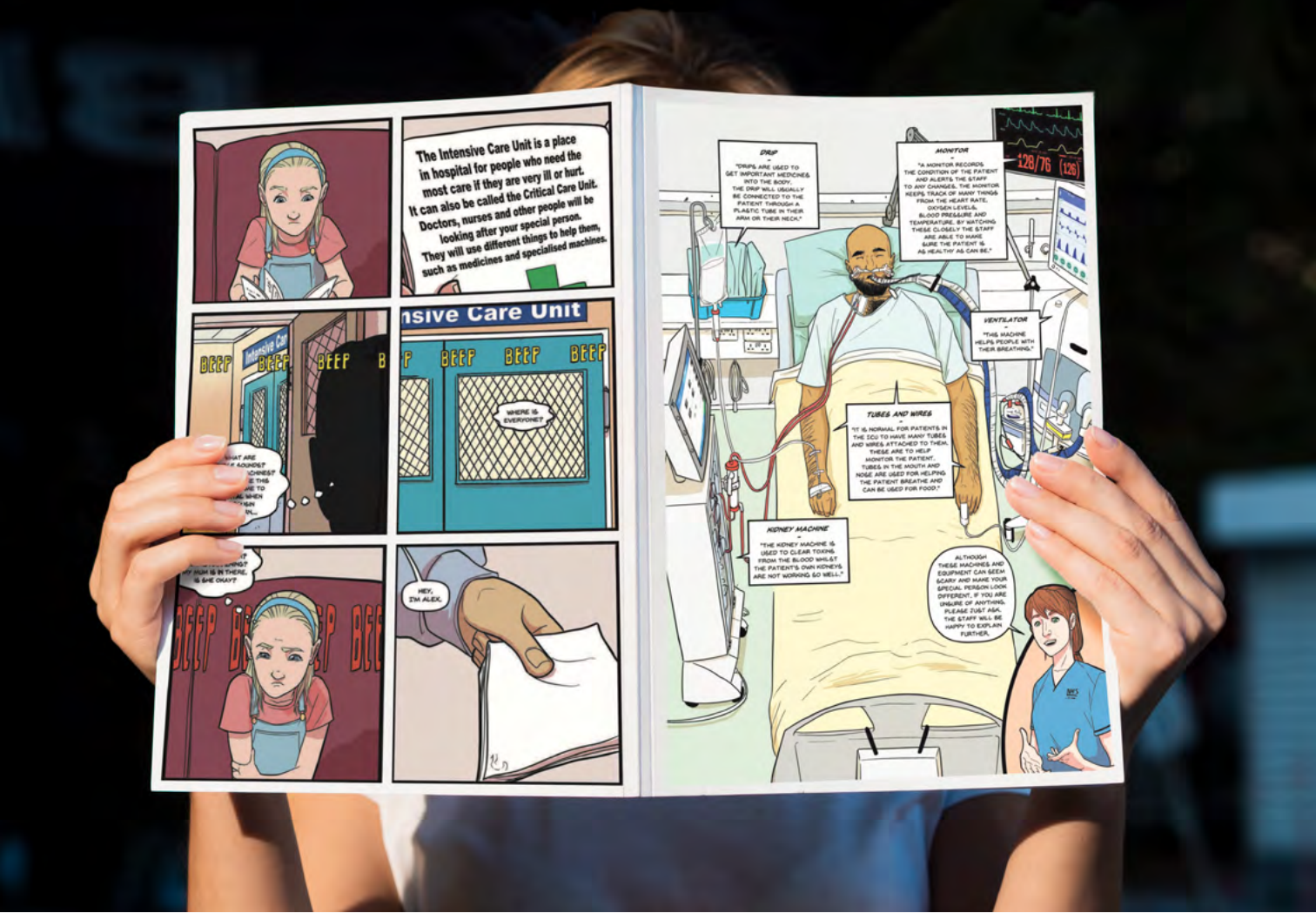
CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE ISSUE 24 | SUMMER 2023

Information for young people visiting ICU



The Faculty of Intensive Care Medicine

In this issue

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WELCOME

Dr John Butler
Clinical Editor

This month marks the 75th anniversary of the National Health Service (NHS). Despite the unprecedented challenges the service is facing it continues to serve the healthcare needs of the population, treating more than 1 million patients a day and providing a high standard of care to patients 24 hours a day, 365 days a year.

Thanks to the dedication and hard work of its staff there are many achievements and successes to be celebrated. However, it is also important that we continually reflect on the service as a whole and analyse the way in which healthcare is being delivered. In his thoughtful article our Vice Dean reflects on the founding concepts of the NHS and asks whether the service remains true to its three essential values established in 1948 and whether there are areas of inequality in our current system which need to be addressed.

Dr Bryden's detailed article gives an update on FICM's involvement in the COVID-19 Inquiry. As a designated core participant for Module 3 our speciality will be fundamental to understanding the impact that the COVID-19 pandemic had on our healthcare systems nationally. This inquiry is an opportunity to both reflect on the tragic events of the pandemic but also to highlight the way in which our specialty adapted positively to the many challenges it faced. It will inevitably allow us to learn valuable lessons that must be used to develop and improve our speciality for the future. I am looking forward to reading more about the Inquiry's findings in the next few months.

There are many excellent articles in this edition including an update on the Neurological criteria for diagnosing death and an interesting discussion about the relationship between our specialty and palliative care. I hope you enjoy reading it.

We welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

Message From The Dean

Dr Daniele Bryden
Dean

I've been reviewing a lot of COVID-related information recently as part of preparation for the COVID-19 Inquiry. The Inquiry has now opened and FICM, in conjunction with the RCoA and Association of Anaesthetists, has been designated as a Core Participant for Module 3 which is examining the impact of COVID on healthcare systems in all four nations. The Inquiry has been set up to examine the UK's response to and impact of the COVID-19 pandemic, and to learn lessons for the future. Among the scope of Module 3 is an examination of the capacity of healthcare systems to respond to the pandemic and how this evolved over time.

It will also consider people's experience of healthcare and examine healthcare-related inequalities. Whatever your views were on how equal our society was or was not becoming before 2020, we saw at first hand that in health terms we appeared to take several steps backwards with some sections of the population.

It's good that as a designated Core Participant we can ensure ICM provision is front and centre of the focus in Module 3. Working with the RCoA and Association we will be able to show our cross specialty co-operation and make best use of resources, whilst recognising that the requirements of intensive care professionals and anaesthetists aren't aligned.

Change and normality

I've been struck by how so many people working in intensive care expressed a desire during the pandemic for the return of 'business as usual', and reflecting on that now, it's clear how much has changed within our specialty, clearly not all of it welcome. Did we really think we could slip back into previous ways of working or was the desire for any form of non-COVID 'normality' at a time of great stress so powerful that considering a professional future in ICM that was permanently different too much to contemplate?

Some of the changes (closer relationships with other specialties/professions, the growth in research participation, the way we dealt with complexity at speed) are ones to sustain and/or take pride in, but others, not least workforce (morale and numbers) and the factors that impact on it, remain a serious concern as we embark on getting on with day-to-day intensive care.

After two years of rapid change at pace, it's increasingly important that we take a longer term view. That means recognition that an approach focusing on a sticking plaster might have been helpful in a crisis, but going forward in a sustainable way to deal with the whole system issues that we find ourselves in, means ICM must try and embed itself in the solutions for many conditions like social inequality, chronic ill health and multimorbidity that at first glance don't look like natural fits for an acute specialty. It also illustrates why the move towards a new College of ICM is right for the future — much of what we deal with on a day-to-day basis requires an increasingly multidisciplinary medical skillset in addition to any technical/practical skills the specialty was formed around. The role of the intensivist of the future is likely to be very different from the one many of us have performed in our careers to date.

Module 3 doesn't start its public hearing element until next year, and much of the detail of our current work is subject to confidentiality, but being on the inside means that we can ensure ICM is front and centre throughout. No information has yet been released as to when the Inquiry will report, but as events unfold, I hope we'll be able to share with you some key insights and information along the way.

Digital solutions

Learning lessons for ICM can't just be about our responses to pandemics and crises but honestly looking at current practices and identifying what we could do better or differently. In some cases that means taking time to define the issues and requirements before embarking on outlining solutions or another piece of guidance. Earlier this year, we co-authored an editorial on digitally enabled remote critical care provision. It plants a marker of intention for future Faculty work and collaboration.

I'm fortunate that my critical care service has had an excellent Clinical Information System (CIS) for many years. Not only does it allow me to deliver patient care more effectively even as I rotate around different units (I work on three units at two sites), it allows our team to have regular discussions regarding complex cases and even conduct MDT meetings with other teams at other hospitals.

The smallest unit I work on has up to eight beds and shared out of hours cover: the CIS allows us to provide a sustainable solution for senior medical staffing for a unit that can look after some very complex multimorbid patients but in numerical terms is very much the spoke not the hub of services. We're not a designated weaning unit, but as we found during COVID, the CIS enabled us to obtain advice on weaning complex patients from units with more experience. There are viable solutions for many of our current difficulties if the technology can be more widely enabled, but the associated issues need to be carefully considered and addressed. ICM is not alone in showcasing what can be done with investment in I.T. services, and we will continue to work with others to push this over the line. Most mature healthcare systems spend 2-2.5% of their budget in this area: the NHS is currently spending in the order of 1%.

Context and perspective

Paradoxically, revisiting the pandemic for the COVID Inquiry has so far been an opportunity for me to put some context and perspective back into events I had remembered very differently. Recognising the ways in which change can be facilitated if the right buttons are pressed has been valuable. It's something that's likely to be beneficial for all of us, either in day to day clinical care or in leadership roles. The famed "magic money tree" of the early days of the pandemic has gone, but we can recognise that work done with care, based on evidence of genuine benefit can have a long life. Enhanced Care, Life After Critical Illness and Care at the End of Life are Faculty projects that have been much quoted and formed the template for many other subsequent pieces of work based on them.

Currently much of the work we're doing as a Faculty and Board is building for the future with new ways of thinking and collaborating informed by the lessons of the recent past. Not so much a case of 'business as usual' but more of 'business unusual'.

Aneurin Bevan, Minister of Health, on the first day of the National Health Service, 5 July 1948 at Park Hospital, Davyhulme, near Manchester.

Critical care and the NHS at 75

Dr Jack Parry-Jones
FICM Vice Dean

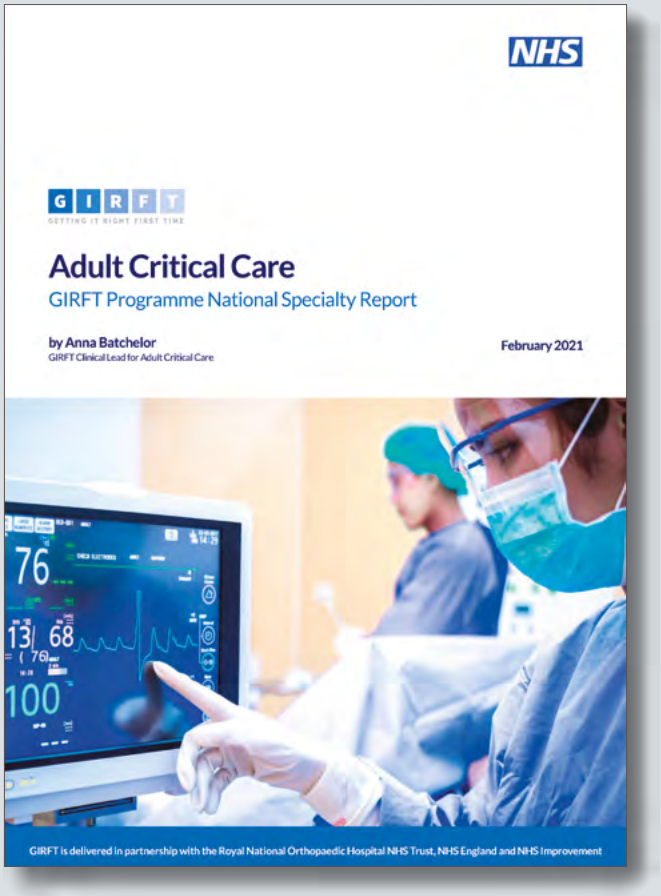
July 5th 2023 marked the 75th anniversary of the National Health Service (NHS). At its conception the NHS had three essential values: "that services help everyone", "that healthcare is free" and that "care would be provided based on need". Notwithstanding the politics of a health service funded by taxation, since 1948, further specialisation and the evolution of new healthcare services have seriously challenged these essential values.

Our specialty was born during this timespan; has it developed keeping all three of these core essentials intact? Do critical care services help everyone, and if they do, is it equal? At the point of delivery critical care is free, but does what you can afford affect what access you have? Are we able to equitably provide critical care based solely on need, or is access to staffed critical care beds variable across the UK? These are difficult questions with some uncomfortable answers.

