

CRITICAL EYE



Issue 17 | Winter 2020

UPDATE FROM THE
NEW DEAN

ENGAGING MEDICAL
STUDENTS IN ICM

GETTING IT RIGHT
FIRST TIME

FICM10



The Faculty of

**Intensive
Care Medicine**

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@FICMNews



WELCOME

Dr John Butler
Clinical Editor

Welcome to the Winter 2020 edition of Critical Eye.

I would like to start by congratulating Dr Alison Pittard and Dr Daniele Bryden on their appointments as our new Faculty Dean and Vice Dean and to wish them good luck in their new jobs. You will both be great!

As the Faculty moves into its 10th anniversary the leadership team continues to drive our speciality forward. The new year promises to be action packed, with events, podcasts, new awards as well as a new FICM logo. Several important publications are expected including the 'Guidance for Development of Enhanced Care Services in Acute Care', 'Getting It Right First Time' and the new Intensive Care Medicine curriculum (*ICM CURRICULUM: Supporting Excellence*). The proposed 14 High Level Curriculum Learning Outcomes (HiLLOs) have now been agreed with submission to the GMC in February. To support the introduction of the new curriculum there will be a new eportfolio and work has already commenced on this project.

FICM Learning (www.FICMLearning.org), the new hub for Faculty education, will launch in February and work is ongoing to finalise the programme for the 2020 Annual Meeting, which will take place on Monday 15th June – so save the date! The Faculty is also delighted to announce the publication of a new resource that is designed to introduce trainees to a career in Intensive Care with direct information and links to online resources. Discover ICM can be found on the faculty website; www.ficm.ac.uk/sites/default/files/discover_icm.pdf.

A short report from the 2019 Census is included in this edition. It indicates that a high proportion of ICM doctors are on high programmed PA activity with a significant proportion wishing to decrease activity. A total of 44.6% of the 130 units responding have unfilled consultant posts with 32.8% having three or more unfilled posts. The report concludes that the future of intensive care medicine is reliant on expanding recruitment, not only to cover current gaps and career plans to decrease commitment, but to ensure that intensive care medicine is a lifelong sustainable way of working.

I hope you enjoy reading this edition. We welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

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

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

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MESSAGE FROM THE DEAN

Dr Alison Pittard

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Hello everyone and welcome to the first Critical Eye of my tenure. It is an honour and privilege to be Dean of the Faculty and I'd like to say a big thank you to the Board for supporting me. It's great working with such a fantastic group of people and I am confident that we will continue the great work of my predecessors Julian, Anna and Carl, especially as I have Danny Bryden by my side as Vice Dean. Carl has been a role model for me over the last 3 years and should now be having a well-earned rest; it will come as no surprise to those of you who know him that nothing could be further from the truth! I'm not going to mention Brexit as whatever I say will be outdated by the time this is published so read on for my update.

FICM 10

It is really exciting for me to be Dean during our 10th anniversary year. To mark this occasion, as well as a new logo and rebranding exercise, there will be events throughout the year to celebrate all that has been achieved. The Trainer Recognition Award was launched last year and I am pleased to announce Dr Andrew Campbell from Wrexham Maelor Hospital as the winner. A series of 10 collaborative statements with our partners will also be released over the next 10 months. There are other organisations with anniversaries in 2020, including The College of Intensive Care Medicine of Australia and New Zealand, who celebrate 10 years of being a college. The foundations for working together have been laid

to promote our specialty around the globe and we hope to collaborate further, with other countries, on topics of mutual interest and relevance to Intensive Care Medicine. We also plan to recognise the contribution made to ICM as a specialty by the first Vice Dean, Professor Tim Evans, in the form of an essay competition. The themes will reflect Tim's interests and his views on the contribution made by all members of the multidisciplinary team. There will be prizes with the overall winner receiving the Tim Evans Award.

Collaboration

As well as planning our anniversary, we continue to make progress with a number of our workstreams and planned publications. These have included multidisciplinary input and collaboration with other Colleges. 'Care at the End of Life' was released in September and publication of 'Guidance for Development of Enhanced Care services in Acute Care' is imminent. The next piece of work from our 'Critical Futures' initiative is 'Life After Critical Illness'. A working party has already been established and preliminary work is underway.

The Faculty works with other Colleges and Faculties through the Academy of Medical Royal Colleges. This gives us direct access to bodies, such as NHS England and Government, whom we can attempt to influence on your behalf for the benefit of patients. One of the

areas NHS England wish to work with the Academy on is the retention of more senior medical staff and, obviously, the issue having the biggest impact here is pensions taxation. I don't profess to understand this in detail but being disincentivised for providing additional work for the benefit of patients is having a direct impact on the ability to deliver core services. We asked for real examples to demonstrate this and I would like to thank those of you who responded to our request. All colleges and faculties undertook the same exercise and the Academy amalgamated this evidence into a letter to the Chancellor and Health Secretary. The only way to resolve this is via a change in taxation; we can only influence this so, in the meantime, I would like to thank you all for doing your best to minimise the impact on patient care.

It is important to ensure that quality improvement initiatives have patient safety at their core and are evidence based. You will be aware of the 'Sepsis Hysteria' article published in The Lancet in October last year and the media coverage of this. Its focus was promoting a more balanced perspective "... to reduce excessive, inappropriate antibiotic use with the concurrent risks of resistance and toxicity." Within Critical Care we have a good track record of antimicrobial stewardship but our colleagues, faced with a patient with possible infection, are pressured to institute 'early' rather than 'timely' antibiotics despite no clear effect on mortality. We are working with the Academy to address this imbalance.

Inclusivity

As a relatively new specialty and one that many people feel is "not for them", we are trying to raise awareness, not only about what a career in ICM looks like, but also to highlight the diversity of individuals who already

work in the specialty. 'Discover ICM', launched in October, provides an introduction to our specialty as a career and 'Critical Foundation' is a framework for Foundation doctors to gain exposure to Critical Care. You can follow these themes on Twitter via #DiscoverICM and access documents on our website.

'Striking the Balance', in September 2019, was the first national meeting of our Women in Intensive Care Medicine Sub-Committee. It aimed to demonstrate that the perceived stereotype of an intensivist is inaccurate and that the barriers that women feel deter them from pursuing a career in ICM can affect anyone. One delegate said they thought, as they didn't have the classic 'type A' personality, a career in ICM wasn't for them but, having heard the speakers on the day and had the opportunity to network, these myths have been busted! Judging by the atmosphere on the day, and the formal feedback, it was a resounding success. Many of the speakers were interviewed on the day and these will appear as podcasts on the website. The committee also commissioned a series of personal blogs which are both insightful and inspirational.

I am very proud of the work that has been undertaken by WICM, under the auspices of the Careers, Recruitment and Workforce Committee, to promote leadership. Our 'Emerging Leaders' programme commenced with an Introductory morning for our first four appointees followed by their attendance at a Board meeting in the afternoon. It was nerve wracking for me as it was my first meeting as Dean so felt I was being scrutinised!

The October Board was the last meeting for Dr Andy Ratcliffe, trainee rep and Dr Peter-Marc Fortune, PICS rep. I would like to thank them both on behalf

of the Board for their contribution. It was my pleasure to welcome to the Board Dr James Fraser, as the new PICS President, and Ms Pauline Elliott, our lay representative. I look forward to working with them and all members and co-optees. I hope you enjoy this edition of Critical Eye.



L-R: Anna Batchelor (Past Dean), Alison Pittard (Dean), Daniele Bryden (Vice Dean), Carl Waldmann (Immediate Past Dean)



LEADING THE WAY

15 June 2020

This year, the FICM Annual Meeting will focus on leadership and the future of ICM, we have an exciting mix of talks, workshops and debates lined up for the day.

Date: Monday 15th June 2020
Location: RCoA, London, WC1R 4SG
Fee: £185 (discounted rate £90)
CPD: 5 points

Programme Includes:

Talks:

Critical Care into the Future

To lead or not to lead – that is the question: a perspective on leadership

Getting it Right First Time

Leadership lessons from the military

Why shouldn't doctors be cynical about making a change

Workshops:

Implicit bias

Debate:

The way to improve ICU care is by local quality improvement not research

ONLINE BOOKING IS NOW OPEN!

