or appraiser on the explicit, specialty standards expected in a given situation or set of circumstances.

Enquiries of this nature will be anonymised by the helpdesk staff before being forwarded to the Specialty Advisors for their input in formulating a College and Faculties' response. To help avoid any possible misunderstanding or ambiguities, all correspondence must be in writing (by email).



Contacting the helpdesk

Before contacting the helpdesk you should first check the frequently asked questions (FAQs) and answers in the revalidation section of the RCoA website – www.rcoa.ac.uk/revalidation. The FAQs are regularly updated and you may find the answer or advice you are looking for.

All enquiries to the helpdesk should be made by email and sent to: revalidation@rcoa.ac.uk. If you do telephone (020 7092 1699), staff on the helpdesk may be able to help you document your enquiry in an email but it is your responsibility to check its accuracy should it need to be referred to our team of Specialty Advisors.

Training and Assessment



Dr Simon Baudouin
Chair

Trainees in Intensive Care Medicine require access to a broad range of research training opportunities, ranging from core research training for all trainees, through a Masters level qualification for individuals who aim to have research as a part of their NHS job plan, to a formal research degree (typically a PhD) for those who aspire to be clinical academics or research-committed NHS clinicians. These tiers of research training have different organisational needs which are the responsibilities of Deaneries, Tutors, and Academic Departments allied to ICM. The FICM is in the process of preparing a document that outlines the training structures which will address these aims.

Core research training

Core academic training should provide competencies that equip a prospective ICM consultant with the research skills required to undertake a typical NHS job. At a recent meeting organised by the FICM in London (December 2011), a consensus emerged that such training would include elements of critical appraisal, basic research skills (electronic literature search, basic presentational skills, the basics of biomedical statistics, and an introduction to writing and publishing research articles).

Individuals would also need to acquire basic knowledge of research regulation and ethics, and it was agreed that a brief (online or taught) Good Clinical Practice (GCP) course and knowledge of research funding opportunities, particularly from the National Institute for Health Research, was highly desirable. These competencies could be easily delivered in a one to three day course, already available from a range of academic providers (e.g. the Cambridge SMART Course <http://www.medschl.cam.ac.uk/anaesthetics/smart-course>).

The FICM would set the standards for such courses, with individual providers then applying to the Faculty for approval of courses. It is possible that the Intensive Care Society might provide one national source of such courses, and this option is being explored in discussions. In addition to achieving these core research competencies, it was felt that trainees should have some knowledge of the pathways for formal research training, and the FICM recommends that there should be a pool of academic advisors developed across the country. In many Postgraduate Deaneries, local academic departments could provide such advice and

mentorship, but it was not intended that these advisors be region-specific; the aim would be to ensure a good spread in both geography and specialism.

Special Skills Modules and Masters in Research

Methods

It is important to recognise that some trainees may wish to access research training that goes beyond core competencies, but not wish to formally pursue a career as a clinical academic. One structure in which such enhanced training may be provided is a modular Masters course for critical/emergency care research, which could constitute a Special Skills Module in Research. It is highly desirable that the FICM provides coordination and leadership for such a programme, which could develop through collaboration between several Universities.

Pathways for formal Clinical Academic training

Pathways for formal research training should map closely to clinical training, allowing seamless integration of the two streams of training. This arrangement will not only allow easier entry to research training, but also allow trainees to re-enter the conventional clinical training structure once their academic aspirations are satisfied. The NIHR in England and Wales recognises several stages of academic training:

- **Academic Foundation Year (AFY)** rotations include a four month period of academic attachment, and provide trainees with exposure to both ICM and research. Centres should develop such rotations as a means of attracting the best and brightest trainees to our discipline.
- **Academic Clinical Fellowship (ACF)** rotations can be established either at ST1-3 (incorporating ACCS training) or ST 4-6. These rotations provide 25% of research time, and aim to allow trainees to develop a high quality application for a research training fellowship application.
- **Clinical Research Training Fellowships (CRTF)** obtained from a national funding body (NIHR, MRC, Wellcome Trust, NIAA) are a common route to achieving a higher degree, but other options, such as research training in the context of a high quality Randomised Controlled Trial, are equally valid.

- **Academic Clinical Lectureship (ACL)**; also referred to as **Clinical Lectureships (CL)** provide 50% of research time, and are targeted at post-doctoral clinical researchers at a late stage of training. These posts are meant to provide a period of consolidation of research training and facilitate preparation of an Intermediate Fellowship/Clinician Scientist application.
- **Intermediate Fellowships (IF)**; subsequent routes to an established post as a clinical academic at Consultant level classically involve obtaining an Intermediate Fellowship/Clinician Scientist grant. However, additional routes for research funding are now available, and it is important that aspiring clinical academics are made aware of these.

While this hierarchy of research training provides a useful framework to plan an academic career, it is important to recognise that these arrangements are not in place in the devolved administrations, where other arrangements for research training may exist. In any case it is essential to embrace a plurality of research training arrangements providing the quality of such training is good.

Training time and Completion of Specialist Training

Over the entire training period, up to one year of full time research can count in full towards accreditation in ICM, but the decision about time counted is an individual

one, made in conjunction by trainers and trainees. Such decisions must be viewed as part of the overall package of training for any individual, and will depend on whether the aim is to achieve single accreditation in ICM, or dual accreditation in a partner specialty (which may involve a crowded training schedule with less flexibility). However, Deaneries should be flexible about counting clinical time for individuals who spend time in posts that have a mix of research and clinical training. In such instances, requirements for clinical training should take account of the performance of trainees and achievement of key competencies and experience, rather than be solely based on time spent in clinical training.

The purpose of ACL posts is to provide 50% time for research training. Achievement of key competencies and experience may permit completion of research training within the remaining 50% of the post, but where this is not possible, Deaneries have a responsibility to ensure that individuals are fully trained clinically. Trainees who achieve Dual CCTs in ICM and a second clinical specialty should recognise that maintenance of clinical skills in two parent clinical specialties, while continuing a credible research career, represents a substantial burden. While this is not impossible, careful thought should be given by trainers and trainees as to whether they feel that a continued career as a clinical academic is compatible with satisfying the needs of revalidation in two clinical specialties.

