



# Critical Eye

Issue 2

Summer 2012

The Faculty of  
**Intensive Care Medicine**

*Inside:*

- » Recruitment
- » Simulation in ICM
- » Collaborating for Quality
- » Examination Development

# Welcome



**Welcome to the second edition of *Critical Eye*. Much has happened in UK intensive care since the first.**

The inaugural Annual Faculty Meeting celebrated new intensivists, leaders in the field and the current status of our specialty. Tim Evans' report gives a lively flavour of a successful day.

We hope that many of you will put the date of the second annual meeting, Friday 1st March 2013, in your diaries and come to the meeting. The provisional programme is included in this issue, along with a booking form.

The first national recruitment process for Intensive Care Medicine has been completed and we include articles giving the perspective from those who organised and ran it and from one of the applicants. Compare and contrast! Detail of our gathering of more information to aid workforce planning is presented in Alisdair Short's report and it seems clear that the processes of recruitment and planning are inextricably linked.

The final DICM examination was conducted in early July and there is now a great deal of ongoing work to develop the new Faculty examinations. The reports from Simon Baudouin and Nigel Webster will update you on these important developments. In parallel to this the Faculty and the Intensive Care Society have joined forces to create a strategic simulation group looking at the development of simulation based training and education for intensive care and to investigate the potential place of simulation in high stakes assessment in UK intensive care, both for trainees and for consultant revalidation.

We would also like to take the opportunity of warmly welcoming the newly elected members of the Faculty Board. Their appointments signal the transition from the founding Board to a fully elected Faculty Board which will develop over the next few years.

This is your forum. Please contact us with ideas and suggestions for future editions of *Critical Eye*.

**Dr Graham Nimmo**  
**Clinical Co-Editor**

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## Clinical Editors

Dr Graham Nimmo  
Professor Monty Mythen

## Managing Editors

Mr James Goodwin  
Mr Daniel Waeland

## Dean

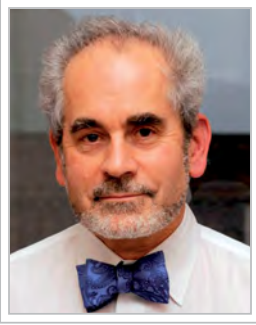
Professor Julian Bion

## Vice-Dean

Professor Tim Evans

Administered by Miss Anna Ripley

# Dean's Statement



**Professor Julian Bion**  
Dean

The work of the Faculty has increased at a near-exponential rate, as the contents of this newsletter demonstrate. The good news is that our activities are creative, positive for our future, and well-supported by our fellows and members and our partner organisations. The challenge for us is that the wider changes in the health service create many uncertainties and disrupt established channels of communication and planning.

Evidence-based standards are fundamental to quality improvement. Carl Waldmann and Simon Baudouin have brought together the committees from the Faculty and the ICS respectively, and are working together to create a new set of national standards. This process will link into commissioning ICM services, for which the Faculty has asked Jane Eddleston and Bob Winter to develop a Critical Care Specialty Reference Group to provide important guidance for local commissioners. Peer review is in development and will be modelled on the excellent work already undertaken by the West Midlands Quality Review Service and Critical Care Network.

Quality improvement needs reliable data and timely feedback. Since the Matching Michigan study closed (shortly to appear in *BMJ Quality and Safety*), the national reporting system for blood stream infections was mothballed with the demise of the NPSA. The Health Protection Agency (soon to be Public Health England) has now agreed to revive the reporting system and develop it into a national surveillance system for all ICU infections in England. This will allow us to link infection data to other reporting databases and to clinical outcomes. The data will be owned and managed by all clinical professional organisations in intensive care. The first meeting of the steering committee will be on September 27th. We will want your views on the best way of collecting standardised datasets and how you would like to receive reports with national benchmarking.

Workforce planning is essential for our future, and for career sustainability. Alasdair Short has reported on developments in this issue. In parallel we have to consider the wider context of the health service, including the Royal College of Physicians' Future Hospital Commission and the Academy of Medical Royal Colleges' working party on 7-day Acute Services. The Faculty is represented in both of these important developments. ICM has a central role in the future development of hospital care, which can only grow in scope, and for which front-line senior clinical leadership will be essential for most, if not all, of the 24 hour period. This cannot be delivered with the current minimalist

provision of consultant sessions and supporting staff. It is clear that a 24/7 service means reconfiguring the entire hospital system, not just isolated components.

Following notification by Baxter of possible interruption in supplies of disposables for the Baxter CVVH machines, the Faculty has been working with the ICS, the Renal Association and the Department of Health to develop a mitigation plan. Supplies may be interrupted from October 8th until the 16th; an alternative supplier has offered to provide sufficient machines, supplies and training to fill this gap. We have drafted a statement and action plan and hope that by the time of publication action will have been taken by the DH and by those ICUs most affected. We have requested a post-resolution meeting with the DH to discuss how they wish to interact with the Faculty and ICS so we can provide effective crisis management.

An important milestone was reached in July with the induction of our first elected Board members: Dr Bob Winter, Dr Simon Baudouin and Dr Alison Pittard. Bob is the physician chair of the Critical Care Networks; Simon has chaired the metamorphosis of the Intercollegiate Board into the Training and Assessment Committee and has taken the new ICM training programme successfully through the GMC approval processes. Alison as Lead RA, working with Dr Tom Gallacher as National Recruitment Lead, has managed the first national recruitment to the new ICM programme: they, the West Midlands Deanery and the RAs and Tutors who undertook the interviews deserve our congratulations on having conducted the process so successfully. We can now also welcome our new trainees, who start their careers in ICM this August.

Concurrently we must bid farewell to those Board members demitting office. Mike Lavelle-Jones has represented surgical interests in ICM the Board admirably. Bruce Taylor has had to retire as President of the ICS on health grounds, and we wish him a rapid recovery. Willie Tullett has supported ICM for a sufficiently long period to have become something of a legend, with his distinctive blend of good humour and Scottish brevity. Finally, Alasdair Short has had a most distinguished career in ICM, including establishing ICNARC and chairing the Intercollegiate Board. Alasdair has agreed to modify his retirement by remaining a co-opted member of the Board to see through the workforce planning issues. We are fortunate to have been served so well by these colleagues as well as our community of fellows and members.



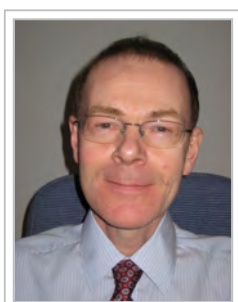
# New FICM Board Members

An election to the Board of the Faculty of Intensive Care Medicine was held on 22nd June 2012. There were three vacancies to the Board and all Fellows of the Faculty were eligible to stand and vote. There were ultimately 20 candidates for the three available seats; the Board congratulates the successful candidates and urges those unsuccessful candidates to stand again in future for vacancies within the Faculty. Their enthusiasm is a credit to the specialty.



## Dr Bob Winter

Bob Winter is current President of the Intensive Care Society and Consultant in Adult Critical Care Medicine at Nottingham University Hospitals. He trained in Nottingham and returned there after going to Burton on Trent, Truro and Bristol where he completed his MD under the supervision of Dr Sheila Willatts. He is also Chair of Pre-Hospital Trauma Life Support UK, medical lead for Mid-Trent Critical Care Network and clinical lead for major trauma in the East Midlands.



## Dr Simon Baudouin

Simon Baudouin is Senior Lecturer in Critical Care Medicine and Honorary Consultant Physician at the Royal Victoria Infirmary, Newcastle upon Tyne. He trained in Respiratory and General Medicine at the Brompton and Kings College Hospitals, London and in Critical Care Medicine, as a JACIT trainee, at the Leeds Teaching Hospitals. His research interests include Acute Lung Injury, the innate immune system in the critically ill and the genetics of sepsis. He currently Chairs the FICM Training and Assessment Committee, is specialty lead for the Northumberland Tyne & Wear Critical Care CLRN Research Network, is a Council member of the Intensive Care Society and is Chair of the ICS Standards, Safety and Quality Committee.



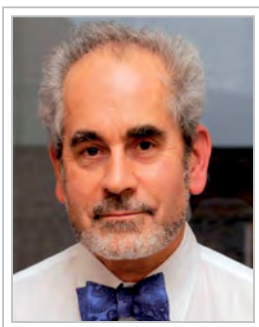
## Dr Alison Pittard

Alison Pittard qualified in Leeds in 1988, became Consultant in Anaesthesia and Intensive Care in 1997 and was awarded an MD in 1998. She is passionate about education and training, starting off as ICM Tutor, then RA for West Yorkshire and was elected as the Lead RA for ICM in 2008. During this time she has represented Tutors and Regional Advisors on the IBTICM and continue to do so as a member of the FICM Board. She took up the post of Associate Postgraduate Dean in the Yorkshire and Humber Deanery in 2009. Currently Dr Pittard is an examiner for the RCoA and the FICM and is involved in implementation of the new curriculum and development of the FFICM exam.

## FICM Board Election Results

Candidate	Votes	Candidate	Votes
WINTER, Robert	147	COOK, Brian	73
BAUDOUIIN, Simon	145	KENNEDY, Nicholas	72
PITTARD, Alison	140	POONI, Jagtar	62
MACNAUGHTON, Peter	119	SMITH, Anthony	59
CORDINGLEY, Jeremy	111	STOTT, Stephen	59
BODENHAM, Andrew	111	WISE, Matthew	49
MACFIE, Alistair	97	BARRERA-GROBA, Casiano	38
BENNETT, Sean	94	FERGUSON, Andrew	35
BERRIDGE, John	88	O'DONNELL, Roddy	35
THORPE, Christopher	78	GANNON, John	32

# Collaborating for Quality: A National Strategy for Intensive Care in the UK



**Professor Julian Bion**  
Dean



**Professor Timothy Evans**  
Vice Dean

The publication in 2000 of *Comprehensive Critical Care*<sup>1</sup> was a landmark for UK intensive care. Written by a multiprofessional clinical and managerial group supported by the Department of Health, the report was a response to evidence over the preceding 20 years of serious underfunding and lack of integration of intensive care within the health system. In 26 pages the report's wide-ranging recommendations established the foundations for improvements in intensive care for the next decade.

More than 10 years on, substantial progress has been made in terms of resources, staffing, research activities, case mix data acquisition, and most importantly in patient outcomes<sup>2</sup>. The last two years have seen the foundation of the Faculty of Intensive Care Medicine, and the establishment of Intensive Care Medicine as a primary specialty. These two latter developments fundamentally alter the future of intensive care, because they bring with them a national responsibility for quality of life-long training and standards of practice. This responsibility is not a remote or hypothetical construct: it is real, personal, and individual, directly involves us all, and is of central importance to ensuring high quality patient care. We will of course rise to this challenge, but in order to do so we need to take a critical look at our current position before defining how best to proceed.

To this end, the Faculty Board has undertaken an analysis of our strengths and weaknesses as a profession and as a clinical service, and of the opportunities and threats associated with the context in which we work. We focused this analysis on the 'implementation pathway' from basic science to better care at the bedside. From this analysis four themes emerged:

- First, while we have become considerably more knowledgeable about critical illness pathogenesis and tissue repair, effective single treatments continue to elude us, particularly for sepsis and the inflammatory response. Indeed, we now have a catalogue of interventions impressive for their failure either

to improve outcomes or even worsen them. At the same time, we find that those interventions which are effective are those which limit the deleterious effects of organ system support and which integrate complex care processes. Integration is a key component in managing complex systems.

- The second theme was that the quality of clinical care is highly variable and frequently unreliable, both in intensive care<sup>3</sup> and more widely throughout the healthcare system<sup>4,5</sup>. Causes of unreliability include disagreements about the interpretation of research evidence to achieve standards of care<sup>6</sup>, variable staff knowledge and training, sub-optimal organisational support, and what are loosely called human factors such as fatigue, communication lapses, frequent handovers, and loss of process control<sup>7,8</sup>. Promoting reliability and resilience requires context-sensitive interventions combined with life-long learning by organisations as well as individuals, and evaluated using mixed-methods research and education involving the social sciences<sup>9, 10, 11</sup>. Intensive care is already in the vanguard of current national initiatives to improve processes of care, such as the Academy of Medical Royal Colleges' 7-day Working Group, and the Royal College of Physicians' Future Hospital Commission.

**“The foundation of the Faculty and the establishment of ICM as a primary specialty fundamentally alter the future of intensive care, because they bring with them a national responsibility for quality and standards of practice”**

- The third theme was the need to improve national data, workforce planning, and resources and support for patients, relatives and clinicians. The UK remains significantly under-provisioned for intensive care beds<sup>12</sup> despite modest increases over the past decade. The case mix programme held by the Intensive Care National Audit and Research Centre is a unique resource, but we still do not have a single accurate source

for information on the number of critically ill patients receiving care each year<sup>13</sup>, or even on the number of intensive care specialists, though our workforce group is addressing this deficiency. Improving performance needs real-time feedback and benchmarking, with clinician ownership of clinically-delivered data<sup>14</sup>.