VISIT THE FICM WEBSITE FOR MORE DETAILS.

www.ficm.ac.uk/news-events-education/ficm-events



LIFE AFTER CRITICAL ILLNESS

Dr Carl Waldmann

Chair, Life After Critical Illness Working Party

Background and aims

In 2016 FICM launched Critical Futures which published details from a survey amongst our fellows.

12 recommendations were made for future work streams; number 12 was to develop a work stream on Life After Critical Illness. NICE had already published its Guideline No 83 back in 2009 which had struggled to get traction. In 2017 NICE had gone a step further and published its Quality Standard 158.

A meeting of interested stakeholders was arranged at the RCoA building in May 2019 by Andy Slack and Joel Meyer, Intensive Care consultants at Guys and Thomas's, from which the FICM work stream merged.

Identified challenges were:

- Unmet needs of ICU survivors are identified as a high priority area
- Rapid expansion in diverse services across UK

- No systematic approach, no platform for collaboration
- Lack of specifications/tariffs

It became obvious from this meeting that a multi-disciplinary UK forum for enhancement of critical care recovery services was needed for adult ICU survivors in the United Kingdom. This area of development required multidisciplinary input from patients, psychologists, physiotherapists, nurses, doctors, occupational therapists and management with knowledge of tariffs.

It was proposed that agreement was needed on terminology, the need for a UK directory of services, potential to develop accreditation status by defining minimum requirements and to suggest what a Gold Standard Service looks like. On October 31st 2019, the Group had its first meeting, and the plan is to publish a document within the next year. Immediate needs were identified including identifying multifactorial patient input, GP involvement from the RCGP, and other key stakeholders. Funding a Follow Up service is obviously a great concern requiring liaison with commissioners.

Work has begun led by Bronwen Connolly on a survey to inform the work stream, which the group have contributed to. The working party will provide regular updates in Dean's Digest / Critical Eye.

CARE AT THE END OF LIFE

In September 2019, we published the Care at the End of Life Guidance. You can download the full guidance from the FICM website along with the Executive Summary and the Summary for patients, relatives and the public: www.ficm.ac.uk/critical-futures-initiative/care-end-life





CRITICAL FUTURES

ENHANCED CARE

Dr Alison Pittard
Dean & Chair, Enhanced Care Working Party

Over the last 18 months I have chaired a working party looking to establish guidance for the development of level 1+/level 1 services. Because of heterogeneity in existing provision, and the fact that current definitions of levels of care do not accurately describe the service being delivered, we have purposely avoided referral to any particular specialty or using levels of care in the name and use the term 'Enhanced Care'. What started out as a document focussing on the perioperative patient has become collaborative guidance with the Royal Colleges of Physicians and numerous endorsing bodies.

As a recommendation in our 'Critical Futures' initiative, improving patient care by bridging the gap between critical care and normal ward care, is a top priority. Enhanced Care is not a substitute for High Dependency Care but allows patients to be managed safely in an appropriate environment dependent on their needs. It facilitates access to Critical Care teams for enhanced advice and support, but not delivery of, Enhanced Care for the benefit of patients. It is vital that this concept is embraced so that we don't find ourselves in a position where critical care is being delivered in multiple sites within organisations. This is not safe for patients.

This document provides guidance for the development of Enhanced Care based on current knowledge and expertise. It offers a pragmatic solution to efficient resource utilisation and may result in improved quality of care, reduced

cancellation of elective surgery and provide cost savings. There are examples of successful implementation of Enhanced Care Services with clear benefit to patients and the overall system. It is hoped that, in time, evidence will be gathered on the effectiveness of these recommendations, which may then become minimum standards and key performance indicators. Research will be required to ensure that the right questions are asked in order to collect the most appropriate data. Recognising and ensuring effective integration and partnership with critical care will be essential. A clear understanding of the patient population will govern the required competence of the extended multidisciplinary team and the determination of what constitutes safe team staffing. At the heart of service design for perioperative Enhanced Care will be the predictability of the patient population to be

admitted. The pathway for acutely unwell patients is much more variable and therefore Enhanced Care for this patient population will require a different model.

Patients requiring this level of care are already in a hospital bed but not necessarily in the best

location. Ensuring that patients remain the focus, their physiology and clinical pathway i.e. emergent or elective, will determine the best place to provide monitoring and interventions safely. I am delighted to say that we are on target to publish this guidance document in the coming months. It encompasses enhanced care for medical, surgical and obstetric patients but can be also be used in other specialties. We hope this framework will be supportive rather than restrictive; development of Enhanced Care will ensure patients receive the right care, at the right time and by the right people. Publication of the report will follow shortly.

“ ENHANCED CARE IS
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GUEST ARTICLES



1

Know the score. A review of the quality of care provided to patients aged over 16 years with a new diagnosis of pulmonary embolism

2

Engaging medical students in ICM

3

Birth and death in our time: Manchester takes end of life discussions to the wider community

Know the score. A review of the quality of care provided to patients aged over 16 years with a new diagnosis of pulmonary embolism

Dr Marisa Mason

Chief Executive, NCEPOD

Clinical Researcher

Dr Neil Smith

Deputy Chief Executive

Clinical Researcher, NCEPOD

Introduction

Despite advances in the ability to prevent, diagnose and treat acute pulmonary embolism (PE) it remains an important cause of morbidity and mortality. Its association with air travel, hospitalisation, active cancer, pregnancy and some chronic conditions is well recognised. Estimates suggest that there are more than 25,000 hospital deaths in the UK each year from venous thromboembolism (VTE). To aid safe and effective treatment it is possible to estimate the risk of adverse outcomes of PE, following diagnosis, using prediction tools like the Pulmonary Embolism Severity Index (PESI). CTPA can also provide objective evidence of right heart strain, an indicator of PE severity, but the consistency with which this is acted upon is unknown. The standard treatment is anticoagulation. The combined recommendations from NICE guideline 144 and Quality Standard 29 recommends that heparin therapy should be started immediately if the time taken to confirm the diagnosis is likely to be more than one hour.

Aim

The aim of this study was to highlight areas where care could be improved in patients with a new diagnosis of acute pulmonary embolism.

Method

A retrospective case note and questionnaire review was undertaken in 526 patients aged 16 and over who either presented to hospital with a PE or who developed a PE whilst as an inpatient for another condition.

Key findings

- There was an avoidable delay in commencing treatment in 18.7% (90/481) patients. More than half of the avoidable delays recorded (49/90) were because an anticoagulant was not prescribed and/or not administered
- A PE clinical probability score was documented in the notes for only 19.7% (80/407) cases where the patient presented with symptoms of PE
- The severity of PE was not recorded for 90.3% (436/483)
- In 50.7% (177/349) of CTPA reports no comment was made on the thrombus burden and in 37.5% (125/333) no comment was made on the right ventricle
- Proformas or other structured reporting systems for CTPA were only used in 14.1% (22/156) of hospitals
- 16.2% (77/474) patients who presented to hospital with clinical suspicion of PE, were cared for on an ambulatory care pathway for all or part of their patient journey
- 22.9% (43/188) low-risk patients were treated on an ambulatory pathway, suggesting potential missed opportunities for the remaining 77.1% low-risk patients

- 17.8% (80/449) inpatients were admitted to critical care. Case reviewers identified another 12 patients who should have been considered for escalation of care.

Principal recommendations

1. Give an interim dose of anticoagulant to patients suspected of having an acute pulmonary embolism (unless contraindicated) when confirmation of the diagnosis is expected to be delayed by more than one hour. The anticoagulant selected, and its dose, should be personalised to the patient. This timing is in line with NICE QS29 2013.
2. Document the severity of acute pulmonary embolism immediately after the confirmation of diagnosis. Severity should be assessed using a validated standardised tool, such as PESI or sPESI. This score should then be considered when deciding on the level of inpatient or ambulatory care.
3. Assess patients suspected of having an acute pulmonary embolism for their suitability for ambulatory care and document the rationale for selecting or excluding it in the clinical notes
4. Standardise CT pulmonary angiogram reporting. The proforma should include the presence or absence of right ventricular strain. The completion of these proformas should be audited locally to monitor compliance and drive quality improvement.
5. Look for indicators of massive (high-risk) or sub-massive (intermediate-risk) pulmonary embolism, in addition to calculating the severity of acute pulmonary embolism in the form of:
 - i. Haemodynamic instability (clinical)
 - ii. Right heart strain (imaging)
 - iii. Elevated troponin or BNP (biochemical)

Escalate promptly based on local guidance and document in the case notes.

