

Critical Eye

Issue 1

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The Faculty of
Intensive Care Medicine



Welcome

Welcome to the first edition of *Critical Eye*, the newsletter of the Faculty of Intensive Care Medicine. The aim of this bi-annual newsletter is to provide updates to the Faculty's fellows and members on the wide-ranging work being undertaken by the FICM, and encourage discussion on the issues facing our specialty as we move into a period of great change, not only to ICM but to the health service in general.

November 2011 marked the first birthday of the FICM, and much has occurred over the first year of the Faculty's existence. Not least of these developments is the creation and implementation of a new, standalone CCT curriculum for Intensive Care Medicine in the UK, to replace the current 'joint' CCT. This will however continue to facilitate dual accreditation in ICM and a partner speciality. This has been the intense focus of an enormous amount of work by the Faculty, in partnership with the GMC and the Conference of Postgraduate Medical Deans, as well as our partner specialties. More detail can be found in Dr Simon Baudouin's report on page 13. Concurrent with this change has been initiation of the development of a new FICM Fellowship examination – Professor Nigel Webster, Chairman of Examiners, discusses this in more detail on page 16.

The Faculty has also been involved in work on revalidation and professional standards, areas in which it is of course vital that we maintain close links with the Intensive Care Society; more information on these topics can be found in the reports by Dr Carl Waldmann and Professor Tim Evans.

Trainee involvement is seen as absolutely vital to the work of the Faculty; Dr Chris Booth covers the areas of trainee representation within the FICM in his report on page 23. The Faculty has also opened the route of membership for ICM CCT trainees, in addition to Foundation Fellowship for consultants. More routes of entry are planned to open throughout the coming year, and Dr Patrick Nee, Membership Lead on the Faculty Board, provides more detail on these entry routes on page 11.

We welcome constructive feedback from the Faculty's fellows and members, so please do get in contact if you would like to contribute to a future edition of *Critical Eye* or if there are any particular topics you would like to see covered. We hope that our newsletter will update you but will also provide a dynamic forum for the exchange of views and ideas on Intensive Care Medicine in the UK.

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Dean's statement



Professor Julian Bion, Dean

Welcome to the first issue of the newsletter of the Faculty of Intensive Care Medicine (FICM), some 13 months after our foundation on 22 November 2010. In this short period the volume of work and rapidity of change has made it difficult to provide accurate and contemporaneous information, but we now have an opportunity to take stock and report on progress. Enthusiasm and support for the FICM have been visibly expressed in the applications for Foundation Fellowship, arriving at a steady rate of around 125 per month, and in the willingness of many individuals and organisations to contribute to our work and the future of intensive care. I will describe briefly the setting in which the Faculty was created, our aims and responsibilities, and our work programme and ambitions for the future.

The formation of the Intensive Care Society (ICS) in 1970 was an expression of a common desire – to improve the care of critically ill patients and their families through professional education and mutual support. 40 years later, the FICM has been established as a complementary and evolutionary development, providing standards and structures for lifelong education and training, but with the adjunctive authority of a primary medical speciality and (through our Trustee Royal Colleges) that of the Privy Council. To have arrived at this point required the determination and vision of many individuals. The Royal Colleges Joint Advisory Committee for Intensive Therapy was formed in the mid-80s with the Department of Health funding a few senior registrar training posts in ICM. This became an Intercollegiate Committee in 1992 and then the Intercollegiate Board for Training in ICM in 1996. In 1999, ICM became a multidisciplinary speciality. In 2010 the GMC required us to develop a primary speciality programme for ICM. We achieved this in March 2011, while retaining the capacity for multidisciplinary training and certification. We have now trained 685 specialists in ICM, and are producing around 120 to 150 specialists each year.

There have been parallel developments in service provision, audit and research, and in quality of care, achieved through the work of the ICS, the Intensive Care Audit and Research Centre (ICNARC), and the Critical Care Networks formed after the publication of Comprehensive Critical Care in 2000. Through the case mix programme (with data from more than one million patients) we have evidence that the investment in additional resources for intensive care has been cost-effective, with reductions in case mix-adjusted mortality and premature discharges from intensive care. Critical care research has flourished, with a growing portfolio of studies to inform best practice, and several strong research groups with high visibility in the National Institute for Health Research.

The aim and responsibility of the Faculty is to bring together these themes of education, clinical practice and research, to improve patient care through training and life-long learning with a sustained focus on excellence. Our strategy for achieving this is based on the principles of integration, partnership, standard-setting, and implementing best evidence.

Our immediate priority is to launch the new ICM training programme successfully. To this end we met with the General Medical Council, the Department of Health and the Conference of Post Graduate Deans in July 2011. We have agreed that the new programme (single-CCT) will start on 1 August 2012; Dual CCT programmes will start in August 2013. We have also secured agreement that recruitment to the ('old') Joint-CCT programme should continue until 31 July 2013, to avoid disenfranchising trainees already in non-ICM ST programmes who wish to access ICM training. We also have broad acceptance that the number of ICM training posts must be doubled in the next year in order to maintain the current rate of production of specialists. To meet the anticipated increase in demand over the next five to ten years will require many more. We believe that the initial increase can be achieved through conversion of non-training posts (Trust doctor and Fellow posts), and transfer to ICM of training posts which are surplus to requirement in other specialities. Regional Advisors and Training Programme Directors are now in discussions with Deaneries and Trusts to see what can be achieved locally.

In addition to setting up the necessary procedures for a national recruitment and appointments system, we must also become advocates for ICM as a lifetime career. We are all role models in this respect. We must engage with undergraduate training; experience in ICM is greatly valued by students for its educational value, practical skills and spectrum of practice and an increasing number are considering it as a career.

I have referred previously to Charles Mayo's statement that 'The safest thing for a patient is to be in the hands of a man involved in teaching medicine. In order to be a teacher of medicine the doctor must always be a student.' We must be persistent in our pursuit of excellence through training, clinical leadership and research. No one organisation or set of individuals has a monopoly of how this will be achieved. It requires a partnership between us all.

Who's who on the Board of FICM?



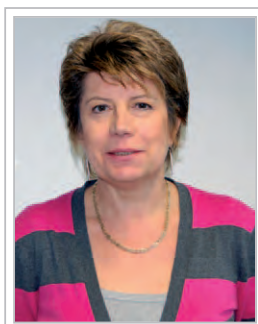
Professor Julian Bion (Dean)

Julian Bion is Professor of Intensive Care Medicine at the University of Birmingham, honorary consultant in ICM at the Queen Elizabeth Hospital Birmingham, and Co-Director of R&D, deputy director of the Birmingham Clinical Research Academy. In October 2010 he was elected Foundation Dean of the FICM. As a member of the IBTICM he led the group which wrote the first competency-based training programme for ICM. As President of the European Society of ICM (2004–2006) he established the European Critical Care Network and led an international collaboration to develop the international CoBaTrICE programme. He is senior clinical lead for the DoH-funded NPSA project (2009–2011). In 2004 he was presented with the Shubin-Weil Award for Excellence by the Society of Critical Care Medicine. He gave the Gilston lecture and received honorary membership of the ICS in 2009. He is the author of numerous scientific articles, reviews, and one textbook. His research interests include quality improvement and patient safety in acute care, the pathogenesis and prevention of multiple organ failure, and education.



Professor Timothy Evans (Vice-Dean)

Tim Evans is Medical Director, Director of Research, and Deputy Chief Executive of the Royal Brompton and Harefield NHS Foundation Trust. He is Head of the Unit of Critical Care, Imperial College School of Medicine, and Consultant in Thoracic and Intensive Care Medicine at Royal Brompton Hospital, London UK. He is a Fellow of the Academy of Medical Sciences, an NIHR senior investigator, and currently Academic Vice-President of the Royal College of Physicians. Professor Evans qualified at the University of Manchester and undertook training in general medicine at the London postgraduate teaching hospitals. He completed a PhD at the University of Sheffield and was MRC Travelling Fellow at the University of California, San Francisco. He undertook further training in respiratory and intensive care medicine in London. He was appointed to the staff of the Royal Brompton Hospital in 1987. His research interests include the vascular biology of sepsis and the pathophysiology of acute respiratory distress syndrome.



Dr Anna Batchelor

Anna Batchelor trained in Sheffield, Leicester and Newcastle and qualified MBChB Sheffield 1980 and FRCA in 1985. She was one of the first cohort of Joint Accreditation Committee (JACIT) trainees in ICM. Dr Batchelor has been a consultant in Anaesthesia and Intensive Care Medicine at the Royal Victoria Infirmary Newcastle upon Tyne since 1993. She served on ICS Council from 2000–2008 was President from 2005–2007. She has also served on the Council of the Royal College of Anaesthetists since 2008.



Dr Chris Booth

Chris Booth is a registrar in Intensive Care Medicine and Anaesthesia in the North West deanery. He graduated from the University of Manchester Medical School in 2003, working in the fields of emergency medicine and acute medicine before joining the North West School of Anaesthesia's training rotation. He is currently completing registrar training in Anaesthesia in the North West and is undertaking advanced ICM training in the same region. Chris represents current and future ICM trainees on the foundation board of the FICM and has been co-opted onto the board through his role at the Intensive Care Society. Since 2009 Chris has been an elected member of the trainee committee of the Intensive Care Society and has recently become chairman of the committee. He has previously represented Intensive Care Medicine from a trainee perspective on the Intercollegiate ACCS Training Board (ICAACT).



Professor Chris Lavy

Chris Lavy is an orthopaedic surgeon in Oxford and holds honorary professorships at Oxford University and the London School of Hygiene and Tropical Medicine. He trained as a GP initially then moved to orthopaedic surgery with junior posts in Oxford, Norwich and Cambridge. He was registrar in Bath then senior registrar at the Royal National Orthopaedic Hospital and did fellowships in Cape Town and Paris. He was appointed consultant orthopaedic surgeon at University College Hospital and The Middlesex Hospital in 1992. In 1996 he went to work with the Christian Mission CBM International to set up orthopaedic services in Malawi. He was a founding fellow and council member of the College of Surgeons of East Central and Southern Africa which was established in 1999 and now covers nine countries in the region. For this he received the OBE in 2007. He has been a Hunterian professor and is now an elected council member of the Royal College of Surgeons of England. His global clinical interests include surgery of the spine hip and knee, and his research interests are focussed around Africa and reconstructive surgery that gets children walking. He is senior author in a new book of vivas for the FRCS(orth). He is currently involved in setting up an orthopaedic hospital in Niger which opens in October 2010.