Faculty Events Calendar 2013

March			
	1	EVENT:	FICM Annual Meeting
	15	MEETING:	FICM Training and Assessment Committee
May			
	20	MEETING:	FICM/ICS Professional Standards Committee
	23	MEETING:	FICM Board Meeting
June			
	21	MEETING:	FICM Training and Assessment Committee
July			
	18	MEETING:	FICM Board Meeting
September			
	4 - 5	EVENT:	FICM/ICS Joint Intensive Care Symposium
	13	MEETING:	FICM Training and Assessment Committee
	27	MEETING:	FICM/ICS Professional Standards Committee
October			
	24	MEETING:	FICM Board Meeting
November			
	22	MEETING:	FICM Training and Assessment Committee
	29	MEETING:	FICM/ICS Professional Standards Committee

National Recruitment



Dr Tom Gallacher
Chair, FICM Recruitment Sub-Committee

In August 2013 trainees wishing to train in Intensive Care Medicine may do so in conjunction with a partner specialty. The trainees will follow dual programmes (having been appointed to each CCT programme in open competition separately) which will deliver both CCT programmes' competencies in full. By virtue of shared common competencies the duration of the dual programmes will be less than the sum of the two component CCT programmes. Currently, dual ICM programmes have been agreed with Anaesthesia, Acute Medicine, Renal Medicine, Respiratory Medicine and Emergency Medicine.

In England, Wales and Northern Ireland trainees on an ICM CCT programme can apply to a partner specialty and then undertake their dual programmes and vice versa, however, both programmes must be in the same Deanery. For 2013, however, East of England trainees will only be able to apply to ICM if they already have a partner specialty NTN. This is a result of regional manpower issues unique to the East of England. Scotland will be running their own recruitment round which will have a similar person specification, interview structure and scoring system to that already established in England and Wales in 2012. However, Scotland will be undertaking a mixed system of reserving a number of posts for dual programmes with anaesthesia and plurality of a number of other posts which will be open to all partner specialties. It is the Faculty's desire to continue to work towards all Deaneries in all four countries, in time, offering standalone ICM training and dual programmes which are equally accessible to trainees from all relevant core training schemes and partner specialties.

For 2013 the Faculty and their partner Colleges have decided not to impose an upper limit of seniority to those wishing to apply for dual programmes, however, this will be kept under review annually. Only those who start their second CCT within 18 months of commencing their first will be eligible for two CCTs. If the time between appointments to the two programmes is greater than 18 months, then the GMC will award a CESR(CP) in the second specialty. If a trainee is successful in their second specialty interview in the same Deanery as their first then they will be entitled to dual programmes.

The advertisement for ICM recruitment will appear on NHS Jobs and the BMJ on Monday 25th February, applications will then open on 11th March and close on 22nd March, short listing (if required) will take place from 28th March until 12th

April and candidates will be invited for interview no later than Monday 15th April. Interviews will take place on 1st and 2nd May at Birmingham City Football Club with capacity for 160 candidates over the two days. The interview format will be the same as 2012 with some minor changes. All Deaneries offering posts for national recruitment will be represented at the assessment centre and it is anticipated that post numbers will be similar to the 72 posts offered last year with Northern Ireland contributing a post for the first time in 2013. An assessment training day, for those representing their Deaneries at the assessment centre, has been scheduled for Wednesday 6th February and it is hoped that all assessors will be able to attend in order to maximise our understanding of the process and optimise quality assurance.

The assessment centre will comprise five stations, two of which will be OSCE type unmanned stations and three stations will have two assessors assigned to each and there will be multiple contemporaneous streams of candidates. The total time from start to finish for candidates will be two and a half hours to include 30 minutes to prepare for the clinical and the presentation stations, 30 minutes each for the OSCE stations, 20 minutes for the portfolio station, 10 minutes for the clinical and presentation stations and 20 minutes to allow for rotation between stations and assessors to record their scores. A *Guidance for Candidates* document has been prepared and will be sent to all candidates with their invitation to interview as well as instructions on how to book a preferred time slot. In addition, there is a comprehensive frequently asked questions page on the Faculty website at <http://www.ficm.ac.uk/sites/default/files/Recruitment%20Release%20ICM%20FAQs%20-%20Interim%20%20Jan13.pdf>

The interview format was very successful last year with an overwhelmingly positive response to the selection centre feedback questionnaire, this was filled in by all candidates immediately upon completion of their selection stations. Feedback from the assessors and lay observers was equally positive. Two small modifications have been made for 2013 – we will have longer at the end of each day to consider candidates' scores and any issues which require clarification and there will be a structured pre-determined veto mechanism to eliminate candidates who it is felt are not suitable for appointment. We are hopeful of another successful and well received recruitment round and look forward to seeing assessors and candidates alike in May.

FFICM Examination



Professor Nigel Webster
Chair of Examiners

The Faculty has representation on the Assessment Committee of the Academy of Medical Royal Colleges and this has proved valuable in integrating our assessments with those of the other Colleges. This committee is working with the GMC to harmonise various aspects of the different College examinations. Recent requests for further information include College and Faculty attitudes towards disability and more detailed information on the candidates sitting examinations. The GMC already receive aggregated examination data from Colleges and Faculties through the Annual Specialty Report (ASR). The ASR is specifically designed to provide assurance to the GMC and the public that Colleges/Faculties are driving the quality of training and the delivery of curricula in line with the GMC's standards.

The present aggregated examination data requested by the GMC allows them to analyse the performance of UK trainees by gender, country of origin and Primary Medical Qualifications etc. However, the GMC find that aggregated data is difficult to validate, analysis of such data is limited and Colleges and Faculties find the present ASR templates time consuming to complete.

Therefore to allow the GMC greater control in the analysis of trainee progression patterns, they have requested that Colleges and Faculties provide data at 'trainee level' which will allow them to establish clean and validated datasets and integrate exam results with ARCP and recruitment data. To achieve this, the GMC have asked that Colleges and Faculties provide individual data fields for all UK trainees, the required fields include: GMC number, first name, surname, trainee level and Deanery, exam result, marks, date of success and a marks breakdown. The GMC have yet to confirm the agreed privacy notice, although the present recommendation is:

"If you are registered or anticipate being registered with the GMC, your personal data will be passed to the GMC for quality assurance purposes and to facilitate the awarding of CCTs".