Social factors

All of us on the frontline of critical care know that our ability to admit a critically ill patient is governed not solely by need, but also by resource. When staffed critical care capacity is at a premium, patients on the cusp of needing immediate admission are delayed, either pending a deterioration making the need for admission indisputable, or a recovery in their condition making admission, at least for the moment unnecessary. The unmet need to admit and manage risk within a critical care environment is variable and often depends on factors independent of a patient's condition.

Critical care remains free but does your wealth and often by extension, your level of education affect what you can access? The need for critical care support is higher in those who are more deprived. The COVID pandemic highlighted with a single disease, the direct correlation between social factors (poverty, ethnicity, gender, disability) and a higher risk of critical illness. A fact that should come as no surprise to any of us. However, less obvious was family visiting and accessing services such as critical care Follow Up and Rehabilitation. We need to ensure equitable access to the services we provide to ensure that that barriers are not unintentionally based on income and protected characteristics.



Equity

The Getting it Right First Time (GiRFT)[1] report for NHS England makes clear that there remains a lot to do to ensure equitable access. The number of critical care beds per capita is variable across the UK and the ability to recruit and retain trained consultant intensivists is regionally variable.

Sub-specialisation, which we have throughout healthcare, is mirrored in intensive care. The ease of access to ECMO, neuro-critical care, burns, liver, and long-term ventilation and weaning are likely to depend on where you live. In future, better communication (digitalisation) and transfer services may help mitigate this but there remains a lot of work to do.

The political argument for a nationalised health care service was hard fought by the likes of Aneurin Bevan MP. Political leadership is necessary for intensive care services to repeatedly make and win the case for more staffed capacity enabling equal access, more National Training Numbers for equal service, and better access to specialist critical care services through digitalised communication and transfer services. Those three essential values remain as important today as they were 75 years ago.

References

1. Getting it Right First Time (GiRFT). Adult Critical Care https://www.ficm.ac.uk/adult-critical-care-girft-programme-national-specialty-report-feb-2021

CRITICAL EYE *Spotlight:*
Intensive Care Medicine and Specialist Palliative Care — opposite ends of the spectrum or two sides of the same coin?

Dr Hannah Richards
Consultant in Intensive Care Medicine

As I walked in on my first day as an Intensivist working with the specialist palliative care team (SPCT) our administrator greeted me. "ICU say can you go straight down please?" Looking concerned she handed me the ominous 'saying goodbye to Daddy' leaflet and sent me on my way to a situation that no amount of morphine and midazolam could fix. It was the first of many referrals that reminded me how much I could learn, as an ICU consultant, working with our hospital palliative care team.

Palliative care and ICM I hear you say! Aren't they total opposites? Isn't ICM about doing everything and palliative medicine about doing nothing? Thankfully not. Through a programme of giving ICM doctors opportunities to work with our SPCT and integrating our 2 teams as a trust, have seen huge benefits in the care we can provide to patients approaching the end of their life in our ICU

Do we need specialist palliative care in the ICU?

It is a fact that ICU patients have high mortality and morbidity rates. Traditionally, however, palliative care teams have rarely been invited into the ICU. Perhaps we feel that with our understanding of analgesia and sedation, wide range of therapeutic options and high intensity nursing that we just don't need an extra team. Perhaps, as is often the case, we just don't speak each other's language and so it's easier to stay in our comfort zones.

In our trust we asked specialist palliative care and ICU staff to rate their confidence in providing 30 aspects of good end of life care identified from ICS guidelines (1). Our results showed that whilst our ICU team were comfortable managing pain or withdrawing invasive ventilation 0% were confident in assessing a patient's spiritual needs. This was in stark contrast to the palliative care team, none of

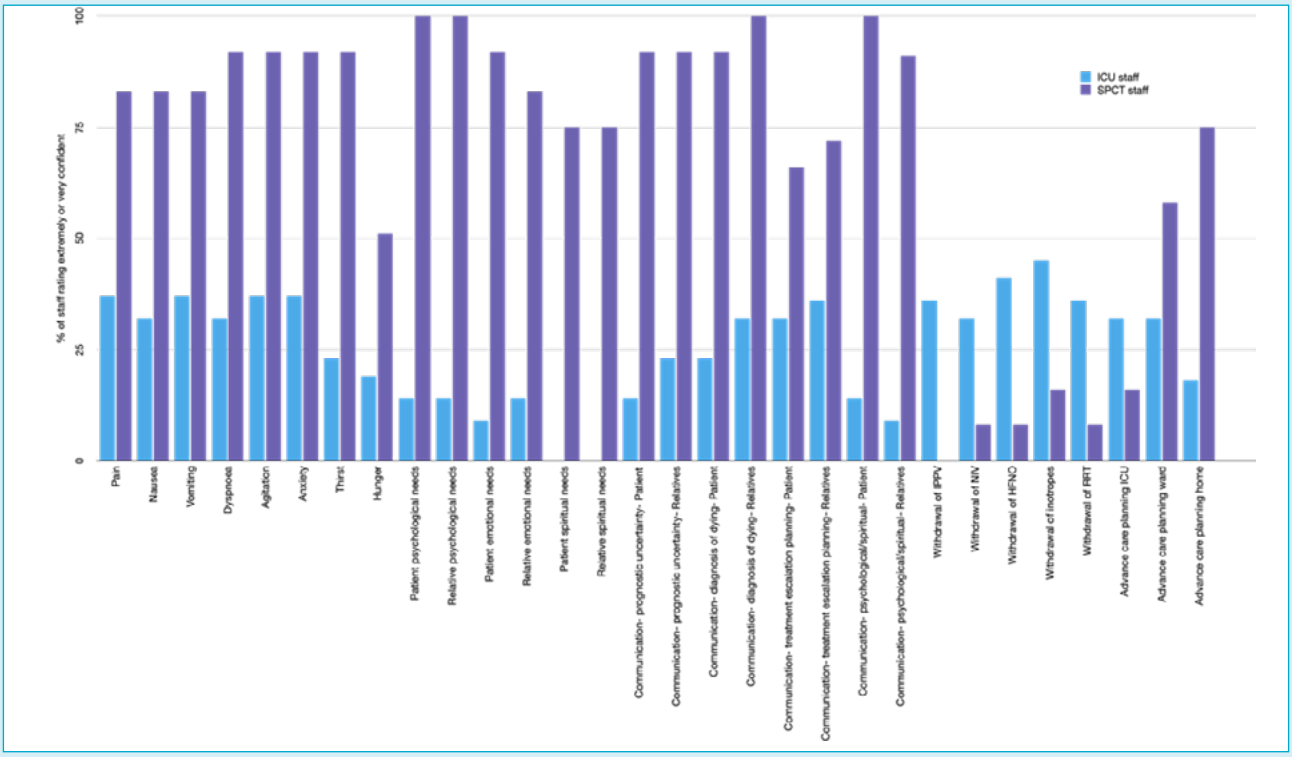


Figure 1. *Pre-intervention percentage of staff rating extremely or very confident in SPCT and ICU staff.*

whom would be confident in withdrawing invasive ventilation but 100% of whom are confident to assess and manage psychological distress in patients and their relatives (Figure 1). We saw that together we have staff who are confident to provide all of the aspects of end of life care our patients need, but neither team can go it alone.

The expertise of our palliative care colleagues however extends far beyond the psychosocial. Specialist palliative care teams have the skills to manage complex physical symptoms in increasingly innovative ways. Whether it is interventional pain management, hospice admission for a ketamine syringe driver or co-ordinating a longed for discharge, palliative care teams open doors for our patients that we, as intensivists, cannot.

How can we integrate the two services?

Timetabled ward rounds, MDT attendance and cross team working have all been successful models of service integration in other trusts. Fundamentally however our experience is that a shared culture of care at the end of life is more important than scheduled visits. We truly begin to integrate our services when we understand each other's language and appreciate each other's skills.

This foundational work has been key in successfully bringing our two teams together. ICM trainees have spent special skills years working with both the Palliative Care and ICU teams. Through this a programme of training for both teams, alongside joint ICU and SPCT reviews was established. This enabled us to share our skills and see the real time benefits for the patients in front of us. Following these interventions we were able to demonstrate improved staff confidence in all 30 areas of end of life care we had investigated (Figure 2).

Our colleagues in palliative care became more confident in the ICU environment and began to see how vital their skills are for our patient population. The alarming ventilator, or invasive lines no longer daunted them and they were able to focus on meticulous holistic needs assessment, advanced symptom control and supporting those around the patient.

As an ICU team we began to see the benefit for our patients in having palliative care support. Whether that be

for management of distressing breathlessness, spiritual care for those in existential distress or even organising a wedding on the unit! As our understanding of each other grew it became routine practice to invite the palliative care team to see our patients, not because it was unit policy, but because we genuinely saw the benefit for those in our care. We saw that far from doing nothing our palliative care colleagues proactively tackled the difficult issues that we didn't know where to start with.

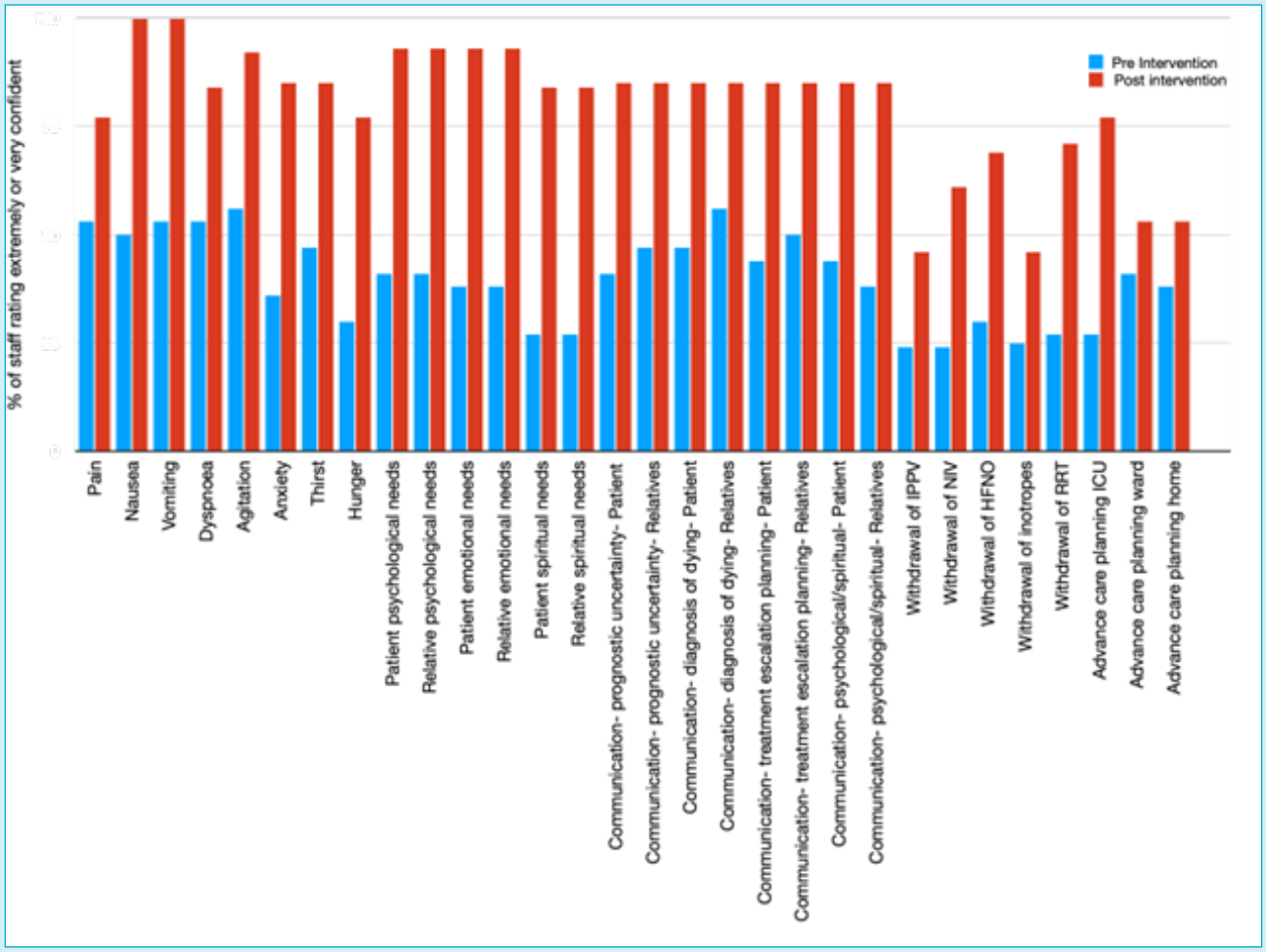
What might the future look like?