Engaging medical students in ICM

Dr Martin Huntley

Consultant ICM - Harrogate & District NHS Foundation Trust
Honorary Senior Lecturer & Undergraduate Lead for ICM – Leeds Medical School

Engaging Medical Students in ICM

When I think back to being a medical student, I can recall very little exposure to Intensive Care Medicine (ICM) and as a result I embarked on my postgraduate training with little insight into what happened behind the doors of the Intensive Care Unit (ICU). Whilst ICM may seem a very complex subject for medical students to grasp, there is undoubtedly a wealth of useful knowledge and experience that can be gained from exposure to it. The real challenge is turning ICM into something that medical students find accessible and engaging, and there has only recently been some guidance on this¹.

Introduction to ICM

Deciding on an effective way to teach medical students about ICM can be challenging. Lecture-based teaching is inherently less engaging and can make it difficult for students to grasp how principles relate clinically. Smaller tutorial-based teaching may facilitate more interactivity and discussion however, these are more labour intensive to facilitate.

Over the past two years I have been able to adapt a series of real-life video case studies, so that students can relive the pathway that patients take from hospital admission to ICU and beyond. This facilitates a learning environment that establishes physiological principles in a clinical context and gives a solid grounding for learning about the assessment and escalation of deteriorating patients and key concepts of organ support. I use real-time echocardiography to teach about the diagnosis and management of shock, and use role play to develop a structure for effective family communication. I get students to debate some of the ethical dilemmas that arise as the cases develop e.g. decisions around admission or the withdrawal of life sustaining treatments. These interactive and varied teaching techniques have helped to create a greater depth of understanding of ICM in preparation for clinical placements on the ICU.

Ultrasound Teaching

Point of care ultrasound (POCUS) use is becoming more established in ICM and this provides a unique opportunity for medical students to gain experience in the application of ultrasound in managing a range of clinical presentations and pathologies. I have established POCUS training for medical students on our ICU with the core aim of developing an appreciation of the basic principles of image acquisition and its use in diagnostics and management. Feedback has shown that the students value this opportunity to gain hands-on experience in a supportive clinical environment.



Medical students with their QI project at the GAT conference

“I have thoroughly enjoyed the ultrasound teaching. I think we’ll inevitably be using this skill as doctors so it’s great to have the opportunity to practice.”

As the number of ultrasound competent intensivists increases, we are likely to be a key environment for providing ultrasound training which is currently being integrated into the undergraduate curriculum².

Quality Improvement Projects

We have recently partnered with Leeds Medical School to support the Extended Student Research & Evaluation Projects (ESREP), where students conduct an 18-month project in a specialty of their choice. This has been mutually beneficial in terms of driving quality improvement initiatives on our ICU and developing skills in audit and research for medical students. All our projects have been integrated into subsequent service improvements and presented at national conferences which is a fantastic way of developing an interest in ICM.

“My project helped me to appreciate aspects of critical care that I did not realise existed. I am now even more interested in pursuing the specialty of ICM”

There is so much that medical students can gain from a placement in ICM, especially if we can develop more innovative ways of engaging them in learning. This is important for ensuring high quality care of critically ill patients and may also help to encourage more doctors in training to consider a career in ICM.

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Birth and death in our time: Manchester takes end of life discussions to the wider community

Natalie Thomas¹, Hawys Williams², Jonathan-Bannard Smith¹, Catherine Applewhite¹, Donna Cummings¹, Lumi Mustafa¹, Tim Harrison³ and Mahesh Nirmalan^{1,2}

1. Critical care unit Manchester Royal Infirmary; 2. Faculty of Biology, Medicine and Health University of Manchester and 3. S!CK Festival Manchester.

Built into the gift of life is the gift of death and dealing with the dying patient is one of the frequent and important tasks entrusted to senior clinicians in any intensive care unit. In this context, “honest listening is one of the best medicines we can offer the dying and the bereaved” said a patient dying of cancer. However, in a modern intensive care unit, where it is possible to keep a dying patient alive for long periods through mechanical devices and pharmacological interventions, it’s rather tempting to see death as a failure of an individual or a system.

Modern media, with its preoccupation on errors, failures and negligence, reinforces this misleading notion of seeing death as a failure rather than a natural and inevitable life process. How often do we hear, that someone has ‘lost their battle’ with a disease? This flawed mind-set sometimes leads to interventions and therapies aimed at sustaining life, sometimes with significant cost both in human as well as financial terms.

The overriding concern in clinical decision making can at times become what is ‘defendable’ rather than what is morally and ethically ‘correct’ or is in the patient’s best interest. With an ever-aging population, end of life discussions have become a frequent component of clinical duties and in many circumstances, the relevant decisions have to be based on entirely subjective criteria such as ‘suffering’, ‘risk-benefit’, ‘quality of life’ and ‘patient’s best-interest’.

All too often, these conversations are held when a

friend or a family member is critically unwell with a next of kin who is totally unprepared for what is to come or to accept the inevitable. In such an emotionally charged environment, it is possible that reason and logic may fall by the wayside and the relevant conversations deteriorate into an adversarial discussion between the healthcare professionals and the family/next of kin.

One way to pre-empt these situations is to set the stage for such topics to be discussed more openly and in public spaces long before it becomes part of decision making involving a friend or a family member. In other words, if conversations/debates related to end of life issues can be initiated in the community through the involvement of patients and the general public, it may be possible that people will be more prepared, informed and objective at times of personal tragedies.

These considerations were at the heart of the exhibition aptly named ‘Birth and death in my life’ which was held recently at the Whitworth Galleries in Manchester. Clinicians from the intensive care unit at Manchester Royal Infirmary and the PPIE (Patient and Public Involvement and Engagement) teams from the University of Manchester partnered with an Independent cultural organisation called the ‘S!CK Festival’ to launch this major engagement event around end of life issues including ‘palliative care’, ‘organ donation’, ‘DNR orders’ and ‘Spiritual care of the dying’ a part of a larger festival that lasted 3 weeks at different venues in Manchester.

In order to connect with the public at a visceral level and capture the extreme emotions involved with death and dying the services of an internationally renowned visual artist, Matt Staubs (<http://matsstaub.com/en>), was commissioned to create an engaging installation which captured these strong emotions.

The installation included videos of conversations between selected people, discussing their memories of birth, illness, dying and death in their own lives. The installation provided the nucleus around which active discussions and QA sessions were conducted with key stake holders. The Whitworth Art Gallery is a large open space with a large garden surrounding the premises and thereby providing an ideal venue to provoke thought and reflections.



Figure 1

The producers also provided a quiet space away from the video installation, where visitors could write letters and thoughts to the people in the videos. Alongside these letters, semi-structured questionnaires were also provided in order to capture qualitative and quantitative data which will be suitable for further analysis. The feedback from the visitors were extremely positive with comments/sentiments such as “the calm and reciprocal nature of all the conversations led me to view their experiences more considerably than I would have before” being expressed by many participants. The data is now being analysed in a more systematic fashion.



Figure 2

Figures 1&2: One of the 12 video installations that were available and the focus group discussion involving key stake holders such as ex- ICU patients, Transplant recipients, organ donors and health care professionals

Given the positive feedback and success it has had in Manchester, the team plans to extend similar events beyond Manchester as part of National and International conferences in related specialties.



CAREERS, RECRUITMENT AND WORKFORCE

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee (FICMRW)

The Faculty held its first meeting with clinical leads, network leads and clinical directors on 10th October.

We meet regularly with leaders at our medical and ACCP training meetings and in workforce engagement events, but as CRW has developed and expanded its work, it's become apparent that having additional direct lines of communication is necessary to better explore the needs of the ICM workforce.