- The final theme was that current changes to the NHS<sup>15</sup> and to healthcare education<sup>16</sup> are disrupting established lines of communication and forms of working, and require us to become more self-sufficient and proactive if we are to develop and maintain a strong professional identity.

From this analysis we developed a framework for exploring these issues in more detail, based on the following five priority areas: clinical care; training and education; laboratory, clinical and implementation sciences; quality assurance and standards; and professional support and career sustainability. The framework has helped to identify key metrics and prioritise actions. It has also demonstrated that to achieve our overall goal of continuous improvements in patient care requires the interaction and collaboration of all partner organisations in the UK. Indeed, the long march of intensive care towards specialty status has resulted in an organic growth of organisations and groups each with its own identity and achievements, but often with overlapping missions and interests. In evolutionary terms, this organic growth is an expression of response to contemporaneous environmental pressures and needs. However, the fossil record shows us that this model may not be sufficiently responsive and resilient when the environment changes.

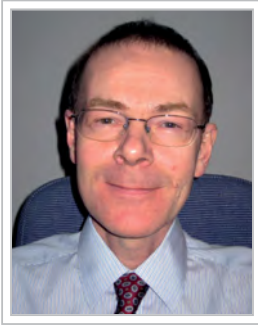
We have therefore proposed to our partner organisations that we set up an independent external commission to examine the current organisational structures for delivering UK intensive care, and to make recommendations for the future on which we can build a national strategy for ICM. We have called this initiative 'Collaborating for Quality', and have rooted it firmly in actions which (directly or indirectly) will benefit patient care. All partner organisations have given the support to this initiative. There will be three commissioners, led by Professor Sir John Temple, who has generously agreed to chair the group. Sir John will inform us of the other two commissioners in the coming weeks. A plenary meeting of all organisations will be held on September 27th. This will be followed by individual meetings with the leadership of each organisation or group. The commission will report its findings and proposals in the New Year.

We anticipate that 'Collaborating for Quality', will, like *Comprehensive Critical Care*, create the necessary conditions for fundamentally rewriting the future of our speciality. Intensive care has a good track record of collaboration, and we are going to need this quality in large measure, merging personal and organisational interests for the greater goal of improving patient care. Royal Colleges have been criticised in recent years for being too partisan<sup>17</sup> and for lacking a strategic view on quality improvement<sup>18</sup>. We believe that the new speciality of Intensive Care Medicine can rise to this challenge<sup>19</sup>, providing a single united voice by combining our various influences in the form of a clinical quality improvement community, patient-focused, data driven, research-inspired, and professionally-led by each and every one of us.

## References:

- 1 Comprehensive Critical Care: A review of adult critical care services. National service framework expert group April 1999-May 25th 2000. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4006585](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006585)
- 2 Hutchings A, Durand MA, Grieve R, Harrison D, Rowan K, Green J, Cairns J, Black N. Evaluation of modernisation of adult critical care services in England: time series and cost effectiveness analysis. *BMJ* 2009; 339: b4353
- 3 Kaushal R, Bates DW, Franz C, Soukup JR, Rothschild JM. Costs of adverse events in intensive care units. *Crit Care Med* 2007;35(11):2479-83.
- 4 McGlynn EA, Asch SM, Adams J, et al. The Quality of Health Care Delivered to Adults in the USA. *NEJM* 2003; 348:2635-45
- 5 Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, Day RO, Hindmarsh DM, McGlynn EA, Braithwaite J. CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust* 2012; 16;197(2):100-5.
- 6 Rhodes A, Moreno RP, Azoulay E, Capuzzo M, Chiche JD, Eddleston J, Endacott R, Ferdinande P, Flaatten H, Guidet B, Kuhlen R, León-Gil C, Martin Delgado MC, Metnitz PG, Soares M, Sprung CL, Timsit JF, Valentin A. Task Force on Safety and Quality of European Society of Intensive Care Medicine (ESICM). Prospectively defined indicators to improve the safety and quality of care for critically ill patients: a report from the Task Force on Safety and Quality of the European Society of Intensive Care Medicine (ESICM). *Intensive Care Med* 2012; 38(4): 598-605
- 7 Bion JF, Abrusci T, Hibbert P. Human Factors in the Management of the Critically Ill Patient. *Br. J. Anaesth* 2010; 105 (1): 26-33.
- 8 Catchpole K, McCulloch P. Human factors in critical care: towards standardized integrated human-centred systems of work. *Current Opinion in Critical Care* 2010; 16(6):618-622. doi: 10.1097/MCC.0b013e32833e9b4b
- 9 Dixon-Woods M, Bosk C. Learning through observation: the role of ethnography in improving critical care. *Current Opinion in Critical Care* 2010; 16(6):639-642. doi: 10.1097/MCC.0b013e32833ef5ef
- 10 Dixon-Woods M, McNicol S, Martin G. Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. *BMJ Qual Saf.* 2012 Apr 28. [Epub ahead of print]
- 11 Joint Royal Colleges of Physicians Training Board (JRCPTB) Learning to Make a Difference Pilot Report: Introducing Quality Improvement Methods to Core Medical Trainees. <http://www.rcplondon.ac.uk/projects/learning-make-difference-ltmd>
- 12 Adhikari NKJ, Fowler RA, Bhagwanjee S, Rubenfeld GD. Critical care and the global burden of critical illness in adults. *Lancet* 2010; 375: 1339-46
- 13 Adult Critical Care data in England – April 09 to March 10. DoH February 17th 2011. <http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/critical-care/adult-critical-care-data-in-england--april-09-to-march-10-experimental-statistics>
- 14 Mountford J, Shojania KG. Refocusing quality measurement to best support quality improvement: local ownership of quality measurement by clinicians. *BMJ Qual Saf.* 2012 Jun;21(6):519-23. Epub 2012 Mar 23.
- 15 Health and Social Care Act 2012. <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm>
- 16 World Class Education and Training, for World Class Healthcare. Introducing Health Education England. <https://www.wp.dh.gov.uk/healtheducationengland/files/2012/06/Introducing-Health-Education-England1.pdf>
- 17 Hawkes N. The Royal Colleges must up their game or die. *BMJ* 2007;334:724
- 18 Cornwell J, Levenson R. A Review Of The Approaches Taken By The Royal Colleges And Specialist Societies To Improving The Quality Of Care For Patients And Populations. Report to The Health Foundation, Nov 2011.
- 19 Ling T, Soper B, Buxton M, Hanney S, Oortwijn W, Scoggins A, Steel N. How do you get clinicians involved in quality improvement? The Health Foundation 2010. <http://www.health.org.uk/publications/how-do-you-get-clinicians-involved-in-quality-improvement>.

# Training and Assessment Committee



**Dr Simon Baudouin**  
Chair

The FICMTAC continues to have a very full agenda and once again I would like to thank the committee members for their hard work and support. The committee also relies on outstanding administrative support in the presence of Andrea Rowe, James Goodwin and Daniel Waeland. A significant portion of the work of the FICMTAC in the last year has been focused on the implantation of the first recruitment round for the new ICM CCT and the further development of the FFICM exam. Particular thanks go to Tom Gallacher and Alison Pittard for their work on recruitment and to Nigel Webster and Andy Cohen for the exam preparations. Both of these very important areas are covered in separate articles.

## **Developing and expanding the ICM CCT**

No curriculum should be static. An important and dynamic medical speciality will be continuously expanding its knowledge base and this should inform clinical practice. The FICMTAC has a number of work programmes based on curriculum revision and expansion. These include:

- The development of modules for the Special Skills year;
- The expansion of ultrasound training and competency acquisition;
- The promotion of research training in ICM.

## **Special Skills year**

The ICM CCT designates one of the years in Stage 2 training (ST5 or ST6) as a Special Skills year, allowing trainees to gain one or more 'Special Skills' in addition to continuing their general ICM training. Dual CCTs trainees will use this year to train in their partner discipline. Single ICM trainees will be able to train in various 6-12 month modules depending on their choice, trainer advice and local availability and support for the module. The first modules are being developed and will include opportunities for further paediatric, neurological and cardiothoracic ICM training, and modules that focus on advanced imaging, research and teaching/education. The list is not intended to be exclusive and other modules can be developed. However, the modules must provide a reliable and quantifiable training experience for the trainee. To ensure this each module must conform to a published standard as reflected in a common FICMTAC module pro-forma. Aims and learning outcomes must be defined, the structure of the training

documented, level of supervision defined and supervisors identified and assessment systems agreed. The need for attendance/pass at any mandatory course should also be included. Each module will need prior approval by the FICMTAC before being accepted for training purposes.

These modules will be set at a level of training beyond that defined by the core ICM CCT curriculum. We believe that this training will benefit both the trainees in terms of allowing some degree of individualised training experience and also benefit the NHS and its patients by allowing a range of extra skills to be in place in ICUs.

## **Ultrasound training**

The use of ultrasound is rapidly increasing in critical care. Currently all training units should be able to provide training in ultrasound guided vascular line placement. In addition many units are performing other ultrasound techniques including cardiac, pleural space and abdominal imaging. It is acknowledged that the level of expertise and training received by would-be ICM ultrasonographers is very variable. The techniques are clearly very beneficial in terms of immediate patient care and the FICMTAC is developing a longer term strategy to allow the incorporation of these techniques into a future revision of the ICM curriculum.

The current ICM curriculum deliberately says little about ultrasound competency beyond vascular access. We believe that the key issue here is supervision of training in ultrasound and we avoided setting the initial "bar too high" due to a lack of fully trained ICM sonographers. In collaboration with other societies/expert groups we are developing detailed guidance on training in these areas. We therefore intend to promote training in a wider range of ultrasound techniques in ICM.

The FICMTAC acknowledges the important role that the ICS has performed in promoting cardiac ECHO training in ICM. An ICS sub-committee, with FICM representation, expertly led by Professor Mike Grounds, has produced detailed training guidance. The group recommend two levels of training; the first programme is aimed at a competency level that most (probably all) future ICM practitioners should be able to obtain during training. The second is a considerably more advanced level that would need an extended training period which is likely to be beyond the CCT.



The Royal College of Radiologists has previously produced guidance on training in non-cardiac ultrasound imaging techniques. Some specialty CCTs also already include modifications of these schemes. For example Respiratory Medicine has training recommendations for chest ultrasound and Emergency Medicine for emergency abdominal imaging. We will create one or more working groups, with collaborators drawn from expert groups, to design and implement training in these areas of imaging.

### Research in ICM

The Faculty aims to promote ICM research and this involves the development and expansion of research training. The current curriculum does contain a number of research-orientated sub-domains which allow ICM CCT holders to acquire some basic knowledge of the research process. The proposed optional research module in the Special Skills year will allow some trainees to develop a more in-depth understanding and expertise in research methodology as applied to the NHS. This will be focused on the growing area of clinical trials research being carried out under the umbrella of CLRN supported Critical Care specialty groups. This training experience would for example equip the trainee to become a regional specialty lead.

There is also a need to support the research training of a future cohort of dedicated Academic ICM researchers. This group will undertake periods of dedicated research outside of the ICM CCT programme. In the past the career structure for this group has been rather ad hoc but the establishment of the National Institute for Health Research (NIHR), the dedicated work of current ICM Academics and the support of major UK Health charities is producing much more satisfactory Academic training pathways. Professor David Menon is leading a FICMTAC sub-group which is helping to better define and support ICM Academic training and promote careers in Academic ICM.

### Dual CCTs

In the UK most Intensivists also practice in another, related field of medicine. This is reflected in the training experience of recent ICM trainees where approximately 70% are also training in Anaesthesia. The FICM and its constituent Colleges feel that dual training is advantageous for a number of reasons including the maintenance of a multi-disciplinary and flexible ICM workforce. The new ICM CCT programme continues to allow for the acquisition of dual CCTs. Trainees will need to compete for both CCTs separately and will complete full training in both specialties. Without any overlap of competency acquisition the duration of training for dual CCTs would simply be the addition of training time for each separate CCT. However the FICM, with the relevant Specialist Training Committees and the GMC have developed indicative training programmes that have identified training opportunities where competencies in both CCTs can be gained simultaneously. This has allowed an indicative training period of 8.5 years in total for dual CCTs. Details of both the single and dual programmes are available on the FICM website.

### e-Portfolio development

The ICM CCT requires trainees to collect and produce, as evidence of training progression, a significant number of documents. Currently this documentation is a paper-based system collected in a traditional portfolio. The majority of speciality CCTs have moved to some form of electronic portfolio (e-Portfolio) system. The FICM intends to also move to an e-Portfolio as the advantages of these systems are clear. All relevant documents, forms and other evidence of training and competency can be securely stored in a single location; the evidence cannot be lost or degraded by the occasional spill of coffee; the evidence is more accessible to both trainees and supervisors and finally the e-Portfolio has the potential to provide a support system for future revalidation following CCT completion.