Dr Hannah Richards

There is so much more to palliative care than morphine and midazolam. As we see the benefits of learning from our colleagues, I hope we will see more and more training opportunities for intensivists; not just to know when to refer but to learn those skills for ourselves. A dedicated SSY curriculum, consultants working across both specialties and formal training courses are just some of the ways that we, as an intensive care community, can embrace the resources that palliative medicine has to offer.

Perhaps the most important thing we have to learn however is to always keep what matters most to our patients at the heart of what we do. In an environment where it is all too easy to become distracted by invasive monitoring, expensive drugs and the latest technology palliative care reminds us that most fundamentally our patients are people. Knowing what matters to them is as important as knowing their PaCO2, knowing what gives

Figure 2. *Precentage of staff (both teams) rating confidence "extremely confident" or "very confident" pre and post-intervention.*



them strength is as valuable as knowing what their blood cultures have grown and treating them with true compassion is as satisfying as a well-placed central line! As palliative care input becomes the norm on our ICUs so does the passion for truly patient centred care. After all you shouldn't have to be dying to have your symptoms well controlled, your worries listened to and your humanity remembered- every patient will benefit as we learn what our colleagues have to teach us.

The Palliative Care Consultant's perspective

Dr Catherine Hayle, Consultant in Palliative Medicine

Whereas many would see our specialties as being on opposite ends of the medical spectrum, it seems quite natural to me that Palliative Medicine and Intensive Care Medicine should be closely aligned. This view was reinforced when two successive senior ICM trainees joined our HSPCT and really thrived. Much of the work of both of our specialties is in caring for patients with uncertain recovery, when skilled communication and symptom control alongside active medical treatment is key. Additionally, despite the best efforts of Critical Care Teams, it is not unusual for patients to die within Critical Care Units. So again, as in palliative care, providing high quality care in the last days of life is a core skill for ICM doctors and nurses. The challenge is that within a Critical Care environment, it is often not possible to get to know the patient as a person prior to their deterioration, so taking time to understand who they are and what matters to them is key. I have seen this happening more and more since our teams have worked together more closely. As well as benefitting patients and those close to them, this can be a rewarding process for staff, enhancing morale.

Our palliative care team have really enjoyed the opportunities for learning this closer collaboration has provided. Through opportunities to shadow staff on the Critical Care Unit and working directly alongside ICM colleagues in our advisory work (initially as senior trainees and now as a consultant colleague), members of our MDT have learned a great deal about understanding prognosis, active management when recovery is uncertain, and delivering care in a high tech environment. Our mission now is to continue to learn through collaboration, and ensure our ICM colleagues can depend on timely and responsive palliative care support whenever they would welcome it.

The Intensivist's perspective

Dr Tom Williams, Consultant in Intensive Care Medicine and Anaesthesia

Palliative care is one of those areas we all think we do a reasonable job with in Intensive Care. But do we? Having a palliative care specialist embedded in our unit, at first as a trainee undertaking a special skills year in palliative care, and subsequently as a consultant, has opened many of our eyes to how much better end-of-life care can be delivered. It has on occasion proved invaluable for patients where there are challenges, be those practical, spiritual, ethical or legal. Our staff feel happier and more empowered when delivering end-of-life care. Links between the palliative care team with our outreach team have strengthened with plans to develop this further.

Critical care is a multi-disciplinary specialty. We frequently involve specialists in the care we provide. Closer working with the SPCT simply extends this to our end of life care. Whether it is an ethical dilemma, the dog at the patient's feet or a supported rapid discharge, many of our patients and their relatives have benefited.

So, do we as a specialty do a reasonable job with end-of-life care? Most of the time we probably do. But for something as important as the end of a patient's life; we should be doing better than 'reasonable.' Closer working with the SPCT can have a huge number of benefits for everyone involved, improve care, and make those difficult moments a little bit easier.

Dr Hannah Richards is a consultant in Intensive Care Medicine at Wirral University Teaching Hospital with a special interest in palliative medicine. Alongside Critical care she spends 1 day per week with the hospital specialist palliative care team providing palliative care to patients across the hospital.

References:

1. Care at the End of Life: A guide to best practice, discussion and decision-making in and around critical care, Faculty of Intensive Care Medicine. 2019.

Fiona Duncan and Dr Pauline Austin. Photo courtesy of NHS Tayside.

Dr Pauline Austin
ICU Consultant

Comic Authors

Dawn McKay, ICU nurse
Fiona Duncan, ICU Recovery Service
Dr Anna Brewster, Anaesthetic Specialty Trainee
Dr Megan Sinclair, English Communications and Comics Studies Lecturer
Mayra Crowe, Senior Lecturer and Spanish Organiser
Prof Chris Murray, Chair of Comics Studies, School of Humanities, Social Sciences and Law
Elliot Balson, Freelance comics artist and creator

VISITING ICU: a comic book for children and young people visiting intensive care

Admission to intensive care is a life changing event, not only for the individual undergoing treatment, but also for their family and friends. Critical illness can be a frightening and uncertain time for all those affected. It can be particularly challenging for children and young people to understand not only what is happening but also the emotions they are feeling.

In addition, it is often incredibly hard for parents and carers to explain what intensive or critical care actually is. These themes became particularly apparent to the Dundee team when supporting a number of families with young children through their ICU journey.

Following these interactions and an attempt to support families and provide age appropriate resources, it was clear that there were relatively few aimed at children age 8-14 years. ICUsteps have fantastic booklets particularly aimed at the younger child but for those who are slightly older we felt there was an opportunity to develop an age-appropriate resource. Financial support for the project was sought and kindly provided by the NHS Tayside organ and tissue donation committee.

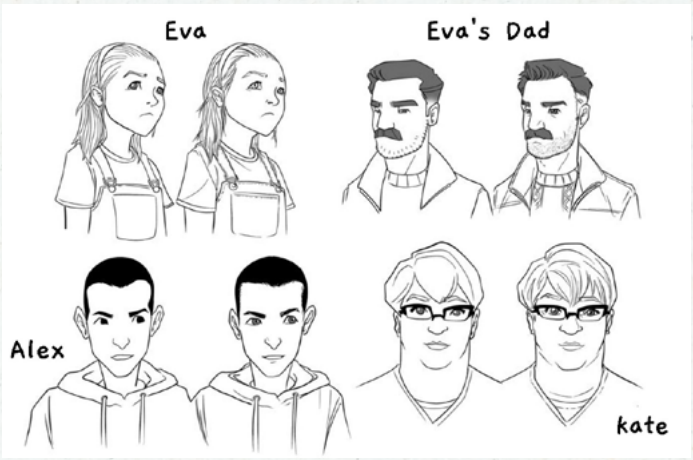
Raising awareness

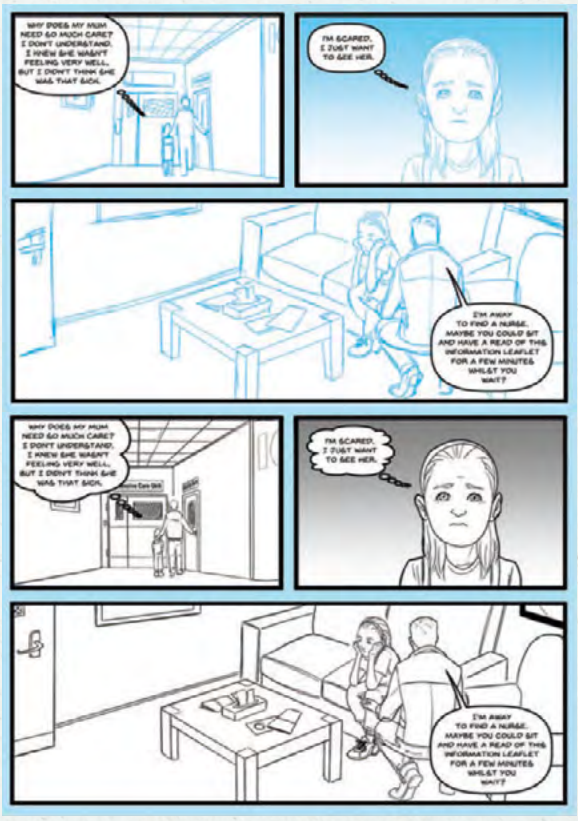
Locally, there had already been a public engagement project led by Mayra Crowe from the University of Dundee in writing and producing a comic raising awareness of organ donation following her own personal experience. *The Gift: Transforming Lives Through Organ Donation*, was the inspiration for using comics as a medium to convey information about intensive care to children and young people.

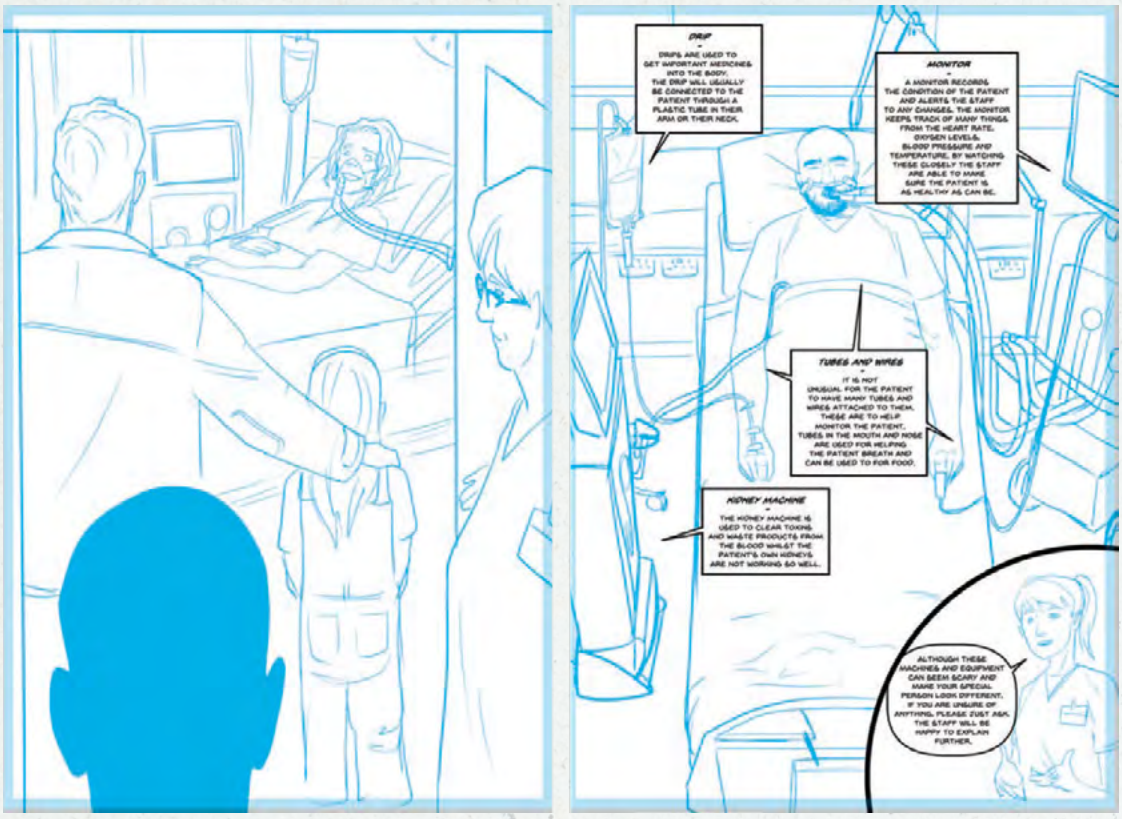
The University of Dundee's Scottish Centre for Comic Studies have produced many public information comics, often dealing with healthcare issues and science communication. Our collaboration began in January 2022 with the first of many 'Teams' meetings. Utilising the 'comic jam' methodology we brought together university academics, artists and healthcare professionals around a virtual table. Whilst we would have ideally met in person, the perpetual presence of COVID-19 meant that we resigned ourselves to coming together in a virtual capacity.

Following a period of research and consultation with our team and young people, we set about identifying the messages we wanted to get across and the vision of what the comic would look like. It was imperative that we delivered a comic that was interesting, relevant and representative of what children

This page and over: *The comic-making process includes character designs, thumbnail layouts, then pencils and inks to create the final art.*







would want to know about visiting intensive care. The first step was to come up with a story and characters and then write a script. Dr Megan Sinclair as scriptwriter, gave us a base upon which we were able to build and adapt the storyline. Developing the characters, their backstories and the choice of words proved more challenging than anticipated amongst the healthcare team — something the comic team were fully expecting. Many hours were spent ensuring the word choice did not convey confusion or be open to misinterpretation and small changes were made right up until the very end.