Dr David Krishna Menon

David Krishna Menon trained in Medicine, Anaesthesia and Intensive Care at the Jawaharlal Institute in India, Leeds General Infirmary, The Royal Free Hospital and Addenbrooke's Hospital, and was an MRC Research Fellow at the Hammersmith Hospital prior to coming to Cambridge. He is Professor and Head of the Division of Anaesthesia, Principal Investigator in the Wolfson Brain Imaging Centre, and Co-Chair of the Acute Brain Injury Program at the University of Cambridge; and Professorial Fellow in the Medical Sciences at Queens' College, Cambridge. In 2006 he was appointed to the British Oxygen Professorship at the Royal College of Anaesthetists. He serves on the Board of Management of the Intensive Care National Audit and Research Centre (ICNARC), as Co-Chair of the Executive Board of the European Brain Injury Consortium, and on the Executive Board of the International Neurotrauma Society. He is a Founding Fellow of the Academy of Medical Sciences, was appointed Senior Investigator of the National Institute for Health Research (UK) in 2009, and was appointed a member of the Founding Board of the Faculty of Intensive Care Medicine in 2010.



Professor Michael (Monty) Mythen

Monty Mythen is Smiths Medical Professor of Anaesthesia and Critical Care, University College London; Director Joint UCLH/UCL Biomedical Research Unit; National Clinical Lead Enhanced Recovery Partnership Programme, Department of Health; Editorial board member for The British Journal of Anaesthesia and Critical Care. Monty completed his UK anaesthesia fellowship (FRCA) in 1990, gained an MD in 1995 and was appointed assistant professor at Duke University Medical Centre, North Carolina, USA before returning to the UK in 1998. He has a wide range of research interests including: perioperative fluid management, haemostasis in the critically ill, endotoxin and endotoxin immunity and the determinants of post-operative morbidity and mortality. Monty served as an elected Council Member of the Intensive Care Society from 2001–2004 and is currently the Chair of the Intensive Care Foundation's Scientific Advisory Board.



Dr Patrick Nee

Patrick Nee is a Consultant in Emergency Medicine and Intensive Care Medicine at Whiston Hospital, Merseyside and Visiting Professor of Emergency Medicine at Liverpool John Moores University. He qualified from Liverpool University in 1982 and trained in general and emergency medicine, anaesthesia/ICM and surgical specialties in a number of UK hospitals before taking a combined post in EM and ICM in 1994, the first of its kind in England. He is the first Honorary President of Emergency Physicians in Intensive Care (EPIC), an organisation that promotes best practice in the management of critically ill patients in the emergency department and supports combined training. Patrick specializes in medicine at the interface between the resuscitation room and the ICU, particularly airway management, and represents the College of Emergency Medicine on issues of adult intensive care. He has authored numerous papers and book chapters. He is a member of the Board of the College of Emergency Medicine and of the Review Advisory Group of the Emergency Medicine Journal. He sat on the National Expert Group that reported as Comprehensive Critical Care in 2000 and the NICE Guideline Development Group on '[Acutely Ill Patients in Hospital](#)' (2007). More recently he has been involved in the DH Clinical Advisory Group setting ICM standards for trauma care in England.



Dr Graham R Nimmo

Graham Nimmo is a Consultant Physician in ICM and Clinical Education in the Western General Hospital, Edinburgh. He graduated from the University of Edinburgh and subsequently trained in Medicine, Anaesthesia and Intensive Care in Edinburgh and Glasgow. He gained MRCP (UK) in 1985 and FFARCSI in 1996. He completed an MD at the University of Edinburgh in 1996 and was elected FRCP (Edin) in 2002. He has represented the RCP Edinburgh on IBTICM since 2003. He has been a consultant in ICM since 1996. He has been extensively involved in undergraduate and postgraduate, multi-professional clinical education. Since 2000 he has been an active member of faculty at the Scottish Clinical Simulation Centre and currently chairs the SICS Education and Training Group and the Scottish Clinical Skills Network. He edits the Lothian Adult Medical Emergencies Handbook and (with Professor Mervyn Singer) The ABC of Intensive Care. Special interests include education, clinical decision making, handover, and end of life care. He is studying for a Doctorate in Education (EdD) in the Institute of Education at the University of Stirling.



Dr Alasdair Short

Alasdair Short recently retired from the role of consultant Physician in Intensive Care Medicine and Deputy Medical Director, Broomfield Hospital, Chelmsford, Essex, having been working as a consultant since 1984. He has been Chair of the Board of Management of the Intensive Care National Audit and Research Centre since 1994. Dr Short graduated from Edinburgh Medical School 1975 and completed postgraduate training in Internal Medicine and Nephrology in Edinburgh and in Intensive Care Medicine at the Victoria Hospital London Ontario with the late Bill Sibbald. He achieved FRCPC in 1982; the FRCP(Edin) in 1986; the FRCP(London) in 1992; and FRCA (Hon) in 2002. He was Secretary and Treasurer of the ICS from 1990–1995 and served on the IBTICM from 1994–2004 (as Chairman from 2001-2003). He has been an examiner for the RCP since 1995. He also served on the Academy of Royal Medical Colleges Working Party – A Code of Practice for the Diagnosis of Death from 2005–2007.



Dr William Tullett

William Tullett is a Consultant in Emergency and Intensive Care Medicine at the Western Infirmary in Glasgow and is extremely proud of the fact he was the first individual, in the United Kingdom, to hold such a joint appointment. He attended Aberdeen University and did most of his post-graduate training in Glasgow. He has been a longstanding member of The IBTICM, representing the Royal College of Physicians and Surgeons of Glasgow and he is an avid proponent of multi-disciplinary access to training in ICM. He has published numerous papers relating to subjects in Respiratory Medicine, Emergency and Intensive Care Medicine and was a winner of the Ig Nobel Prize for Public Health in 2000.



Dr Carl Waldmann

Carl Waldmann has been a Consultant in ICM and Anaesthesia at the Royal Berkshire Hospital in Reading since joining as Director of ICU in 1986. Apart from his interests in the management of Head Injured patients in a DGH, the procurement and implementation of a Clinical Information System in ICU, his main passion has been the setting up and running of an ICU Follow-up clinic in Reading, where he sees around 100 new patients annually. He was a member of ICS Council until May 2006, where his main duties were as Hon. Treasurer and Chair of the Meetings Committee. From May 2007 to May 2009 he was President of the ICS. He was the Editor of Care of the Critically Ill and until 2004 the Editor of JICS. Carl was also was Chair of the section of Technology assessment and Health Informatics (TAHI) of the European Society of Intensive Care Medicine until 2008. He is a member of the PACT editorial board and recently was editor of the Oxford Desk Reference textbook on the Law and Ethics in Intensive Care textbook. Carl also has an interest in pre-hospital care and is club doctor for Leyton Orient FC.



Dr Simon Baudouin (Co-optee, Chair FICMTAC)

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, the genetics of sepsis and outcomes following critical illness. He is the Royal College of Physicians (London) representative and Chairman of the FICM Training and Assessment Committee (formerly the Intercollegiate Board for Training in Intensive Care Medicine), Specialty Lead for the Northumberland Tyne and Wear Critical Care CLRN Research Network, Council Member of the Intensive Care Society and Chair of the ICS Standards, Safety and Quality sub-committee.



Dr Mike Fried (Co-optee, President of the Scottish Intensive Care Society)

Mike Fried studied pharmacology at the University of Edinburgh receiving a BSc(Hons) in 1977. He read medicine at University College Hospital Medical School, London graduating in 1982. His trainee years were spent in London, Bath, Glasgow and Edinburgh. Since 1996 he has been a Consultant in Anaesthesia and Critical Care Medicine in NHS Lothian working at St John's Hospital in Livingston. He is also a member of the critical care team at the Western General Hospital, Edinburgh. His major interest is transport medicine: He has been a member of the Scottish Ambulance Service's inter-hospital transport board. Currently, he is the clinical adviser to the Scottish Government Health Department's national review of retrieval services. He is a member of the Scottish Ambulance Service air re-procurement board, a member of the Care of Burns in Scotland (COBIS) steering group and President (elect) of the Scottish Intensive Care Society.



Group Captain Neil McGuire (Co-optee, Defence Medical Services)

Neil McGuire has been a serving Officer in the Royal Air Force Medical Service (RAFMS) since 1986. He is a Consultant in Anaesthesia and Intensive Care Medicine and since Sep 2007 he has been the Defence Consultant Adviser (DCA) in Anaesthesia, Pain Management and Critical Care to the UK Surgeon General. In May 2011 he was appointed as the Senior Consultant in the RAFMS.

As DCA Neil is responsible for all anaesthetists within Defence Anaesthesia. He oversees training, Consultant placements in the National Health Service (NHS) and advises on operational deployments. He is also responsible for the equipment that is used in anaesthesia, pain management and ICM and the ongoing development of clinical care in the deployed environment in these areas.

Neil is an Honorary Consultant at the John Radcliffe, Oxford in Anaesthesia and ICM which he has held since 1995. He is a Royal College of Anaesthesia Assessor, a co-opted member of the AAGBI Council Advisory and he is a member of the Standards and Safety Committees of the AAGBI. Neil also represents Defence on the Board of the FICM.



Dr Alison Pittard (Co-optee, Lead RA in ICM)

Alison Pittard qualified in Leeds in 1988, became a 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, before becoming RA for West Yorkshire and being elected as the Lead RA in ICM in 2008. During this time she represented Tutors and Regional Advisors at the IBTICM and continues to do so on the Faculty Board. Alison took up the post of Associate Postgraduate Dean in the Yorkshire and Humber Deanery in 2009. She is currently an examiner for the RCoA and the FICM and is involved in implementation of the new curriculum and development of the FFICM exam.



Dr Bruce Taylor (Co-optee, President of the Intensive Care Society)

Bruce Taylor, Consultant in ICM in Portsmouth, has been a member of ICS Council since 2003 and was elected President in May 2011. He chaired the Critical Care Contingency Planning Group, and was involved with the Healthcare Pandemic Influenza Group and the Emergency Planning Clinical Leadership Advisory Group. He has also contributed to the work of the Flu-CIN group and represents ICM at the frequent meetings of the PICO and SAGE groups. In addition to chairing some of these international sessions he was also involved in the creation and editing of the resultant H1N1 critical care guidance.