The FICMTAC has formed an e-Portfolio Working Group, ably led by Louie Plenderleith and is drawing up a specification. There are a number of potential providers of such portfolios and the Faculty is considering its options. Faculty members will be only too aware that the NHS has many striking examples of failed IT projects! Fortunately successful e-Portfolios already exist so the working group can build their specification on successful models and also learn from past experience. However, there are a number of unique features to the ICM CCT which may require specialised development, such as trainees entering higher training from multiple routes, the need to capture the complementary training experience of dual trainees and the method of recording training levels and progression as reflected in the training progression grid found in *Part II* of the CCT are all important features that need to be reflected in the e-Portfolio.

High on our list of essential specifications are ease of use; both for trainees and trainers. The composition of the e-Portfolio Working Group mirrors this need with the inclusion of a number of both junior and more senior trainees many of whom will already have experience in the use of e-Portfolios (and who are more e-communication orientated than most senior members).

The structure of the e-Portfolio will reflect the CoBaTrICE domains and sub-domains with the ability to link evidence to these sub-domains. We also want the portfolio to assist trainees and trainers in setting and achieving their training goals. We envisage a training stage reporting system that, in real time, will show trainees their progression against both short term (placement, yearly ARCP) and longer term (CCT completion) training goals and allow trainers to identify training needs and gaps in training. The ultimate choice of developer will depend on many factors including track record in the field, development and maintenance cost, enthusiasm of the developers, reliability and ease of future modification including ownership of data. The decision is important because we will be entering a long-term relationship with the e-Portfolio provider. A few organisations have changed their portfolio providers but this process is difficult and costly so getting it right the first time is important.



# FFICM Examination Development



**Professor Nigel Webster**  
Chair of Examiners

Work has been underway to prepare for the first sitting of the FFICM examination in January 2013. I have been greatly assisted by Andrew Cohen, my deputy, and the leads for the three parts of the examination – Alison Pittard (MCQ), Julian Millo (OSCE) and Gary Mills (SOE). We are in the process of formulating questions and getting them loaded onto the FileMaker Pro system as used by the Royal College of Anaesthetists for their examinations.

## MCQ

The MCQ component of the examination is completely new and needed to be developed from scratch. We were allowed access to the Final FRCA database to select and rework questions that could be used for ICM but the majority of our questions are completely new, having been written by the FFICM examiners. Examiners formed groups of three or four and were allocated two domains of the CCT curriculum to base their questions on. Prior to submission they were peer reviewed by the MCQ core group members.

Once all questions were received the MCQ core group checked them for errors of fact etc. Some of the questions were deemed to be better developed in a different format – Single Best Answer (SBA) – and were therefore excluded but will be eventually re-formatted to this style. With the adapted questions from the FRCA this has left over 300 MCQs to enter into the new database which has just recently been completed and the questions are being formatted to fit into the requirements of the optical mark reader system used by Speedwell.

The MCQ core group is currently exploring other types of questions. We have SBAs to develop and will introduce these to the exam in 2014. We are also considering Extend Matching Questions (EMQs) but at present it is not clear if we will be able to use them.

The other big task on our agenda is a new Primary FFICM examination which will also be in MCQ format. This will be a basic science examination and we hope, as well as developing new material, that we will be able to look at questions currently used by our partner colleges. The Faculty is approaching them to discuss this further and future developments will be reported on the Faculty website and in *Critical Eye*.

## OSCE

The aim of the Objective Structured Clinical Examination (OSCE) component of the new FFICM examination is to recreate a 'normal working day' on duty for the Intensive Care Unit (ICU). In a normal working day, a trainee will manage a number of medical and surgical patients with an interesting variety of problems. During any typical normal working day, trainees review patient history, perform physical examination in a systematic yet focused manner, interpret data from monitors and investigations (most commonly arterial blood gases, laboratory data, electrocardiograms, chest X-rays

and CT scans), plan patient management and perform a range of procedures. The trainee may be called to deal with life-threatening emergencies anywhere in the hospital.

Back in the ICU, the trainee will communicate with patients, their relatives, the supervising consultant and the multidisciplinary team. In addition to the diagnostic and therapeutic skills already listed, the trainee is expected to ensure that care is delivered in a compassionate and professional manner, including at the end of life. The breadth of

knowledge and skills required is set out in the syllabus<sup>1</sup>. Candidates will be given the opportunity to demonstrate a selection of the required knowledge and skills in the OSCE component of the examination.

The OSCE is a development of the clinical viva component of the old DICM. In this viva, common and important clinical problems were discussed. The viva was based on clinical history, examination findings

“ In addition to diagnostic and therapeutic skills, the trainee is expected to ensure that care is delivered in a compassionate and professional manner - candidates will be given the opportunity to demonstrate a selection of the required skills and knowledge in the examination ”

and the results of investigations including images. The OSCE format allows a slightly broader range of clinical questions. To use tension pneumothorax as an example, a candidate may be asked to examine a mannequin representing a ventilated patient. This is probably more valid than being told a list of physical examination findings.

Actors, equipment, data and both part-task and whole-patient simulators will be used to recreate a 'normal working day'. When candidates are expected to examine a patient, perform a task or demonstrate communication skills, clear instructions will be given.

Each station lasts for seven minutes, followed by a one-minute interval. During the interval, the candidate waits outside a cubicle and reads a short introduction, which will indicate the type of station and what is expected. Examples of the OSCE stations are given in the accompanying table. Marks from each station contribute to the overall mark.

### SOE

The SOE core group are working up new questions and modifying those previously used in the old DICM. The format of the questions will be broadly the same as the DICM although the mode of the examination will be more like an OSCE as the candidates will move between stations and will be asked questions on the one subject at each station. A notice outside each of the station will highlight the topic to be covered in the station.

The reasoning behind this way of conducting what is effectively a usual structured oral examination is to expose the candidates to the maximum number of examiners as possible. Following on from the principle of the 'home ICU' the questions are those that may be asked during a ward round or teaching session or journal club at any ICU in the UK. They test knowledge of the principles behind the work we do.

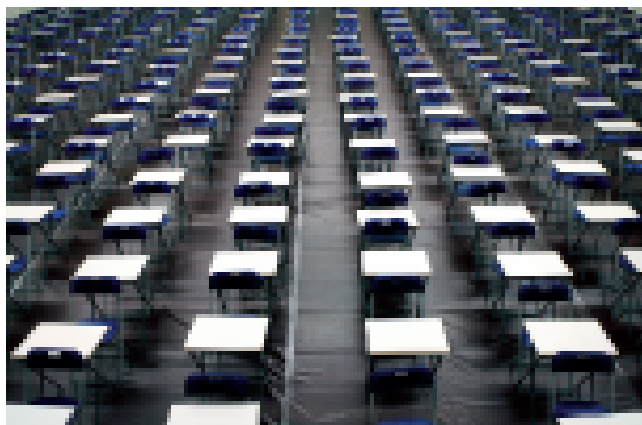
The examiners are all practicing intensive care clinicians. Candidates are all asked precisely the same questions. There is no negative marking and candidates are expected to give clear and concise answers.

### DICM

Finally, the last sitting of the UK Diploma in Intensive Care Medicine was held on 10th and 11th July 2012 at Churchill House. The DICM has served the intensive care community well for over a decade and the Faculty would like to thank all who contributed to its creation, development and delivery, and congratulate all successful diplomates. The final Diplomas will be awarded at the next Annual Faculty Meeting in March 2013.

#### References:

<sup>1</sup> <http://www.ficm.ac.uk/sites/default/files/document-files/cct%20in%20icm%20part%20iii%20-%20syllabus%20%28aug2011%20v1.0%29.pdf>.



## OSCE Examples

Candidates will be expected to perform a variety of tasks at each of the thirteen seven-minute OSCE stations. There is a one-minute interval between stations during which the candidate is provided with written instructions as to what to expect. Illustrative examples are given below:

- The focus of this station is the initial management of extensive burns. The examiner will show you photographs of a burnt patient. You will be expected to describe your management plan.
- The focus of this station is the management of an acute medical emergency. The examiner will show you arterial blood gas data. You will be expected to make a differential diagnosis and then describe your management of the most likely diagnosis.
- The focus of this station is CXR interpretation. You will be shown a number of CXRs. Please answer the questions on the sheet provided.
- The focus of this station is central venous catheter insertion. You will be expected to cannulate a manikin. The examiner will ask you to demonstrate certain aspects of your technique.
- The focus of this station is communication. You will interview the son of a critically ill patient who is concerned about the treatment that his mother is receiving. The examiner will give you detailed instructions.

For further example questions please check the FFICM Examination pages of the Faculty website, [www.ficm.ac.uk](http://www.ficm.ac.uk).

# Professional Standards Committee



**Dr Carl Waldmann**  
Chair

The Professional Standards Committee first met in April 2011 and since then there have been three further committee meetings.

## Purpose

To encourage and facilitate the establishment, maintenance and improvement of good practice in all aspects of Intensive Care Medicine. The Committee will be concerned with quality improvement matters that arise within the Board of the Faculty of Intensive Care Medicine, with particular reference to clinical audit, clinical effectiveness, clinical guideline development, continuing professional development (CPD) and the integration of any such areas into the revalidation process.

## Co-operation with other bodies

The Committee has continued to work in liaison with the Colleges, other national bodies and specialist societies such as the Intensive Care Society, the National Institute of Health and Clinical Excellence, the Care Quality Commission, and the Intensive Care National Audit and Research Centre and the MHRA.

## Strategy

The strategy is to create evidence based standards for critical care. The PSC already works with the Standards, Safety and Quality Committee (SSQ) of the ICS and the Professional Standards Committee of the Royal College of Anaesthetists, and discussions are afoot to work in collaboration with ICNARC. The Respiratory Failure Networks proposal for example, will ensure involvement from the Critical Care Networks and Commissioning. Ultimately it is the aim to set up a forum for Quality Improvement.

## Standards

There will be a need to determine whether Standards are the same as Key Performance Indicators. It will be important to determine the relationship between Quality Improvement and Performance Management. We will need to consider what to do if there is only poor grade evidence for some of the standards. Consensus is needed for those standards supported by weak or no evidence. We need to develop the concept of dynamic standardisation where the standard is the subject of

ongoing research and may need to be modified in the light of new evidence. Under consideration will be how we take research and audit evidence and translate this into standard setting, Quality Improvement and Performance Management.

## Consultations

As an example of our work streams, since the Committee started, we have:

- submitted 12 quality indicators for consideration by NICE. As yet there has been no reply;
- responded to Baroness Young about the EU Commission on Mobility of Healthcare professionals within the European Union;
- taken on the responsibility for the critical care section of the RCoA Audit Recipe Book;
- been invited by The Academy of Medical Royal Colleges to contribute to discussions on developing good practice and promulgating new initiatives aimed at involving and supporting carers in hospital and community health settings.
- been asked to on the Joint British Diabetic Societies Inpatient Group on the Management of Hyperosmolar Hyperglycaemic State (HHS) in adults new Guideline, which, though interesting, it was felt could not be endorsed as there was no intensive care input into the drafting of the document.

Naturally this is small selection of the many consultations we are asked to undertake on a yearly basis.

## Meetings

On 2<sup>nd</sup> March we had a combined meeting with the ICS Standards, Safety and Quality committee. A way forward for collaboration was agreed, in which the two bodies

had felt that as much information as possible should be assembled from the Networks, the Scottish Intensive Care Society Quality Improvement Group and all other stakeholders. It was agreed that Drs Tim Gould and Chris Danbury should co-ordinate a working group to develop nationally agreed standards and quality indicators. In conjunction with this it was proposed that Quality Improvement and Revalidation should all be linked to this work. We expect this to start a process of greater cross-working between the two standards committees.

“We need to develop the concept of dynamic standardisation, where the standard is the subject of ongoing research and may need to be modified in light of new evidence”



# Regional Update



**Dr Alison Pittard**  
Lead RA in ICM

It's been a busy time since I last wrote for *Critical Eye*. So much change but we have weathered the storm, I think, and come through the other side almost unscathed, with trainees in a programme leading to a CCT in Intensive Care Medicine. Regional Advisors and Faculty Tutors have been busy liaising with deaneries, fielding questions from potential and current trainees and identifying posts to put into the new training programmes. Perhaps we all thought that, at this stage, we could sit back and relax! But no there is, and always will be, so much to do.

Whilst everyone was planning posts and programmes regionally, behind the scenes the recruitment process for these programmes was being planned. There was a degree of trepidation as the 'make-up' of new appointees was unknown. This made finalising numbers of posts we would offer difficult and it wasn't until the week before the recruitment process that we had final numbers. A sigh of relief could be heard across the country if you listened carefully! The actual selection process, held in Birmingham, was a dream with the most amazing positive feedback from candidates and selectors. The two days were organised to military precision thanks to Ms Manjit Kaur and her team at the West Midlands Deanery.