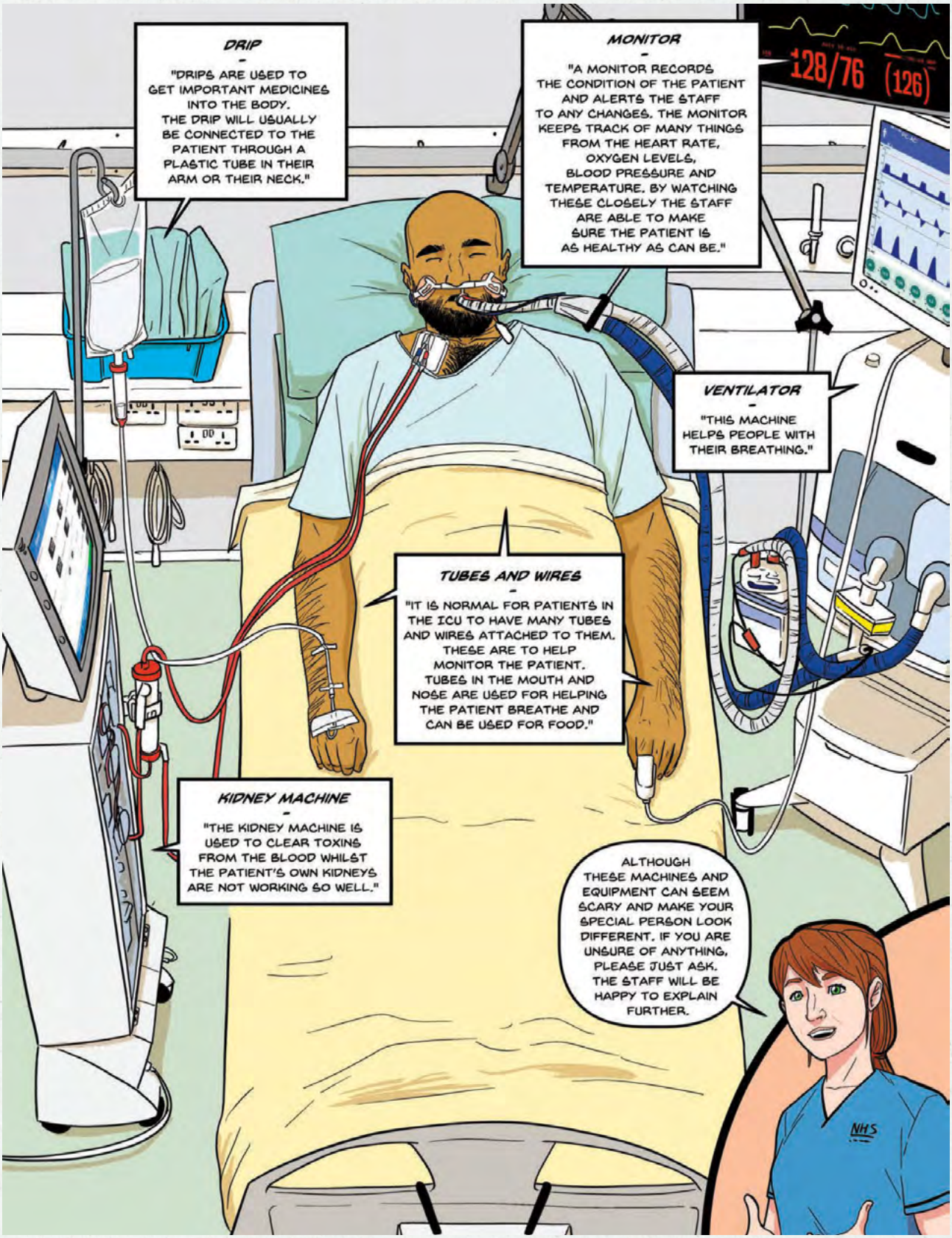
True to life

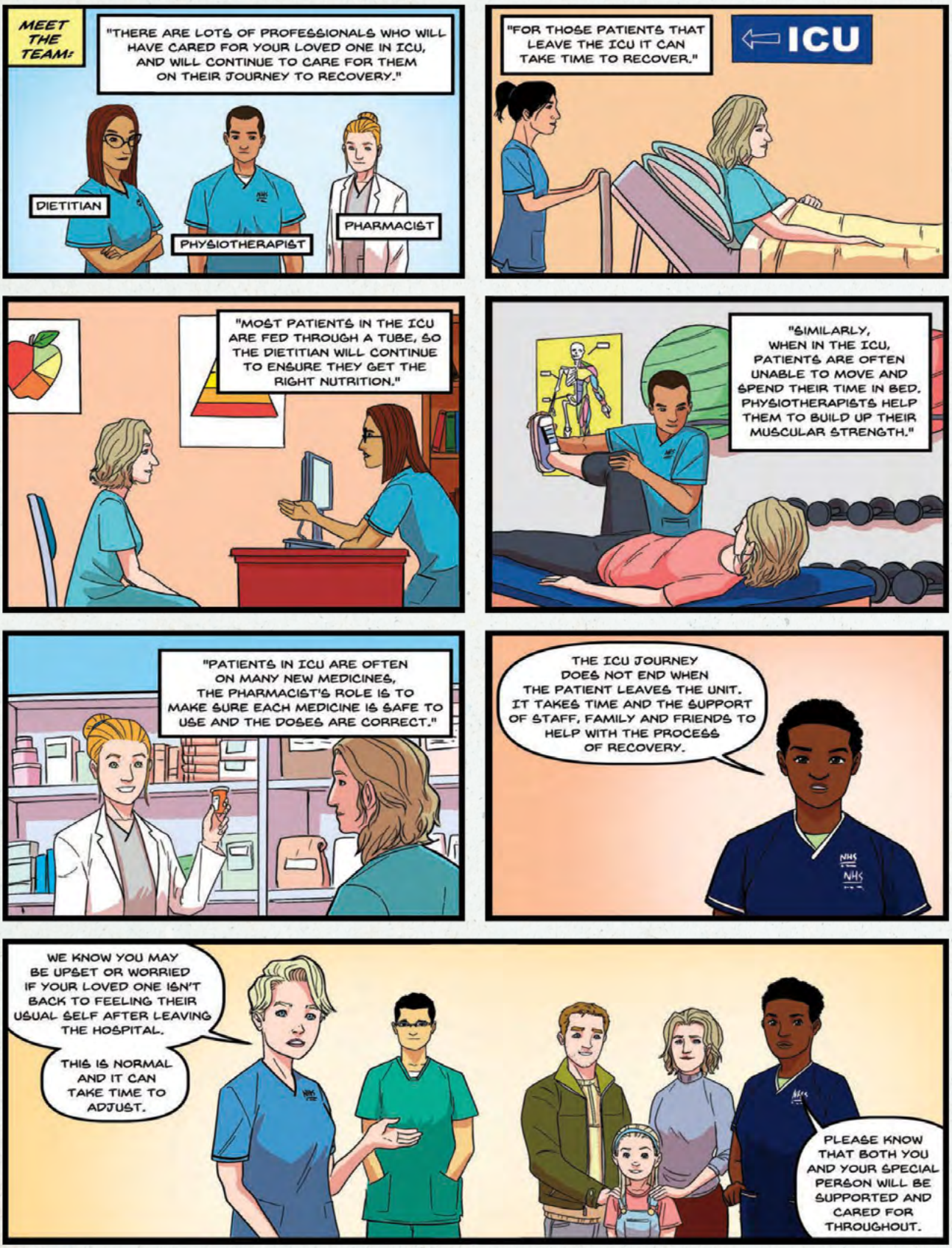
Once we had the story more or less complete, it was time to engage the artistic skill of comic creator and freelance artist, Elliot Balson. The characters were brought to life in layout sketches to figure out how the story could be told in the form of a comic. The team wanted images that would make an impact and feel true to life, but which would also present information that would help young people understand what was happening in ICU. The artwork effectively illustrated the sights and sounds encountered in ICU whilst also visually tackling the challenges of issues like delirium. It was also important to the team that the comic was as true to life as possible and great care was taken to ensure we had accurate representation of healthcare team members and their uniforms.

Throughout the process we were expertly guided by Professor Chris Murray and Mayra Crowe who provided valuable insights into the comic-making process and ensured we stayed true to our initial intentions. After collating some further information and support details we were finally ready to go into production. *Visiting ICU: Information for Children and Young People Visiting Intensive Care* was finally published by 'UniVerse publishing' at the University of Dundee and launched at a celebration evening in April 2023.

Get your copy

Since publication we have had many positive comments and feedback and have distributed paper copies to a number of intensive care units across Scotland. The comic has been endorsed by the Scottish Intensive Care Society and we would welcome other critical care areas to download a free electronic copy from the Discovery Dundee portal at discovery.dundee.ac.uk.


DRIP
"DRIPS ARE USED TO GET IMPORTANT MEDICINES INTO THE BODY. THE DRIP WILL USUALLY BE CONNECTED TO THE PATIENT THROUGH A PLASTIC TUBE IN THEIR ARM OR THEIR NECK."
MONITOR
"A MONITOR RECORDS THE CONDITION OF THE PATIENT AND ALERTS THE STAFF TO ANY CHANGES. THE MONITOR KEEPS TRACK OF MANY THINGS FROM THE HEART RATE, OXYGEN LEVELS, BLOOD PRESSURE AND TEMPERATURE. BY WATCHING THESE CLOSELY THE STAFF ARE ABLE TO MAKE SURE THE PATIENT IS AS HEALTHY AS CAN BE."
128/76 (126)
VENTILATOR
"THIS MACHINE HELPS PEOPLE WITH THEIR BREATHING."
TUBES AND WIRES
"IT IS NORMAL FOR PATIENTS IN THE ICU TO HAVE MANY TUBES AND WIRES ATTACHED TO THEM. THESE ARE TO HELP MONITOR THE PATIENT. TUBES IN THE MOUTH AND NOSE ARE USED FOR HELPING THE PATIENT BREATHE AND CAN BE USED FOR FOOD."
KIDNEY MACHINE
"THE KIDNEY MACHINE IS USED TO CLEAR TOXINS FROM THE BLOOD WHILST THE PATIENT'S OWN KIDNEYS ARE NOT WORKING SO WELL."
ALTHOUGH THESE MACHINES AND EQUIPMENT CAN SEEM SCARY AND MAKE YOUR SPECIAL PERSON LOOK DIFFERENT. IF YOU ARE UNSURE OF ANYTHING, PLEASE JUST ASK. THE STAFF WILL BE HAPPY TO EXPLAIN FURTHER.
NHS


MEET THE TEAM:
"THERE ARE LOTS OF PROFESSIONALS WHO WILL HAVE CARED FOR YOUR LOVED ONE IN ICU, AND WILL CONTINUE TO CARE FOR THEM ON THEIR JOURNEY TO RECOVERY."
DIETITIAN
PHYSIOTHERAPIST
PHARMACIST
"FOR THOSE PATIENTS THAT LEAVE THE ICU IT CAN TAKE TIME TO RECOVER."
ICU
"MOST PATIENTS IN THE ICU ARE FED THROUGH A TUBE, SO THE DIETITIAN WILL CONTINUE TO ENSURE THEY GET THE RIGHT NUTRITION."
"SIMILARLY, WHEN IN THE ICU, PATIENTS ARE OFTEN UNABLE TO MOVE AND SPEND THEIR TIME IN BED. PHYSIOTHERAPISTS HELP THEM TO BUILD UP THEIR MUSCULAR STRENGTH."
"PATIENTS IN ICU ARE OFTEN ON MANY NEW MEDICINES, THE PHARMACIST'S ROLE IS TO MAKE SURE EACH MEDICINE IS SAFE TO USE AND THE DOSES ARE CORRECT."
THE ICU JOURNEY DOES NOT END WHEN THE PATIENT LEAVES THE UNIT. IT TAKES TIME AND THE SUPPORT OF STAFF, FAMILY AND FRIENDS TO HELP WITH THE PROCESS OF RECOVERY.
WE KNOW YOU MAY BE UPSET OR WORRIED IF YOUR LOVED ONE ISN'T BACK TO FEELING THEIR USUAL SELF AFTER LEAVING THE HOSPITAL.
THIS IS NORMAL AND IT CAN TAKE TIME TO ADJUST.
PLEASE KNOW THAT BOTH YOU AND YOUR SPECIAL PERSON WILL BE SUPPORTED AND CARED FOR THROUGHOUT.

Regional Advisor Update

Dr Andrew Sharman
Lead ICM Regional Advisor

This is my first piece for *Critical Eye* and it comes at a time when there is much disharmony around us. The NHS feels like it is imploding. I know many of you will have struggled with your role in industrial action both ethically and financially, especially after so much sacrifice for the NHS during the pandemic. Whatever decisions you made, you are supported and as a trainers and fellow doctors we all understand.

2023 will be a year of discontent — none of which I can solve in this article but let's try and look for some positives. The Training, Leadership and Management (TLAM) conference for trainers was again very successful this February. Luckily it was online as there were rail strikes (always be prepared!). A thoroughly enjoyable day thanks to a great set of speakers. Thank you so much for all those who gave up their time to talk.