Once the form of words has been confirmed this will be put in place no later than 31st March 2013 and will be reflected on examination application forms and posted on the Faculty website. Individual candidate data will form part of the ASR from September 2014, data submitted before this date will continue to be provided in the present aggregated formats. A summary of the GMC's proposal will be posted on the Faculty website in January 2013. The Colleges are also being required by the GMC to reveal more data about ethnicity and equality. Some breakdown of this is provided in an aggregated format through the ASR, although no Colleges routinely analyse or publish examiner marking by candidate ethnicity. The Faculty will need to consider this form of analysis and provide information for eventual dissemination via the GMC.

“ To allow the GMC greater control in the analysis of trainee progression patterns, they have requested that Colleges and Faculties provide data at ‘trainee level’ which will allow them to establish clean and validated datasets and integrate exam results with ARCP and recruitment data ”

As an initial step the GMC has recently issued a report from the Colleges providing some provisional information. This first report covers the reporting year 2010-2011 and does make interesting reading. It highlights the overall results of the exams of various Colleges as well as an overview of the

results broken down by Primary Medical Qualification and training grade at the time of examination. The GMC is in the process of developing a consistent long term data collection of more detailed information.

The main table of the document details numbers of candidates taking the various examinations along with pass rates. Numbers of candidates and pass rates vary considerably – between 3 (RCPATH) and 3,864 (RCGP) for candidate numbers; and for pass rates between 0% (RCPATH with only 3 taking the exam) and 100% (DICM, RCR and FRCS Cardiothoracic). To take two Colleges with differing pass rates and large numbers of candidates - MRCPCH Part 2 consistently has on average over 1000 candidates at each sitting with a pass rate of around 40% compared to MRCS which has between 1500 and 2000 candidates at each sitting with a pass rate of around 55%.



Although I have not done a statistical calculation, just looking at the figures, it would seem that having the UK as a source of primary medical education is associated with a higher success rate in most of the College examinations. The other categories are broken down into EEA, non-EEA and unknown. There are no details available as yet on ethnicity and gender.

The AoMRC Assessment Committee is also interested in collecting data about the allowances that Colleges make for those with disabilities. The Equality Act 2010 can present challenges to Colleges for those candidates who declare a disability (either physical or psychological). However, there is now a legal responsibility under the Act to ensure that the examinations are capable of fairly maintaining academic standards and rigour, whilst at the same time showing compassion and common sense. For postgraduate medical examinations the reasonable adjustment duty does not apply to competence standards, which apply to all candidates i.e. where there is no reasonable adjustments possible of what is being assessed. However, it is possible for a competence standard to be challenged if it disadvantages people with a particular disability when it is not shown to be objectively justified. For some parts of the FFICM it

will be possible to provide facilities and 'reasonable adjustments' for those with disabilities but for others it will prove difficult. If notified in advance the Faculty will try to make provision. The FFICM Examination Regulations already make standard provisions for dyslexic applicants at the MCQ and allow 25% additional time for applicants who provide a relevant educational psychologist report at the time of application. This is in line with the majority of Medical Colleges. The regulations also state that all other requests for special consideration for dealing with disabilities are considered on an individual basis and every attempt is made to make 'reasonable adjustment'. We have also learnt that the GMC is taking a particular interest in assuring that Colleges examine communication skills. We have included at least one such station in the OSCE examination for the FFICM exam but of course communication skill is also assessed by other means. Other Colleges for example have detailed writing letters, MSF, MDT, CEX, WPBA as well as OSCE as their means of assessing communication skill.

The GMC report is available as a pdf download from: www.gmc-uk.org/Exam_Data_Summary.pdf_49797108.pdf.

Examination Calendar October 2012 - July 2013

	FICM MCQ Examination		FICM SOE Examination	
Applications and fees not accepted before		Monday 15 October 2012		Thursday 13 December 2012
Closing date for Exam applications		Thursday 29 November 2012		Thursday 7 February 2013
Examination Date		Wednesday 9 January 2013		Tuesday 19 March 2013
Examination Fees		£455		£545

Examination Calendar August 2013 - July 2014

	FICM MCQ Examination		FICM SOE Examination	
Applications and fees not accepted before	Monday 15 April 2013	Monday 14 Oct 2013	Thursday 11 July 2013	Thursday 12 December 2013
Closing date for Exam applications	Tuesday 28 May 2013	Tuesday 26 November 2013	Thursday 22 August 2013	Thursday 6 February 2014
Examination Date	Wednesday 17 July 2013	Wednesday 8 Jan 2014	Wednesday 9 Oct 2013	Tuesday 18 March 2014
Examination Fees	TBC	TBC	TBC	TBC

Regional Update



Dr Alison Pittard
Lead RA in ICM

“All great changes are preceded by chaos” - Deepak Chopra

We are in a period of change with respect to how doctors are trained in Intensive Care Medicine and the development of new ways of working in Intensive Care Units. For the first time in UK history we have doctors training solely in the specialty of Intensive Care Medicine. So much work has been undertaken to reach this point yet this is merely the start.

As my colleagues and I breathed sighs of relief as that particular chapter ended the next one had already begun; recruitment for 2013. That in itself is taking up a huge amount of time for Regional Advisors and Faculty Tutors yet there is still plenty of other work that continues to put demands on us.

We are in the process of revising the ‘Guidance for Training’ document to provide more advice regarding trainee numbers relative to beds. This will include an update on training requirements during the various stages of the CCT curriculum. However I think the majority of work at regional level has been the negotiation with partner specialties to streamline the implementation and ongoing management of dual programmes.

The curriculum for ICM training has always included experience in other specialties and therefore trainers have become adept at managing, what can be at times, complicated programmes. These have also been tailored to the individual so the transition from the joint programme to single and now dual programmes is a relatively smooth one. Training Programme Directors are coordinating the movement of trainees with different needs and at various levels of training between several specialties.