The Faculty would also like to thank Dr Bob Winter for his service on the Board during his tenure as President of the ICS.



Dr Jane Eddleston (Co-optee, DH Representative)

Jane Eddleston is a Consultant in Intensive Care Medicine in Manchester Royal Infirmary, Clinical Director of Critical Care and Head of Division. She is also the Clinical Lead for the Greater Manchester Critical Care Network and was the Department of Health Advisor for Critical Care from 2005 till March 2011. She has extensive Clinical and Managerial experience in Critical Care and Acute Care.

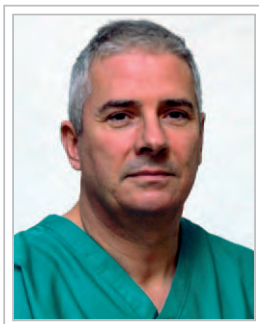


Mr Peter Rees (Co-optee, Lay representative, Patient Liaison Group)

Peter Rees is a retired Primary Headteacher with a particular interest in the health and allied services, especially for the young and elderly. A recent positive experience of anaesthesia following a fracture began his interest and involvement with the RCoA as a PLG Lay Member. He works as a University Tutor for the Institute of Education at Reading University on the Graduate Teacher Programme, for the University of Winchester on the BA Primary Teaching degree and Chairs a Sure Start Children's Centre Partnership Board in Winchester. He is also an Independent Member of the Adoption Panel for Hampshire County Council.

The Royal College of Surgeons of Edinburgh is represented on the Board by Mr Mike Lavelle-Jones.

Fellowship and Membership



Dr Patrick Nee,
Membership Lead



Mr Daniel Waeland,
Faculty Manager

The FICM Foundation Board met for the first time on 22 November 2010. At that meeting the Dean, Professor Julian Bion, invited a small working group to consider the issue of membership and fellowship categories. The group is led by Dr Patrick Nee (College of Emergency Medicine), with Dr Chris Booth (trainee representative) and Daniel Waeland (Faculties Manager). The group receives wise counsel from Dr Alasdair Short (RCOA) and from the Dean himself.

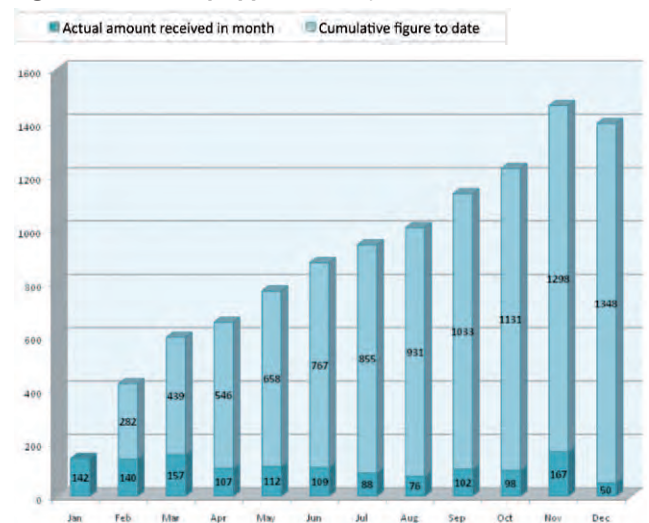
Foundation Fellowship

It was important to begin to enrol new fellows into the Faculty as early as possible. Foundation Fellowship was deemed to be the most appropriate pathway for senior intensivists working in the UK. Intensive Care is, of course, a broad church, which includes colleagues from different base specialties, many of whom received their training overseas and are, quite reasonably, not members or fellows of any UK college. It was recognised from the start that there would be talented and committed individuals who would not be covered by the initial admission criteria. However, in the first year of operation, the majority of applicants would be processed most efficiently by setting down straightforward eligibility criteria.

Beginning on 1 January 2011, the FICM Board began to consider applications from fellows in good standing of any of the FICM trustee colleges, who hold a substantive or honorary consultant post in the United Kingdom with a defined, contracted clinical commitment to ICM. Retired consultants, in post as at January 2010 were also eligible. Applications, countersigned by the applicant's Clinical Director, were considered during a 12 month 'window'. Successful applicants acquire the post-nominal FFICM, which does not confer specialty status, and there is an annual subscription of £205 for the 2011–2012 financial year.

At the time of writing nearly 1,600 applications have been received, with up to a hundred more received each month (Figure 1). Most clearly comply with the published requirements and are accepted immediately. Some are returned for further information, while others are referred to other categories of Fellowship, vide infra.

Figure 1 Fellowship applications by month



Trainee membership

A new standalone training programme has been recognised by the GMC and national recruitment to these posts will begin in August 2012. Future generations of trainees will enrol in programmes leading to a single CCT in ICM, or dual programmes with partner specialties.

Training was previously overseen by the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM). That Board has now transformed into the Training and Assessment Committee of the Faculty, FICMTAC. New trainees must therefore register with the Faculty. Registration opened in April 2011 and application forms are available from the Faculty website, as above. There is also a General Registration Form for trainees completing modules of ICM training outside of an ICM CCT

programme, who wish to register an interest in ICM and ultimately obtain a letter of sign-off from the Faculty. An appropriate category for these trainees, presently being discussed, will be opened in 2012.

In due course, Fellowship of the Faculty will be gained by success in the new FFICM examination. The first diet, leading to FFICM by examination, will be held in early 2013.

Other categories of Fellowship

There are, in uncertain numbers, ICM practitioners who do not satisfy the criteria for Foundation Fellowship or membership, who nevertheless want to engage with the Faculty, and contribute to its objectives. They include non-consultants, consultants not associated with any of the trustee colleges, jointly trained individuals without an ICM post, persons trained overseas and those trained in the UK but working abroad. An immediate priority is *Associate Fellowship*, applications for which open in the new year. which will be for those who do not hold a full Fellowship or membership or one of the trustee colleges. Applicants must obtain associate or affiliate membership status with a UK college as appropriate.

Fellowship ad eundem may be awarded to Associate Fellows of the Faculty if they have made a significant contribution to the objectives of the Faculty, through their work in the delivery and development of intensive care services, research or teaching. Such individuals will usually be serving as Regional Advisors, Faculty Tutors or in similar high level roles.

The rights and privileges of Fellows and Members are set out in Table 1. In addition, fellowship of the Faculty carries with it a number of responsibilities that extend beyond the payment of the subscription. Everyone associated with the FICM must be committed to furthering the objectives of the Faculty; promoting and delivering safe, evidenced-based clinical care while maintaining the highest professional standards through one's relationships with patients, their relatives and those we teach and work alongside within the multi-disciplinary environment of the Intensive Care Unit.

The aim is to be as inclusive as possible, but we are constrained by a number of factors, largely as a result of our status as an intercollegiate faculty of seven colleges, and subject to their regulations. The colleges offer different categories of membership and fellowship that are not consistent with one another. For example, *Affiliate Fellowship* in the Royal College of Physicians of the UK is equivalent to *Associate Fellowship* in some other colleges.

For all future routes of Fellowship, it will be necessary to enjoy similar status with one of the trustee colleges.

What replaces Foundation Fellowship?

Fellowship by Assessment will open on in January 2012 and is for consultants who have achieved a CCT in ICM or equivalent competencies in the specialty. The criteria will be similar to those required for Foundation Fellowship to the end of the year 2011. Applicants must hold the relevant qualification from one of the trustee colleges.

Table 1

Rights and Privileges of Fellows and Trainee Members of the Faculty
<p>Fellowship</p> <ul style="list-style-type: none"> » to be allowed to use the post-nominal FFICM and the description 'Fellow of the Faculty of Intensive Care Medicine' » to attend, speak and vote at General Meetings of the Faculty » to be nominated for election to membership of the Board » to vote in Faculty elections respective to any residential qualifications » to be appointed to Committees, Working Parties and other groups of the Faculty » to be nominated by the Faculty under the auspices of the Royal College of Anaesthetists for appointment to any Advisory Appointment Committee » to be appointed to a Court of Examiners » to be appointed a Regional Advisor in Intensive Care Medicine or Faculty Tutor » to use the facilities of the RCoA buildings » to attend available Faculty events » to benefit from the arrangements organised by the Faculty for participating in Continuing Professional Development
<p>Trainee membership</p> <ul style="list-style-type: none"> » to be nominated for election to be the Trainee Representative of the Faculty » to vote in Faculty elections for the Trainee Representative of the Faculty » to receive copies of the Faculty newsletter, <i>Critical Eye</i> » to attend available Faculty events » to benefit from the arrangements organised by the Faculty for participating in training and assessment.

Training and Assessment Committee



**Dr Simon Baudouin,
Chairman**

The new FICM Training and Assessment Committee (FICMTAC) grew directly out of the old Intercollegiate Board for Training in ICM (IBTICM). The transition from IBTICM to FICMTAC has been very smooth and this has been considerably aided by the fact that many members of the old Board agreed to continue in their previous co-opted roles. In addition James Goodwin, who was the previous IBTICM administrator, greatly assisted the transition by providing continuity in his role as the new FICMTAC chief administrator, ably assisted by Andrea Rowe.

If the mechanics of the change from IBTICM to FICMTAC were evolutionary then the work that the training group has been addressing could be fairly described as rather more revolutionary in terms of the future delivery of critical care training. This is because the IBTICM and latterly the TAC have developed a standalone ICM training programme that will lead to an ICM Certificate of Completion of Training (CCT) which will be approved by the GMC. This development, along with the creation of an ICM Faculty, is an important milestone in the maturation of ICM as a specialty in its own right in the UK. It also mirrors other, similar, developments that are occurring in both Europe and North America.

One way of estimating the importance of the new CCT is by reviewing the history of ICM training in the UK. ICM training grew out of recognition that the knowledge and skills that form its basis require a training and assessment programme that differ significantly from those in either anaesthesia or medicine. As such it has followed a well trodden path that will be recognisable to many specialties that were originally sub-specialties. Good examples here are the medical specialty 'ologies' that now have their own CCT programmes.