Thought-provoking for me was the talk on differential attainment by Dr Liza Keating, discussing this important topic before the publication of the GMC document *Tackling Disadvantage in Medical Education* — this is well worth a read. There are no easy solutions, but I am proud, that as a Faculty, we have this in the forefront of our minds. By acknowledging and recognising the issues, we can start creating solutions. The afternoon was given over to the trainees and how they see ICM training. It was an honest reminder of how hard training remains. Role modelling and trainers who are supportive, open minded and encouraging cannot be underestimated. Hopefully next year it will be face-to-face.

Contact your trainers

March is always a busy month- exam season and recruitment. Exams are never an easy time, and seem to become an increasing hurdle as training progresses. Congratulations to those who were successful. It is truly a great achievement and one to be proud of. If you were unsuccessful this time please do get in contact with your local trainers. We all understand how heart-breaking (and expensive) it is to not get the results you were hoping for. We are here to help, support and guide you, please use us.

On to the annual recruitment process — congratulations to all those who were successful this year. Welcoming new trainees from diverse training backgrounds, with a wealth of experience and skills is one of the strengths of the ICM training programme. Creating a training programme for you, will often be bespoke and unique to you. The new curriculum allows for this, moving to a more capability-based programme where you can show progression in your learning and pinpoint areas for further development. I hope you will all embrace your uniqueness and individuality.

Engaged and committed

So I will end on positives. Intensive Care Medicine remains a thriving, demanding, and rewarding career. The training programme goes from strength to strength. We have engaged, committed, and interested trainers who are determined to get the best out of trainees. As doctors we have shown, so recently, that we can overcome any challenge. We should be proud of ourselves. Keep strong!

Training, Assessment and Quality (FICMTAQ)

Dr Chris Thorpe
Outgoing TAQ Chair

Dr Sarah Clarke
Incoming TAQ Chair

Time to catch our breath! It's been full on for everyone involved with training in ICM over the last few years — both doctors in training and trainers. There is no doubt, training was heavily affected by COVID. Delivery of our bespoke, individualised multi-specialty scheme was seriously tested.

Indeed, it was so tested that the GMC allowed progression outside of the usual parameters and we, along with other Colleges and Faculties, had derogations to ensure that trainees remained on track as much as possible. It was not just the nuts and bolts of delivering a broad scheme. Resilience and creativity were tested to the limit, to maintain standards and progression, and the intensity of that time is something we hope not to experience again any time soon.

The exam went online, a complex undertaking which was a big adjustment for both examiners and trainees. A very fruitful discussion with training leaders led to our developing a much needed revamp of exam resources on the FICM website — thanks to all involved for that. This project continues through our dynamic and enthusiastic StR Sub Committee Chair, energetically led by Matt Rowe.

New curriculum

Then there has been the introduction of the new curriculum. Transition from old to new has proceeded remarkably well, though the whole process has been a huge amount of work. Both trainers and trainees have had to get up to speed with outcomes-based training and the new Lifelong Learning Platform for the portfolio. We are still monitoring the change but so far, so good.

This summer will see our dedicated Regional Advisors quality assuring other region's ARCPs for the first time, great progress to unify practice and promote quality. The GMC-approval and on-boarding of the triple CCT (undertaken by physicians) is the next big curriculum challenge. This is likely to need close attention as we integrate 2 Physician specialties with ICM, a relatively complex undertaking as all three CCTs are expected by the regulator to be delivered in a constrained time. This will need close collaboration between all three TPDs.

Special skills

So, it feels now as though we are starting to head back to normality (whatever that is?!). For example, trainers are starting to look at how to improve their training schemes — including developing new Special Skills Years (SSYs). Guidance on the principles of developing these will be on the website shortly, but

> Trainers are starting to look at how to improve their training schemes — including developing new Special Skills Years (SSYs).

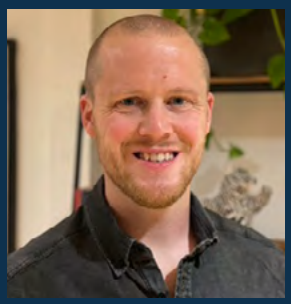
it involves submission to the GMC to approve these additions. Their requirements include that a year's SSY training will prove of worth to a consultant in Intensive Care Medicine, that there is a workforce need (not just interest factor), that it can be delivered in similar units across the United Kingdom, and finally that the capabilities of the SSY go beyond the scope of the existing curriculum. So not an easy undertaking, but we look forward to working with interested units and presenting some new SSYs to the GMC.

Finally, face to face meetings have started up again and it is amazing how much we appreciate them! Their function and purpose are much greater than the agenda, and it has been so lovely to catch up with friends and colleagues. It looks as though a hybrid approach is here to stay though — at least the technology for achieving this took a huge leap forward during COVID.

Get involved

So all in all, TAQ keeps busy with existing and new projects and challenges. As ever, we rely on our Fellows and Members for the support, suggestions and contributions. Please get in touch if you would like to be more involved.

Trainee Update



Dr Matt Rowe
FICM Trainee Lead Representative

As our specialty continues to evolve, so too does its work force. Intensivists in training are coming from an increasingly diverse background and as the future of our specialty, it is essential their interests are properly represented.

This year saw the first direct trainee involvement in the Training Leadership Annual Meeting (TLAM) with trainees from around the country sharing their experiences on a national level to those with responsibility for delivering training in the UK. This was universally well received and has support to be an ongoing fixture in the future.

The StR Sub-Committee continues to thrive and is working on a number of projects for the coming 6-12 months and I'd like to welcome our newly appointed representative for dual training with Emergency Medicine, Dr Fraser Waterson. It has long been a suspicion of mine that trainees from non-anaesthetic backgrounds have a different experience to those coming from anaesthesia and much of the committees work this year will be looking at how we can better support intensivists in training irrespective of entry route. Additionally, we hope to improve how the regional representative network, the StR Sub-committee and trainees from around the country communicate, with Waqas and I working on a new system by which concerns can be escalated to the Faculty.

I'm delighted to say we've had an amazing amount of interest in the upcoming reverse mentoring project, from both the trainees and senior faculty members willing to take part, which will be up and running very soon. I hope this exciting project can go some way towards reducing differential attainment and the unconscious bias we know many trainees face on a daily basis.

Dr Victoria Robson
Chair of Examiners

FFICM Examinations

The twentieth sitting of the FFICM exam took place in January (MCQ) and March (orals) of 2023. In the years since FFICM started, the exam has evolved from being an optional qualification taken by joint CCT trainees to one of the few mandatory summative assessments in the single and dual CCT training programmes.

Purpose

The majority of the other assessments within the training programme are formative, and trainee-selected. The exam's purpose is to demonstrate in a fair manner that a trainee has the required capabilities to progress into Stage 3 training (including a broad spectrum of knowledge, understanding, skills, behaviours and attitudes as defined by the ICM training curriculum) required to treat critical care patients safely. It has an important role in assuring trainees who are awarded a CCT in Intensive Care Medicine have met the standards required to become an ICM consultant in NHS.

Developments

Since the first sitting in 2012, a number of changes have occurred. For example the MCQ has changed from true/false to single best answer questions, the structured oral exam questions have become more structured and the question banks have been expanded and reviewed regularly to ensure questions remain consistent, up to date and appropriate. Work has also been done to improve examiner training, and question banks and delivery methods have been moved to online platforms. A webpage containing lots of resources to help candidates with their exam preparation has been set up and each Chair's report now contains a list of topics which a number of candidates did not answer well.

Exams review

The independent report into all examinations run by RCoA (including FFICM) has been published. Currently a review of the FFICM exam is underway, considering the most appropriate testing methodology, with a view to ensuring the exam remains relevant and uses 'best practice'. A new committee to oversee the implementation of all the RCoA exam changes has been set up, although overall responsibility for FFICM remains with the Faculty of Intensive Care.

Any changes planned will be trialled before being introduced, regulatory approval will be obtained, and changes will be publicised at least 1 year in advance. Until then, the exam will continue to run in the current format, which remains valid and is approved by the GMC.

Recent results

In January 2023, 167 candidates sat the MCQ: 137 (83%) passed. The pass mark was 63.8%, determined by Angoff process with 1 standard error subtracted.

In March 2023, 145 (80.1%) of 181 candidates passed the OSCE component and 128 (80.5%) of 159 candidates passed the structured oral component. Pass rates vary from sitting to sitting; these are the highest for a number of years. Overall 142 (74%) of the 192 candidates in the oral components passed and achieved the final fellowship qualification.

As at most oral sittings, a number of visitors were present. These were Faculty Tutors and Regional Advisors in ICM as well as a senior examiner from another specialty. They commented on the appropriate standard of the questions and fairness of examiners.

Thank you

Examiners devote a lot of time to question writing, revising and standard setting, as well as oral examining. I am grateful to them, in particular to the sub-group leads and Deputy Chair and also to the RCoA Exams Department who deliver our exams.

FFICM Exam Timetable

	FFICM MCQ	FFICM MCQ	FFICM OSCE/SOE	FFICM OSCE/SOE
Applications and fees not accepted before	25 Sep 2023	11 March 2024	26 June 2023	11 Dec 2023
Closing date for exam applications	23 Nov 2023	25 April 2024	7 Aug 2023	2 Feb 2024
Examination date	**10 Jan 2024**	**27 June 2024**	**02 - 05 Oct 2023**	**18 - 21 March 2024**
Examination fees	£560	TBC	Both £695 OSCE £385 SOE £350	Both £695 OSCE £385 SOE £350
MCQ/ SOE Standard Setting meeting	18 Jan 2024	8 July 2024	TBC	TBC
Results released*	31 Jan 2024	16 July 2024	31 Oct 2023	16 April 2024

Dr Tim Meekings
Recruitment Lead

ICM Recruitment Update

At the time of writing, the 2023 national ICM recruitment round has recently concluded. Although the final figures are not currently available, we anticipate once again that ICM will have a high fill rate, confirming the enduring popularity of our challenging but extremely rewarding specialty.

To those who were successful, we offer our congratulations and look forward to welcoming you. To those who were unsuccessful this time, we hope you have the opportunity to try again and wish you every success.

Recruitment process

The ICM recruitment process consists of two main parts: portfolio self-assessment with subsequent verification by an assessor, and an online multi-station interview. Frontline consultant intensivists play a major role in the process — from updating and streamlining the portfolio scoring, to assessing and reviewing the portfolio applications, designing and setting the interview questions and acting as interviewers. We feel it is vitally important that the very people you will be working alongside during your training are fully involved in the assessment and selection of intensivists of the future.

There are many elements of the ICM recruitment process, that we cannot control. For example, changes to the portfolio self-assessment scoring to remove the ability to give credit for additional degrees and named courses were announced by MDRS and applied to all specialty recruitment processes. Vacancy numbers are set by NHS England and the other SEBs and often not finalised until the recruitment process is well underway. For those wishing to apply in a particular region, it is important not to put too much emphasis on what may seem to be a small number of available posts, as these may increase by the time the posts are offered. Our advice would be to apply for a post in the region you want to work in or where you are already in a partner specialty and then focus on performing as well as you can in the recruitment process.

Interviews

For the online interview, recent experience has demonstrated that there are ways you can help prepare to give yourself the best possible chance at being successful. Aim to practice talking through how you would manage a clinical case or prioritise a competing list of tasks with a trusted colleague or supportive supervisor, so that you are used to this when it comes to the online interview. For the interview itself, remember to dress professionally and ensure you are in a quiet and uninterrupted environment, with a reliable internet signal. This should mean that you can concentrate on giving the best possible account of yourself to an interview panel, who will want you to do well.

2024 recruitment

Applications for the 2024 ICM recruitment round are likely to open towards the end of 2023. Once again, there will be a portfolio self-assessment and this will be used to then shortlist candidates for interview. As always, we will try to shortlist as high a proportion of applicants as possible to give as many as we can the opportunity to attend for an interview. The interviews will be held online again and are likely to continue to be delivered in a multistation format to enable each candidate to be assessed by as many different consultant Intensivists as possible.

We continue to strive to recruit a high calibre and high quality workforce to train in ICM and be our colleagues in the future – we look forward to meeting you.

Careers, Recruitment and Workforce (FICMCRW)

Dr Matt Williams
FICMCRW Chair

The first six months of my time chairing the Careers, Recruitment and Workforce committee has just flown by. Having barely had time to draw breath, I would like to acknowledge, with thanks, my predecessor Jack Parry-Jones for his astute stewardship of the committee, therefore handing me a well-oiled machine! This is also due to considerable input by all the committee members.

Providing safe critical care services is core business for acute hospitals; this is ever more challenging when faced with burgeoning elective surgical pathways, an ageing and more co-morbid population, and new treatment modalities. Maintaining an appropriately trained, motivated workforce is key to this.