The other challenge is how to manage the gaps in rotas this fluidity creates on a background of reduced training numbers in some specialties. Historically service provision in intensive care has come from anaesthesia. Whilst the curriculum for specialty training in anaesthesia includes 6 months ICM, the reduction in anaesthetic training numbers will result in gaps in ICU rotas. At the moment we do not have enough ICM trainees to be self sufficient but hopefully increased training numbers and an expansion of critical care practitioners will facilitate this.

The biggest headache is how to manage single and dual programmes during Stage 1 of the curriculum. We cannot predict the training requirements of those entering ST3 as it will depend on the core programme they have undertaken, making the construction of rotas problematic. Hopefully, as the pool of ICM trainees increases, the effect of this uncertainty will ease. We can also stagger rotation times as the various elements of training within each stage can be undertaken in any order. This should limit the burden of too many ‘novice’ trainees in a single department. Once Stage 2 is reached the training requirements begin to equalise, so predictability returns and finally some stability.

We have a fantastic opportunity to create a world renowned training programme but uncertainty can be stressful. We don’t have a crystal ball and there isn’t a right or wrong way to do things but a pragmatic approach is essential to ensure it works for the benefit of our patients.

This is my final regional update for *Critical Eye*. Having started as a Board Tutor in 1998 I progressed to Deputy Regional Advisor in 2002 and took over my current role of RA in 2005. There have been many developments during my tenure and I have been fortunate enough to be involved in these as Lead RA. It is time for me to hand over the reins and an election process is currently underway to appoint successors. I would highly recommend these roles, they can be enormously rewarding and we are a friendly group, which in itself brings benefits. Training and education are areas where we really can make a difference. I will continue to be involved as an elected member of the Faculty Board but for now all that is left for me to say is ‘goodbye’ and thank you for the privilege.

“Lay a firm foundation with the bricks that others throw at you” - David Brinkley

Online CPD system
for FICM Fellows and Members



To register for an account go to: www.cpd.rcoa.ac.uk
Or contact the RCoA Revalidation and CPD team at
cpd@rcoa.ac.uk or 020 7092 1729



Trainee Update



Dr Mike McAlindon
FICM Trainee Representative

I have recently been elected as FICM Trainee Representative and may I take this opportunity to thank all of those that voted. As Trainee Representative, I sit on the Faculty Board as well as the Faculty Training and Assessment Committee (FICMTAC) and have been co-opted to the ICS Trainee Committee. Since the development of the Faculty, this role has been filled by Dr Chris Booth, Chairman of the ICS Trainee Committee. I would like to thank him for all the excellent work he has done during this period of change in ICM training and the support he has given me since my appointment.

Since August 2012, the new ICM CCT trainees have begun to find their feet and are taking the new curriculum forward; their feedback to the Faculty has been invaluable in facilitating effective delivery of this new training programme. This will continue to be a close working relationship and trainee opinions continue to be highly regarded by the Faculty.

In August 2013 we anticipate ICM recruitment to step up a gear. The ICS have held career days in both Salford and London for trainees with career intentions in ICM. These have been well received and those attending have represented a strong pool of enthusiastic trainees for the future. We hope that this enthusiasm will be reflected during recruitment this year with an increasing demand for ICM CCT training posts.

This year those trainees already on the single CCT programme will have the opportunity to form a Dual CCTs programme by applying to one of the approved partner specialties of Anaesthesia, Medicine (Acute, Respiratory or Renal) and Emergency Medicine. We anticipate an increased demand for the new programme to also come from trainees applying to the ICM CCT from within the partner specialties as well. An increase in demand will ensure that we are able to recruit the best candidates to ICM through open competition.

Recruitment to the Joint CCT in ICM will continue to be available until 31st July 2013 and those trainees eligible to apply are encouraged to utilise this route of entry. This year senior trainees (up to ST7) from partner specialties will also still be able to apply to the ICM CCT within their Unit of Application to form a dual training programme. This situation is not ideal in the eyes of many however it remains the most inclusive way forward. This will ensure that all those that wish to apply for ICM training are able to do so, thus avoiding another 'lost tribe' of trainees.

“ Since August 2012, the new ICM CCT trainees have begun to find their feet and are taking the new curriculum forward; their feedback to the Faculty has been invaluable in facilitating effective delivery of this new training programme ”

As we all know the new curriculum is still being fine-tuned and will continue to evolve in the future. The Special Skills Year (SSY) is one such area in which work is still being carried out. Modules in development include; transfer and retrieval medicine, cardiac, neuro, paediatrics, research and education. Plans for other modules, such as leadership and management, are in discussion. The FICMTAC remains flexible on additional SSYs and trainees will be able to apply for individualised modules of training on a case by case basis.

It is however important to note that trainees forming a dual training programme will need to use the SSY for training in their partner specialty. This may be important for those individuals keen to pursue a career in academic medicine or train in Pre-Hospital Emergency Medicine (PHEM) as it will be difficult to 'triple accredit' during the proposed training time. Further discussions are taking place to address these issues. In any case, trainees are encouraged to consider the reality of such a career path, especially in the new era of revalidation, where competencies will need to be rigorously maintained in all areas.

The first sitting of the new FFICM Final Examination took place in January. Concerns have been raised by some trainees regarding the cost of the exam, particularly for those who have already been through



post-graduate exams in partner specialties. It is important to remember that the exam is an integral part of the ICM training programme. Both the FICM and Faculty of Pain Medicine have set their exam rates similar to those of the RCoA. There are, for obvious reasons, continuing links between the FICM and the RCoA and crossover in how administrative tasks, such as the exams, are performed is to be expected. The exam is 'non-profit' for the FICM and the increased expense per person is as a result of relatively few people sitting the exam and a lack of 'economy of scale'.

The FFICM exam cost is in keeping with (or cheaper than) most Fellowships in other specialties and as a result this is unlikely to be changed in the near future. Despite this a good number of candidates have applied to sit the inaugural MCQ examination. As experience with the new exam increases, further information will become available and we hope to produce a trainee guide to the examination in the future.