Historically, the move to a standalone specialty began in the UK with the formation of the IBTICM. Its formation was prompted by the recognition that ICM training did need a multi-disciplinary base with a curriculum that reflected this fact. The IBTICM was formed by nominated members who represented the constituent colleges, with expertise and interests in the field of ICM. This included representatives of the RCoA, the RCP and the RCS (including the Scottish Colleges), and the Faculty (later College) of Emergency Medicine as well as deanery and lay representation. The original composition of the IBTICM was therefore very similar to the current FICM Board.

The IBTICM achieved a great deal. Probably its greatest successes were the establishment of over 150 ICM training schemes, the development of an ICM curriculum and the creation and support of a network of highly motivated Regional Advisors and local Board (now Faculty) Tutors. The IBTICM adopted what in retrospect can be viewed as a transitional approach to ICM training. All ICM trainees entered from other specialties and trainees were required to already possess a National Training Number in a complementary discipline before competitive entry to an ICM training programme. The advantage of this approach was that it was very flexible and could accommodate entry to ICM training from both multiple specialties (principally anaesthesia, medicine and emergency medicine) and at multiple entry points above ST3. However this approach also carried some disadvantages including a view held by some that ICM was a 'junior partner' in training and that ICM training had to fit around other specialties. However a much more important issue was whether the old joint training scheme could continue to deliver complete ICM training. The old scheme relied on an assumption that much of the necessary competencies

would be acquired whilst training in a complementary specialty. Many changes to training, not the least of which was the gradual reduction in training hours due to the European Working Time Regulations, began to challenge this model.

For those unfamiliar with the old joint programme it consisted of three months of Basic ICM, six months of Intermediate and 12 months of Advanced training. In addition six months of 'complementary' training (anaesthesia for physicians, medicine for anaesthetists) was also required. The success of the scheme is testified to by the fact that over 400 trainees have successfully completed the joint programme and are joint CCT holders. It has also achieved the goal of allowing access to ICM training from anaesthesia, medicine and EM. Currently of those who are in training 68% are also anaesthetists, 23% physicians and 9% EM trainees. The lack of surgical trainees probably reflects the limited areas of overlap in training. This fact was acknowledged by the RCS during early discussion on the new CCT and dual training opportunities.

The structure of the old joint programme allowed considerable leveraging of existing training posts. Many trainees who competed for higher ICM training had completed a considerable part of the programme during their Anaesthetic training. This training was counted towards ICM accreditation although it was retrospective. Many of these applicants therefore only required the final one year of Advanced training in ICM to gain ICM accreditation. Inevitably training in ICM will, in some cases, now take a little longer and the FICM is making a strong case for an expansion in ICM training posts.

Joint to single CCT

PMETB (whose functions have now been subsumed by the GMC) required the regular resubmission of postgraduate training programmes for re-approval. Prior to the resubmission of the ICM joint programme the IBTICM had been aware of some concerns that PMETB had voiced concerning the structure of the programme. However the complete rejection of the old joint CCT came as a surprise to the IBTICM. The principle reason for this rejection was the fact that in the PMETB statutes ICM is a standalone discipline (not a sub-specialty) and therefore legally requires a standalone CCT. This required the submission of a training programme that fully described the totality of training from entry to training (at CT1 level) to exit (at the appropriate ST level). It was clear that the old joint programme did not fulfil this criterion. Entry was

variable usually between ST4–6 and the acquisition of many competencies were assumed to occur (without precise definition) during 'parent specialty' training, some of which was often retrospective.

Although disappointing at the time this ruling has presented ICM with a real opportunity as it has enabled the FICM to develop a complete, standalone ICM training programme that will lead to an ICM CCT. The implications of this are far-reaching as it means that trainees are no longer required to choose a primary non-ICM specialty and then later also train in ICM. Many (possibly the majority) will choose to train in two separate specialties (e.g. Anaesthesia and ICM) but these disciplines will enjoy equal status in terms of training.

The single ICM CCT

A GMC-approved CCT must be structured to reflect multiple domains in a structured template which represent features of good education and clinical practice. The domains include, for example, details on how the curriculum was designed, who were the consultees, what assessment systems will be used and how they will be validated. Quality control issues are included as is lay input into the whole process. The overarching purpose is to ensure that trainees who receive a CCT are competent to practice independently at the defined level of expertise. The process is inevitably a little bureaucratic but it does ensure that UK training schemes are produced to uniformly high standard. Recent discussion in the North American critical care literature acknowledge that European ICM training programmes are in many ways much better structured than those in North America.

Curriculum design

One major problem with the old joint CCT was a lack of explicit description of the totality of training needed. It did define entry criteria but did not really specify the exact competencies needed for entry. In addition complementary competencies were not defined but assumed to be acquired during complementary attachments to training. When designing the new curriculum the FICMTAC curriculum group (ably led by Anna Batchelor) had to make a number of important decisions with clear implications for the implementation and delivery of the programme. One of the most important (and difficult) of these was the way in which trainees can enter ICM training from the Foundation programme. The curriculum group, following guidance from our constituent colleges, wished to allow entry from all the traditional ICM partner disciplines including anaesthesia, medicine and EM. The need to allow for entry to training of

those with quite diverse training backgrounds proved a significant design challenge as the GMC requires a standalone CCT to be entered from Foundation level. One solution that was considered was to only have a dedicated ICM CT entry route. The obvious model for this is a version of the existing ACCS programme. These already provide a good balance of exposure to the relevant acute disciplines. However this approach was ultimately rejected because many high quality trainees may wish to seek dual accreditation and may therefore elect to enter core anaesthetic or medical training (although the ACCS route is also possible).

Following highly useful and collaborative meetings with the GMC, the committee adopted a solution which splits the CCT into an initial four year Stage 1 portion. The curriculum defines competencies and learning outcomes that must be achieved by all ICM trainees by the end of Stage 1. It therefore accepts that trainees will enter ICM ST3 posts, following competitive interviews, with different sets of existing competencies depending on the core or ACCS programme that they have undertaken. Their training needs will therefore differ during ST3 and 4 (for example CMT entrants will need more exposure to Anaesthesia for ICM). By a process of individualised training all ICM trainees will have acquired the same set of competencies to the same level of skill, by the end of ST4.

The committee acknowledges that this approach does present some potential difficulties to those tasked with the implementation of the curriculum. These issues are currently being addressed by an FICM implementation group. Various solutions to the need to provide some flexibility in trainee attachments have been discussed including possibilities of true supernumerary training posts. The FICMTAC also acknowledges the considerable work that Faculty RA and FTs along with TPD are undertaking to translate the aspirations of the CCT into a working product.

The CCT curriculum

The development of the ICM CCT curriculum was greatly simplified by the previous work of the pan-European CoBaTrICE initiative. The CoBaTrICE group developed a consensus on important ICM skills, knowledge and attributes that characterise a competent, independent ICM practitioner, by a repeated Delphi process. This was then systematised into a series of major domains and dependent sub-domains. This very comprehensive scheme was adopted by the curriculum committee as the UK ICM syllabus. A few minor modifications were made to reflect more recent changes in knowledge and practice.

The adoption of the CoBaTrICE syllabus did present some important issues in terms of designing the training programme. CoBaTrICE describes the detailed attributes of a fully qualified Intensivist; it does not describe the method of reaching this goal. However the CoBaTrICE structure is compatible with a spiral learning scheme, whereby competencies are initially acquired at a beginner level and then revisited throughout training until expert level is reached. Such a spiral scheme was defined in a progressive training grid that uses a simple and intuitive descriptor model of progressive skill acquisition. The grid also simplifies the task of an ARCP panel in ensuring adequate training progression from year to year.

The assessment structures and tools used in the CCT will be very familiar to most trainers and are adopted from those used in the Foundation programmes and in current higher training. Trainees are asked to collect evidence of competency acquisition and progression, mapped onto CoBaTrICE domains, using various tools including WPBAs and log books of cases.

The total indicative duration of the single ICM CCT is seven years (CT1 to ST7). It allows for a one year period in Stage 2 training (ST5 and 6) where trainees can choose from a number of options that will enhance their skills. For dual CCT trainees this one year will be spent in a partner discipline. The structure of dual CCT programmes is currently being finalised by the FICMTAC. These will inevitably prolong training time compared to a single CCT programme. However both the Faculty and our trainees see many advantages to dual qualification including a more flexible workforce and the continuation and expansion of multi-disciplinary ITU consultant teams.

2011 Standalone ICM CCT Curriculum
www.ficm.ac.uk/icmctcurriculum.ashx

FFICM Examination Development



**Professor Nigel Webster,
Chairman of the Court of Examiners**

With the establishment of the standalone curriculum in ICM the FICM has had to establish a new examination process. The examinations of the FICM will be an integral part of the assessment and will enable national standards to be applied fairly for all learners irrespective of where or by whom they are trained. In the recent examiner recruitment round, the Faculty received over 70 applications for only five vacant examinerships. This was a heartening display of the goodwill existing within the specialty, though it unfortunately meant that high quality candidates had to be turned away; we hope that they will re-apply when a greater number of examiner slots become available.

The exams will form part of an overview of a trainee's progression and achievement. The exam is part of the triangulation utilising various assessment methods relating to knowledge, skills and attitudes. It is important that knowledge be specifically assessed separately, as knowledge and skill in procedures appear to be independently acquired – examinations are therefore necessary. Validity of the examination process will be achieved by blueprinting the knowledge, application and clinical competencies to the curriculum. This will give high levels of both face and content validity.

The examination will build on the experience of other Royal Colleges' examinations and will also utilise the best components of the FCICM (Australasian) exam – this examination and training programme has gained widespread recognition for its quality.

FFICM Primary examination

A primary examination will be developed over the course of the next two years. It is envisaged that at least initially, trainees will wish to undertake training in a specialty in addition to ICM. A pass in the primary

examination of one of the other relevant Colleges – MRCP(UK) (full), MCEM (full) and FRCA Primary – where similar assessments of basic medical science are made – will be considered acceptable as an entry requirement for training in ICM. This is in keeping with the same criteria as the FCICM examination. However, in Australasia more candidates are now taking the FCICM Primary exam and it is hoped that this will in time be the case with the FICM Primary. This primary examination is planned to consist of multiple choice questions testing factual knowledge in the areas of science as related to clinical practice including: anatomy, biochemistry, physiology, pharmacology, physics, clinical measurement and data interpretation. The examination will be over three hours and will comprise a total of 90 questions as a combination of possible formats including multiple true-false, single best answer and the extended matching questions. Negative marking will not be used for incorrect answers. It is envisaged that the examination will be taken at any stage of training – including Foundation training – before ST3.