Leadership is embedded within our clinical work and it's no surprise that there are a considerable number of Medical Directors who cut their teeth in critical care. At the October meeting, both Keith Girling and Steve Brett challenged the audience to think about their own leadership and how to add value to an organisation. I've been involved in medical leadership for a decade and looking back, my development has relied on a mixture of personal drive, wise advice/ senior support and being in the right place at the right time. The path isn't a clear one even now despite a greater push for leadership development to start in training.

Audience members supported those views and

argued for greater opportunities to support new leaders and develop the next generation. They suggested more information and guidance needs to be provided for trainees around professional issues and support provided for those consultants newly stepping up to the plate as local leaders.

CRW have been ahead of the curve, so 2020 will see more information in this area. The Consultant Intensivist in Transition materials developed from the Oxford course run by James Day will be ready in early 2020. These will allow local tutorials for senior ICM trainees to prepare them for dealing the non clinical aspects of consultant working

The Emerging Leadership cohort of early female leaders is just starting and CRW will be taking the lessons learned from that pilot to consider how the Faculty can widen leadership development for all new leaders, male and female. Expanding mentoring and networking support between leaders is something the Faculty is ideally placed to support and CRW will be looking ahead to 2020 and additional ways it can develop all our leadership needs.

FICM WORKFORCE CENSUS 2019

Dr Richard Porter

Workforce Lead

In 2019, the Careers, Recruitment and Workforce Committee surveyed the UK's senior clinicians within Intensive Care Medicine to ascertain working patterns and attitudes to future career planning.

Overall

1106 people responded of which 126 were the clinical lead for their intensive care unit (ICU). Of this 827 (74.8%) were male and 270 (24.4%) female with 9 (0.81%) preferring not to say. Figure 1

shows the age range of this cohort and demonstrates that the number of doctors practicing intensive care decreases once they reach the age of 60. Three intensivists are still practicing over the age of 71.

Figure 2 illustrates the number of programmed activities (PAs) intensivists are job planned per week. 481 (48.3%) work between 10 and 12. However, 408 (41.0%) are working more than 12 PAs per week – this may either reflect working more than 48 hours per week of

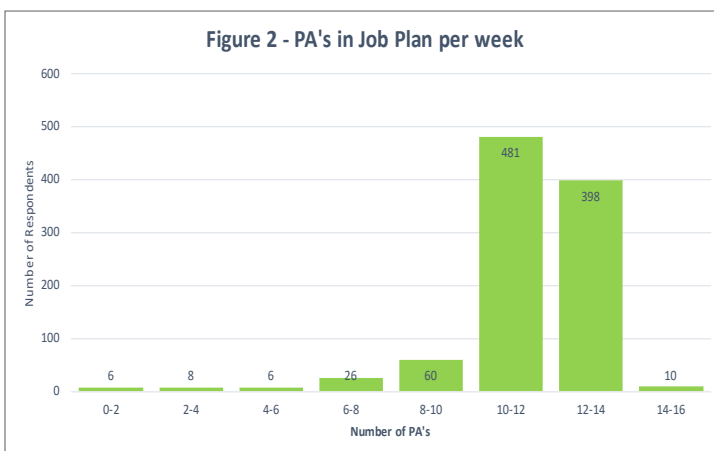
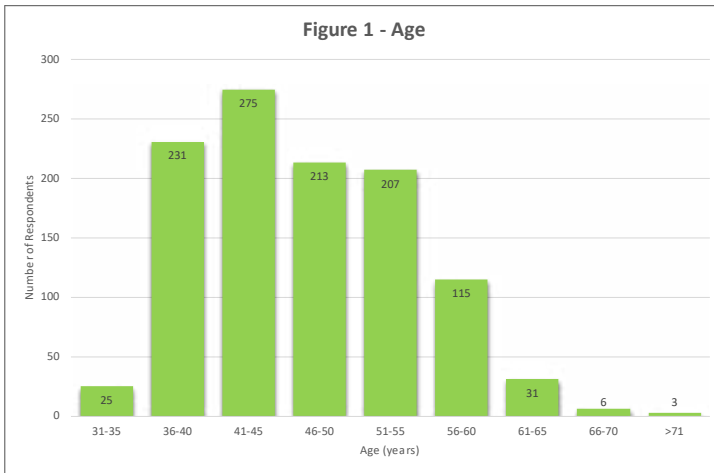
programmed activity or bias towards working more unsocial hours which carry a greater PA allocation. This is a concerning finding as levels of activity at this level may become difficult to sustain particularly in

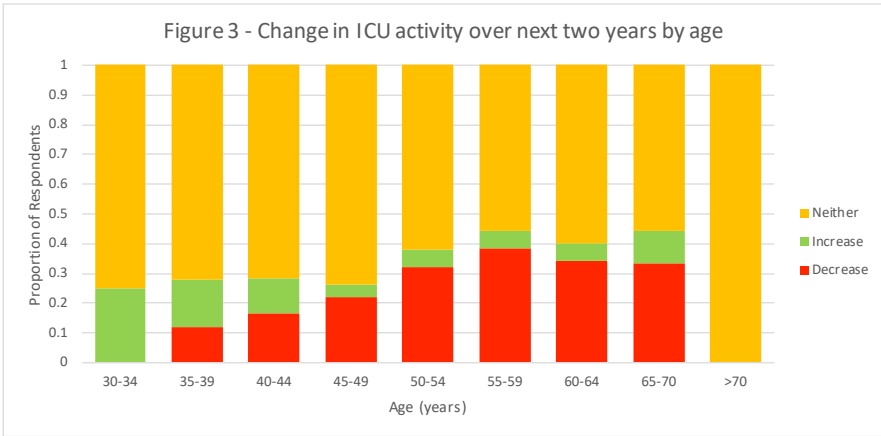
the event of stressful periods in either home or work life.

When looking at what intensive care consultants are planning to do over next two years in terms of intensive care medicine activity it is clear more

are planning to decrease rather than increase: 246 (23.2%) versus 95 (9.0%) respectively. When plotted against age it is clear that decreasing ICU becomes more prevalent as you get older. This is demonstrated in figure 3.

The reason for decreasing ICU commitment is shown in figure 4. Burnout is the reason given for 108 cases (27.1%) with family commitment in 56 (14.1%) cases. Pension tax was the main reason in 46 (32.9%)





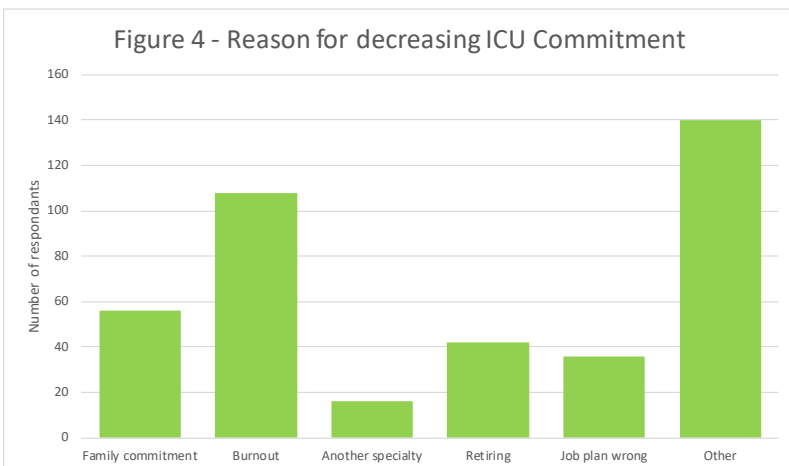
cases. Overall there were 398 respondents describing a reason for decreasing intensive care medicine activity. This is more than the 246 planning to decrease over the next two years so this may include those planning to decrease on a different time scale and those who have recently decreased commitment.

A total of 58 (44.6%) of the 130 units responding to the census have unfilled consultant posts. 19 (32.8%) had three or more unfilled posts.

In summary this census indicates that a high proportion of doctors working in intensive care are on high programmed PA activity. There is a significant

proportion wishing to decrease activity and that burnout does contribute significantly to the need for individuals to reduce working commitments. Pension tax does not contribute comparatively in a major way at present, to those wishing to decrease Intensive Care Medicine commitment. There are a large number of units with Consultant vacancies on the intensive care rota.