The e-Portfolio is now in development in association with NHS Education for Scotland (NES) and it is hoped that this will be available following recruitment in August. The NES platform may be familiar to some trainees and we hope that this familiarity will facilitate its use. At this stage, trainees appointed to the ICM CCT from a partner specialty will be required to maintain an e-Portfolio in both specialties when forming a Dual CCTs programme. Issues of interaction between e-Portfolios will hopefully be addressed in due course.

The RCoA ICM e-Learning modules are being revisited with enthusiasm and the Faculty will be involved in their development. These are currently aimed at Core Trainees however it is envisaged that modules for ST3+ FICM trainee members will become available in the future.

As trainee membership continues to expand, our voice within the Faculty will become louder. I have been elected to feedback your opinions and highlight any areas of concern with regards to training. Therefore, if there are any issues that need to be raised or information I can provide then please feel free to contact me. The Faculty are keen for us to be heard!

Regional Focus: Northern Ireland

Dr Conn Russell
RA and ICM Training Programme Director,
Northern Ireland

There have been many changes in postgraduate training in Northern Ireland in 2012, bringing fresh challenges to FICM Faculty Tutors and RAs alike. I took over as Regional Advisor and Training Programme Director just over a year ago from Paul Glover, his excellent service is to be commended along with the timing of his departure to coincide with National Recruitment for ICM!

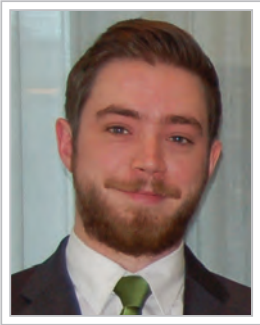
With a population of 1.8 million served by 11 critical care units (including paediatric and cardiac), we share many of the frustrations common to the rest of the UK when changing political opinion brings new directions in the delivery of acute care.

Northern Ireland sat out of the first round of ST3 National Recruitment, though I had the pleasure of attending the interviews as an observer in April. I am pleased to say that we will be participating in National Recruitment for 2013, whilst continuing to appoint to the Joint CCT programme for the final year. Competition has traditionally been very high for our ICM posts, ensuring a steady stream of excellent trainees and some difficult decisions for consultant appointment panels. We have good links with several units in Australia and many trainees avail of opportunities to complete fellowships and enjoy a very different climate in the advanced year or beyond.

Our main challenge for the coming year will be to steer through the changes required to implement ST3 ICM, though I am optimistic that the programme will be more straightforward to deliver on the ground than it is to explain to the other specialty RAs! Northern Ireland had previously a strong connection with the College of Anaesthetists in Dublin, with examiner and candidate representation at Anaesthesia and ICM exams.

Recent changes to the curriculum have implications for many trainees and consultants with Irish fellowships with regards to exam eligibility, CCT awards and membership of FICM. Although the majority of our ICM trainees come from an Anaesthesia background, there is growing interest from other specialties. It will be important to encourage the talent and enthusiasm of these trainees by the emergence of more substantive posts with a major ICM commitment.

Trainee Routes of Entry to the Faculty



Mr James Goodwin
Faculty Supervisor

There are two methods by which trainees may register with the FICM. These membership routes have evolved from the previous methods by which trainees undertaking ICM training would register with the Faculty's predecessor, the Intercollegiate Board for Training in Intensive Care Medicine.

Trainees who may register with the Faculty fall into two distinct categories:

ICM CCT Trainees

These are trainees who have been appointed, via open competition, to a programme culminating in the award of a Certificate of Completion of Training in ICM. This can be either the new standalone CCT in ICM or the outgoing Joint CCT programme.

These trainees should complete an FICM CCT Trainee Registration Form, available online at:
<http://ficm.ac.uk/membership/icm-cct-trainees>.

ICM CCT trainees will then progress through their CCT programme; after completing Stage 1 training they will be awarded a Stage 1 Training Certificate. Whilst in Stage 2 ICM, they must pass the FFICM Final examination. Upon completion of Stage 3 training, they are then awarded their ICM CCT.

ICM Affiliate Trainees

These are trainees who are completing blocks of ICM training *outside* the ICM CCT programme, who wish to have this training subsequently recognised via membership of the Faculty. This route was formerly known as 'General Registration'. The Faculty has for some time been seeking to incorporate General Registration into its membership processes – this has now come to pass.

The rationale for recognition of trainees undertaking ICM outside the ICM CCT programme was, and continues to be, that:

- Until such time as the number of ICM CCT training posts is equal to the number of ICM consultant jobs, there will be a need for units to be staffed by additional doctors.
- These doctors should be trained in ICM in a manner consistent with the standards of the Faculty.

- Under the 'General Registration' system, these doctors did not pay any form of subscription to train in intensive care, and as such formed a huge and nebulous trainee cohort. Whilst the number of ICM CCT trainees could always be fixed, the exact number of people doing some form of ICM training was impossible to know because trainees could submit a General Registration form and never be heard from again, or register and only resurface 4-5 years later when completing their training. The small subscription required to be an Affiliate Trainee should phase out this problem.

As such these trainees should now complete an Affiliate Trainee Registration Form, available online at:
<http://ficm.ac.uk/membership/icm-affiliate-trainees>.

Affiliate Trainees will continue in their parent CCT, acquiring blocks of ICM training which should be in line with the policies and systems of the Faculty and signed off by FICM Tutors and Regional Advisors.

Affiliate Trainees will be eligible to apply for Affiliate Fellowship of the Faculty upon completion of training commensurate with either:

- **Stage 1 level ICM** (as defined by the standalone CCT in ICM) – if the trainee entered Higher Specialist Training after 1st August 2012.
- **Intermediate level ICM** (as defined by the Joint CCT in ICM) – if the trainee entered Higher Specialist Training before 1st August 2012.

The Faculty recognises that it is not ideal to have differing eligibility requirements for Affiliate Trainees to become Affiliate Fellows; however it was felt to be unfair to expect those trainees already within the system to suddenly achieve Stage 1 ICM (which involves a greater requirement of medicine training than the Joint CCT), and equally it was felt to be impractical to allow trainees entering HST after the new curriculum's introduction on 1st August 2012 to continue being assessed against the defunct Joint CCT standard. It is also recognised that a transitional period is inevitable, and that the pre-August 2012 'Intermediate' trainee numbers will reduce over time. The training levels described above were agreed by the Faculty with its Trustee Colleges.