Whilst there is frantic activity regionally, matching people to posts, at the Faculty we are looking at recruitment for 2013, including Dual CCTs Programmes. There is some concern amongst our partner specialties about the impact this will have on their own training programmes. This appears to be particularly so for Anaesthesia who, not only have seen their training numbers reduce but are unclear as to how their own trainees will acquire their ICM competencies. In June myself and other representatives of the Faculty Board attended the RCoA Regional Advisor and College Tutors' meeting in Bristol where, hopefully, we were able to explain how the two specialties could integrate.

Dual CCTs Programmes have been agreed with a number of specialties and will have an indicative minimum period of 8.5 years instead of 7 for a single CCT programme. Although the ICM programme has three stages the order of training blocks within each stage is interchangeable provided they are a minimum of 3 months and can be negotiated between Anaesthesia and

ICM Training Programme Directors depending on local need. Gaps created in one specialty programme by a trainee acquiring competencies in a second specialty can be backfilled with LAT appointments.

As RAs and Tutors we are inundated with trainees seeking advice. They seem to be the same irrespective of specialty or region and to help, the Faculty has and will issue statements as things become clearer. Is it wise to undertake training leading to a single CCT in ICM? Will there be consultant jobs at the end? If wanting to gain two CCTs which specialty should be secured first? What about anaesthetists who don't want two CCTs but still want some exposure to ICM? And what opportunities will the latter have at consultant level? Trainees who commenced their specialty training in 2011 should continue to apply for training under the Joint CCT programme. The GMC has allowed appointment to this programme until 31st July 2013 and this will continue to be managed locally. Those trainees who commenced their specialty training in August 2012 should apply for a second specialty as a Dual CCTs Programme in the 2013 recruitment process.

It is clear that over the coming years there will be a gradual change in the way our Intensive Care Units are staffed. In the first instance most people will wish to gain two CCTs and the advice to trainees, whilst we have stepped entry, will depend on individual circumstances. The Faculty is currently working with the Centre for Workforce Intelligence to plan for the future. The number of CCTs in ICM awarded will need to increase in order to match the number of advertised consultant posts in ICM so it is vital that trainees continue to be exposed to ICM outside of the CCT programme.

The Faculty plans to subsume Intermediate and Advanced 'sign-off' into its membership processes, details of which will be posted on the website when finalised. In the short term at least these new membership categories will continue to be criteria for consultant posts. We have come a long way and I doubt our journey will ever end. Our aim is to ensure our specialty is equipped with high quality doctors providing the best possible care for our patients.

*"It doesn't matter where you are, you are nowhere compared to where you can go"* - Bob Proctor.

# National Recruitment to the ICM Specialty Training Programme



**Dr Tom Gallacher**  
Chair, FICM Recruitment  
Sub-Committee



**Dr Alison Pittard**  
Chair, Harmonisation Working  
Group, Lead RA in ICM

The first ever recruitment exercise to Intensive Care Medicine as a specialty in its own right presented us with a fantastic opportunity, not only to select the best but to do this using a system that is fit for purpose. The Modernising Medical Careers (MMC) change programme placed more emphasis on delivering robust methods for assessing and developing doctors throughout the career life-cycle. In a major DH report called *Proposals for Reform of the SHO Grade*, Sir Liam Donaldson (Chief Medical Officer for England, 2002) argued that:

*“Reform must take account of [...] weak selection & appointment procedures: these are not standardised and are frequently not informed by core competencies.”*

Most of the research and implementation of selection systems, within a medical context, carried out over the last 10 years has focussed on primary care. The aims were to develop best practice processes for selection in medicine using tools and techniques for assessment that are standardised, fair, defensible, reliable, valid, cost-effective and feasible. Subsequent studies have focused on other specialties, including anaesthesia, obstetrics and gynaecology and paediatrics identifying competencies and developing competency-based application forms, structured, competency-based reference reports and assessment centres. The evidence points towards assessment centres being the most effective way of determining future potential.

In Primary Care, 11 competencies were identified as being important using this methodology. All of these attributes were found to be of relevance to high performing anaesthetists but in addition, vigilance and teaching were also ranked. As Intensive Care Medicine (ICM) is a relatively new specialty there is no comparable literature to refer to therefore we have had to extrapolate from other specialties. These 13 competencies were cross referenced with the ICM curriculum and competencies for Anaesthesia and ACCS to produce a final list of 10. An electronic job analysis was performed to identify the core and specific competencies felt to be important in Intensive Care Medicine. FICM Regional Advisors and Board Tutors were asked to rank the competencies in order of

importance. These behavioural indicators have been used to develop questions on the application form and stations at the assessment centre, giving candidates the opportunity to display the attributes that we feel to be important for quality and success in the practise of Intensive Care Medicine. Not all of these competencies were looked for at the assessment centre as some competencies are better targeted in training rather than the point of selection (e.g. vigilance). There are also other competencies that can be assessed which are not necessarily core. Not all core competencies are assessed at every station.

The Faculty established a Harmonisation Working Group, reporting to the Recruitment Sub-Committee, whose remit was to develop the tools to be used for selection. This work was undertaken by Alison Pittard, Daniele Bryden, Victoria Robson, Andrew Gratrix, Gordon Craig and Mike Clapham. It is hoped that these will be developed further in the future and new stations created by Faculty RAs and Tutors.

The ICM assessment centre built on best practice, attempting to reduce sources of error/bias in traditional interview selection procedures by using trained assessors to observe, record, classify and evaluate behaviours during the various exercises. Assessors require thorough training and a training day, accompanied by a handbook, was held for those who would be involved in the selection process.

We have now completed the first recruitment process in England and Wales. Northern Ireland and Scotland chose to observe the process in 2012 and we are hopeful they will take part in 2013 to allow their trainees to participate in the new programme. There were 68 posts available throughout England and 4 in Wales and we had a 72% fill rate as illustrated in Figure 1, below.

This new programme is unique in United Kingdom medical training in that a trainee will be permitted to hold two National Training Numbers (NTNs) and upon successful completion of training will be awarded two CCTs in two separate primary specialties.

In order to achieve this the Faculty of Intensive Care Medicine, the Royal College of Anaesthetists, the Joint Royal College of Physicians Training Board and the College of Emergency Medicine have constructed new training programmes which will provide the necessary competencies for anyone undertaking a CCT programme in ICM and another approved CCT programme. These programmes, known as Dual CCTs Programmes, are shorter than the sum of the individual specialty programmes since where competencies can be obtained in either specialty they are not repeated in the partner programme.

subsequently reject posts as is evident from the above figures. In addition, from 2013 the process of post allocation will become automated using the UK Offers System, a system designed to specifically prevent a trainee from holding more than one offer at any given time – a pre-requisite for appointing to two training programmes simultaneously in the same recruitment round. By temporarily separating the two processes the administration of posts can be undertaken at a local level with manageable numbers and variability.

Fig 1: ICM posts and fill rates for 2012 recruitment.

Deanery	Number of Posts	Accepted	Holding	Vacant positions	Occupancy
KSS	4	0	0	4	0%
London	19	17	0	2	79%
Mersey	4	4	0	0	100%
North Western	12	8	0	4	67%
Northern	6	3	0	3	50%
Oxford	4	2	0	2	50%
Severn	4	4	0	0	100%
SW Peninsula	2	1	0	1	50%
Wales	4	2	0	2	50%
Wessex	2	2	0	0	100%
West Midlands	5	5	0	0	100%
Yorkshire and Humber	6	4	0	2	67%
<b>TOTAL</b>	<b>72</b>	<b>55</b>	<b>0</b>	<b>20</b>	<b>72%</b>

The recent recruitment process dealt only with recruitment to the standalone ICM programme. This means that trainees were applying for their only NTN i.e. Intensive Care Medicine since the opportunity to apply for a second NTN will not be introduced by the Faculty until August 2013. Trainees will then be able to apply for a second CCT programme in Intensive Care Medicine or a partner specialty, depending on which specialty was entered first. Upon obtaining a second NTN a pre-determined dual training programme will be provided. This means that trainees in ICM in 2012 can apply to a partner specialty and trainees in a partner specialty can apply to ICM in the 2013 recruitment round.

It is said that if you find yourself starting a sentence with the words “Why don’t you just...” it normally reveals a lack of appreciation of the problems. There are good reasons for this staggered approach to recruitment. There are 14 Deaneries in England alone and there are 5 partner specialties. Some specialties recruit using a national process and others utilise regional processes all taking place at different times over a 3 month or so period. There is the opportunity for two recruitment rounds as well as the possibility of specialties running a clearing process. The allocation of two training posts in the same Deanery at the same time would be unmanageably complex as trainees hold and

The Faculty are currently in discussion with many stakeholders including the GMC, Department of Health, Royal Colleges and COPMed to finalise the detail of how recruitment to dual programmes will work. We will establish how many posts will be available in each Deanery, the recruitment process, and in particular, on what basis Dual CCTs programmes will be awarded. It is the Faculty’s position that both posts in a Dual CCTs programme should be in a single Unit of Application but this position has not been ratified or agreed by our stakeholders. We are also trying to resolve how we can ensure there is the opportunity in open competition for anyone in the appropriate specialties to be appointed to a dual programme. Clearly, in this regard we cannot allow everyone who wishes to undertake dual training to do so, but equally we must not exclude potentially excellent trainees because of administrative training issues such as empty slots on rotations.

The Faculty’s over-riding principle remains that we should select the best trainees for ICM based on merit who will ultimately deliver the best care to our future patients. The opinion of those involved in this first process was that the standard of candidates was certainly high and we would hope to continue to attract the best. We will continue to strive for excellence and modify our tools accordingly but for now we will concentrate on next year.



# Trainee Update



**Dr Chris Booth**  
Trainee Representative

The rapid pace of development that has occurred since the formation of the FICM has continued in recent months with the first round of recruitment to the new primary specialty ICM training programme. The first cohort of doctors will enter the system at the beginning of August and it is important that both trainees and trainers recognise that, whilst there may be initial teething problems, this is the start of the future of training in ICM in the UK.

The individuals who have been successful in applying to the programme will come from a variety of backgrounds; some will wish to undertake primary specialty training whilst others will be planning to apply for dual training with a partner specialty. All will be welcomed to the FICM as trainee members and can expect the full support of the Faculty in their training.

With the primary specialty ICM appointments complete for this year the FICMTAC and Recruitment Sub-Committee's attention will focus on the route of entry into dual training and how such programmes will function at a practical level. Current planning suggests that individuals will need to competitively apply and be appointed to an ST3 post in their partner speciality through UKOFFS next year. It is worth reflecting that the current Joint training programme also requires an individual to be competitively appointed to both training programmes; the advantage of the new system is that the order in which an individual can be appointed to the training programmes is flexible.

For example, an individual wishing to train in Acute Medicine and ICM can now apply to ICM in their first year of application before applying to AM in the second, or vice versa. Previously such an individual would have been restricted to applying for AM first before being appointed to ICM later in their higher specialist training. There are important issues to highlight whilst planning the process including the problems presented by appointment to geographically separate programmes. Trainees can be reassured that these issues are being addressed during the planning process.

For those doctors who have been successful during the recruitment programme this is an exciting time. The new programme offers the unique opportunity to spend a year during ST5 or ST6 undertaking training in a 'Special Skill'. Trainees who go on to undertake dual training will need to spend this year in their partner specialty. Doctors undertaking primary specialty training should be encouraged to consider what they would like to undertake during this year. The FICM is actively engaged in creating Special Skills years' curricula in areas including Pre-Hospital Medicine and Echocardiography. There may also be an opportunity for individuals to create their own special year in an area of special interest; if this is the case then clearly forward planning will be crucial to success.

## Fellowship of the FICM

January bought the closure of the initial Foundation Fellowships. Eventually all Fellowships will come through the new FFICM examination. Until the exam is available

there must be an alternative route and this is currently operating as Fellowship by Assessment. Doctors who have completed their CCT programme in ICM and have taken up a substantive consultant post in ICM are eligible to apply under this route. Concerns have been expressed about individuals who have completed their training (with a Joint CCT) but have not taken up a substantive consultant

post for various reasons (e.g. locum positions, experience abroad, fellowships) not being eligible for Fellowship. It is anticipated that the Fellowship by Assessment route will remain open for the foreseeable future to those who have completed the Joint CCT programme prior to the new FFICM exam being available, allowing them to join the Faculty as Fellows once they take up a substantive consultant post.

The new final FFICM examination will undergo its first sitting in January and March 2013 consisting of an MCQ following by an SOE/OSCE day. The examination calendar and fee structure is now available on the FICM website ([www.ficm.ac.uk](http://www.ficm.ac.uk)). This will be a compulsory exam for those undertaking the new primary specialty training

“From its inauguration the FICM has recognised the vital importance of representation from doctors in training in all matters pertaining to ICM in the UK”

programme, but for those in the current Joint-CCT programme it is optional. There are obvious reasons to sit the exam and all trainees who will still be in training once it is available should be encouraged to do so.