Quality data

To this end, we have been seeking to gather as much quality triangulated data as we can on our workforce, and to engage with key stakeholders such as NHS England and their equivalents in the devolved nations. The FICM conducted its annual census, of clinical leads, in 2022. We publish some of the analysis elsewhere in this issue. The 2023 census will look to strengthen our understanding of the issue all ICUs are faced with. The Scottish Critical Care Delivery Group's detailed census resulted in the Scottish government supporting 16 newly funded ICM specialty training posts for 2023.

A quick snapshot survey of the regional advisors regarding consultant vacancies versus training numbers demonstrates geographical variations that need considering. Details on small and specialist ICUs are being sought as we try to better understand and articulate, the challenges of recruiting to these units. All of this helps with FICM's lobbying for appropriate increases in workforce; this is timely, with NHS England conducting workforce strategy planning meetings that FICM attend and with the government's long-awaited NHS workforce plan.

Recruitment

Regarding supply, the annual national recruitment round recently completed. I am sure we will all make them very welcome in our amazing specialty in August. There are increasing numbers of doctors pursuing CESR pathways; FICM has been developing its information resources to support these doctors and their supervisors, and increasing our bank of CESR assessors.

Intensivists come from heterogenous routes, which definitely enriches the specialty and its teams. Examples of the varied job plans and routes to the specialist register (via dual/triple CCT or CESR) are being developed by the careers leads working with the FICM StR representatives. Looking after staff wellbeing and assisting those returning to work in critical care has been addressed in the *Critical Staffing* three part series.

Equality and diversity

The Faculty continue to address EDI in every aspect of the work we do, and to support this, we are looking to recruit a lead for EDI to the CRW committee. We will also be seeking new members soon as some current members complete their tenures. Please do apply if you are interested in the areas of work undertaken by CRW - the vacancies will be up on www.ficm.ac.uk. The Faculty represents you; you will be very much welcomed to help steer its future.

Smaller & Specialist Units Advisory Group (SSUAG)

Dr Jack Parry-Jones
SSUAG Chair

What is a 'small', what is a 'remote' and what is a 'small and remote' unit? How many critical care units fall into each category, and where are they in the UK. Would a new way of defining these units allow a better, wider understanding of their issues and therefore allow us to provide better support. As the incoming chair of SSUAG, it seemed a good starting point to reconsider where we have got to.

In the current version of *Guidelines for the Provision of Intensive Care Services* (GPICS) small is defined as a unit serving a population of fewer than 200,000 and remote as a unit more than 30km away from the next nearest unit. These definitions have their origin in the work of the Nuffield Trust.

Population and beds

Whilst broadly useful, many in critical care find it difficult to use these definitions to understand and delineate which units we are talking about, and where they are geographically. Most people don't know the population their hospital serves and even if they do, in coastal areas where many of these remote units are, this population changes significantly in holiday periods. The number of staffed critical care beds however does not.

For 'remote' units, 30km away from the next nearest unit isn't really useful when what it is more important is knowing how much time does it takes for help to arrive for a critically ill child, or how quickly transfer services be arranged for specialist neuro-critical care, ECMO, burns, liver or long term ventilation and weaning etc. What is most relevant for 'remote' units is rapid access to help. This help is nowadays rarely defined by distance but instead by time, access to transfer services or expert advice.

Understanding

A better understanding of the numbers and understanding the issues related to small and remote units should allow us to support units better. The Faculty is involved in collaborative work on digital support for remote sites and through the SSUAG we have recently surveyed the Critical Care Networks and FICM Regional Advisors on a re-look at definitions for small and remote units. We have also worked across NHS England, Scotland, Wales and Northern Ireland using their annual stocktake or other means on how many units have fewer than eight staffed critical care beds as an alternative measure to define 'small'.

Essential service

It matters because many of these units provide an essential service without which their hospital is likely to close, or be significantly downgraded. Remote units and therefore remote hospitals are often providing essential local employment as well as an essential service to relatively isolated populations. These units often struggle to recruit and retain intensivists. Trying to address this requires us to better understand what particular barriers exist to recruitment and retention, and for those already working in these units, we need to better understand how we might best support them in their work.

The SSUAG has representation from across the UK. If you are interested in potentially participating, please contact: dtillbrook-evans@ficm.ac.uk

Women in Intensive Care Medicine (WICM)

Dr Liz Thomas
WICM Chair

The Women in ICM committee had their first face-to-face meeting since January 2020 in April. We all enjoyed being able to have a meeting in person and we achieved a lot. The more spontaneous thing was to host a webinar to promote the work of WICM and to try and engage the hundred plus members of our Wider WICM group. The webinar was held in May and Dr Aoife Quinn and I spent an hour chatting about all things WICM.

The attendees were interactive and informal feedback was excellent. We will run another webinar in the future — keep your eyes peeled!

Striking The Balance

Our annual event Striking The Balance is being planned for October this year. We will have a diverse programme promoting a career in Intensive Care Medicine for all. Although Striking The Balance is hosted by WICM everyone is welcome to attend. This event will be online this year and will have an early bird booking rate. We had great feedback from last year's event and some really good suggestions for content so we are taking that on board to make this year's event even better.

The Women in ICM Emerging Leadership (WICMEL) fellowship programme is running this year too. The programme allows four female junior consultants to undertake a leadership module, attend two FICM committee meetings and gain experience of chairing a committee, with mentorship from a FICM board member. Applications are open and advertised on our website, via Twitter and in Dean's Digest. The programme has run twice already and the fellows have all gone on to take a wide range of leadership roles, including one as Medical Director.

Get involved

Early in the Autumn we have a number of the WICM committee ending their terms — we have vacancies for a consultant and a new SAS role. I have been on WICM for just over three years now, and it really is a great working group who promote ICM as a career for all. I have really enjoyed meeting ICM doctors from around the country and having the chance to make a positive impact, sharing the joy (and whilst not ignoring the difficulties) of a career in ICM. We hope many of you are inspired to apply — and also, the Wider WICM group is always open to new members — whatever your gender. The WWG receive news of our work, and if we need extra help for a project we go to the WWG group members first. To join the WWG email contact@ficm.ac.uk.

FICM Thrive

FICM Thrive, the mentoring scheme for ICM consultants in the first five years of their ICM career is turning two! We are always on the look out for new mentors. It doesn't take long and the feedback from our current mentors has been excellent. The details are on the FICM website and mentoring can really help both the mentor and mentee, and is recommended by the GMC. And, I should give a public thank you to everyone who has been a mentor for the scheme this far. We couldn't do it without you and we are glad that the feedback shows you have found mentoring worthwhile.

We love hearing from you so do feel free to drop us an email at wicm@ficm.ac.uk or contact us via Twitter @WomeniCM.

FICM Census 2022

Dr Richard Porter
Census Lead

Dr Matt Williams
CRW Chair

In 2022, the Careers, Recruitment and Workforce Committee surveyed the Clinical Leads within intensive care across the United Kingdom to ascertain current working patterns and to assist with workforce planning.

We received a total of 151 responses from Clinical Leads, from a possible 256 units.

ICM and allied specialties

The clinical leads provided information on 2,092 consultants. Of those, 371 (17.7%) undertook ICM as a single specialty. Of the 1,721 Consultants who did an additional specialty, anaesthesia was by far the most common with 1,534 (89.1%) undertaking it. Please see Table 1 for the relative frequencies for practice in additional specialties if not doing ICM as a single specialty.

Other included clinical specialties such as haematology, gastroenterology, microbiology; and other areas of interest including medical examiner roles and management roles.

Clinical Lead recognition

The PA allowance for the Clinical Lead role was provided by 147 leads. The distribution of allowance can be seen in Figure 1. As can be seen the majority of clinical leads receive one to two PAs.

One hundred and forty-eight Clinical Leads provided a response regarding management supplement. Of these 23 (16%) indicated they received a management supplement with 17 indicating the amount. This varied between £250 and £21,544.

EDI

The FICM is actively engaged with understanding the issues behind and encouraging support for improving equality in regard to Equality, Diversity and Inclusion (EDI). Data is being sought in all areas of the FICM's work, and to this end, 102 clinical leads responded to questions on gender, age and ethnicity. 17.6% of clinical leads in 2022 are from a minority ethnic background. Tables 2 and 3 show their age brackets and gender at the time of census.

Additional Specialty	Number of Consultants (%)
Anaesthesia	1,534 (89.1)
Acute Internal Medicine	43 (2.5)
Emergency Medicine	26 (1.5)
Renal	14 (0.8)
Respiratory	24 (1.4)
Surgery	2 (0.1)
PHEM	13 (0.8)
Transfer Medicine	28 (1.6)
Other	37 (2.1)

Table 1. *Demonstrating relative frequencies of additional specialties.*

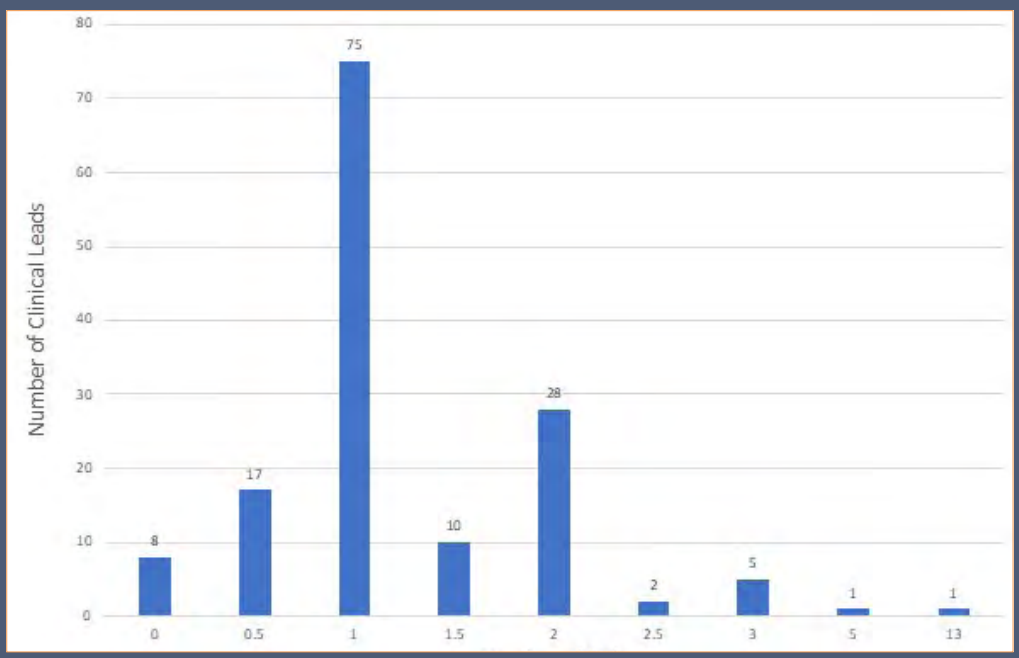


Figure 1. *Graph showing the frequency of PAs allocated for the Clinical Lead role.*

Row Labels	Count of Age
35-44	36
45-54	52
55-64	14
Grand Total	102

Row Labels	Count of Gender
Female	32
Male	69
Prefer not to say	1
(Blank)	
Grand Total	102

Table 2. *Age (above).* **Table 3.** *Gender (right).*

Advanced Critical Care Practitioners (ACCPs)

Dr Gregor McNeill
ACCP Subcommittee Co-Chair

The ACC Sub-Committee would like to thank Carole Boulanger who is stepping down from her role as Co-Chair after being in post since the group's foundation in 2013. Probably more than any other individual, Carole has been instrumental in the inception and development of the ACCP role across the UK.

We say a huge thanks to Carole for the colossal work she has done for the Intensive Care Specialty over the past decades. We are very pleased that Carole will still be working with the Sub-Committee to support specific projects going forward. We welcome Natalie Gardner as our new ACCP Co-Chair alongside myself.

Growth of the ACCP Role

As reported in the last edition of *Critical Eye*, central funding from Health Education England (now merged with NHS England) has led to a significant expansion in ACCP numbers across England. In parallel there remains strong interest in the ACCP role across all four nations. The Scottish Government has recently Commissioned NHS Education Scotland to evaluate future ACCP Workforce planning and the results of their report are awaited. Even without the benefit of central funding, ACCP numbers continue to expand with ACCP programmes now established in almost all mainland Scottish Health Boards.

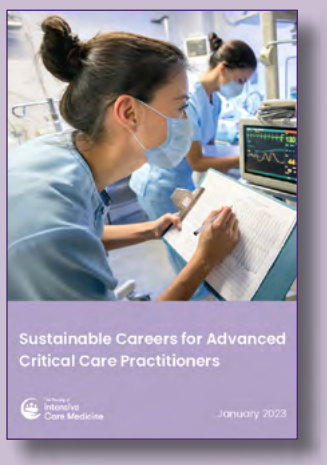
With the growing prominence of the ACCPs, there is an increasing interest in becoming an ACCP from those that have undertaken Advanced Practice in other areas. The ACCP Equivalence route supports those who wish to train by this route and we are on hand to advise those who wish to pursue this.