FFICM Final examination

The second part examination can be taken at any point during Stage 2 of the new training programme. Eligibility to sit the second part FFICM examination is either a pass in the FICM Primary examination or a pass in the primary examination of one of the complementary specialty colleges, plus completion of Stage 1 training. The examination will comprise three sections: MCQ, OSCE and the structured oral examination SOE. Some candidates may be exempted from the MCQ section of the examination by carrying a previous pass in that section.

The MCQ part of the examination will test factual knowledge in the areas of science applied to clinical practice including resuscitation and initial

management of the acutely ill patient; diagnosis, assessment, investigation, monitoring and data interpretation; disease management; therapeutic interventions and organ support; perioperative care; comfort and recovery; end of life care; paediatric care; transport; patient safety and health systems management. It will take the same format as for the FICM Primary examination and again negative marking will not be used.

The objective of the OSCE section is to test knowledge and skills essential to the safe practice of intensive care. Candidates will encounter 12 active OSCE stations and possibly a few rest stations and trial additional question stations for validation purposes. Candidates will be allocated two minutes to read the question outside each area, and then spend eight minutes at the station being questioned. There will normally be at least one examiner at each station. The stations will include basic and more difficult questions to allow demonstration of an appropriate level of competence, management, etc. It is envisaged that the OSCE will also include stations where the ability to communicate with relatives and staff and handle ethical and administrative problems will be tested; the ability to demonstrate ICU procedures will be tested; there may be an entire station for radiological interpretation of X-Rays, CT scans and MRI scans. It is also hoped that eventually simulation will be used as part of the assessment process.

Each individual section will be marked separately, and each will not influence the marks in any other section.

The objective of the SOE section is to test knowledge in clinical science as applied to the practice of intensive care medicine. Candidates will encounter 12 active SOE stations and a few rest and question trial stations may be provided. In these sections the focus will usually be on clinical problems. Questions will be mapped onto the individual components of the curriculum.

The objectives of the OSCE and SOE sections are to:

- » Perform an orderly, purposeful and relevant sequence of assessment.
- » Carry out correctly the assessment of potential clinical signs.
- » Derive an acceptable diagnosis (not necessarily the correct diagnosis) and relevant differential diagnoses.
- » Request and interpret relevant investigations including further investigations.

- » Discuss an appropriate plan of management (including priority setting) for the patient.
- » Define ethical problems in the patient's management.

Results

Results will be delivered to the candidates at a designated time and place after the examiners' meeting. Successful candidates will be presented to the Court of Examiners immediately following announcement of results. A report will be distributed after every examination to Supervisors of Training, Regional Advisors, the Court of Examiners and trainees. It will be prepared by the Chairman of the Court of Examiners. The purpose of the report is to provide feedback to potential candidates and those involved with teaching and training programs. It provides information about overall performance of candidates in various sections of the Examination and highlights particular problems candidates may have had in these sections.

Feedback

Candidates who fail the examination will receive a letter after the examination detailing their performance and the sections of the examination in which they failed. Feedback will also be supplied to the candidate's Supervisor of Training and may include suggestions as to how best to prepare again.

Validity and reliability

The validity of the components of the exam relies on the blueprinting of the questions to the relevant sections and level required in the curriculum. Reliability poses two main challenges. Firstly this is a new curriculum which does not have an established set of examinations with historical experience or statistics to demonstrate reliability. Thus the examination has to be developed anew. Secondly the numbers of candidates are likely to be less than one hundred and thus fall into the category of small cohorts according to the GMC.

The MCQs will be Machine-Marked Tests (MMT) for the assessment of knowledge both in the Primary and Final FICM. We have developed a new bank of questions and in accordance with the suggestions laid down in the GMC document for small cohorts we propose to use an expert group utilising the Angoff method. This will set the standards utilising examiners considering their expectation of the responses from a borderline candidate. As the numbers of candidates grows then reliability statistics can be calculated. There are aspects of the design that make OSCEs more

reliable than unstructured observations. These will include: structured marking schedules; wide sampling across different tasks; use of global test scores, and use of multiple observers. The OSCE stations are all now being designed anew, drawing on experiences from other examining organisations. The stations will require piloting, examiner training in design and marking. Standard setting for OSCE stations will again use criterion-referenced methods – Angoff – to set the pass mark for each station.

There are concerns about reliability and the possibility of bias and prejudice affecting the outcome of oral assessment and this has led to criticism of its use in the past. This is one of the problems of using traditional long and short clinical cases which are still used in some college's and society's examinations. This is particularly the case when it is used for a high-stakes assessment such as the FFICM examination. PACES used in MRCP attempts to get round these problems using a structured marking system and agreement between examiners on the day of what is to be expected of the candidates. The proposal for FFICM is to conduct this part of the examination in a similar fashion to the OSCE with stations specifically testing knowledge on a focused part of the curriculum in a structured fashion with standard setting using the Angoff method to set the pass mark for each station.

Finally, we recognise the importance of collecting validity and reliability measures. Individual performance statistics on examiners will be established using concordance measures. Individual examination questions will be standard set prior to use and their predictive ability measured on completion of the examination. Consideration will be given to inclusion of questions with 'high predictive ability' in future examinations once the question bank has been well populated and validation undertaken.

National Recruitment to the new CCT in Intensive Care Medicine



**Dr Tom Gallacher,
ICM National Recruitment Lead**

In October 2011 the General Medical Council (GMC) formally recognised the new Intensive Care Medicine curriculum and assessment system and as such Intensive Care Medicine became a new primary specialty. We will recruit to the new CCT programme in the 2012 MMC Medical Specialty Training national recruitment round for commencement of posts in August 2012. This cohort of 2012 trainees will later be able (but not in 2012 – see below) to apply to a partner specialty and if successful be appointed to a second primary specialty programme and will therefore at the end of training be awarded two CCTs. There are currently five partner specialties with ICM, namely, anaesthesia, emergency medicine, acute medicine, renal medicine and respiratory medicine.

If a trainee is successful in being appointed to ICM and a partner specialty it has been agreed with the GMC that there are competencies common to both curricula and which can be achieved in either or both programmes. These common competencies have been mapped out by FICM and the relevant Colleges and this has allowed us to develop training programmes which cover all the competencies of two entirely independent CCT curricula without the need for the competency acquisition to be repeated. As a result, these combined training programmes that we now refer to as a Dual CCT programme is shorter in time than the sum of both CCT programmes being run consecutively due to the economies of time afforded by the common competencies. At present, higher specialist training in a dual CCT programme leading to the award of a CCT in ICM and a CCT in a partner specialty takes a maximum of 6.5 years (in addition to the trainee's core training programme).

Entry into the ICM CCT programme can be via one of three defined core training programmes: Core Anaesthesia Training (CAT), Core Medical Training

(CMT) or any branch of Acute Care Common Stem (ACCS). The Faculty have agreed with the GMC that ICM should attract the best doctors to the specialty regardless of their core training programme – so called 'plurality of access' – and this requires considerable flexibility of programme content determined by the trainee's previous experience to allow successful acquisition of Stage 1 ICM competencies. For example, trainees coming from CMT will require training in anaesthesia, and those from CAT training in medicine.

Recruitment is the responsibility of the FICM Recruitment Sub-Committee (RSC) of the Training and Assessment Committee. We have representation on the RSC from Joint Royal College of Physicians Training Board, Royal College of Anaesthetists, College of Emergency Medicine and the Department of Health, all of whom contribute to the planning of our new recruitment process. This will be nationally co-ordinated by West Midlands Deanery, and there will be a single selection centre. Every region in England and Wales will be represented in both the shortlisting and the interview processes thus maintaining the necessary and vital local input to selection. A single interview process allows for optimal quality assurance, though clearly we will need time to accumulate meaningful data to inform the process.

Application will be via the MMC Medical Specialty Training system using the standard procedure of an online application form based on the person specification. Both of these are bespoke and designed by teams led by members of the RSC. Shortlisting will utilise an online tool and each application will be double marked. The interview will consist of five interview stations. Three of these will be face to face stations with two interviewers per station and the remaining two stations will be OSCE type stations. There will be multiple interview streams and the

interviews will be conducted over two days on 17 and 18 April. Candidates will be asked to list in order their preferred Units of Application and will be allocated to these according to their ranking. This process therefore ensures each region is able to appoint the highest ranked candidate who expressed an interest in training there, and trainees get their highest preference according to their ranking.

There are a total of 70 posts available for England and Wales for 2012. At present Scotland will not be offering any posts for recruitment in 2012; Northern Ireland, in line with their regional policy, will observe the process for the first year and have nominated an observer.

As explained earlier there is no such thing as a dual CCT. There is the opportunity for trainees who wish to train in ICM to also concurrently train in another CCT specialty. These curricula and their respective recruitment and assessment processes are completely independent of each other, but as a result of common competencies shared by the curricula the total training time can be shortened by virtue of a dual training programme referred to as the Dual CCT Programme. It cannot be emphasised enough that it is *the programme that is referred to as dual*. There is a commonly held misbelief that trainees can be appointed to a dual CCT: this is not the case. A trainee must be appointed to both primary specialty programmes which will lead to a CCT in fair and open competition according to their suitability to train in that specialty as laid down in the eligibility criteria of the respective curriculum and according to that specialty's selection process. If we accept that it would be impossible to assess someone's suitability to train in Emergency Medicine if we somehow had to take into account their ability to train in Radiology – both of which are primary specialties – we can see the flawed nature of allowing a trainee's ability to train in ICM to be influenced by their ability to train in, for example, Acute Medicine, also a primary specialty. Both recruitment processes need to be independent and designed to select trainees most suited to train in that specialty otherwise selection cannot be said to be 'fair and open'.

There is a desire in some quarters to link CCT recruitment to specific programmes, often referred to as 'badging' of posts. In this system, the programme is set and the trainees are recruited according to programme availability. For example, a dual programme consisting of Emergency Medicine and ICM would only be able to recruit doctors into ICM training who already possess an NTN in Emergency Medicine. This would exclude doctors with both a medicine or

anaesthesia background from applying for training in ICM. Under those circumstances we would not be recruiting the most suitably qualified doctors to ICM (although the most suitably qualified doctor may well indeed come from EM) but would in fact be selecting doctors to fit predefined programmes. This is not permissible, since appointment to a CCT programme must be in fair and open competition and the eligibility criteria are as laid down in the curriculum not as laid down in a training programme.