### **e-Portfolio**

The FICM are pursuing the development of an e-Portfolio system for training. Several systems have been proposed and a working group has been formed to evaluate the options. A group of trainees including recent Foundation doctors, who have tangible experience in the use of the NES e-Portfolio system, have been recruited to provide input as the future users of the system. This approach should negate problems previously experienced with the functionality of e-Portfolios for trainees and trainers alike.

### **Logbook**

For some period of time it has been recognised that keeping a logbook of cases in ICM presents considerable difficulties; in comparison to anaesthetic or surgical disciplines episodes of care are ill-defined creating a potentially endless series of data to collect and process. The value of such data in demonstrating training competencies has also been questioned. Previous incarnations of an ICM logbook produced under the banner of the IBTICM were criticised by trainees for being unwieldy and oppressively time consuming to complete.

The FICMTAC has been working with the Trainee Committee of the ICS to produce a basic logbook summary that can be used as evidence of relevant experience at an ARCP. This has been published on the FICM website. There is no current plan to produce a method of data collection itself (i.e. an electronic database/logbook tool) as efforts are correctly being directed toward the e-Portfolio instead.

### **Multi-Source Feedback Tool**

The MSF tool used as a workplace-based assessment has been revised following concerns that the previous incarnation was excessively long, contained domains that non-medical colleagues were unable to assess and provided no opportunity to highlight areas of excellence. The new tool utilises the Team Assessment of Behaviour methodology and encourages assessors to make comments on both areas of concern and areas of excellence or strength.

The tool is in two parts; forms for distribution to team members and a summary sheet for use during a feedback meeting with the Faculty Tutor. Both are available on the FICM website along with a guidance document outlining the Faculty's expectations for their use.

### **Trainee Representation**

From its inauguration the FICM has recognised the vital importance of representation from doctors in training in all matters pertaining to ICM in the UK. Initially representation has been provided through appointment of the Chair of the ICS Trainee Committee as a full member of the Faculty Board. The FICM now has an established group of trainee members and as such

it is appropriate that Board level representation is drawn from this group in the future.

The first elections for this post took place on 27th July 2012. The role is a unique opportunity to provide influence in a developing specialty; candidates should be highly motivated and committed to providing accurate representation across a wide range of issues. The successful candidate will receive significant support from and will become a co-opted member of the Intensive Care Society's Trainee Committee, ensuring continuing access to a wide range of trainee opinion and providing links to more junior trainees.

On a personal note the completion of the trainee elections brings to an end of my time on the Faculty Board as the Trainee Representative. During my tenure I have witnessed rapid change in ICM within the UK as the FICM has begun the process of establishing itself. Throughout this period a primary motivation of the Board has been ensuring that the training of doctors in ICM is of the highest quality and I have witnessed an immense amount of effort to ensure the introduction of the new programme is both timely and equitable. I would like to thank my colleagues on the board for their warm welcome, continuing support and willingness to listen and engage with the trainee viewpoint. I wish my successor every success and look forward to welcoming them in my role as the Chair of the ICS Trainee Committee.

## **FICM Board Trainee Representative Election Results**

An election for the FICM Trainee Representative was held on 27th July 2012. All registered trainee members of the Faculty (as trainees appointed to an ICM CCT programme) were eligible to stand and vote, however the voter turn out was very low. The role is the trainees' chance to directly influence Board policy and it is hoped turn out will increase in future.

There were ultimately four candidates for the role. The Faculty is pleased to welcome the successful candidate, Dr Michael McAlindon of Worcester Royal Hospital.

The Board also wishes to thank the other three candidates for their interest in the position and urges them to continue their enthusiasm for being involved with the work of the Faculty.

<b>Candidate</b>	<b>Votes</b>
<b>McALINDON, Michael</b>	<b>10</b>
<b>OLUSANYA, Olusegur</b>	<b>9</b>
<b>O'SULLIVAN, Finbar</b>	<b>7</b>
<b>GLEN, John</b>	<b>7</b>

# The ST3 ICM Interview - an applicant's view



**Dr Zoe Brummell**  
Trainee

At the time of writing I am waiting to find out what my future holds, waiting to see whether I will become one of the first batch of intensive care trainees appointed to ST3 as part of the new Intensive Care Medicine training programme. I have wanted to become an intensivist since the 2nd of August 2007, when I was fortunate enough to work on the Liver Intensive Care Unit at Kings College Hospital as a CT2 in Hepatology.

When I first heard about the new intensive care training programme I was concerned and more than slightly apprehensive. I had changed from being a gastroenterologist to an anaesthetist with the idea that I would apply and undertake an Advanced training year in ICM and then a Joint CCT in Anaesthesia and ICM. However after further investigation, several emails to the chairman of the ICS Trainee Committee (Dr Booth) and time to reflect, I started to feel excited about the possibility of training entirely as an intensivist.

So since the end of summer last year I have been closely following events on the FICM website and more latterly the West Midlands Deanery recruitment pages. I checked in detail the person specification for ICM to enhance my application where possible. I registered for the application form at the earliest possible opportunity and carefully filled it in. I received my invitation to interview at Birmingham City Football Club and less than four weeks later was on the train to Birmingham.

I had tried to prepare as best I could for the interview, ordered and re-ordered my portfolio, read up clinical guidelines, practiced presenting in front of colleagues and tried to imagine what the reflective practice and task prioritisation exercise OSCE stations would entail. Some of these elements of interview were entirely new to me and I found difficult to prepare for. I arrived very early; I have been early for everything since I nearly missed my Primary FRCA viva due to reading about the stress response for the umpteenth time!

It is odd turning up to a football stadium in a suit; the last time I had been into a football stadium I was 15 years old and a Nottingham Forest Season ticket holder. The process of registering for the interview was very straightforward and the administration staff were incredibly friendly. We were given individual name tabards and timetables for the interview

process. I was slightly unnerved by the 'written exam', which appeared to be one and a half hours long. This actually turned out to be 30 minutes of task prioritisation, followed by 30 minutes of reflective practice, then 20 minutes to prepare for the clinical scenario station and 10 minutes to prepare for the presentation, all in a room with a view of Birmingham City's pitch.

The task prioritisation exercise was quite stressful; I tried to imagine what I would actually do faced with the need to manage the five situations in a safe and timely fashion. Clearly some of the situations were more urgent (life-threatening) than others and some were more time consuming than others. Choosing the order was more difficult than explaining why I had chosen that order and I could have done with another 10 minutes and more paper (or smaller writing). I enjoyed the reflective practice exercise, but struggled to remember all the personal skills I needed to demonstrate. The clinical scenario was very suited to my gastroenterological background and I was delighted by the choice of topic for the presentation station.

My first actual face-to-face interview was the presentation, which seemed to go well, the consultants were attentive and friendly, helping me to put up the sheets on the flipchart. The clinical scenario station was probably my low point of the day, I don't think I did myself justice and I'm certain that the consultants at this station would have been very surprised to find out that I was once a medical registrar.

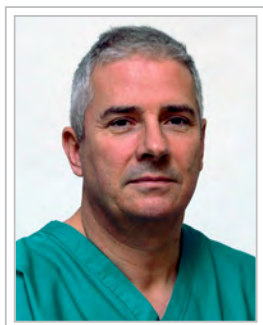
The portfolio station was much more relaxing, I had to show why I had scored myself certain points on the application form and answered some completely reasonable questions. At the end of the interview we gathered in the registration room and were thanked by Professor Bion for attending and invited to ask questions.

All in all I thought it was a very well organised and thought out interview that was reasonably fair and gave the opportunity to display a variety of skills.

Thank you to Dr Pittard, Dr Gallacher, Professor Bion and all the Regional Advisors involved in designing, setting up and running the interviews.



# Fellowship and Membership



**Dr Patrick Nee**  
Membership Lead

Since the last edition of *Critical Eye* the window for Foundation Fellowship has closed, with approximately 1600 applications received by 31st December 2011.

The objective of the Faculty is to be as inclusive as possible, recognising that the ICU family, as it now stands, comprises clinicians from many different specialties, with varied training and including many doctors trained outside of this country. However, it is also important to acknowledge that from 2013 Fellowship will be earned by successful completion of the FFICM examination. Consequently, it would be inappropriate to award the post-nominals to all who applied, with no assessment of their eligibility in terms of qualifications and experience. We are also constrained by the regulations of the trustee colleges. So that, for example, full Fellowship may not be awarded unless the applicant is a Member or Fellow in good standing of one of the UK colleges.

Applications are presently invited for the following membership categories:

## **Fellowship by Assessment (FFICM)**

Open to medical practitioners holding a substantive or honorary NHS or Defence Medical Services consultant post in the United Kingdom with a sessional or other contracted daytime clinical commitment to Intensive Care Medicine. The applicant must be a Fellow or Member in good standing of one of the trustee college and hold the appropriate postgraduate diploma from that college.

## **Associate Fellowship (AFICM)**

Open to substantive or honorary UK consultants with a contracted daytime clinical commitment to ICM who are not full Fellows of one of the FICM trustee colleges. (For example those who hold FCARCSI or Associate Fellowship of the RCoA).

## **Affiliate Fellowship**

Open to substantive or honorary UK consultants with some contracted clinical commitment to ICM but which does not meet the criteria for daytime clinical commitment required for full Fellowship. There are no post-nominals associated with this membership route.

## **Membership (MFICM)**

Open to non-consultant career grade UK doctors with a contracted daytime clinical commitment to ICM who are not eligible for any Fellowship route.

## **Trainee membership**

Open to trainees appointed, via competitive interview, to a programme of training leading to a CCT in Intensive Care Medicine. All trainees appointed to an ICM CCT programme must now register as Faculty trainees. Trainees must hold a valid National Training Number. Trainees completing modules of ICM training outside of an ICM CCT programme are not eligible for trainee membership. However, the Faculty plans to introduce further routes of entry for these trainees in 2012.

Applications for all categories from the beginning of 2012 represent a steady start, but we continue to grow our numbers. At the time of writing the numbers received are:

Fellowship by Assessment (FFICM)	42
Associate Fellowship (AFICM)	20
Membership (MFICM)	3

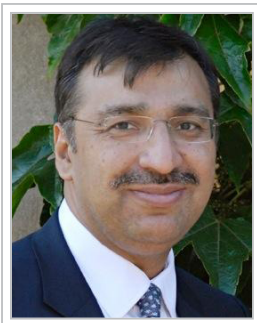
Further details on rights and privileges conferred with Fellowship and Membership, advice on subscriptions fees and application forms are available through the Faculty website, [www.ficm.ac.uk](http://www.ficm.ac.uk).

“The objective of the Faculty is to be as inclusive as possible, recognising that the ICU family comprises clinicians from many different specialties with varied training”

As a Faculty, we have more work to do in order to provide an appropriate ‘home’ for everyone delivering medical care for critically ill patients. We have yet to accommodate trainees without a programme leading to CCT in ICM, we have not yet started to recruit overseas, and we are exploring the enrolment of Advanced Critical Care Practitioners.

I would like to close by expressing my gratitude to Daniel Waeland and his team, who make up what the Dean has called the Civil Service; James Goodwin, Andrea Rowe and Anna Ripley. I suspect the Faculty as a whole would not function without their continued outstanding support.

# Human Patient Simulation in Intensive Care Medicine training



**Dr Sid Khan**



**Dr Ben Shippey**

Human Patient Simulation (HPS) is on the rise throughout the world. It has expanded from its beginnings in the mid 1980s to become an established component of training and assessment programmes in a variety of medical and surgical specialties. These specialties tend to be labour intensive, where crisis situations evolve unpredictably, and patient care takes place in an environment of ad hoc teams, limited information and heuristic-driven decision-making. Highly skilled individuals and a high degree of team coordination are required to deliver safe and effective critical care practice and it is therefore surprising that Intensive Care Medicine has been slower than other specialities such as Anaesthesia, Emergency Medicine and Surgery to adopt this educational method.

However, national and international initiatives over the last five years have raised the profile of simulation as a useful formative educational tool, and there is increasing enthusiasm within the UK for the introduction of HPS into the ICU itself. Most learners report a high degree of satisfaction following a HPS educational experience, but there is little high quality evidence available with regards to the validity, reliability and translation to improved clinical practice of HPS training. Despite this challenge, simulation has already been adopted in some parts of the world as a summative assessment tool, either as part of a training programme or as a component of a revalidation/ reaccreditation process. Many UK hospitals now have the ability to provide mid-fidelity simulation training.

Intensive Care Medicine HPS delivered locally is time efficient, it has the advantage of familiar equipment, environment and personnel, but cost constraints, and the absence of a purpose-built facility tend to mean lower fidelity simulation. Robust funding, space and staffing can be difficult to obtain. The alternative, providing dedicated courses in central simulation centres with high fidelity manikins, has the advantage of higher physiological fidelity, but delivered in an unfamiliar environment. It is also logistically more difficult, though not impossible, to train whole teams in a remote centre. Therefore simulation activity should be designed and delivered to suit the educational objectives of the

planned intervention, and delivered in the most suitable environment available.