Once Affiliate Trainees are confirmed as Affiliate Fellows they may apply to sit the FFICM examination. Please note that there are no post-nominals associated with Affiliate Fellowship.

Affiliate Trainee status is only open to doctors in training. Affiliate Trainees must either achieve Affiliate Fellowship or resign their Affiliate Trainee status upon gaining their parent specialty CCT. Affiliate Trainee status (which can lead to Affiliate Fellowship and then FFICM if the trainee passes the exam) is not the Faculty offering any form of training sign-off, but a standard of training it requires in order to confer levels of Faculty membership.

For ease of identification, the CCT Trainee form is blue and the Affiliate Trainee form is yellow – this mirrors the old IBTICM paperwork system of differentiating between the two possible categories.

Going forward

The Faculty would urge ICM trainers to encourage all the General Registration trainees currently have in their hospital or region to join the Faculty as Affiliate Trainees, unless they are already undertaking an Advanced block of ICM training and thusly so near the end of their training as to make Affiliate registration pointless. For General Registration trainees who are currently

undertaking Advanced ICM, the Faculty will still produce 'Advanced sign-off' letters to denote completion of this training.

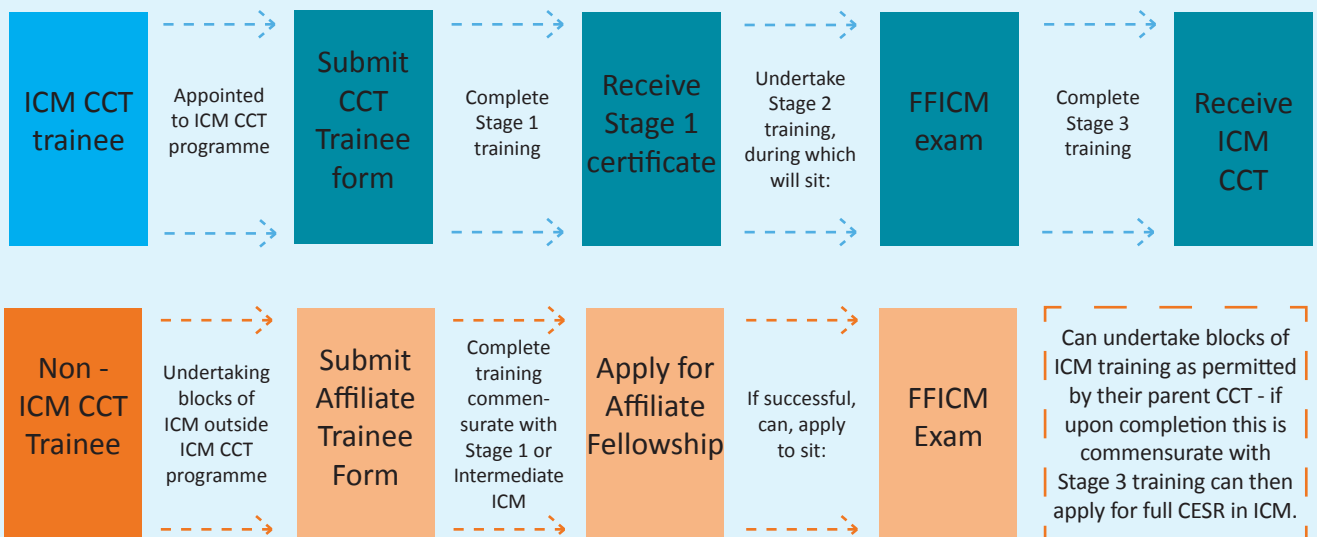
General Registration trainees who have already submitted a General Registration form but not yet completed their Intermediate block do not have to re-register as Affiliate Trainees (though the Faculty would encourage them to do so); however when they complete this block they will not receive an Intermediate sign-off letter, but will be able to apply for Affiliate Fellowship.

The Faculty recognises that inevitably there will be some trainees whose appointment dates do not line up with the above; for this reason it will still issue 'sign-off' letters when necessary, judging each case on its merits. However the general drive will be to move non-ICM CCT trainees onto the Affiliate Trainee/Affiliate Fellowship pathway.

Current General Registration trainees who do wish to join the Faculty as Affiliate Trainees should complete the full Affiliate Trainee form; however they do not need to have the form counter-signed by their Faculty Tutor and Regional Advisor, as this confirmation of training status will have been provided with the original General Registration form.

ICM Training and Membership Routes

Below are the current routes of training and Faculty membership for trainees undertaking ICM both as part of and outside of an ICM CCT programme. Trainees with any questions regarding registration with the Faculty should contact the FICM secretariat at ficm@roa.ac.uk.



Please Note: According to current GMC regulations, the second CCT in a Dual CCTs programme must be taken up (not just appointed to) no later than 18 months after a trainee has taken up the initial CCT programme. If the second specialty is entered beyond this 18 month window then the GMC will award a CESR(CP) in the second CCT speciality. However, the GMC is currently reviewing all aspects of its Dual CCTs process via a dedicated working group. Any further developments in this regard will be disseminated by the Faculty and highlighted in *Critical Eye*.



Professor Kathy Rowan
Chief Investigator



Mr Paul Mouncey
Trial Manager

Overview

ProMISe is the first collaborative, NIHR-funded research effort between emergency, acute and critical care medicine. It is co-adopted onto the NIHR CRN Critical Care and Injuries & Accidents Specialty Groups (Portfolio number: 9820). It is also part of an important international collaboration alongside two similar trials being conducted in the United States (ProCESS - Protocolized Care for Early Septic Shock, opened March 2008) and Australasia (ARISE - Australasian Resuscitation In Sepsis Evaluation, opened October 2008). An individual patient data meta-analysis will be performed across the three trials.