Clearly, we cannot recruit trainees to a CCT programme if there will be no specialist post available for them at the end of training. The responsibility for determining future specialist needs lies with the Centre for Workforce Intelligence (CfWI). At the present time ICM is perceived by CfWI as a specialty where an increase in CCT holders is likely, and in the coming year they will be examining this issue more closely with hopefully formal recommendations being made in next year's report. Thus, the argument that plurality of access will generate trained doctors for whom there are no specialist posts is not valid.

In 2012 a trainee may, via MMC Medical Specialty Training, apply to both ICM and a partner specialty but will only be able to accept one or other. Similarly, if a trainee with a current National Training Number (NTN) in a partner specialty successfully applies to ICM and is offered a post then they will have to give up their partner specialty NTN and accept an ICM NTN. Dual programmes will not be introduced until 2013 recruitment. Trainees who wish to pursue a dual programme can apply to ICM first and then a partner specialty in the next year's recruitment round, or vice versa. What has not yet been ascertained is how many dual programmes will be available in 2013. It is likely, though this has not been formally ratified, that dual programmes will be run in a single Unit of Application (UoA) – most commonly a single deanery – and therefore applicants for a second CCT will have to already be in a partner CCT specialty within that UoA. For example, a dual programme in West Midlands Deanery will only be available to applicants who currently hold an NTN in ICM or one of our five partner specialties within West Midlands Deanery and who are then successfully appointed to a second specialty in West Midlands Deanery. Applications from other UoAs who already possess a first CCT would not be accepted.

During the introduction of the new ICM CCT, in order to ensure that any trainee who wishes to train in ICM is able to do so, the Faculty have secured from the GMC permission to continue recruiting to the current

joint CCT until 31 July 2013. Anyone who is appointed to the joint CCT programme before 31 July 2013 will have their training recognised by the GMC regardless of when that training commences or is completed.

When the dual programmes are introduced in 2013, the Faculty have the agreement of the GMC that commencement of a second CCT programme can occur within 18 months of commencing the first. This is known as stepped recruitment. A trainee can apply for a second CCT greater than 18 months after commencing the first but if they are successful and appointed they must utilise the CESR-CP (Combined Programme) route for registration.

Stepped recruitment is necessary logistically, and desirable professionally, since it affords a trainee extra time to consider their future career intentions and whether training in two specialties is indeed their preferred career path. Logistically it is necessary to facilitate the construction of dual programmes as described above and in addition, recruiting simultaneously to two CCTs during a single recruitment process introduces insurmountable logistical problems.

Firstly, to be 'fair and open', each appointments process needs to select the highest ranked candidates based on performance in the selection process. Clearly, the selection processes will differ markedly between specialties but they cannot differ between candidates since this would not pass the 'fair and open' test. Let us take the example where we attempt to recruit to a predefined dual programme with anaesthesia and ICM. A trainee ranks highly in ICM, but does not score highly enough to merit an offer from anaesthesia but does score highly enough still to be appointable to anaesthesia. It would clearly not be fair to another trainee who wished to pursue anaesthesia training alone, and who was ranked higher, to be denied an offer of an anaesthesia post simply to accommodate a predefined dual programme with ICM.

Secondly, it is not possible to merge interview scores from independent selection processes and come up with an aggregate score that could be used to appoint to a predefined dual programme since each primary specialty is obliged to appoint the highest ranked candidates according to that specialty's own selection process. All primary specialties operate independently of each other in this respect according to their curricular requirements. It is only the common competencies shared by ICM and its partner specialties that allow the subsequent construction of a dual training programme to reduce repetition of competencies and shorten total training time.

Appointments must still be made based on specialty selection processes not programme availability, and therefore, trainees must be appointed to two specialties in open competition and then a dual programme constructed to facilitate their training needs.

Thirdly, the intended process for running the recruitment round will utilise an offer system which will allow applicants to hold one post throughout the recruitment round if they wish. In future years this is likely to be an automated process. If later offered a post they prefer, they can reject the first held post and hold or accept this new offer. The applicant can hold only one offer, but there is no limit to number of times this can be exchanged for another post before the end of the recruitment round, when obviously the last offer must be finally accepted or rejected. This prevents applicants being forced to accept an early offer for fear of being unsuccessful in a subsequent interview, and means that interview timings do not disadvantage either the applicant or the specialty. This system does not allow an applicant to hold two offers.

Fourthly, there is the problem of geographically matching offers of appointment to a single UoA if an applicant were allowed to hold two offers. Bearing in mind that there are five partner specialties with ICM and 14 deaneries in England alone it follows that the possible permutations would lead to predictable chaos. It would not be feasible to track which trainees were holding offers, where they were holding offers and indeed to inform all elements within the system when offers had been accepted or rejected. This would inevitably lead to unfilled training posts whilst trainees wishing to train in ICM were denied the opportunity, and almost certainly to trainees being made offers of posts which have already been filled. In the recent past, trainees have had to endure recruitment processes which were ultimately demonstrated to be sub-optimal and the Faculty are keen to avoid any risk of repeating this in our inaugural recruitment process.

The person specification is now on the MMC Medical Specialty Training website and the advertisement for applications will appear on the 3 February on the NHS Jobs, BMJ and West Midlands Deanery websites. The application window will open on 17 February and will close on 5 March. To assist trainees and their supervisors the Faculty have placed a comprehensive Recruitment FAQ on the website under National Recruitment for ICM.

National Recruitment for Intensive Care Medicine
www.ficm.ac.uk/nationalrecruitmentforicm.ashx

Regional update



**Dr Alison Pittard,
Lead RA in ICM**

As the RA representing the trainers on the Faculty Board it is all too easy to be entirely comfortable about the exciting developments in our specialty. This is because I know the interests of our patients and professionals are at the heart of all deliberations. However many people are very unsettled about what the future holds particularly those who are part way through their training programme. We all have our own view on how it should be but the Faculty has had to comply with many GMC regulations and has therefore been reticent to communicate information until it knows the facts. This hasn't helped us plan future specialty training programmes with our Postgraduate Deans and Training Programme Directors.

The previous sections will have answered many questions and no doubt created some new ones! So what now?

From August 2012 it will be possible to enter a training programme at ST3, leading to a single CCT in Intensive Care Medicine. However, we know from trainee surveys that the majority will also want to train in a partner specialty leading to dual certification. It is imperative that Regional Advisors, Training Programme Directors and Postgraduate Deans discuss potential ways of delivering these programmes which will help inform the recruitment process. We have approximately 140 joint CCT posts in the UK which, if converted into the new five-year CCT programme, will result in 28 posts nationally. For a variety of reasons the Centre for Workforce Intelligence (CfWI) predicts an increased requirement of up to 200 CCTs in ICM to be awarded annually. So where will the money come from? Although the Faculty will ask for it, fresh funding for new posts is unlikely to be forthcoming and therefore there needs to be some creativity. Some specialties will see a reduction in training numbers producing opportunities for funding ICM posts. Many hospitals employ Trust doctors and Fellows to staff ICUs and perhaps these could

be converted into training posts. These are just some thoughts and there may be others but it will be up to the deaneries to tell the Faculty what they are able to deliver.

The single CCT will be the backbone of our specialty and this programme will be launched in August this year. However, it is envisaged that those deaneries which can provide a single CCT should also be able, and wish to, offer dual CCT programmes and this will be encouraged. So how will it work? We have looked to those specialties that already offer dual accreditation so as to avoid reinventing the wheel. For small specialties national recruitment works best and the West Midlands Deanery will coordinate this. It is vital that as trainers we continue to have input into this process and the Faculty recognise this.

So what about trainees already in specialty training programmes who wish to gain a CCT in ICM? Don't panic. The GMC have agreed to allow entry into the joint CCT programme until August 2013. This means that any trainee who wishes to follow this route needs to be 'appointed' by this date but can then undertake the training at the appropriate time. For TPDs and RAs this equates to pre-appointing to ensure that CCT output from the joint programme is maintained until the first 'new' CCT is awarded in 2017. It is difficult to predict what the job market will be like for holders of a single CCT in ICM in 2017 but this route will be seen as an opportunity for some and has to be offered in order to develop dual training programmes.

As Regional Advisors and Faculty Tutors we can create the intensivists of the future, not only by the training models used but by a careful selection process into the specialty which the Faculty is encouraging us to have ownership of. Change can be unsettling but as long as we remain engaged we have an opportunity to influence our specialty and the way we train the future workforce.

Trainee update



Dr Chris Booth,
Trainee representative

The first year of the FICM has seen great progress in many aspects of training in Intensive Care Medicine, not least the ratification of the new ICM CCT programme. As a group of doctors in training we are fortunate to be in a specialty that values and respects the opinions of its trainees; from the outset the FICM has insisted on trainee representation on all important matters pertaining to training in ICM.

Trainee representation at Faculty level has evolved from the previous representation on the IBTICM, drawn from the Intensive Care Society's Trainee Committee. We are represented on the Faculty Board, the Training and Assessment Committee (FICMTAC) and the Professional Standards Committee (FICMPSC). The link between the Society and the Faculty trainee representation is important; the Society's Trainee Committee provides a wide pool of trainee opinion from which to feed into the Faculty Board. From November 2012 the trainee representative on the Faculty Board will be elected from the trainee membership of the Faculty, but it is intended that the link between trainee bodies of the FICM and ICS will continue in order to provide best representation of the wide range of opinion found within the trainee population.

Trainee membership of the FICM is now open to trainees in ICM based in UK who have been appointed to the joint CCT programme in ICM. This has replaced the previous CCT registration with the IBTICM and is a requirement for new appointees to the programme. Trainees who have previously registered with the IBTICM are also encouraged to become a trainee member of the Faculty, though they are not required to do so in order to receive their joint CCT. Membership will confer the right to be nominated and to vote in elections for the trainee representative position on the FICM Board. Further information can be found on the Faculty website.