Critical care HPS is potentially a transformational learning experience for individuals or teams. It can provide a safe controlled environment for the learner to rehearse technical skills required to perform risky procedures without endangering patients, and carefully scripted scenarios can provide exposure to important but rare or complicated clinical events. Crucially, HPS can facilitate the integration of knowledge, skills and behaviours that enhance safe patient care. Clinicians have become increasingly aware that critical incidents are often caused by human error related to human factors rather than lack of medical knowledge, skill or resources. HPS training can provide one aspect of training in the non- technical skills that are required in critical care, including team dynamics, leadership skills, communication, vigilance, situational awareness, judgement, and decision-making.

Intensive Care Medicine presents its own challenges with regard to HPS. While some of critical care practice is undoubtedly of the “acute crisis” variety (e.g. the patient presenting with symptoms and signs of subarachnoid haemorrhage and increased intracranial pressure), much is not (e.g. the patient ten days after laparotomy for intestinal perforation with fever and slowly rising pressor requirement), and it is important that we use simulation to address educational outcomes that are achievable in a sensible time frame. Authenticity and immersion are the keys to avoiding a lack of engagement with HPS. Unfamiliar equipment and unbelievable physiology can cause the learner to disengage, and even the most advanced simulators available behave unpredictably at the extremes of the programmed physiological model, particularly when simulating complex lung dynamics. Critical care teams are large, creating a choice of simulating a team in the simulated environment for an individual participant, or addressing the varied learning needs of the whole critical care care team within the same scenario.

Successful HPS requires that appropriate educational goals are set prior to planning the educational

intervention. It can be tempting to intensive care physicians to concentrate on the accurate reproduction of the physiology and pharmacology of the situation in the simulator – and this can overwhelm the intended educational outcome of the scenario. We advocate that each scenario design should start with a consideration of the learning needs of the participants, and it should be developed to offer the opportunity for suitable behaviours to be demonstrated. It is useful to consider both technical behaviour, e.g. adherence to failed intubation algorithm, and non-technical behaviour, e.g. task prioritisation and allocation, when designing scenarios. Using a predesigned set of scenarios designed to cover a curriculum can make this easier.

Under the aegis of the European Society of Intensive Care Medicine, the Simulation Applied to Intensive Care Medicine Training (SAInT) group developed one such resource pack of simulation scenarios mapped to the ESICM CoBaTriCE ICM curriculum, which is commercially available. Similar material provides the basis of basic level ICM HPS in the Scottish Clinical Simulation Centre, which, while not yet embedded in the training programme, is actively promoted by trainers in Scotland.

The key components of HPS are briefing, simulation scenario and debriefing. The purpose of briefing is to inform participants of the aims of the HPS including clear learning objectives and time frame. The participants need to be assured of confidentiality, unbounded space and a non-judgemental supportive learning environment. It is important that before the HPS begins there is time for orientation and familiarity with the technical aspects of manikins. Successful HPS requires those taking part to have a shared mental model and suspend disbelief by treating the manikin as they would a real patient. A positive experience is more likely if the scenario does not lead to harm or death and candidates are ensured of emotional safety.

Subsequent analysis of performance within the simulator can also tend towards the analysis of knowledge or algorithm-based outcomes rather than the behaviours within the scenario that led to them. The simulator is an ideal environment to demonstrate the effect of human factors on patient outcome, particularly if we use video-assisted facilitated debriefing to identify and discuss non-technical elements of performance. It is this debriefing skill that is often the least appreciated, but perhaps the most challenging for an inexperienced simulation facilitator to acquire.

Many centres offer ‘training the trainers’ courses, and these are a good introduction to the skills needed to facilitate this aspect of simulation training. Some centres offer further ‘supervised practice’ as a facilitator,

recording debriefing and using video assisted ‘meta-debriefing’ to further improve performance. In addition, HPS facilitators need mastery of the simulator technology, scenario design, subject expertise, communication skills and an understanding of the educational needs of participants. Some of these educational needs will be mandated by curricula.

The recently introduced ICM curriculum was published with suggestions that evidence of some competencies might be obtained in a simulated environment, and it therefore provides an opportunity to integrate a program of simulator activity into a national training programme from the outset, promoting quality and equity of access to HPS throughout the UK. With these developments in mind, we have formed a group

to promote, shape and guide the development of HPS as an educational tool for UK Intensive Care Medicine training.

The group has representation from both the Faculty of Intensive Care Medicine and the Intensive Care Society, and includes representatives from the Royal College of Anaesthetists, well-established simulation centres, the armed forces, and Intensive Care Medicine trainees.

We intend that the group will have four main activities:

- Actively promote the introduction of simulation into training programmes throughout the UK, by developing and sharing clinical scenarios, based around the ‘Top 30’ cases identified in the ICM curriculum, coordinating the efforts of the ICS and FICM, and publishing a guide intended to facilitate the integration of HPS into training programmes.
- Quality assure the provision of ICM HPS throughout the UK by setting standards for HPS activity, and Faculty training, providing access to suitable Faculty training programmes.
- Investigate the potential of HPS as a summative assessment tool, by developing, piloting and validating assessment tools that can be used in the simulated environment.
- Co-ordinate the production of research into simulation by maintaining a database of research projects and opportunities.

HPS is rapidly being adopted as an educational intervention in critical care. Intensive care presents challenges both generic to simulation training and specific to critical care, which require skilled facilitators for successful educational outcomes. The revision of the ICM curriculum presents the opportunity to embed simulation experiences within a national training programme. The FICM/ICS Simulation Group aims to promote and coordinate these activities in order to provide a consistent and high quality experience for UK ICM trainees.

“ Intensive care presents challenges both generic to simulation and specific to critical care, which require skilled facilitators for successful educational outcomes ”

# CPD Update



**Mr Don Liu**  
RCoA Revalidation and CPD Manager

The General Medical Council (GMC) has recently published new guidance on continuing professional development (CPD), linking the process firmly to a doctor's annual appraisal and revalidation<sup>1</sup>. Doctors will be expected to confirm they meet the attributes and domains of Good Medical Practice through presentation and discussion of supporting information (or evidence) in their revalidation portfolios during their appraisal. One category of supporting information is evidence of CPD – the other categories being information reviewing and evaluating the quality of professional practice and, finally, feedback on or how others (colleagues and patients) perceive the quality of a doctor's work.

## Principles of CPD

The GMC has set out a number of principles in guiding doctors when approaching their CPD:

- *Personal responsibility* – you are responsible for identifying your CPD needs, planning how to address those needs and undertaking activities that will support your professional development and practice;
- *Reflection* – you should reflect regularly on your standards of professional practice;
- *Scope of practice* – you must remain up-to-date and competent in all areas of your practice;
- *Individual and team learning* – you should strive to maintain and improve the standards of your own practice and those of any teams in which you work;
- *Identification of needs* – your CPD should be informed by assessment of both your professional needs and the needs of service users;
- *Outcomes* – you must reflect of what you have learnt through your CPD and record any impact (or expected impact) on your performance and practice.

Along with the CPD guidance the GMC has also issued an information sheet for employers outlining their responsibilities in helping you to meet the above principles<sup>2</sup>. Employers are responsible for making sure that their workforce is competent and up-to-date and, therefore, should maintain and develop the skills of their medical staff through facilitating access to appropriate resources (including time).

## College and Faculty Guidance

The GMC guidance highlights the role medical Royal colleges and faculties have in CPD including providing specialty guidance, advice as to best practice and online tools to record and manage CPD effectively. The guidance issued by colleges and faculties map to the Academy of Medical Royal College's *Ten Principles for CPD Schemes* document and a central requirement is that doctors should achieve an average of 50 CPD credits per year (250 credits over a five-year revalidation cycle<sup>3</sup>). One credit equates to one hour of educational activity.

To ensure that there is a balance in the types of learning activities doctors engage in, the RCoA guidance indicates that a minimum of 20 external and 20 internal credits should be obtained each year<sup>4</sup>. The other ten credits allow a degree of flexibility in practice. External activities include attending conferences to remain abreast of current best practice or educational visits to centres of excellence. Internal activities, to maintain high standards of practice within the workplace, include participation in local audit and clinical governance meetings. Internal also includes personal study such as journal reading and e-learning.

## CPD Matrix

The Faculty of Intensive Care Medicine (FICM) has produced a matrix for CPD – a framework of three levels of knowledge and skill areas to be covered in CPD<sup>5</sup>. Level 1 is the same as Level 1 in the RCoA CPD Matrix and lists the core knowledge areas that doctors practising in Anaesthesia, Intensive Care Medicine and Pain Medicine should cover. This should not be too much of a burden as the expectation is to cover the 30 knowledge areas in Level 1 over a five-year revalidation cycle.

What knowledge and skills areas to cover in level 2 is dependent on your scope of practice including on-call responsibilities. The level 2 areas for Intensive Care Medicine (as defined by the FICM) are obvious areas for consideration for readers of *Critical Eye*. However, if your clinical practice extends beyond Intensive Care Medicine you should consider the knowledge and skill areas listed within the matrices of your parent college. Remember, one of the GMC principles is that you must remain up-to-date and competent in all areas of your professional practice.



For Level 3 the FICM has defined areas that intensive care specialists should have expertise in (e.g. rehabilitation and recovery from critical illness). Some of your CPD activity in covering these advanced areas should be from participation in 'State of the Art' meetings and conferences. If your clinical expertise extends beyond Intensive Care Medicine refer to Level 3 of the RCoA or other parent college CPD matrices for guidance as to advanced areas to cover.

It is worth remembering that both the FICM and RCoA matrices are intended to act as guidance only, as the responsibility for CPD rest with the individual. However, the matrices do provide a starting point in helping to formulate a personal development plan and discussing and evaluating the scope of CPD covered with your appraiser.

### RCoA Online CPD System

Members of the FICM are entitled to register for access to the RCoA online CPD system. The system has been developed with the GMC guidance in mind, as it will provide you with an online space to record your CPD and credits gained and detail your reflection on and learning outcomes from each activity. Also useful will be the ability to map your activities to the knowledge and skills areas of the CPD Matrix. This in turn will provide an ongoing visual indicator of what you have covered and what you need cover over a five-year revalidation cycle.

For your annual appraisal we are developing the functionality (due to be released in September 2012) allowing users to summarise their CPD credits and activities into a PDF certificate/document that can be downloaded and then uploaded into local hospital appraisal systems or appended onto electronic appraisal forms. Another feature of the online system

is a database of approved CPD activities. The RCoA introduced a scheme to approve events (conferences, workshops, seminars, etc) organised by CPD providers, including the FICM and specialist societies. CPD assessors are asked to review applications based on certain quality criteria. Once approved users of the online system can map to these events in the database, reflect on any learning outcomes and claim their CPD credits. Users can also search for a list of upcoming approved events using the CPD Matrix areas (see Fig 1). The approval process is quality assured and reviewed by a CPD Board, which includes representatives from the faculties of intensive care and pain medicine and specialist societies and associations in anaesthesia.

To register for a username and password to access the online CPD system, please go to: <http://www.rcoa.ac.uk/revalidation-cpd/online-cpd>. For further information please email [cpd@rcoa.ac.uk](mailto:cpd@rcoa.ac.uk).

#### References:

- 1 General Medical Council. Continuing professional development: guidance for all doctors. London: GMC, 2012. [http://www.gmc-uk.org/CPD\\_guidance\\_June\\_12.pdf\\_48970799.pdf](http://www.gmc-uk.org/CPD_guidance_June_12.pdf_48970799.pdf)
- 2 General Medical Council. Information sheet for employers about 'Continuing Professional Development: Guidance for all Doctors'. London: GMC, 2012. [http://www.gmc-uk.org/CPD\\_info\\_sheet\\_June\\_12.pdf\\_48968022.pdf](http://www.gmc-uk.org/CPD_info_sheet_June_12.pdf_48968022.pdf).
- 3 Academy of Medical Royal Colleges. The ten principles for college/faculty CPD schemes. London, AoMRC: 2007. [http://www.aomrc.org.uk/component/docman/doc\\_download/9327-10-principles-of-cpd.html?Itemid=33](http://www.aomrc.org.uk/component/docman/doc_download/9327-10-principles-of-cpd.html?Itemid=33).
- 4 Royal College of Anaesthetists. Guidelines for continuing professional development (including the RCoA CPD matrix). London: RCoA, 2012.
- 5 Faculty of Intensive Care Medicine. CPD matrix for intensive care medicine. London: FICM, 2011. <http://www.ficm.ac.uk/cpd-and-revalidation>



Diary   Activities   Planning   Personal Filing Cabinet   Reports

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Subscribe to CPD Approved Events For Category: Adult ICM

Title	Start Date	End Date	Url	Origin	Action(s)
<a href="#">CORE TOPICS by The Association of Anaesthetists of Pakistani origin in the UK and Ireland</a>	14/07/2012 13:00	14/07/2012 17:30	No link available	The Association of Anaesthetists of Pakistani origin in the UK and Ireland	<a href="#">Subscribe</a>
<a href="#">The ICE Course: An Introduction to Critical Care Echocardiography</a>	31/10/2012 08:45	31/10/2012 17:00	No link available	Brighton and Sussex University Hospitals NHS Trust, Brighton	<a href="#">Subscribe</a>
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Filter by Event details:

Title:

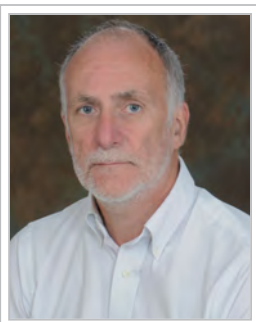
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Origin:

CPD Matrix Categories:

Fig 1: A list of Level 3 Adult ICM approved CPD activities.