The future of intensive care medicine is reliant on expanding recruitment, not only to cover current gaps and career plans to decrease commitment, but to ensure that intensive care medicine is a lifelong sustainable way of working.





WORKFORCE ENGAGEMENT: Wessex

Dr Matt Williams
Regional Advisor

On a rather grey late autumn day, a good number of multi-disciplinary representatives from almost all of the region's units attended the Wessex Workforce Engagement meeting at the Hampshire County cricket ground. This was the ninth such day that the Faculty has supported. These events aim to identify current and future critical care workforce and demand issues, and the opportunity for attendees to explore potential solutions.

With delegates hopefully not too distracted by the view of the outfield, Drs Danny Bryden and Jack Parry-Jones, from the FICM Careers, Recruitment and Workforce Committee, opened the batting by setting the scene and objectives for the day. Following this, I presented an overview of the history and the current context of Intensive Care Medicine in Wessex. Then Dr Kathy Nolan, the Medical Lead for the Wessex and Thames Valley Critical Care Network, gave a wider perspective on the changing demographics, and the multi-disciplinary staffing positions and challenges, for the region.

Wessex has 9 hospitals, with 12 ICUs including specialty neurosciences, cardiac and paediatric ICUs based at University Hospital Southampton. The region spreads across the more densely populated Hampshire, and the more rural Dorset and south Wiltshire. The region's population is steadily growing and growing older, like much but not all of the UK. Over the last 15 years, there has been a growth in Critical Care provision, mainly with Level 2 beds, and Consultant numbers. The communication and support between ICUs and colleagues is good helped by there being a vibrant Wessex Intensive Care Society and that many of the consultants trained in the region.

There followed two round-table discussion sessions, facilitated by Danny and Jack. From these, several threads emerged: retention and career progression of the non-medical workforce, out of hours middle

grade resident cover, the need to attract and train more consultants in ICM, and a strong common theme of a need to secure psychology provision in most of the region's ICUs.

Three Trusts have been training ACCPs in recent years, and have them embedded in their units. However, there is concern about the future retention of these valuable staff and their options for career progression; units have already seen some of these highly trained colleagues move to different ICUs. Similarly, the question of how to retain skilled nursing staff was also discussed. With many nurses being used to staff wards when occupancy dips, working antisocial hours and with limited opportunities to progress to a higher band in intensive care, a number of nursing staff eventually look to seek career progression outside critical care. The constant turnover leads to problems with skill mix and an increased training burden on unit educators.

The meeting highlighted that most of the ICUs will need to recruit consultants in the next few years. In addition, significant numbers of ICM consultants are due to retire in the near future and many others are reducing clinical activity for reasons that have been highlighted in the FICM census. Unfortunately, despite growth, the number of ICM specialty trainees due to complete training over this time is unlikely to meet this gap; this will be exacerbated by a number of years of under-recruitment to training. There are a number of on-going efforts to encourage future recruitment to our specialty.

I would like to thank Danny, Jack, Daniel, Natalie and Susan from the Faculty for organising and supporting what was a stimulating and productive day. I look forward to receiving the Faculty report in due course. The day appeared to display an engaged, proactive set of ICUs in Wessex looking to get on the front foot in facing the hostile deliveries ahead.



RECRUITMENT UPDATE

Dr Tim Meekings
Recruitment Lead

As the nights draw in and we start to see some frosty mornings, the planning process is well underway for next year’s National ICM Recruitment round. As in previous years, the interviews are planned to take place at The Hawthorns in West Bromwich across a three day period in March (17th-19th). In common with previous years, the interview will consist of four face-to-face stations and one written station. The face-to-face stations will include portfolio assessment, a task prioritisation exercise, a presentation and a clinical scenario. For the written station, the candidate will be asked to reflect on an element of their practice and extrapolate the lessons learned from this. There will be two interviewers in each face-to-face station and, as previously, there will be quality assurance with trained observers and a lay representative watching proceedings to ensure a fair process.

In 2019, there were 305 applicants of which 290 were shortlisted and 281 subsequently attended for interview. During the interview process, 263 candidates were felt to be appointable to the ICM training programme. These 263 candidates were ranked by their overall interview score, and then offered posts depending upon their preferred region. After a matching process, 161 of the available 169 posts nationally were filled, resulting in a 95% fill rate.

There are plenty of resources for the prospective candidate to learn about and prepare for the interview process. On the Faculty website (www.ficm.ac.uk) there is a section dedicated to 2020 Recruitment. The ‘Discover ICM’ brochure can

be downloaded from the website – this provides a simple overview of a career in ICM, with information about the training programme, links to some useful online resources and recruitment FAQs. The website also contains details about the timeline for 2020 and guidance on core programme equivalence, to help the applicant gain an understanding of the requirements to enter

“**THE ‘DISCOVER ICM’ BROCHURE CAN BE DOWNLOADED FROM THE WEBSITE - THIS PROVIDES A SIMPLE OVERVIEW OF A CAREER IN ICM, WITH INFORMATION ABOUT TRAINING, LINKS TO USEFUL ONLINE RESOURCES AND RECRUITMENT FAQs**”

ICM training at the ST3 level. There is also a guide to the training units in each region, so that the candidate can see what each area can offer in terms of training and experience in each hospital. Finally,

there is a reassuring first hand account of what the interview day is actually like!

The Intensive Care Medicine National Recruitment Office (ICMNRO) at Health Education West Midlands has a website with a comprehensive guide to the recruitment process for 2020 (<https://icmnro.wm.hee.nhs.uk>). This has a link to a downloads section which contains some useful information. Amongst this, there is a matrix describing which skills each station is designed to assess along with a good and a bad example of some reflective practice written work. In the near future, this section will also be updated with an applicant guide for 2020 and a copy of the self assessment criteria for the portfolio station – this is not only invaluable for 2020 applicants, but is also an excellent guide for career development for more junior trainees who may be interested in applying for ICM training in the future.

Applications for ICM training in 2020 open on the 29th January, we wish you the very best of luck and hope to meet you in March!

ADVANCED CRITICAL CARE PRACTITIONERS



Ms Carole Boulanger

Co-Chair: ACCP Sub-Committee



Dr Simon Gardner

Co-Chair: ACCP Sub-Committee

HEE Funding for Continuous Professional Development

The ongoing financial constraints that NHS Health Boards and Trusts across the UK have experienced for several years now, has greatly restricted the availability of dedicated funding for nurse and AHP education and CPD. In order to address this in England, Health Education England (HEE) have recently announced that £150 million is being made available from 2020/21 and thereafter to enable employers to provide a £1,000 CPD training budget over the next three years for each NHS nurse, midwife and AHP within a Trust. This funding will support staff to ensure they continue to be able to deliver high quality care for patients, adapt to the changing needs of the population and build rewarding, lifelong careers in the health service.

Trusts have already been notified as to their indicative funding allocations. The FICM ACCP Sub Committee would therefore encourage ACCPs, ACCP trainers, clinical leads and department heads to access and utilise this funding. Decisions about what CPD should be undertaken will be for individuals and teams to discuss and agree with their line managers. Employers are instructed specifically to try to use the new CPD funding for workforce development and

transformation – ACCPs are very much in the vanguard of workforce transformation and therefore fulfil this criterion. This new money will hopefully represent a genuine opportunity for qualified ACCPs to be able to access high quality, ongoing CPD, an area which previously has been marginalised and under-funded.

ACCPs and Professional Categorisation

In recent weeks, there have been further intensive discussions between HEE and FICM representatives regarding the future direction for ACCPs as a specialty group. As discussed in the previous edition of Critical Eye, there has been ongoing debate as to whether ACCPs should in future 1) be classified as Advanced Clinical Practitioners (ACP), 2) be classified as Medical Associate Professionals (MAP) or 3) remain as they stand currently (i.e. a 'stand-alone' post). Option 3 has largely been rejected due to the educational, funding, regulatory and governance opportunities that the ACP or MAP options represent and the inherent risks of being out with any specific advanced practitioner group.