Background

In 2001, Rivers et al reported the results from a randomised controlled trial in a single US hospital, comparing six hours of early, goal-directed, protocolised resuscitation with usual resuscitation in patients presenting at the emergency department with emerging septic shock. Protocolised resuscitation significantly reduced hospital mortality (from 46.5% to 30.5%) and shortened hospital length of stay for survivors. The trial showed such a large effect size that it is impossible to ignore, but also impossible to believe! Was this absolute risk reduction (ARR) of 16% a true effect, or was the trial limited by being single-centre (small sample size) based in inner city Detroit and being conducted, analysed and reported by the protagonist (intervention unblinded)? Furthermore the intervention is unclear – was it physiology based instructions/therapies or Dr Rivers (who delivered the intervention)? It is essential, therefore, to investigate if this intervention works in a UK setting.

What is ProMISe?

A multicentre randomised controlled trial of the clinical and cost-effectiveness of early, goal-directed, protocolised resuscitation for emerging septic shock. In consultation with potential sites, the Rivers' early goal-directed resuscitation algorithm was adapted for use in the UK. Edwards Lifesciences is providing a Vigileo monitor on loan free-of-charge to each participating site for the duration of the study and the PreSep catheters (for continuous ScvO₂ monitoring) are provided by grant funding.

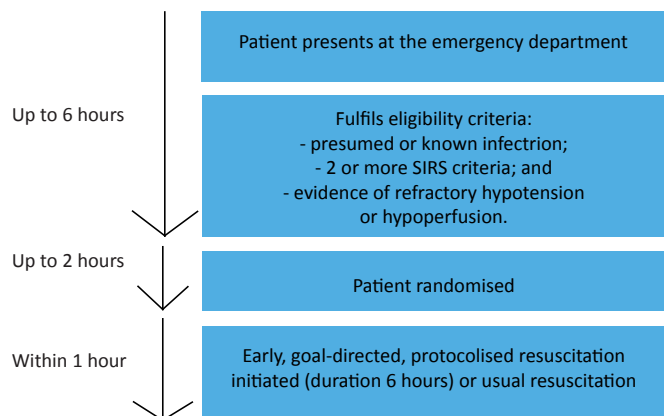
Sample Size

Target: 1260 patients; Aim to achieve 80% power to detect ARR of 8% in 90-day mortality from 40% to 32%.

Progress

Trial opened: 15 February 2011; 47 sites open; 652 patients recruited (as of 30 November 2012)

Patient timeline



Recruiting sites

Sites and patients recruited (as of 30 November 2012):

Addenbrooke's Hospital (18), Arrowse Park Hospital (15), Barnsley Hospital (12), Bedford Hospital (9), Birmingham Heartlands Hospital (10), Blackpool Victoria Hospital (1), Bristol Royal Infirmary (6), Broomfield Hospital (11), Chelsea and Westminster Hospital (12), Derriford Hospital (7), Dorset County Hospital (7), Frenchay Hospital (12), Hinchingsbrooke Hospital (9), Hull Royal Infirmary (14), John Radcliffe Hospital (5), Kettering General Hospital (11), King's College Hospital (5), Leicester Royal Infirmary (18), Leighton Hospital (11), Manchester Royal Infirmary (27), Medway Maritime Hospital (22), Musgrove Park Hospital (20), New Cross Hospital (6), Newham University Hospital (2), North Devon District Hospital (5), Poole Hospital (38), Queen Elizabeth Hospital Birmingham (9), Queen Elizabeth Hospital Gateshead (18), Royal Berkshire Hospital (29), Royal Bournemouth Hospital (11), Royal Lancaster Infirmary (10), Royal Preston Hospital (12), Royal Surrey County Hospital (12), Royal Sussex County Hospital (16), Royal Victoria Infirmary (2), Salford Royal Hospital (22), Stafford Hospital (15), The Great Western Hospital (10), The Ipswich Hospital (10), The James Cook University Hospital (7), The Queen Elizabeth Hospital, King's Lynn (43), The Royal Blackburn Hospital (1), The Royal London Hospital (8), University College Hospital (17), University Hospital of North Staffordshire (16), Whiston Hospital (45), Worthing Hospital (13) and York Hospital (6).

We got off to a flying start in terms of site participation and we hope this will help us complete recruitment first (ProCESS – 680 patients left to recruit, ARISE – 460 and ProMISe – 608).

Would you like to join us...?

If you are enthusiastic about this important trial, and would relish the opportunity to work closely on research with your emergency department, we would love for you to become a ProMISe site. We are aiming to complete recruitment by the end of 2013, so there is still time to make a difference – please contact Mr Paul Mouncey (Trial Manager) at promise@icnarc.org or on 020 7269 9277.



The Royal College of Anaesthetists

The Faculty of Intensive Care Medicine

Annual Meeting

Friday 1st March 2013, RCoA, London



The College of Emergency Medicine

Changing the Healthcare System

The post bill NHS in practice

Education and training in the new NHS

The role of Colleges and Faculties



RCPE

The Royal College of Physicians of Edinburgh

Changing Practice

The future hospital

Commissioning quality in intensive care

Revalidation: will it lead to better doctors?



Royal College of Physicians

New Knowledge in Critical Care

Sepsis

Head and spinal injury

ALI

Genomics



The Royal College of Physicians and Surgeons of Glasgow

Annual Faculty Lecture

Professor the Lord Darzi



The Royal College of Surgeons of Edinburgh

The Faculty Annual Report and Award of Fellowships



The Royal College of Surgeons of England

Online booking available via:

www.ficm.ac.uk

PLACES STILL AVAILABLE

£155 for Consultants

£80 for Trainees

5 CPD credits



ANNUAL MEETING APPLICATION FORM

For Fellows and Members of the FICM

Payments will be processed by the Royal College of Anaesthetists Finance Department Please complete this form in BLOCK CAPITALS and return to Churchill House, 35 Red Lion Square, London, WC1R 4SG or via fax (020 7092 1730).

Your details

Full name:

*Faculty Reference Number:

GMC:

Address:

Postcode:

Please ensure you complete your full postal address

Is this your main mailing address?