# Workforce Planning in ICM



**Dr Alasdair Short**  
Workforce Lead

Considerable change is taking place in the provision of many services that require support by critical care and the pace of this change is likely to accelerate in the near future, not least because of the implementation of the recent Heath and Social Care Bill. It is essential for the Faculty to understand the current workforce numbers and patterns of those working in ICM across the UK.

This is necessary to provide the best estimate of the number of trainees that will be needed to enter formal specialist ICM training in order to provide the ICM service of the future. It is accepted that new treatment/management protocols will likely cause unpredicted changes that will affect service provision given that there is a 7-9 year lead time to the achievement of a CCT in ICM. There had been a plan to work with the Centre for Workforce Intelligence (CfWI) to do an in depth study into ICM informed by the data we are collecting, however due to a change in priorities at the CfWI this will not be taking place and, working with the RCOA, the Faculty will develop a plan for the development of the ICM workforce.

Until 18 months ago the central government figures for ICM workforce were buried within the figures for Anaesthesia and it was impossible to determine with any degree of precision the contribution of PAs to ICM from the RCoA census performed in 2009. In order to gain the necessary information the FICM Workforce Advisory Group was formed and the Phase 1 census was designed and sent out to all the ICUs within the UK last spring. The aim was to get as much detail as possible with regards to the provision of ICM facilities, the number of consultants and their DCC-PAs in ICM, on call patterns etc. The returns were slow in coming but after further chasing we had obtained over 80% cover.

Since that time we have also circulated a Phase 2 census for all the consultants who have been registered as Foundation Fellows of the Faculty which we felt would include the vast majority of those providing DCC-PAs in ICM. This would provide some cross referencing data with the first survey and also give the data for SPA and other activity directly linked to ICM. So far there has been a somewhat disappointing return of 56%. I would like to thank all those who have completed and returned the census and encourage all those who have yet to complete the form to do so. We can only plan for the future workforce with the best information possible. We will publish the summarised data. No individual data will be published. Please see <https://www.surveymonkey.com/s/icmcensusphase2>.

## Examples of headline results from Phase 1:

- Unit size: 22 units (13%) < 8 beds; 102 units (53%) >11 beds.
- Average DCC-PAs per hospital: 24 (range 0-99) these include hospitals with more than 1 unit. (This is a figure that will be made much more accurate once we get more complete data from the Phase 2 survey);
- ICM cover pattern: weeks - 74 units; blocks of days - 50 units; single days - 47 units; Mix of types -10 units; 24 hour consultant on site rota - 1 unit;
- Out of hours cover by consultants without daytime ICM DCC-PAs: 61 units; prospective cover in all but 7 units;
- On call rota variation from 1/4 - 1/19 (median 1/8);

## Some findings from Phase 2 to date:

- Specialty breakdown of Consultant posts (n=1122)

Anaesthesia and ICM	1020
ICM alone	57
Respiratory Medicine and ICM	12
Emergency Medicine and ICM	8
Other specialties and ICM	33

- Age structure: 25% of the Consultant's responding are over the age of 50 (8% > 55);
- Total contracted PAs (response n = 905): Median = 12 (range 3 - 15) with a large minority reporting performing over contract;
- Programmed PAs in ICM: Median 4 PAs (range 1 - 11).

From the summarised data it may be seen that there is a considerable variation in the way that ICM is provided. Unsurprisingly the variations seem to be related to individual unit or hospital size, geographical issues and the specialties provided. In view of the importance of getting as accurate figures as possible, please could everyone ensure they have completed the second census which has been sent electronically to all Fellows of the Faculty in consultant posts. This will inform the negotiations for the future ICM workforce. If there is an issue with receiving or filling in online please contact the Faculty.

From the results of the second census we will then reconstitute the Workforce Advisory Group with input from the Intensive Care Societies to analyse the individual results and provide a full report and analysis to inform the planning of the workforce for the future. There is to be a meeting on the 9th November to consider all the issues regarding ICM workforce planning and therefore if all could do their best to complete the census as completely as possible before the middle of September (to allow for data analysis) we would be most grateful.

# UK Severe Influenza Surveillance System



**Ms Nicki Boddington**  
Senior Scientist,  
Health Protection Agency



**Dr Richard Peabody**  
Consultant Epidemiologist,  
Health Protection Agency

Following a successful pilot in 2010/11, the Health Protection Agency (HPA) ran a hospital-based influenza surveillance system to monitor severe disease during the 2011/12 season. The UK Severe Influenza Surveillance System (USISS) sentinel system was developed to provide a surveillance system to rapidly describe the epidemiology and impact of severe influenza on the population. The system fills a gap in surveillance of influenza in the UK, identified post-pandemic by the Hine Review and the Chief Medical Officer's Statistical Legacy Group. The scheme is supported by the Royal College of Physicians, Faculty of Intensive Care Medicine and the Intensive Care Society and has received National Information Governance Board (NIGB) approval.

During the 2011/12 season a sentinel network of 36 of 170 (21.2%) Acute Trusts from across England were recruited using stratified random sampling. Trusts were asked to submit data via a secure web-tool. A case was defined as any person who was hospitalised and had a laboratory confirmed influenza A (H1 or H3) or B infection.

Consultant microbiologists and infection control teams at each participating sentinel Trust submitted a weekly aggregate report of all cases admitted to hospital the previous week, by age group and flu type, at any level of care. Each Trust also submitted individual level data on cases admitted to Intensive Care Units (ICU)/High Dependency Units (HDU).

Following the intense influenza activity observed in 2010/11, seasonal influenza activity seen in 2011/12 in the United Kingdom through several indicators was low and late. This pattern was also reflected by the data collected through USISS. Over the period from 3 October

2011 (Week 40) to 20 May 2012 (Week 20), a total of 543 hospitalised cases of laboratory confirmed influenza were reported by participating Trusts (see Fig 1). Of the 543 cases, 283 were influenza A unknown subtype (52.1%), 190 were influenza A (H3N2) (35.0%), 63 were influenza B (11.6%) and seven were influenza A (H1N1) pdm09 (1.3%). A total of 46 cases (8.5%) were admitted to ICU/HDU. The proportion of hospitalised H3N2 cases admitted to ICU/HDU was 12.1% (23/190) and of B was 11.1% (7/63).

The system is complemented by the USISS mandatory ICU scheme, a national mandatory ICU surveillance scheme, established in cooperation with the

Department of Health, reporting the aggregate number of admissions and fatal cases of confirmed influenza cases in ICU/HDU by NHS trust across England by flu sub-type and age-group. Similar systems are in operation in Wales, Northern Ireland and Scotland.

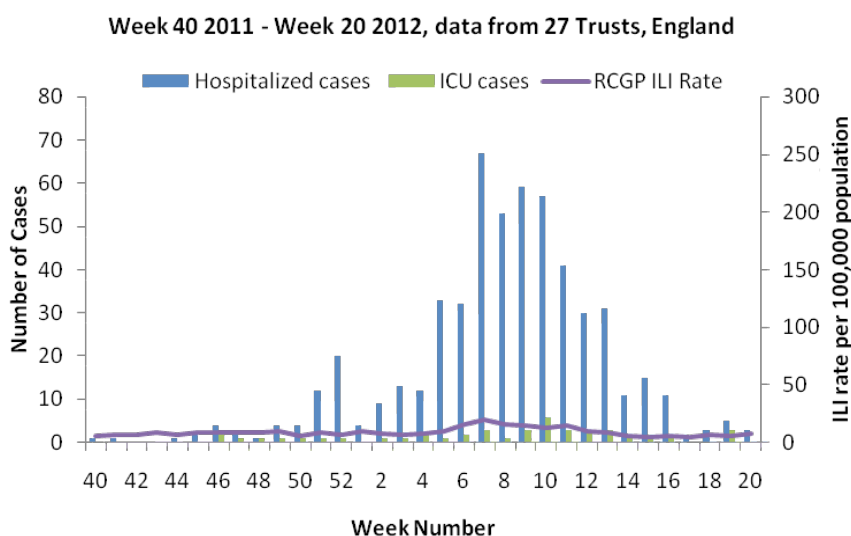


Fig 1: Weekly number of hospitalised cases and RCGP ILI consultation rate.

Both systems will be operating during this forthcoming 2012/13 season. Prior to the start of the season HPA will be approaching Acute NHS Trusts in England for the sentinel network to report hospital-wide aggregate data on cases of confirmed influenza admitted to hospital and individual level data on confirmed influenza cases admitted to ICU.

More information on influenza and USISS weekly data is available on the HPA website ([www.hpa.org.uk](http://www.hpa.org.uk)) and will be reported this forthcoming season through the HPA National Influenza Report.



# First Annual Faculty Meeting



**Professor Timothy Evans**  
Vice Dean

Over 100 delegates attended the Faculty Day held at the Royal College of Physicians on 6th February 2012. Additionally, some 30 members of the Faculty Board, distinguished speakers, diplomates and those receiving Fellowships in recognition of their contribution to the specialty were in attendance. The aim of the day was to bring together the intensive care community some 12 months after the foundation of the Faculty by its seven trustee (parent) colleges.



*Professor Sir John Tooke giving the Annual Faculty Lecture*

The day was divided broadly into four sessions. The first of these was aimed at informing the fellowship of major advances in UK critical care, both in terms of service provision and academic advancement. Specifically, Professor John Watson, Head of Respiratory Diseases at the Health Protection Agency London informed the audience of the epidemiology of the 2009/10 and 2010/11 H1N1 influenza outbreaks, with the remit of answering the question as to whether or not the UK population escaped lightly. Issues relating to the evolution of the virus, and its spread from localised outbreak to epidemic were presented in detail. In the UK, the idea of containing the spread of the virus by isolating victims rapidly gave way to a treatment phase, by which time a maximum of some 900 ICU beds were occupied by flu victims. The impact on specific groups of patients, for example the pregnant and peri-partum, was discussed.

In a subsequent presentation by Professor McAuley of Queen's University Belfast and Dr Simon Finney of Imperial College and the Royal Brompton Hospital recounted how extracorporeal membrane oxygenation was used to support those with the most severe forms of acute of respiratory failure. The way in which ECMO centres

were established rapidly but effectively, treating some 200 flu victims over the two separate epidemics has had a significant impact on the way in which critical care services have evolved subsequently with the establishing of permanent centres able to deliver such support. A major publication (JAMA 2011; 306: 1659-1668) demonstrates the ability of the UK intensive care community to collaborate in the delivery of a novel clinical service and produce world class research in such circumstances.

In the second session, the Faculty was privileged to welcome Professor Steve Field, Chair of the NHS Future Forum; Dame Carol Black, Chair of the Centre for Workforce Intelligence; and Sir Bruce Keogh, Medical Director of the NHS to provide their views of the prospects for the NHS in the next decade. In his presentation on 'Reforming the Reforms', Professor Field indicated that the Healthcare Bill currently passing through the House of Lords (as at February 2011) has been modified by the 'listening exercise' initiated by the Government in which he has played a prominent part. Professor Black provided a detailed description of the composition of the current and future medical workforce, and predicted how it will change significantly in the next few years. Professor Keogh indicated that the current reforms with their emphasis on the quality, safety and effectiveness of care were crucial if the service is to maintain patient focused care and a corporate and professional identity.

The afternoon incorporated two sessions. In the first the Faculty Board processed in splendid academic garb purchased by generous grants from two of the parent colleges (RCoA, RCP London). With appropriate ceremony, successful candidates in the United Kingdom Diploma of



*Dr Andrew Georgiou receiving his DICM from the Dean*



Intensive Care Medicine examinations were presented with the relevant certificates by the Dean.

Subsequently, three individuals who have made particular, long lasting and highly significant contributions to the development of the specialty were honoured by the award of Fellowships. Dr Judith Hulf, former President of the Royal College of Anaesthetists was instrumental in laying the groundwork for the formation of the Faculty and for ensuring it would be hosted and supported financially in the early years of its life by the RCoA. Dr Sheila Willatts, an eminent intensivist in her own right with an international reputation had chaired the Intercollegiate Board for Training in Intensive Care Medicine and ensured that the first ICM training programmes were developed. Finally, Professor Iain Ledingham, an early pioneer in research and education relating to the speciality, was honoured.