At present the potential MAP route is still viewed as problematic. The main reason for this is that MAP inclusion would necessitate a 'direct entry route' into ACCP training i.e. graduates could access this without prior experience as a healthcare worker within critical care. The FICM ACCPSC has always been of the view that significant prior workplace experience within critical care was an essential requirement for recruitment to ACCP training. Critical Care can often be a complex, demanding, challenging and emotive working environment – we believe that the desire to work at an advanced level within critical care can only truly be understood within the wider context of already having worked within that environment.

Higher Education Institute Accreditation

There are a slowly increasing number of HEIs across the UK who now deliver an ACCP Masters course. In an effort to ensure some degree of quality and consistency amongst HEI ACCP courses, FICM is considering an HEI accreditation process. The initial proposals for this process have been approved by

the FICM Board. The aims and objectives of this accreditation process are;

- Establish and monitor national standards for the design and delivery of ACCP programmes.
- Ensure that programmes of study are designed to meet the specifications of the Curriculum Framework for the Advanced Critical Care Practitioner and delivered within a conducive learning environment.
- Enhance the quality of ACCP programmes.
- To ensure proposed ACCP programmes meet the standards of professional competence as laid down in the Curriculum Framework for the Advanced Critical Care Practitioner.
- To ensure proposed ACCP programmes meet the accepted standards for higher education.
- To ensure that programmes are supported by appropriate staffing and resources and operate within an appropriate academic and professional culture including the assurance and development of quality.
- To share good practice across providers of ACCP programmes as a mechanism of quality enhancement.

- To support a hub and spoke training strategy for ACCPs.

ACCP Equivalence and Credentialing

From November 2017, the ACCPSC made the decision to close the route of access for Member status to Advanced Critical Care Practitioners (ACCPs) who were not on an ACCP specific Higher Education Institution (HEI) training programme. This has led to the requirement to ascertain an equivalence pathway for those who still desire or require ACCP Member status. (See the ACCP Programme Specification).

The process of gaining this 'equivalence' may be considered to be a form of credentialing. Credentialing is becoming increasingly common as a method for various national healthcare agencies to assess the background and legitimacy of healthcare workers to practice at an advanced level through assessing their qualifications, experience and competence.

A draft proposal for an ACCP Equivalence pathway has been submitted to the FICM Board and further details regarding this process will be publicised in due course. This work mirrors other national level work on Advanced Practice credentialing that is currently underway within HEE, The Royal College of Nursing, The Health and Care Professions Council etc.



ACCP CONFERENCE 2020
Thursday 4th June 2020
CRB Education Centre, Royal Victoria Infirmary,
Newcastle Upon Tyne.
Online booking is now open
Visit the FICM website for more details:
www.ficm.ac.uk/news-events-education/ficm-events



WICM UPDATE

Dr Rosie Baruah
Chair: WICM

Striking the Balance

We had our first meeting, “Striking the Balance”, on 27th September – and it was a brilliant, inspiring day. Sarah Marsh, our meeting organiser, has written a piece all about this meeting – if you were there we hope you enjoyed it as much as we did and if you weren’t we hope you come to our next event!

Emerging Leaders Programme

This has been led by Manni Wariach. We have appointed four ICM consultants to our WICM Emerging Leaders programme. The impetus behind this programme is the desire to increase the number of women involved in ICM leadership both nationally and locally. Only 7.5% of consultant applicants for FICM Board level positions have been female, and at the most recent voting round for new trainee board members only one out of the eight candidates was female. The year-long WICMEL programme matches each Fellow with a Board level mentor to allow them to discuss and develop leadership goals, backed up with Open University leadership e-learning modules. The fellows will also have the opportunity to attend Faculty Board and committee meetings.

Mentoring

Nish Desai is leading the mentorship programme for WICM. Our aim to set up a mentor programme within the Faculty to allow any intensivist, at any career stage, to access a mentor to help personal and professional development. As an initial scoping exercise we will be sending out a survey to all trainee and career grade Faculty members in November and would urge you to fill this in – the better the response rate, the better our programme can meet the needs of the ICM workforce.

Return to Work

WICM Sub-Committee member Roisin Haslett and virtual group members Lorna Burrows and Victoria

McCormack have produced a Return to Work document focussed on doctors in training returning to work after a period of planned or unplanned absence. This will feed into a wider piece of work by the Careers, Recruitment and Workforce Committee called “Critical Staffing”, which will include guidance for all staff groups working in ICM. We hope this document will allow departments to ensure their RTW processes align with national standards.

Social media and blogs

Steph Cattlin, WICM’s SoMe lead, oversees the WICM blog and Twitter feed @WomenICM. We publish monthly blogs on the ficm.ac.uk website on a range of topics related to the goals of WICM. We are keen to hear from anyone who has something they want to say on the topics of diversity, equity and inclusion – say it in a @WomenICM blog! Email wicm@ficm.ac.uk if you are interested.

New members

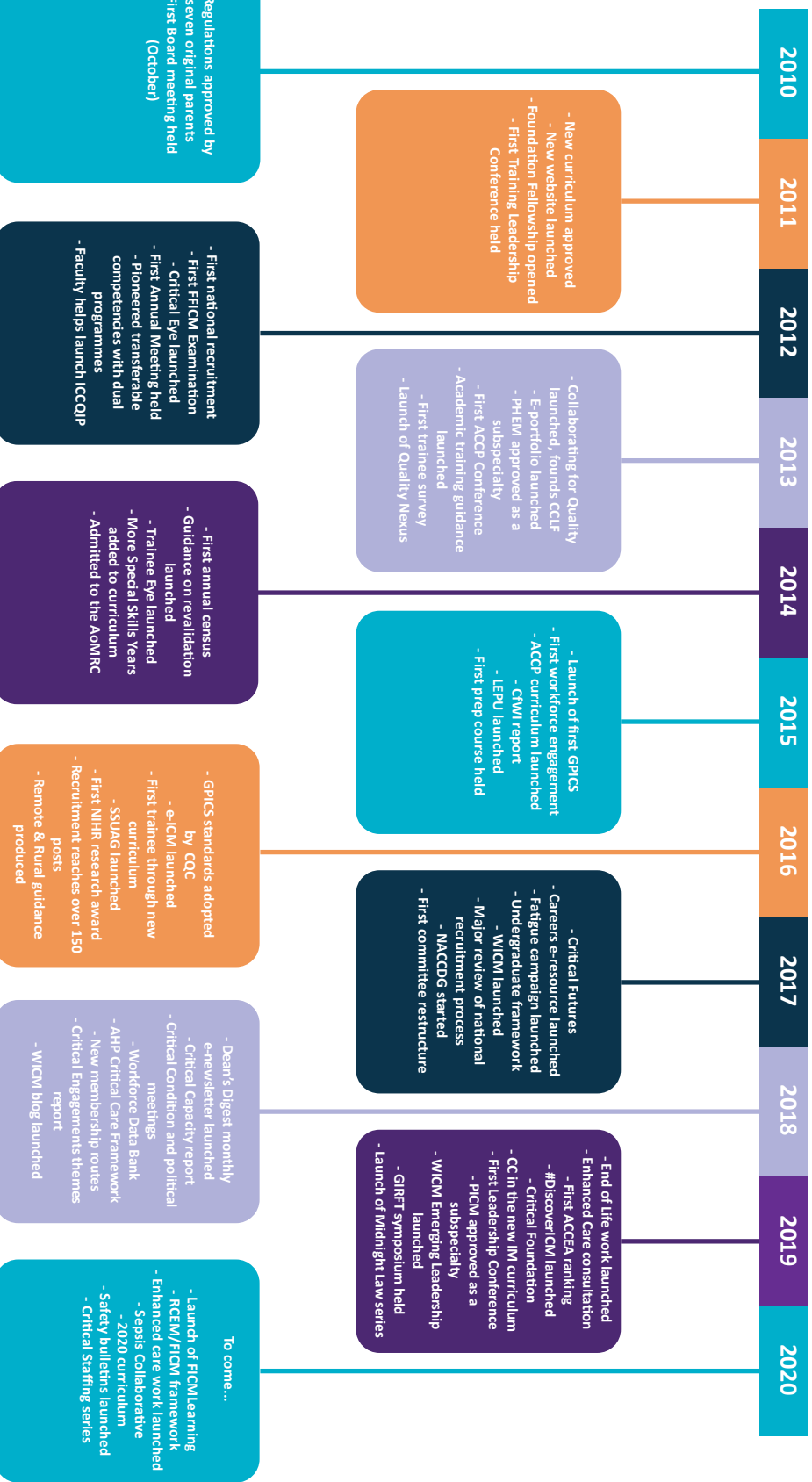
Finally, we are delighted to welcome 6 new members to the WICM committee:

Samantha Batt-Rawden (trainee member)
Inge Elsayed
Kate Flavin
Hannah Potter (trainee member)
Liz Thomas
Christine Watson

The WICM group is committed to increasing the profile of ICM as a specialty that anyone can thrive in, regardless of gender or personality type and we look forward to continuing work on our projects. If you think there is anything else we should be focussing on please let us know – DM us through @WomenICM or email at wicm@ficm.ac.uk.