The next step following trainee membership is of course fellowship, which will confer the post nominals FFICM. From early 2013 the route of fellowship by examination will be open as the new Faculty exam comes online; success in the exam will lead to the FFICM. Clearly there will be a cohort of trainees who will complete their CCT programme prior to this route being available. For those whose CCT date will be in the interim period the route of Fellowship by Assessment will be available; the details of this are not fully confirmed but it is expected that a CCT in ICM or documentation of equivalence, plus a consultant post with sessional commitment to ICM will be the likely requirements.

The issue of ICM CCT holders who have obtained a consultant post solely in their parent speciality persists; currently these individuals are not eligible for Foundation Fellowship. The Faculty is aiming to be inclusive and this issue is the subject of discussion by the Membership Advisory Group, which will become the Faculty's Membership and Equivalence Sub-Committee.

The new ICM programme is scheduled to begin in August 2012 and the recruitment process will start towards the end of this year. Initial recruitment will be to single CCT programmes, with dual programmes possible from August 2013. It has been uncertain which route will be more popular as previous surveys of career intentions in ICM have focused on trainees already in ICM training near to their CCT date; no information has been available regarding the preferred career paths for the next generation of intensivists. The FICM and ICS Trainee Committee have been attempting to address this issue by running a survey of junior doctors opinions about careers in ICM. The survey has been a huge success with nearly 800 responses from doctors in Foundation training and CT1/2 posts in ACCS, core anaesthetic training and

core medical training. The survey has captured a wide cross section across all UK deaneries and represents the only data available on career intentions of doctors at this level. Interim data has already been fed into discussions with COPMeD, providing trainee influence on the planning of ICM programmes. Whilst full results are not available yet early analysis suggests an overwhelming preference for dual CCT training.

During this time of change and with the introduction of the new programme it is vital that we provide information to the individuals who want to train in ICM. The need to provide the most up-to-date information must be balanced by ensuring that any information is accurate and reflects definite rather than possible outcomes. Throughout the period the FICM will continue to provide updates on the training program, and the ICS trainees committee will assist in disseminating information. Trainee doctors should check the FICM and ICS websites regularly for the most up-to-date information.

Professional Standards Committee



**Dr Carl Waldman,
Chairman**

The Professional Standards Committee first met in April 2011. The job of chairing this committee, though challenging, has been made much easier due to the calibre of the committee members and the excellent support from Daniel Waeland, Andrea Rowe and James Goodwin. Having gained a lot of experience from my time as President of the Intensive Care Society (2007–2009), it is my hope that this experience can be put to good use in the development of the new faculty.

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.

Mechanism

- » the identification and development of the most appropriate of procedures to improve the treatment of patients and the delivery of intensive care services;
- » the continued development of clinical audit in all aspects of Intensive Care Medicine at a national and local level;
- » the formulation of guidelines of good, effective and safe intensive care practice;
- » the publication, dissemination and exchange of information, including commending good practice identified elsewhere;
- » the development of mechanisms to feed back lessons learned from audit and other quality initiatives into the improvement of intensive care for patients.

Co-operation with other bodies

Where appropriate, in its activities, 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. The Chair sits on the ICS SSQ committee and the Professional Standards Committee of the Royal College of Anaesthetists.

Meetings

- » The Committee hold at least four meetings per year and may meet more frequently.
- » The minutes of the Committee’s meetings will be presented to the Board for approval.
- » The establishment of a sub-committee, working party or working group shall be agreed where reference to the Faculty Regulations.

Constitution

Chair	Dr Carl Waldmann
Deputy Chair	Professor Chris Lavy
FICM Vice-Dean	Professor Tim Evans
Member	Professor Charles Hinds
Member	Dr Jane Eddlestone
Lay-member	Mr Keith Young
RA member	Dr Timothy Gould
ICS SSQ representative	Dr Chris Danbury
Trainee representative	Dr Daniel Harvey
Administrators	Mr Daniel Waeland Mr James Goodwin Miss Andrea Rowe

Strategy

The strategy of this committee 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 Quality Improvement Forum.

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.

Documents of national interest

The PSC has already played and will play a vital role in consideration of documents sent out for review and comment from colleges, associations, societies and national bodies. We have recently commented on the updated NICE guidance on Infection Control (originally written 2003) and on a document produced by the RCOG, RCA, AAGBI, OAA and ICS on [‘Providing Equity of Critical Care and Maternity care for the critically ill pregnant or recently pregnant woman’](#).

A pathway has been developed for considering these documents and ensuring appropriate comments are relayed back to the originating organisation. In addition we have liaised with the MHRA and will be ensuring that appropriate Medical Device alerts are available on the FICM website.

Revalidation development



**Professor Tim Evans,
Vice-Dean**

The FICM has been formed at a challenging time for UK medicine as a whole. Aside from the financial constraints under which service providers are increasingly likely to labour, and the clinical demands of successive winter 'flu epidemics, revalidation is set to 'go live' in 2012. For the Faculty Board this comes at time when the GMC has approved a 'standalone' training programme leading to a CCT in ICM. Consequently, the Faculty needs increasingly to assume the role of assisting its fellowship to re-accredit; a process hitherto taken on by parent colleges most relevant to fellows' base specialty.

Where are we now in this evolution?

The GMC has issued two pieces of guidance which have been available on their website from April 2011. These are concerned respectively with developing a ['Good Medical Practice Framework'](#) (GMPF) for appraisal and revalidation, and with identifying documents that can be regarded as providing supporting information for the same purposes. The GMPF consists of four domains covering knowledge, skills and performance, safety and quality, communication partnership and teamwork; and maintaining trust. Each domain contains three attributes which define the scope and purpose of each, and relate to practices or principles for the Profession as whole. The principles and values of the GMPF have been adapted from the GMC's advice in their Good Medical Practice publication and are examples of the types of professional behaviours expected of all doctors. The FICM is in the process of adapting each document for use by its fellows.

How will these generic (i.e. applicable to all practitioners) domains be assessed?

This will occur at trust level through enhanced appraisal, which will need to include multi-source feedback (MSF) at least once in each five-year cycle. GMC-sponsored and commercially provided MSF tools developed to date have been designed principally to assess the performance of clinicians with continuing care responsibilities, who may have much greater effective patient contact than intensivists. However, development work led by the RCoA aims to address the lack of validated patient feedback questionnaires which are appropriate for use in short consultations, with the aim of providing guidance concerning the timing and mode of administration of such surveys in specific areas of practice, including critical care. Pending the completion of such work the FICM is adapting (with permission) existing RCoA material with the aim of producing interim guidance concerning peer and patient feedback.

What of specialty specific revalidation?

Guidance to specialties on the supporting information required for revalidation is now emerging through a piece of work managed jointly by the RCoA, RCP London, RCP Edinburgh, RCPS Glasgow and RCPGP. A working group is now carrying out a consistency check to determine whether common guidance notes can be provided to practitioners from different specialties. The Board is seeking to adapt this for Faculty use, with the aim of producing a position paper identifying core supporting information for doctors in ICM and which will be published on our website when complete.

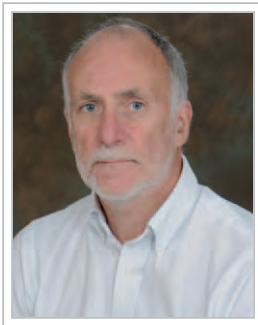
Electronic systems will be needed to facilitate effective revalidation. Parent colleges are considering whether to invest in this and the Faculty aims to support this initiative, which is likely to involve an established commercial software house and significant financial investment.

What should practising intensivists do about 2012?

First, ensure you undertake effective appraisal annually with an appraiser trained in the relevant systems. This should include MSF at least once in every five-year cycle, selecting feedback from sources identified in the Faculty's position paper. This system will evolve and develop over time, but relevant other material (e.g. patient surveys) can and should be included to inform the process. Second, ensure your CPD is up to date and relevant to your areas of clinical practice. Again, the Faculty will provide guidance in this respect. Third, you should ensure you and your colleagues collect information concerning the quality of your clinical practice, using national guidance (e.g. from the Intensive Care Society) and standards of care (e.g. from the National Institute of Clinical Excellence (NICE)) relevant to the service you provide. Evidence of regular audit against such quality markers will be needed.

Remember, the GMC has indicated that it expects the majority of consultants to clear the hurdle of revalidation without difficulty. Starting as it does in the Olympic year, this seems encouraging and the Faculty will assist its fellowship to do so in every possible way. Watch this space.

Faculty Workforce Advisory Group



**Dr Alasdair Short,
Chairman**

There is currently a major review within the DH of the Medical Workforce and as many of you will know, attempts are being made to match the number of trainees to projected consultant vacancies in the future. The Centre for Workforce Intelligence (CfWI) is carrying out this work for the government and currently submitting their initial report. This task is being made very difficult by the current lack of accurate data on the quantity of consultant time dedicated to intensive care provision.

The Faculty is working with the CfWI to ensure that the best and most accurate data can be fed into the process. We are also working closely with the RCoA and the ICS to separate as far as is possible the intensive care components of consultant activities from those primarily dedicated to anaesthesia. To this end the Workforce Advisory Group have been tasked to obtain accurate data as quickly as possible. With a lead time of at least eight to nine years it is essential that the projections for trainee numbers are as good as they can be.

There is no complete current and accurate database of those providing dedicated Direct Clinical Care/PAs in Intensive Care Medicine and the Faculty fellowship database is far from complete at this stage of its development. We have therefore attacked the problem by issuing an ICM workforce census in two phases.

The first phase questionnaire was initiated in March 2011 and attempted to establish the way that ICM was provided within individual hospitals and Trusts with their plans for the development of ICM provision (increase or decrease). We also requested the contact details for those providing dedicated ICM DCC PAs and SPAs in order to then carry out phase two: a census of the activities of those individuals and their plans regarding their future ICM activities.

To date we have obtained a response rate of 75% from the initial data request. We are very grateful to those who have taken the effort to provide data and the current response rate is considerably better than normal. I shall be contacting the remaining 25% personally to help fill the remaining gaps as soon as possible. Phase two of the census was launched in September 2011. I would ask that if you have been contacted as part of the second phase of the census but have yet to respond, please do so as soon as possible. The census can be found at the following link: www.surveymonkey.com/s/icmcensusphase2.

Once this census has been completed the database will be maintained at the Faculty with an annual/biannual update to track the medical workforce providing ICM to the UK. This will then allow workforce planning for the future with a much higher degree of confidence that decisions are based on accurate and current data.

Summary data from the data gathering will appear in the next edition of *Critical Eye*.