Sustainable Careers

The FICM ACCP Sustainable Careers document was published earlier this year. This document provided a framework to encourage equity of role across the UK with practical ways to support and promote retention and progression of staff within a rewarding career. It outlines a career pathway for the ACCP role and offers key recommendations covering seniority structure, working patterns, professional leave as well as consultant time to support the role. If you are an ACCP or an ICM consultant colleague who works with ACCPs this is a key document for you.

Curriculum Review

The FICM ACCP Curriculum has undergone its third review since publication in 2015, the update reflects ACCP alignment with the Centre for Advancing Practice under NHS England and some changes in the ICM curriculum. Following a consultation period, this updated version will be published shortly to facilitate any university changes needed for trainees entering training from September 2024.



ACCP Conference 2023

The ACCP Conference returned once again to Red Lion Square for 2023. As ever, it was a sell out event. This year the conference offered a great opportunity to discuss more recent ACCP developments such as the national expansion of the, role as well as the growing number of Optional Skills Frameworks (OSFs) that are now available from FICM. Our huge thanks to all attendees and speakers for such a fantastic event, and to the Faculties events team for ensuring everything ran so smoothly. Watch this space and www.ficm.ac.uk/events for more on 2024!

Emma Taylor
FICMPSC

Critical Care Pharmacists

Recently released, the Adult Critical Care Pharmacy Workforce Strategy sets out the evidence and current standards in place for pharmacy staff working in critical care. Recent survey data shows that there is unwarranted variation in critical care pharmacy service provision between Trusts and within geographical locations across the UK.

In order to address this, the Workforce Strategy sets out short (3 years) and medium term (3-5 years) aims for all three broad categories of pharmacy staff working within critical care — Pharmacists, Pharmacy Technicians and Pharmacy Assistants. Some of the key aims for Pharmacists include:

- To meet the current standards set out in D05 and GPICS 2.1
  - This is also backed by the GIRFT report
  - This includes providing a seven-day ward service, which the vast majority of units are still unable to achieve.
- For all Lead Pharmacists to be credentialled by the Royal Pharmaceutical Society (RPS) within 3-5 years. The specialised credentialling process developed as a joint venture between the RPS, UKCPA and FICM is expected to be released summer 2023.
- To have at least one Consultant Pharmacist in every Operational Delivery Network (ODN) in the next 3-5 years.

The strategy also focuses on Pharmacy Technicians and Pharmacy Assistants. There is much less data and standards surrounding these staff groups, with GPICS 2.1 simply stating "There must be sufficient patient-facing pharmacy technical staff to provide supporting roles" but no additional guidance around this. The workforce strategy suggests:

- To increase the provision of Pharmacy Technicians (within 3 years)
- For Pharmacy Technicians to support medicines preparation and administration (3-10 years) of intravenous and enteral medications
- To increase the provision of Pharmacy Assistants (within 3 years)

A key part of the strategy is regular audit of service provision, and the recommendation is to complete an audit every two years to assess this, and to form plans to close any identified gaps. The strategy suggests that ODNs may be able to assist with this by conducting peer-review visits. Audit gaps may be considered by the CQC as part of routine visits, and could be commented on within their reports. Vitally important is for units to collect any data of workforce impact e.g. financial impact of a Pharmacy Assistant returning medications for reuse; or surveys of nursing staff demonstrating improved satisfaction following introduction of a Pharmacy Assistant, and to publish this evidence of the impact that these staff members have.

So there is lots to do. The Adult Critical Care Pharmacy Workforce Strategy is available on FutureNHS and also on the UKCPA Critical Care community page. We suggest that your unit's Lead Pharmacist should link in with the ODN and discuss whether a peer review audit may be feasible in the near future. Watch out for the imminent release of the Advanced Critical Care Pharmacist Credentialling pathway from the RPS, UKCPA and FICM. And finally, additional funding for critical care training for pharmacy staff may be available again this year from NHSE — as soon as we have details about this we will circulate it to you!

Professional Affairs and Safety (FICMPAS)

Dr Dale Gardiner
FICMPAS Chair

FICMPAS is 'concerned with quality improvement matters that arise within the FICM, with particular reference to clinical effectiveness, clinical guideline development, continuing professional development (CPD) and the integration of any such areas into the revalidation process.' The two major focuses of work are, as our name suggests: professional affairs and safety. We have seen important developments in both.

Revalidation

Dr Mike Spivey has done a great job in revamping the revalidation information on the FICM website. This replaces the older, and longer, PDF information document which was felt less necessary now that revalidation has become routine. Additionally there are many other resources available from the GMC and the Academy of Medical Royal Colleges (AoMRC).

A source of stress during revalidation is gathering patient feedback. The Faculty remains committed to the use of appropriate **team-based feedback** in lieu of individual doctor feedback **for ICM practice**. This is particularly important for colleagues who only practice ICM. The Faculty's full statement on patient feedback for revalidation can be read here. This type of feedback should be supported by the responsible officer as it is within the latest GMC guidance. Members of FICMPAS, and the wider Faculty Board, continue to make representation to this effect in meetings with the AoMRC so that their guidance aligns with this necessity of ICM practice.

Safety

I hope you have all seen the new look Safety Bulletin Issue #7, edited by Dr Peter Hersey. Twelve short safety cases are shared and most have hyperlinks to additional information. The safety incidents come from the National Reporting and Learning System (NRLS), though Dr Hersey is working to be able to draw from a wider source of incidents. What really delighted me was walking into my coffee room and finding a few colleagues with phones open (no surprise here) reading and discussing the Safety Bulletin!

As Dr Hersey says in the Safety Bulletin's introduction, "The purpose of the Safety Bulletin is to highlight incidents that are rare or important, and those where the risk is perhaps something we just accept in our usual practice. It is hoped that the reader will approach these incidents by asking whether they could occur in their own practice or on their unit. If so, is there anything that can be done to reduce the risk?" Please consider using the safety bulletin as a topic in one of your M&M or quality improvement meetings.

GPICS v3

The editorial team has been assembled! I hope to have more to say soon at a future update.

LEPU

A sub-committee of FICMPAS is the Legal, Ethical and Policy Unit (LEPU). A new Midnight Law has been released 'Pitfalls in the Assessment of Mental Capacity (Scotland)'. This is important for our colleagues in Scotland as the law is different. In Scotland 'best interests' and the Mental Capacity Act are not applicable. Instead any intervention must be to the 'benefit' of the patient and is covered by the Adults with Incapacity (Scotland) Act 2000. These are not just semantic changes in terminology but carry legal weight. The LEPU Midnight Laws have a number of Scotland-focused publications which will be of interest to Scottish colleagues.

Reporting restrictions and serious medical treatment cases – a difficult (evidenced) balance

Alex Ruck Keene KC (Hon)
FICMLEPU, Barristier and visiting professor at King's College London

Stuart Marchant
Partner for Bevan Brittan LLP

Hannah Taylor
Partner for Bevan Brittan LLP

In the conjoined appeals of Abbasi and Haastrup [2023] EWCA Civ 331, the Court of Appeal has grappled with the questions of (1) the jurisdiction of the High Court to grant reporting restriction orders ('RROs') providing for the anonymity of professionals involved in treating children involved in serious medical treatment cases; and (2) the circumstances under which such RROs should continue after the death of the child.

Whilst the decisions under challenge in the two cases related to proceedings relating to children, the same broad principles apply in relation to proceedings before the Court of Protection in respect of adults unable to make their own decisions about medical treatment.

The background to the case

As the Lord Chief Justice, Lord Burnett, giving the judgment of Court of Appeal, identified in the opening of the judgment:

1. *[RROs] often protect the identities of all those involved in the care of a patient in respect of whom an application to withdraw treatment is made. That is usually to protect the privacy of the patient, of the patient's immediate family and of those concerned in the treatment of the patient as well as to safeguard the integrity of the proceedings. Such proceedings are apt to generate a great deal of passionate debate which spills over into harassment of those involved in the proceedings, picketing of hospitals and interference with the working of the hospitals.*

There are too many who involve themselves in these kinds of debate who lack all sense of proportion and display intolerance of anyone who disagrees with them. Some are not willing to admit that there may be two legitimate points of view. Nonetheless, the circumstances in which it is lawful or ethical to withdraw treatment is the subject of legitimate debate.

2. *The context of the appeals is the modern practice in the Family Division of the High Court of granting indefinite anonymity orders to a wide range of medical (and non-medical) carers in cases of this kind. On 23 June 2021 Sir Andrew McFarlane P ("the President") dismissed separate applications by the parents of two children to discharge the RROs made in in each case: [2021] EWHC 1699 (Fam).*

The appeal and the decision

The parents, in both cases, had applied for the RROs to be discharged (i.e. removed) after the death of their children — so that the parents could refer to the proceedings, and those professionals involved in them and the care of their children, freely. The first judge, Sir Andrew McFarlane (who is the President of the Family Division of the High Court) kept the RROs in place.

On appeal, two arguments were advanced behalf of the parents. The first was that there was no jurisdiction at all for the High Court to grant RROs preventing the naming of individuals who were neither parties nor witnesses (either during the currency of proceedings, or after their end).

The second was that the balance the President struck between Articles 8 and 10 of the European Convention on Human Rights (i.e. the balance between the rights to privacy of the clinicians and the right to freedom of expression of the families) was wrong and he failed to give sufficient weight to the open justice elements in play in these cases (i.e. the principle that cases should be heard, and their outcomes given, in open court so that society can be clear as to how justice has been delivered).

The Court of Appeal was clear that there had been jurisdiction to make the RROs. However, it was more troubled both as to their scope (in particular their unlimited duration), and as to the approach that the President had taken to the applications to vary them.

In particular, the Court of Appeal considered that he had taken into account matters which did not fall to be weighed in the balance when considering the Article 8 Convention rights of the hospital staff. The Trusts had submitted that one of the reasons for maintaining the RROs and continuing the anonymity of professionals involved in the patient's care was the wider impacts that failures to protect the hospital staff against unwarranted attacks on them on social media and elsewhere would have. The Trusts submitted this would have a detrimental impact on the wider health system if professionals were in fear of being identified in these kinds of court proceedings.

The approach taken by the President, Lord Burnett considered, was not open to the courts (as opposed to Parliament), representing as it did such a serious inroad into the principle of open justice. Lord Burnett emphasised that:

121. *The courts will be astute to protect from harm individuals caught up in litigation when it is appropriate to do so. In appropriate circumstances that protection will include*

> *the use of injunctions to mitigate the risk of future harm. The civil and criminal law both provide protection from various aspects of online attack, some preventative and other to provide a remedy for legal wrongs. To that extent nobody is obliged simply to 'put up with' abuse.*
>
> *However, the courts cannot shut down legitimate debate save when the rights of those affected by that debate, or put differently the adverse consequences, are of such strength as to outweigh the right to free expression. Experience has shown that end-of-life proceedings can generate a fire storm on social media, sometimes fanned and taken advantage of by organisations and individuals with strongly held beliefs about the morality of withdrawing treatment. The fire storm often overwhelms calm debate. RROs become essential to protect the integrity of the proceedings and those caught up, directly and indirectly, in them. Indefinite orders are a different matter. They require careful scrutiny, clear evidence and an intense evaluation of competing interests.*

The proper approach, Lord Burnett considered, was to be found in the approach taken by Lieven J in the Abbasi case:

> 127 *[…] of limiting the duration of the anonymity given to Newcastle and placing the onus on the trust to seek an extension. We also commend her approach in focusing on a limited number of individuals who required protection albeit that we recognise that when an order is made urgently such a refined focus may not be possible initially. We also commend the approach in the Re M case where the order came to an end automatically unless an application was made successfully to extend it. The period of 28 days in that case was the considered conclusion of all concerned on the facts in play. Circumstances may call for different periods.*

On the facts of the two cases before them, the Court of Appeal allowed the appeals and discharged the RROs.

Comment

The law relating to anonymity is procedurally complex, as is made clear in a table two of us have drawn up to try to help clinicians and their advisers navigate the provisions. The Court of Appeal has cleared up one area of procedural complexity (confirming that it is permissible for the Court to grant an RRO in these types of cases which anonymise not only the parties/witnesses, but also professionals caring for the patient); it has also restated in clear terms the (admittedly complex) balance that the law seeks to strike between the interests at stake; between the rights of the caring professionals to confidentiality and privacy and the rights of family members and the press to freedom of speech.

It is possible that this case may go further, as the Trusts in question are seeking permission to appeal from the Supreme Court. However, it is clear on the basis of this judgment that in any case going forward — whether in relation to children or adults with impaired decision-making — that:

1. As 'refined' a focus as possible is required by both the relevant parties and the court upon those individuals most clearly requiring protection

2. The protection may be required to ensure the continued anonymity of the subject of the proceedings / their family; to maintain the integrity of the proceedings; or to secure against a risk of harm to a professional

3. The focus may need to be refined as matters continue to unfold (and, in particular, in light of any relevant social media activity of concern)

4. Any application to continue the RRO after the end of the proceedings on the basis of continuing risk must be based upon clear evidence as to the nature of that risk; and

5. Indefinite RROs (at least in respect of securing the anonymity of professionals, rather than the person or their family) are likely to be the exception rather than the norm.