FICM10

Celebrating the First Ten Years of the Faculty Of Intensive Care Medicine



FICM10

The FICM are celebrating our ten year anniversary in 2020. We have lots of events planned throughout the year, we'll keep you informed but you can also keep updated on the FICM website: www.ficm.ac.uk/ficm10. Here are a selection below.

New Logo - We are pleased to announce the launch of the new logo to coincide with our 10 year anniversary.



#FICM10 - We'll be doing lots of social media communication throughout the year, keep an eye out for #FICM10.

We will be doing monthly 'Did You Know' tweets about the FICM. Look out for the lightbulb.

We also want to be highlighting what you guys do outside of work with our #ICMand campaign, so let us know if you have any interesting hobbies you would like to share!

Annual Meeting - Leading The Way
Make sure you save the date and come along to our meeting on 15th June 2020.

Essay Prize
We will be launching an essay competition later in the Spring, keep an eye out on the website and in Dean's Digest for more information.

FICM10 Trainer Award

We kicked off the FICM10 celebrations with the FICM Trainer Award.

We received 20 nominations, thank you to everyone who nominated and thank you to all our trainers for your continued hard work.

The winner was Dr Andy Campbell. Congratulations!



Dr Campbell is the sole ICM trainer in the Wrexham Maelor Hospital, a DGH in North Wales.

Since starting as a consultant in the department, Dr Campbell has revolutionised the unit in terms of clinical practice, teaching and training.

He is a valued member of the team, a great teacher and is always a source for the latest guideline or journal released. He is a well respected within both the department and the wider hospital and is certainly responsible for providing resources for trainees to be the best doctors they can be.



STRIKING THE BALANCE

Dr Sarah Marsh

Deputy Chair: FICM Education Sub-Committee

Balance = a situation in which different elements are equal or in the correct proportions.

Balance is important in intensive care. Whether that is amongst our teams, in conjunction with our home life or just to do with fluids. Achieving balance is an increasing priority for many of us, whether that be in the diversity of our workforce or in attempt to safeguard ourselves against stress and burnout related conditions.

According to census results, the “average” intensivist in the UK is male, around 48 years old and works up to 50-75% of their DCC in Intensive Care Medicine (ICM) alongside anaesthesia.^{1,2} The landscape in ICM in the 21st century is changing however, and we know that the makeup of ICM is increasingly diverse. It consists of all sorts of people from an array of specialities, delivering care with different models of working. Indeed it requires this diversity to achieve and maintain excellent standards in the high-stakes, complex environment in which we work.

In view of this the autumn meeting at FICM was based around “balance”, what it might look like and how to achieve it. It was the first meeting organised by the Women in Intensive Care Medicine sub-committee and was designed to cover topics that looked at the softer areas of ICM that can be challenging to master, and how to encourage the development of these skills. Over 50 delegates attended including parents with small babies who enjoyed the lectures via a video-link to the boardroom – a first for the building.

The morning covered “Succeeding as an Introvert”, “Dealing with Failure” and “Leading with Authenticity”, followed by “Being an Effective Ally” and “Barriers to a Career in ICM”. Recognising that ICM is a fast paced specialty requiring multidisciplinary working in a stressful environment packed with action and noise, it could be argued that this would be more suited to the extroverts among us. However, Dr Jacqueline McCarthy told us how to thrive in ICM as an introvert with tips on

finding your voice and getting it heard, and practical pointers for the parts of ICM that may be inherently uncomfortable. Dr Ritoo Kapoor discussed failure; it should be predicted, expected and planned for. The take home message was that it shouldn’t be seen as a negative event but as part of a process in trying to be the best that we can. Dr Liz Thomas’s lecture was about leading with authenticity. It doesn’t necessarily mean that you need to have been a leader before – you can develop the skills on the job by surrounding yourself with supportive people and setting realistic goals.

Dr Nazir Lone discussed the concept of allyship – an ally being a person who works to understand the imbalance in opportunity and then strives to change it. He told us that to be an ally you must understand your personal biases, and reflect on your own power and privilege. We must ensure others are heard, offer mentorship and open opportunities, and promote to others that equity is win-win; ask, listen, show up, speak up. And also recognise that we don’t truly understand the challenges faced by others as they are not the same as our own.

Dr Roisin Haslett has been studying the barriers to a career in ICM over the last 10 years. Her research has shown that the perceived impact of rota patterns and inflexibility of working models has an impact on decision making with regards to a career choice in ICM. Timely career advice from those with knowledge and experience in ICM, an early introduction to the specialty and a need for diverse role models were key recommendations made from her research. Flexibility for all in the workplace would also be hugely beneficial, as needs and demands on us personally and on our families are different at different stages of life. The afternoon session was split into workshops. The first workshop centred around mentorship with Alison Wheatley from Aspire – what makes a memorable mentor, how to develop your profile as a mentor and building successful relationships with your mentees. The second workshop had several parts.

Chadwick Consultancy encouraged people to “know yourself to manage yourself”. Understanding your own biases and the biases faced in ICM can help to unlock previously unknown potential. A triad followed of Drs Matt Morgan, Segun Olusanya and Nazir Lone on their take on “how to... write, balance and speak”. Matt encouraged us to pick up a pen and write the things that are hard to speak. Segun told us that there is no perfect balance as the sweet spot continuously changes, but you should give yourself permission to stop if you need to and limit any guilt. Nazir gave some great pointers about how to prepare, deliver and review your teaching.

The final presentation of the day came from Dr Alison Pittard who gave a very personal, honest and heartfelt account of her career journey so far, from primary school to becoming the Dean of FICM. She described the undulating pathway of her career so far and the

people important to her along that journey.

The take home message from this, and really of the whole day was that anything is possible. Sometimes you just have to put yourself out there and see what happens. Above all make sure you have a good support network around you and try to find your own balance point, rather than someone else's. Dr McCarthy finished with a quote that I feel sums up the day for me, so I shall do the same! “Find out who you are and do it on purpose” (Dolly Parton)

1. Pittard A, Bryden D, Parry-Jones J. Recruitment to Retirement – Workforce in Intensive Care Medicine. Accessed Nov 2019. https://www.ficm.ac.uk/sites/default/files/ficm_workforce_census_-_update_for_fellows_and_members_1.pdf
2. Workforce Data Bank for Adult Critical Care. 2018. Faculty of Intensive Care Medicine. https://www.ficm.ac.uk/sites/default/files/workforce_data_bank_2018_updated_for_website.pdf

IMPROVING THE RETURN TO TRAINING EXPERIENCE IN ICM

Dr Helen Jordan, ST5 Anaes/ICM SE Scotland
Dr Laura MacNally, ST6 Anaes/ICM Y&H

Returning to practice after a prolonged period of absence may be a stressful and potentially vulnerable time.

There are in the region of 5000 trainees, approximating to 10% of the national trainee workforce, in approved time away from their training at any given point. This may be for any one of a number of reasons including maternity, shared parental or carers leave, out of programme research, out of programme experience, out of programme career break, sickness leave or rarely, fitness to practise issues¹.

The workforce demographic in Intensive Care Medicine and its associated specialties is changing. Since 2012 there has been a 20% increase in the number of

female consultants in Intensive Care Medicine and currently 39% of all trainees in intensive care medicine are female². This, together with an increasing trend amongst trainees towards taking a period of time away from training for research and other activities, suggests that there are likely to be increased numbers of trainees undergoing a return to practice at some point in their career pathway.