Telephone:

Email:

Hospital:

Event details

Date:

Code:

Event title:

Registration fee:

Payment details (please use BLOCK CAPITALS)

A cheque is enclosed made payable to the Royal College of Anaesthetists

I wish to pay by the following debit/credit card:
(please tick)



Cardholder's name:

Signature:

Card Number:

Valid from:

Expiry date:

Issue number:

Security code:

Terms and conditions

- Please note this meeting is only open to Fellows and Members of the Faculty.
- Additional copies of this form can be downloaded from www.ficm.ac.uk.
- Please be aware that programmes are subject to change and you should check the Faculty website for regular updates.
- Our events are open to all grades, unless specifically stated otherwise.
- When an event is full, this will be publicised on the website. To be placed on a waiting list, please contact the Faculty of Intensive Care on 020 7092 1746. We will then contact you as soon as a place becomes available.
- Lunch is included in the registration fee unless otherwise indicated.

Booking and payment

- Bookings will be accepted by post or fax only on a first come, first served basis.
- Bookings will not be accepted unless the appropriate fee and application are received together.
- Please note that places are not reserved until payment is received.
- Confirmation of a place will be sent to you within 14 days of payment being received. If you do not receive this, please contact the Faculty.

Cancellation policy

- Notice of cancellation must be given in writing to the Faculty of Intensive Care or by email to: ficm@rcoa.ac.uk at least ten working days prior to the event to qualify for a refund.
- All refunds are made at the discretion of the RCoA Finance Department and are subject to the deduction of an administration fee.
- Delegates cancelling less than ten days before the event will not be entitled to a refund.
- Name changes for attendees will be accepted; please inform the Faculty of Intensive Care seven days prior to the event.

* If you are a member of the RCoA, this is the same as your college reference number. If you do not know your Faculty number, please contact us.

JOINT INTENSIVE CARE SYMPOSIUM

4 - 5 September 2013

RCoA, London

Fee to be announced May 2013

Wednesday 4th September

Cardiology Update

Grown up congenital heart disease: How to manage an unstable patient?

Do we fail the failing heart?

Dysrhythmias: dispelling the myths

Changing times - changing ICM

An ageing population

Major surgery: When do we need ICU?

Anorexia, obesity and ICM: problems with extremes of body habitus

How I....

Manage resistant infections in ICU

Manage the injured spinal cord

Investigate brain injury on the ICU

Burnout in ICU

Burnout - what burnout?

Sources of occupational stress in ICM

A suitable job for a woman?

Thursday 5th September

Do we still need to worry about

Tight glycaemic control

Low tidal volume ventilation

Surviving sepsis

What fluid to use

A Career in ICM

The role of the Faculty (education and training)

Career advice

Trainees Survey

What's new in ICU

In renal medicine

In imaging

In paediatrics

The national ECMO service

Law and Ethics

Reliability of the expert witness

An acute legal service for ICM

Further details will be posted on the FICM and ICS websites in 2013.

www.ficm.ac.uk

www.ics.ac.uk



Revalidation E-PORTFOLIO

FREE ACCESS FOR FELLOWS AND MEMBERS

The Revalidation E-Portfolio provides doctors with an easy-to-use, private and secure online space for storing and managing all supporting information required for appraisal and revalidation.

“We hope that Fellows and Members make full use of the Revalidation E-Portfolio when reviewing and reflecting on their work. Doctors can take control as to who can view their supporting information or what items are selected for presentation at appraisal.”

Dr Peter Venn
RCoA Council Member and
Revalidation E-Portfolio Lead

Accessing the Revalidation E-Portfolio

RCoA, FICM and FPM Members can self-register to set up an account to access the Revalidation E-Portfolio.

To do this go to:

www.rcoa.ac.uk/e-portfolio-and-cpd-systems.

You must have your GMC and College reference number to hand to self-register.

For further information contact:
revalidation@rcoa.ac.uk

The Revalidation E-Portfolio is:

- Free to all subscribing Fellows and Members of the RCoA, FICM and FPM.
- Customised for storing and managing supporting information privately or outside of a doctor's workplace.
- Easily accessible online so that users can upload and retrieve data anytime, anywhere.
- Useful for doctors working for more than one organisation or moving between employers allowing them to take their supporting information with them.
- Accessible by an appraiser and responsible officer given permission by a doctor to view their supporting information online.
- Structured and aligned with the requirements for revalidation as specified by the General Medical Council.
- Intended to be helpful through links to key RCoA, Academy, GMC and UK Departments of Health guidance on revalidation.
- Developed by a cohort of eight medical royal colleges representing most secondary care specialists.
- Secure and compliant with data protection legislation and the rules of the Information Commissioner's Office.
- Fully incorporated into Equiniti 360° Clinical's Revalidation Management System designed to help trusts manage the revalidation process.

Forthcoming Events 2013

FEBRUARY

- 4 **The ICS National FICM Exam Preparation Course**
Churchill House, London
- 15 **Core Topics for Training and Revalidation in ICM**
Churchill House, London
- 28 **Focused Intensive Care Echo Course**
Churchill House, London

MARCH

- 13 **ICS Seminar - Mechanical Ventilation**
Churchill House, London

APRIL

- 12 **Core Topics for Training and Revalidation in ICM**
Churchill House, London
- 19 **ICS Seminar - The Surgical Patient**
Churchill House, London

MAY

- 9 **ICS Practical Seminar - An Introduction to Chest Ultrasound for Intensivists**
Churchill House, London
- 20 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

JUNE

- 4 **ICS Seminar - Trauma Update**
Churchill House, London
- 20 **ICS Practical Seminar - Critical Care Simulation at the Point of Care**
Churchill House, London

SEPTEMBER

- 4-5 **FICM & ICS Joint Intensive Care Symposium**
Churchill House, London
- 11-12 **BASIC Assessment and Support in Intensive Care Course**
Churchill House, London
- 25 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

OCTOBER

- 23 **ICS Seminar - Microbiology for Intensivists**
Churchill House, London

NOVEMBER

- 11 **Core Topics for Training and Revalidation in ICM**
Churchill House, London
- 21 **ICM Career Day**
Churchill House, London

DECEMBER

- 16-18 **The State of the Art Meeting**
TBC, London

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Intensive Care Medicine

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