The current members of the Workforce Advisory Group are:

- Dr Alasdair Short (Chair)
- Dr Alison Pittard (Lead RA in ICM)
- Dr Carl Waldmann (FICM)
- Mr Daniel Waeland (Faculty Manager)

Advanced Critical Care Practitioners



**Dr Anna Batchelor,
Chair, RCoA Anaesthesia Related
Professionals Committee**

In 2000 the then government launched the Changing Workforce New Ways of Working (NWW) programme, part of which was aimed at educating and training people to take on some aspects of roles normally undertaken by a more conventionally trained professional. There were many strands to NWW, including Anaesthesia Practitioners, now known as Physicians Assistants (Anaesthesia) (PA(A)), Medical Care Practitioners, Surgical Care Practitioners, Theatre Practitioners, Endoscopy Practitioners and Emergency Care Practitioners. The list was almost endless. The overarching theme was to take people who mostly had some healthcare experience (although this was not universal) and train them for a particular role. This would facilitate the expansion of the NHS. A component of the NWW agenda was the 'Skills Escalator', and such was the enthusiasm with which this was espoused by Andrew Foster HR director of the NHS he said in 2002 'In theory you can start as a porter and end as a consultant!'

These quotes are taken from an NHS National Workforce Projects document:

'The Skills Escalator strategy is a means of enhancing the supply of NHS staff. This is because it promotes the development of the existing workforce and it attracts a wider range of people (such as the long-term unemployed or socially-excluded members of the local community) to join the NHS workforce, enlarging the available pool of labour.'

'The Skills Escalator brings together lifelong learning, equality and diversity, regulation, recruitment and retention, pay modernisation and the Career Framework and the Changing Workforce programme.'

An upbeat message and an interesting contrast to the current aim of reducing public sector pay and employees.

Critical care was not part of the initial wave of practitioner programmes but the team leading the Critical Care Modernisation Agency thought there was scope for developing practitioners in critical care and established in 2004 a New Ways of Working in Critical Care (NWWCC) working group led by an SHA head of nursing, Mrs Julie Pearse. I was invited to be a member of this group along with representatives from the IBTICM, ICS, Royal College of Nursing and the British Association of Critical Care Nurses. With the end of the Modernisation Agency the remaining funding was used to establish pilot sites to investigate the roles of advanced and assistant practitioners in critical care.

The Advanced Critical Care Practitioner (ACCP) idea was not new; there were examples from the USA of both practitioners and Physicians Assistants in ICM. The physician assistant role (despite the title having been hijacked in the UK) is a rather peculiarly US role in that the person is indeed an assistant to a particular physician and helps him/her to discharge that role. The assistant is responsible to the physician and the physician is responsible for the assistant. These roles whilst not widely available were well embedded in some areas of the US. In the UK many areas particularly cardiac ICUs had already developed in house practitioner programmes, however these were largely local solutions to local problems and there was no national training programme or defined scope of practice. It had already been seen that nurses who had undertaken advanced training in one location would not have that training recognised elsewhere, which was wasteful and demoralising.

It was becoming clear that trainee medical staffing in ICUs, which has traditionally depended on anaesthetists, was going to be a problem as the European Working Time Regulation (EWTR) and reducing trainee numbers started to bite. An Advanced Critical Care Practitioner seemed a useful aim.

The new role should provide a career path for nurses or other allied health care professionals who wanted to progress and achieve promotion whilst remaining in the clinical area. We set about producing a 'Competence Framework for an Advanced Critical Care Practitioner'. We also produced a similar document for Assistant Critical Care Practitioners, aimed at developing a band 4 worker able to take on some of the bedside nursing care in critical care currently undertaken by band 5 (staff) nurses. These documents were published in March and May 2008.

Extract from National Educational and Competence Framework for Advanced Critical Care Practitioners:

'The role described in this document is based on the medical model of teaching, responsibility and care delivery, and is designed to develop a high-level, trained, accredited, recognised, transferable practitioner to address a service need in critical care and the career aspirations of experienced staff who wish to stay in a clinical role. Senior medical support will be available for clinical advice either directly or indirectly as appropriate. Access to medical support will be on-site and within minutes. Access to multidisciplinary professional support and advice is essential and must be available.'

The Advanced Critical Care Practitioner will:

- » *Have advanced knowledge and skills in critical care and provide a direct contribution to the assessment, treatment and planning of care, and evaluation of the outcomes of patients with critical illness*
- » *Function as part of the critical care team and will work within a defined scope of practice and to clinical standards agreed nationally and applied within a local clinical setting*
- » *Prescribe elements of care and treatment that will be delivered by other members of the healthcare team*
- » *Be able to refer the patient for diagnostic tests and to other healthcare professionals for a specialist opinion*
- » *Have a high degree of autonomy and authority to make clinical decisions, supervised by a medical consultant in intensive care medicine*
- » *Be required to undertake audit of the service and their practice as well being subject to peer-review and appraisal*
- » *Be involved in the training and supervision of others'*

The Framework uses the CoBaTrICE set of competencies which are now the basis for training

doctors in the UK as well as much of Europe. This will facilitate integration of ACCPs into in-house training and CPD schemes and illustrates, in language with which hopefully everyone will become familiar over the next few years, the similarities and differences between the ACCP role and that of medical trainees.

Since publication, acceptance of the concept has spread quite widely across England and Scotland with interest expressed by units in Wales and Northern Ireland. Several sites have taken up ACCPs and the first cohorts of trainees have completed or are nearing completion of two-year training programmes. This is a pleasing development of the project but to meet the aim of a nationally recognised and transferable role we need to standardise the curriculum and produce a nationally accepted final exam, which if we follow the model of PA(A)s would lead to acceptance onto a register of practitioners and hopefully some association with either the Royal College of Anaesthetists or Faculty of ICM. Through the Anaesthesia Related Professionals Committee of the RCoA, after two meetings of trainers, trainees and representatives from Higher Educational Institutions held in 2010, we have appointed Dr Graham Nimmo and Dr Simon Gardner as joint clinical leads. Work is ongoing to develop a full curriculum which we hope will be adopted nationally and lead to the production of a truly new and welcome group of workers to the delivery of our service.

We are keen to hear of units training ACCPs to the National Framework and look forward to working with you in the future, please feel free to contact me through email via the RCoA.

Advanced Critical Care Practitioner document

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084011

Assistant Critical Care Practitioner document

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085583.

Events and Meetings

January 2012

26 January 2012	Meeting: Board of the FICM
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February 2012

06 February 2012	Event: First FICM Annual Meeting
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March 2012

02 March 2012	Meeting: FICM Professional Standards Committee
16 March 2012	Meeting: FICM Training and Assessment Committee

April 2012

05 April 2012	Meeting: Board of the FICM
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June 2012

15 June 2012	Meeting: FICM Training and Assessment Committee
28 June 2012	Meeting: FICM Professional Standards Committee

July 2012

19 July 2012	Meeting: Board of the FICM
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September 2012

14 September 2012	Meeting: FICM Training and Assessment Committee
28 September 2012	Meeting: FICM Professional Standards Committee

October 2012

25 October 2012	Meeting: Board of the FICM
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November 2012

16 November 2012	Meeting: FICM Training and Assessment Committee
29 November 2012	Meeting: FICM Professional Standards Committee

ANNUAL MEETING

Monday 6th February 2012

At the Royal College of Physicians, London

The FICM is delighted to announce that the Faculty's first ever Annual Meeting for fellows and members will be held on 6th February 2012. The meeting will cover the work of the Faculty during its first year of existence and feature many notable speakers including Dame Carol Black, Sir Bruce Keogh and Professor Sir John Tooke.

Programme Highlights include:

Annual Faculty Lecture: Science Shapes Medicine

Professor Sir John Tooke

Session: The NHS in the Next Decade

A Quality Product

Sir Bruce Keogh

Medical Director NHS

The New NHS: Reforming the Reforms

Professor Steve Field

Chair of the NHS Future Forum

Workforce Requirements

Dame Carol Black

National Director for Health and Work

Session: Critical Care in a Pandemic: H1N1

H1N1: Did We Get Away Lightly?

Professor John Watson

Head of Respiratory Diseases

Health Protection Agency

H1N1 and ECMO: What Was Achieved?

Professor Danny McAuley,

Senior Lecturer and Consultant in ICM

Dr Simon Finney, Consultant in ICM

Registration Fee:

Consultants: **£150**

Trainees: **£75**

Event Code: F33

This meeting is approved
for **5 CPD credits**

For the full meeting programme,
please see www.ficm.ac.uk

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.
- 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.
- All of our events have CPD approval of five credits for a full day.
- Lunch is included in the registration fee unless otherwise indicated.

Booking and payment

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

Cancellation policy

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

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

Forthcoming Events

JANUARY 2012

30 **ICS Practical Seminar - FEEL**
Churchill House, London

FEBRUARY 2012

6 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

16 **ICS Practical Seminar - Safe Airway Care in the Critically Ill; lessons from NAP4 and beyond**
Churchill House, London

MARCH 2012

7 **ICS Practical Seminar - An Introduction to Chest Ultrasound for Intensivists**
Churchill House, London

27 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

APRIL 2012

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

MAY 2012

24 - 25 **Trauma Update 2012: ESICM, ICS & SCCN Joint Conference**
The Royal Society, London

31 **ICS Seminar- Liver Failure - Medical and Surgical Aspects**
Churchill House, London

JUNE 2012

8 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

14 - 15 **RCoA, ICS & RCoP Joint Intensive Care Symposium**
Churchill House, London

18 **ICS Seminar - Post Cardiac Arrest Care**
Churchill House, London

SEPTEMBER 2012

13 - 14 **ICS Practical Seminar - BASIC**
Churchill House, London

26 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

OCTOBER 2012

10 **ICS Seminar - ICM Career Day (TBC)**
Mayo Building, Salford Royal Hospital

25 **ICS Seminar - Acute Kidney Injury**
Churchill House, London

NOVEMBER 2012

9 **Core Topics for Training and Revalidation in ICM**
Churchill House, London

25 **ICS Seminar - ICM Career Day (TBC)**
Churchill House, London


DECEMBER 2012


10 - 12 **The State of the Art Meeting 2012**
Venue TBC

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

www.ics.ac.uk www.intensivecarefoundation.org

 search: Intensive Care Society trainees

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