Developments in Diagnosing Death using Neurological Criteria

Dr Dale Gardner
PAS Chair

Nationally and internationally there is considerable work being undertaken to modernise and update codes of practice relating to the diagnosis of death using neurological criteria (DNC).

Canada

Last month the Canadian Journal of Anaesthesia published a special issue on 'Defining and Determining Death in Canada.'

The centrepiece of the issue is the publication of Canada's 2023 Clinical Practice Guideline.[1] Canada is adopting a brain-based definition grounded in the "permanent cessation of brain function." This definition unites circulatory and neurologic criteria around cessation of brain function. This is a welcomed update from the UK perspective as since 1979 the UK has been insisting that "brain death represents the stage at which a patient becomes truly dead."[2]

To pick out three key differences between Canada's 2023 Clinical Practice Guideline for diagnosing DNC and current UK practice I would highlight:

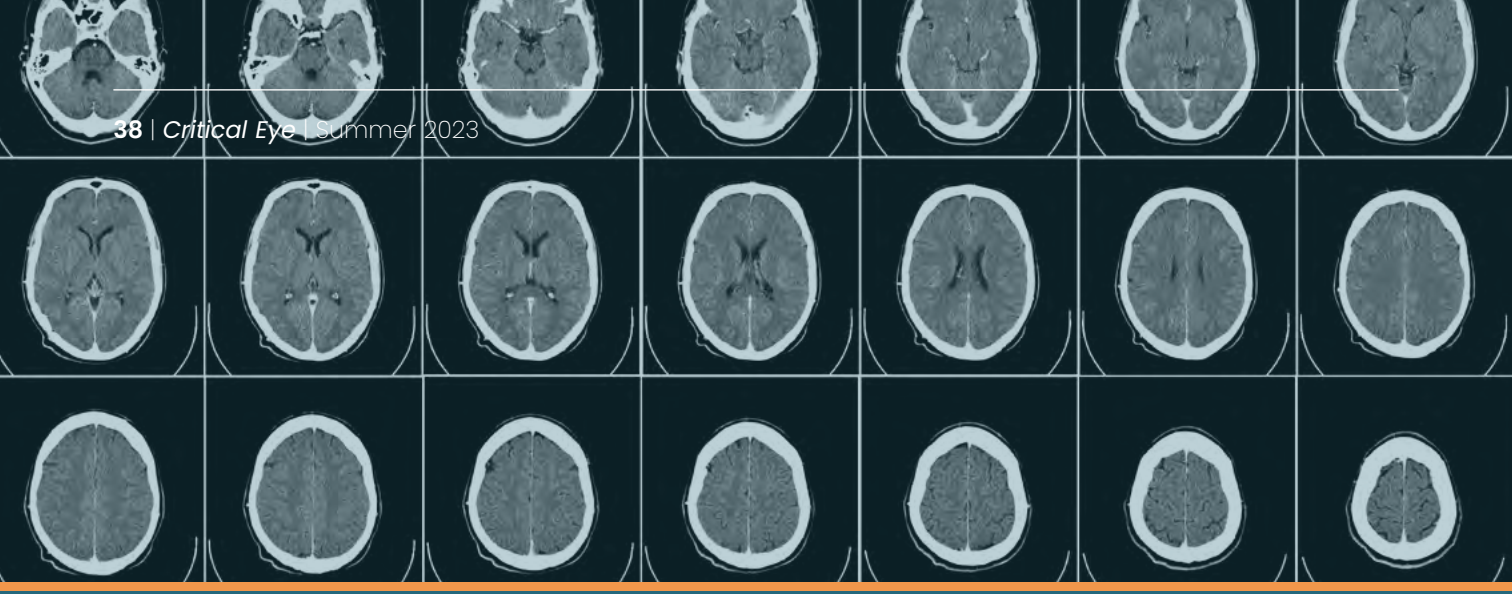
1. Only one clinical test is required in Canada except in children under one years of age or where provincial legislation requires two tests in organ donation.

2. In the Canadian apnoea test there is no starting PaCO2 goal or minimum time-based requirement like the UK five minutes. Instead the patient must achieve a rise in PaCO2 of 20 mmHg (2.7 kPa) and reach a threshold of PaCO2 of 60mmHg (8.0 kPa) and pH is ≤7.28. They even include the option of exogenously administered CO2 for patients with high pre-test probability for cardiorespiratory instability.

3. In infratentorial brain injury without significant supratentorial involvement, ancillary investigation is required to make the diagnosis.

Despite these differences the specific diagnostic criteria for DNC outlined in Canada's 2023 Clinical Practice Guideline reflect and build upon the increasing consensus occurring in national and international criteria. This includes the work of World Brain Death Project which was published in 2020 and sought to provide minimum testing standards.[3] Using this world consensus, South Africa was able to publish its first national guidance on DNC in 2021.[4] For reference the Australian and New Zealand Intensive Care Society updated their guidance in 2021.[5]

While Canada's 2023 Clinical Practice Guideline is excellent, the true triumph for Canada in the special issue is the 24 other publications on death determination which informed the guideline. These papers represent Canada's commitment to consensus



building, international leadership and the delivery of high-quality science on the topic of death determination both from a clinical perspective and in evaluating family and societal understanding. The UK will certainly benefit from Canada's efforts as we seek to update our own code of practice (see below). I had the honour of leading one of the accompanying editorials and if you are interested it can be found here.

Consensus Guideline for CT Angiography

In the Winter 2022 *Critical Eye*,[6] I alluded to a FICM working group that was collaborating to publish a UK consensus guideline for cerebral CT angiography (CTA) as an ancillary investigation to support a clinical diagnosis of DNC. This work was led by Dr Elfyn Thomas on behalf of the Faculty and Professor Rob Dineen on behalf of the British Society of Neuroradiologists and has now been published in *Anaesthesia*,[7] *Clinical Radiology*[8] (very helpful for showing to radiology colleagues) and the FICM Website.[9]

Key highlights from this consensus guideline

In what circumstances do you need an ancillary investigation?

Where there is an intention to diagnose death using neurological criteria:

1. Ancillary investigation is required in the following circumstances:

- Where a comprehensive neurological examination, including the apnoea test, is not possible.
- Where continuing effects of confounding conditions (e.g., red flags) cannot be excluded.

2. Ancillary investigation should be considered in the following additional circumstances:

- Uncertainty regarding the interpretation of possible spinally mediated movements.
- To promote understanding of the clinical confirmation of death using neurological criteria to families who are uncertain or unaccepting of such a diagnosis.

What about paediatrics and ECMO?

Unfortunately there was insufficient evidence to make a recommendation in paediatrics and patients on ECMO.

What is the technique?

- CTA image acquisition at 0, 20 and 60 seconds after contrast injection with evaluation of opacification of intracranial vessels at four anatomical locations: cortical segments (M4) of the middle cerebral arteries and internal cerebral veins. A clinical diagnosis of DNC cannot be supported if the CTA demonstrates contrast opacification of any of the vessels specified in the four-point criteria.
- The scan should be reported by a consultant radiologist. In centres that do not have an available in-house neuroradiologist, a consultant neuroradiology review of the images should be sought from the regional neurosciences centre.

RCPCH Clinical Alert

In February 2023 the Royal College of Paediatrics and Child Health (RCPCH) published a clinical alert relating to the invalidity of the apnoea test in the context of high cervical spinal cord injury.[10] This followed an expert group review of a 2022 case of an infant where the diagnosis of DNC had to be reversed later when the patient had return of spontaneous, albeit abnormal, breathing.

The RCPCH alert is a reminder that the Code of Practice specifies that "If there are reasons to suspect

that an underlying high cervical spine injury and associated cord injury are causing the apnoea, then the apnoea test becomes invalid."[11] The nationally endorsed testing forms ask:[12]

Short version

"Is the apnoea due to neuromuscular blocking agents, other drugs or a non brain-stem cause? Consider: cervical injury, any neuromuscular weakness."

Long version

"Is the apnoea due to neuromuscular blocking agents, other drugs or a non brain-stem cause (e.g. cervical injury, any neuromuscular weakness)?"

The expert panel considered the importance of human factors in this case and specially the language used in the Code ("causing the apnoea"), and in the testing forms ("due to… cervical injury"). In the setting of devastating traumatic or hypoxic injury these terms may result in the treating clinician focusing upon a singular causality rather than consider the broader aetiology to the apnoea that can occur. Future updates to the code will consider more expansive terminology. For example, 'Could the apnoea be contributed to by cervical injury?' Such revised terminology is applicable in other preconditions to testing.

My pragmatic interpretation for adult practice is to have an open mind to the need for spinal precautions upon ICU admission (or earlier) and for clearing of the cervical spine in the standard way. In my unit this translates to radiological CT spinal clearance in trauma. If there is proven cervical spine injury on CT, the options for diagnosing DNC are:

1. MRI to exclude spinal cord injury.

2. CT angiography as an ancillary investigation in addition to the full clinical tests.

3. Conclude that a diagnosis of DNC is not clinically possible.

AoMRC Code of Practice Update

The Academy of Medical Royal Colleges (AoMRC) is leading a working group to modernise and update the 2008 Code of Practice. The ethos of the working group is to maintain the authoritative nature of the AoMRC Code of Practice which has been accepted by UK courts on multiple occasions while finding ways to complement and support international consensus. A draft document for consultation is hoped to be published before the end of 2023, with an aim for formal publication in early 2024. The RCPCH is also updating their guidance for children in tandem with the AoMRC.

Conclusion

Intrinsic to the diagnostic process in medicine is a commitment to learn, to advance and to be better. The activities listed above seek to do just that. What seems clear to me is that this effort is increasingly global in scope and ambition.

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Dr Peter Hersey
FICM Safety Lead

Safety Bulletin

The first FICM Safety Bulletin was first published in December 2020; the archive of every edition is on the FICM website. The bulletin's aims are to highlight areas of risk in our practice and to signpost any associated learning or resources. It forms part of FICM's focus on patient care, and in future editions of *Critical Eye* we look forward to updating you on our other work in patient safety.

The raw data for the bulletin is provided by NHS England — we receive a report of all moderate and severe harm incidents reported from critical care areas. This method of accessing data is like the approach taken by the Royal College of Anaesthetists and the Association of Anaesthetists when producing the SALG (Safe Anaesthesia Liaison Group) reports that you may also be familiar with. We work with SALG as co-opted members to ensure there's minimal overlap and consistent messaging. Once written, the bulletin is reviewed by an editorial group representing experts from several professional groups and bodies to ensure that any interpretation or recommendations are sound.

As well as being an educational resource, a further advantage of writing the reports is that it allows an opportunity to review the submitted dataset from a clinical perspective. This in turn allows us to work with partners in NHSE and the MRHA to help highlight any areas of concern and any required action. Relationships such as this are beneficial to our specialty, and we are working to develop more along similar lines.

In previous editions of the bulletin, we attempted to provide a complete summary of all the data we had available. This was no easy task — the raw data is significant in volume, and key messages risk being missed. We were also always aware that we were reporting an incomplete dataset, as not all incidents are reported and there is reporting bias in those that are.

A new look

For the most recent editions of the safety bulletin therefore, we have tried a new approach. Instead of reporting all incidents we have selected those of particular interest or learning. The report is shorter, with an aim to produce a document that will be read 'when received' or in a spare two minutes. Further information is included within hyperlinks, so that it is easily accessible but doesn't interrupt the flow. We are aware that the information included in the report is limited and we know that can be a source of frustration. Unfortunately, we don't have access to anything more than what was written in the original incident report. We are also aware that all the data comes from England, but we are beginning a process to investigate accessing data from all four nations.

We do hope you like the 'new look' safety bulletin and find it a useful resource to help promote a safety culture in your own setting. We don't pretend that reporting of incidents alone will stop them recurring but hope to stimulate conversations in your own units.

Thank you

As a final comment, we would like to extend very grateful thanks to Professor Gary Mills, my predecssor as Safety Lead. The safety bulletin came into being through his vision and he has personally undertaken a massive amount of work to take it to where it is today.

If you have any suggestions or comments for the bulletin, please get in touch via contact@ficm.ac.uk.

The seventh and eighth issues of the *Safety Incidents in Critical Care Bulletin* are out now, summarising NHSE/I-sourced data on critical care incidents classified as moderate or severe in patients above the age of two in a more digestible and readily available form for doctors, nurses and AHPs working in critical care.

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The Faculty of
Intensive
Care Medicine

www.ficm.ac.uk

@FICMNews

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