Annual Faculty reports were introduced by the Vice Dean. The results of the two-phase workforce survey lead by Dr Alasdair Short provided the first detailed information as to the nature and distribution of ICU beds in England, Wales and Scotland. The data concerning individual consultants' contractual arrangements and commitments to the speciality will be invaluable in predicting service provision and recruitment/training requirements. Subsequent reports dealing with the emergence of the 'standalone' CCT programme in ICM, and the Diploma examination were presented by the Chair of the Training and Assessment Committee, Dr Simon Baudouin. Issues relating to recruitment to training programmes and the role of the Regional Advisors were presented by Drs

Gallacher and Pittard. A question and answer session enabled delegates to raise pertinent points concerning each area with the Board. Finally, access routes to the Faculty were described by Dr Patrick Nee and the role of the Professional Standards Committee in developing this specialty was addressed by Dr Carl Waldmann.

In the final session of the day the Faculty was honoured to be addressed by Professor Sir John Tooke, President of the Academy of Medical Sciences, in the Inaugural Annual Faculty Lecture entitled 'Science Shapes Medicine'. Sir John provided a masterful overview of the way in which innovation leads directly to changes in patient care, before describing recent changes to the NHS science base and structure (e.g. the emergence of academic health science centres and partnerships) likely to be highly relevant to the (future) scientific base of ICM.

At the closure of the day's proceedings the Dean indicated that it had been a highly successful first year for the Faculty which had enrolled nearly 1600 foundation fellows. The ability of the Faculty Day to attract leaders of the National Health Service, to display the contribution the speciality had made over two winters to managing victims of some of the worst viral epidemics encountered in recent decades were all matters to celebrate. However, possibly the most significant and moving experience for those present was to witness the emergence of new specialists in Intensive Care Medicine in the form of a successful diplomates, and to honour those who have passed through their professional careers enhancing the experience of those who follow behind.

## Professor David Bennett

*Born 19th August 1938, died 21st February 2012*

Consultants and professors are often liked, respected and admired but few are loved. The avalanche of tributes and accolades that have flooded in since David's tragic and premature death demonstrate the intense warmth and affection in which he was held. He was one of the founding fathers of British critical care and a leading figure on the international stage.

He qualified from the Middlesex Hospital, London in 1963. He was a British Heart Foundation Research Fellow at the National Heart Hospital, a Medical Research Council Senior Registrar at Charing Cross Hospital and then Lecturer, Senior Lecturer, Reader and, in 1997, Professor at St George's Hospital Medical School. In 1974 he became the first Director of the Intensive Care Unit at St George's Hospital. After formally retiring in 2007 he maintained research and teaching interests as a Visiting Professor at Guy's and St Thomas' Hospitals.

His pioneering work in haemodynamic monitoring and physiology began in the 1960s with seminal work on electrocardiography, Doppler ultrasound (both suprasternal and oesophageal) and pulmonary artery catheters, followed by later studies with gastric tonometry, lithium dilution and central venous saturation.

He strongly promoted their incorporation into routine clinical practice. He often utilized such techniques to experiment on a wide range of then-novel pharmacological compounds including glyceryl trinitrate, dopexamine, new hydroxyethylstarches, pentoxifylline, esmolol and carvedilol, and the first use in human septic shock of nitric oxide synthase inhibitors.

His later research career championed the concept of perioperative circulatory optimization initially proposed by Shoemaker to improve outcomes in high-risk surgical patients. Having confirmed the benefits in a landmark study published in JAMA in 1993, and reinforced by subsequent studies, David became an impassioned advocate, travelling the globe to promulgate and proselytize.

He was a superb teacher, nurturing successive generations of intensivists who went on to develop successful research, clinical and leadership careers in their own right, yet who all acknowledge an immense debt of gratitude to their motivational guru.

He leaves a wife (Kathron), daughter (Gabby), two grandchildren, two adoring daschunds, and many other broken hearts.

# Royal Society of Medicine - Critical Care Medicine



**Dr Chris Meadows**  
Honorary Treasurer, RSM Critical Care  
Medicine Section

The Royal Society of Medicine is a 200-year old independent, apolitical organisation founded on the bedrock of medical education, of which it is currently one of the largest providers in the UK. The Section of Critical Care Medicine at the RSM arose from its predecessor, the Sub-Section Steering Group, in January 2011 and is dedicated to providing an academic programme second-to-none. The aims and objectives of the Section are:

- to provide a forum for the discussion of Critical Care and related subjects;
- to enhance the relationships between Critical Care and other specialties and;
- to provide continuing medical education for consultants, trainees and students specifically designed to assist their needs.

With these in mind, recent meetings have focused on the best of established critical care and the promise of new translational research and technology; advances in neuro and cardiorespiratory intensive care therapies including ECMO; the recognition of 'critical illness' and how to manage it; and a critical retrospective of the handling of the 'flu pandemic and epidemic.

Future meetings include a ventilation masterclass; an evidence-based review of the extensive 'fluids' literature including an analysis of research and probity; and a focus on the rapidly changing world of organ donation and transplantation.

One of the unique strengths of the RSM is the common language spoken by all specialties represented by 57 Sections under one roof. Joint meetings are an opportunity to share ideas, build relationships and explore issues that traverse specialty boundaries. Forthcoming joint meetings include those with Adult Congenital Heart Disease, Anaesthesia and Coloproctology.

The Critical Care Medicine Section has an established 'after-work' evening tutorial programme designed for ICM trainees. These popular, oversubscribed series have concentrated on areas of the ICM curriculum in which not all trainees may be fortunate enough to have gained clinical experience during their training programme. Recent topics have included paediatric ICU for the adult intensivist, toxicology and liver ICU.

This year, the Section will be launching a travel bursary for students who intend to spend time in an intensive care unit as part of a period of elective study.

The forthcoming academic programme for the Critical Care Medicine Section at the Royal Society of Medicine is as follows:

## **28<sup>th</sup> September 2012**

Joint meeting with Adult Congenital Heart Disease  
*Includes:* a sequential approach to anatomy; effects of ventilation and inotropes on the congenital circulation; shunts, cyanosis and univentricles; panel discussion of difficult cases.

## **16<sup>th</sup> November 2012**

'Blood, Sweat & Tears': Fluids and electrolytes in the critically ill  
*Includes:* Starling's forces; volume vs pressure; fluids and brain injury; the rational use of blood and blood products; the 'ideal' fluid; probity.

## **8<sup>th</sup> February 2013**

What is 'critically ill' and how would I spot it? specifically for Foundation and Core trainees  
*Includes:* hypoxia, tachycardia, oliguria, pyrexia and coma; case-based presentation and management.

## **5<sup>th</sup> April 2013**

Challenges and triumphs in critical abdominal surgery  
*Includes:* enhanced recovery and daycase colorectal surgery; emergency abdominal surgery; abdominal compartment syndrome; gut failure on the ICU.

## **4<sup>th</sup> July 2013**

Controversies in organ donation and transplantation  
*Includes:* speakers from both sides of the donation/transplantation divide; ethics; international viewpoints.

## **Running throughout the Academic Calendar**

the Critical Care Medicine Trainees Tutorials. Topics for 2012/13 will be announced shortly.

To find out more or to register for forthcoming meetings please visit the RSM Critical Care Sub-Committee website: [www.rsm.ac.uk/academ/smtcrit.php](http://www.rsm.ac.uk/academ/smtcrit.php).



## ANNUAL MEETING

Friday 1<sup>st</sup> March 2013

*At the Royal College of Anaesthetists, London*

09:00 – 09:30	<b>REGISTRATION</b>
09.55	<b>Introduction and Welcome</b> <i>Prof. Julian Bion (Dean)</i>
<b>Session 1:</b>	<b>Changing the healthcare system</b>
10:00 – 10:20	<b>The post bill NHS in practice</b> Dr Jennifer Dixon
10:20 – 10:40	<b>Education and training in the new NHS</b> <i>TBC</i>
10:40 – 11:00	<b>The role of college and Faculties</b> Professor Terence Stephenson
11.00 – 11.15	<b>Panel discussion</b>
<b>Session 2:</b>	<b>Changing practice</b>
11:15 – 11:35	<b>The Future Hospital</b> <i>TBC</i>
11:35 – 11:55	<b>Commissioning Quality in Intensive Care</b> Dr Mark Britnell, KPMG
11:55 – 12:15	<b>Revalidation: will it lead to better doctors?</b> Sir Peter Rubin, GMC
12:15 – 12:30	<b>Panel discussion</b>
<b>12:30</b>	<b>LUNCH</b>
<b>Session 3:</b>	<b>New knowledge in critical care</b>
13:00 – 13:20	<b>Sepsis</b> Dr Anthony Gordon
13.20 – 13.40	<b>Head and spinal injury</b> Professor David Menon
13.40 – 14.00	<b>ALI</b> Professor Gavin Perkins
14.00 – 14.20	<b>Genomics</b> Professor Charles Hinds
14.20 – 15.00	<b>Panel discussion</b>
<b>Session 4</b>	
15.00 – 16.00	<b>The Faculty Annual Report and award of Fellowships</b>
<b>16.00</b>	<b>REFRESHMENTS</b>
16:15 – 17.00	<b>Annual Faculty Lecture</b> Professor the Lord Darzi
17.00	<b>CLOSE OF MEETING</b>
<b>17.00 – 18.00</b>	<b>RECEPTION – Drinks and canapés</b>

**Please Note:** *The FICM reserves the right to make changes to this programme at any time if necessary.*

# 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 1733).**

## 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](http://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](mailto: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.



## Forthcoming Events 2012

### SEPTEMBER

- 13 - 14 **ICS Practical Seminar - BASIC**  
Churchill House, London
- 26 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London

### OCTOBER

- 10 **ICS Seminar - ICM Career Day**  
Mayo Building, Salford Royal Hospital
- 23 **ICS Seminar - Nurse & AHP Research Day**  
Churchill House, London
- 25 **ICS Seminar - Acute Kidney Injury**  
Churchill House, London

### NOVEMBER

- 8 **ICS Regional Seminar - Neuroscience**  
Mayo Building, Salford
- 9 **Core Topics for Training and Revalidation in ICM**  
Churchill House, London
- 25 **ICS Seminar - ICM Career Day**  
Churchill House, London

### DECEMBER

- 10 - 12 **The State of the Art Meeting 2012**  
The ICC, East ExCeL, London

## Echocardiography Accreditation

Two separate accreditation processes for Transthoracic Critical Care Echocardiography will shortly become available. Both processes have been endorsed by the ICS Council and the BSE Council. Further details on the ICS website.

**Focused Intensive Care Echo (FICE)** describes a set of core echocardiography skills essential to the management of the haemodynamically unstable patient. Detailed information regarding this module will be available through the ICS website by September 2012. [FICE@ics.ac.uk](mailto:FICE@ics.ac.uk)

**BSE(British Society of Echocardiography) - Accreditation of Critical Care Echocardiography** is a revised and restructured accreditation process; the new syllabus has been designed specifically to address the needs of the intensivist. The first sitting of the written component of the exam will take place on the 1st November 2012 during the BSE annual conference. [accreditation@bsecho.org](mailto:accreditation@bsecho.org)

# The State of the Art Meeting 2012



## Critical Care - with a focus on what really works!

Best practice, personal experience & insight from acknowledged experts in the field

**Monday 10 - Wednesday 12 December 2012, The ICC, East ExCeL, London**

The UK's Largest meeting for Intensive Care Professionals. Join us for a 3-day 3-track meeting

### Key Note Speakers:

Prof Alain Combes, France  
Prof David Menon, UK  
Prof Claudio Ronco, Italy  
Prof Monty Mythen, UK  
Prof Gordon Rubinfeld, Canada  
Prof Mervyn Singer, UK  
Prof Taylor Thompson, USA  
Prof Jean-Louis Vincent, Belgium  
Prof Tim Walsh, UK  
Prof Hannah Wunsch, USA

### Topics:

Acute Kidney Injury, The Patient's Experience, The Future of ICU, Surgical Outcomes, Severe Acute Respiratory Failure, Outcomes in ICU, Infection Controversies, Cardiovascular updates, Quality in ICU, Trainee sessions: Life at the Coalface and The Cauldron, Blood matters, Improving Outcome and Diagnosis, Foundation Updates, Research and Clinical Practice Free Paper Presentations.

Rates frozen from 2011 Early Bird registration available before the 24/09/12\*

\*full fee breakdown available on the ICS website



The Intensive Care Society  
Churchill House, 35 Red Lion Square  
London WC1R 4SG

T: 020 7280 4350 F: 020 7280 4369 E: [events@ics.ac.uk](mailto:events@ics.ac.uk)

[www.ics.ac.uk](http://www.ics.ac.uk) [www.intensivcarefoundation.org](http://www.intensivcarefoundation.org)

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Churchill House | 35 Red Lion Square | London | WC1R 4SG  
tel 020 7092 1653 | email [ficm@rcoa.ac.uk](mailto:ficm@rcoa.ac.uk) | online [www.ficm.ac.uk](http://www.ficm.ac.uk)