There is evidence to support the fact that time away from clinical practice may impact upon clinical skills retention. The 2014 General Medical Council Skills Fade Literature Review found that time out of practice results in skills attrition, the speed and degree of which varies according to multiple factors³.

Multiple concerns have been highlighted by returning trainees, including:

- Attrition of clinical knowledge, technical and non-technical skills
- Being expected to function at pre-leave level immediately on return
- Working out of hours without local supervision immediately after returning
- Missed developments in local and national guidelines

In addition to this, a reduction in clinical confidence is almost universal amongst returning trainees and may negatively affect trainee wellbeing and performance and potentially workforce retention and patient safety. Trainees returning to work in ICM can be single or dual specialty trainees or may be from another specialty rotating through an intensive care block. The initial return to training period may have been undertaken in another specialty but further support may then be required on return to intensive care medicine. The temporal gaps between specialty rotations may be particularly significant for those who train on a less than full time basis and may further hinder a successful return. The ICM curriculum is expansive and this can lead to challenges in planning how to support “all trainees” when their needs may be very different. Development of an individualised approach for each returning trainee is imperative.

The Academy of Medical Royal Colleges (AoMRC) first published return to work guidance in 2012 (revised in 2017) recommending a formal return process for anyone returning to practice after more than three months away. Health Education England (HEE) have built upon this with the Supported Return to Training programme, which has resulted in central funding of regional resources for both trainees and trainers, together with development of a robust return to training process. In conjunction with this project, the Royal College of Anaesthetists (RCoA) have developed a Return to Work Network with the aim of reviewing and

developing return to work courses, sharing best practice and ensuring equity of availability of anaesthetic return to practice resources across the UK. The Faculty of Intensive Care Medicine has recently ratified ICM-specific Return to Work Guidance which embodies the following key points:

- TPD to coordinate the return to work
- Each ICM training unit to have a dedicated return to work consultant lead
- Planning meetings to take place
 - Prior to absence (if absence planned)
 - Prior to return
 - Post return
- Initial period of more closely supervised practice immediately following return.

This policy will be published in full in the next few months.

Returning to practice after a period of time away can be a challenging process and if not adequately supported may negatively impact on trainee wellbeing and potentially, patient safety. Given the evolving workforce demographic in ICM together with the particular challenges of dual specialty training, embedding a robust return to practice process and ensuring access to associated resources for returning practitioners is essential.

References:

1. Health Education England. Supported Return to Training. 2017. Available from <https://www.hee.nhs.uk/sites/default/files/documents/Supported%20Return%20to%20Training.pdf>
2. Faculty of Intensive Care Medicine Census 2018. Available from <https://www.ficm.ac.uk/workforce/census>
3. General Medical Council. Skills Fade Literature Review. 2014. Available from <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/skills-fade-literature-review>



UPDATES

1

**Smaller and Specialist Units
Advisory Group**

2

Getting it Right First Time

3

FICM Support for ACCEA 2020



SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

How many Critical Care patients can you realistically look after at once? A recent paper looked at the optimum patient number to be looked after by a single Intensivist during daylight hours and came up with a U-shaped curve for hospital mortality, with the optimum number of 7.5. Many units operate during the day with roughly this number – including larger units that are split into more manageable sized pods. This number also seems about right for the number of patients a doctor can hold in his or her head at any one time. Handovers can be increasingly straightforward the lower the number you are looking after. The number also spookily echoes Miller's Law.

The psychologist George A Miller published a paper in 1956 entitled "The magical number seven, plus or minus two: some limits on our capacity for processing information". Miller looked at the memory span of adults, which encompassed the longest list of items that could be repeated back in correct order. He found that this was around 7 items, and that this remained similar even if the amount of information within each item varied e.g. words or figures of different length. He therefore thought that each item could be thought of as a 'chunk' of information. Miller also looked at the one-dimensional absolute-judgment task. In this, a particular stimulus corresponds to a particular response. An individual therefore has to memorise these pairs, and produce the appropriate response when prompted. As the number of coupled input:output pairs increases, the task becomes more difficult. So the performance of the person undertaking this test tends to get very good results up to 5 or 6 different stimuli, but then starts to deteriorate as the number increases beyond this.

The last strand was that he found that people could quickly identify the number of dots without counting them up to about 7. The conclusion

he made from these three aspects was that the number of objects that we can consciously hold in our mind at any one time is 7 ± 2 .

Of course this is a stretch. Miller was talking about short-term memory, and retention of patient information is needed over a much longer time scale. Nevertheless, it does seem to strike a chord and recollection of details on individual patients gets more difficult with increasing numbers. Can we extrapolate this to out of hours work? There are less decisions needed by the intensivist on call for patients already on the unit, and perhaps for the majority of patients, intervention is limited overnight. The necessary information can be supplied as needed for those patients that do deteriorate. Intuitively though, being able to retain detail on your patient following handover has got to be helpful, and make conversations in the small hours easier. The number of patients on smaller units is of course limited, and therefore the Patient: Intensivist ratio (PIR) does not increase out-of-hours. This means that the on call consultant can still retain more detail on the individual patients under her/his care. This aids decision-making and helps to maintain a manageable out-of-hours workload in smaller units, and perhaps is one of the reasons that smaller hospitals in the UK can maintain outcome measures that match more heavily resourced tertiary centres.

Lastly, the latest version of Guidance for Training Units is on the FICM website, and includes a paragraph on encouraging placements for training in smaller units. This is of key importance in future consultant staffing and hopefully we will gradually see more trainees having attachments to all sizes of hospital.



GETTING IT RIGHT FIRST TIME

Dr Anna Batchelor
GIRFT ICM Lead

When I was Dean the Faculty sent out a questionnaire asking where you thought ICM was and should be going 15 years after Comprehensive Critical Care. You told me you were mostly struggling to stay still, let alone move forward, that many of you had problems recruiting consultants, trainees, nurses and AHPs, had continuing unmet need for level 2 care, battled with inappropriate requests for admission and were too often asked to make End Of Life decisions on patients outside the unit. That burn out was just around the corner. I'll be honest, that probably wasn't what I was hoping to hear! But I was not surprised.

Fast forward 5 years and I have the privilege to come and meet you in your world, to discuss your service, your data and what problems and successes you have. Even better we all get to discuss that with (hopefully) board level members of your hospital so together we can explore how you can Get It Right First Time.

So, what was I hoping to hear? That critical care has embraced our role of supporting all services in the hospital to deliver the best, safest, most appropriate care for all patients. That our specialty is proactive in detecting patient deterioration early and preventing further decline. That our outreach services have built trust with ward staff, so referrals are made early. That we are embracing rehabilitation and patient support; from the moment of admission to after discharge from hospital.

What is so encouraging during deep dive visits is, in fact, that you do share my vision of the future of our specialty. But you often lack the resource to make that vision a reality. Nothing in the GIRFT ICM data pack can or does tell us anything definite about your ICM service. The discussion that we have (and I will confess it often goes on longer than we had planned) with clinicians, nurses, AHPs, managers, medical directors and, hopefully, Chief Executives illuminates the data and produces a clear view of where there are problems and what could be done to improve.

This discussion only really works well when there are many members of the clinical team present so if I haven't visited you yet please invite consultants, nurses, all the AHP groups, the data collectors, trainees, the CC network leads, service users, the more the merrier. Please don't feel Caroline (the GIRFT project manager who tries to organise me) and I are there to criticise or judge you, we are there to hear it how it is and support you. Visits go best when everyone joins in and we have had some really fascinating and enlightening discussions.

Caroline takes notes and we send back a record of our discussions and our recommendations, the local GIRFT implementation manager will be back afterwards to discuss how the recommendations can be implemented.

From a national point of view the messages are coming through loud and clear and we are putting together our report for publication hopefully in spring 2020.

To those of you we have already visited can I say a heartfelt thank you. Often you arrive with trepidation, or resistance and put up an initial defensive barrier, I'm sure I would do the same. I hope our conversations have removed some of your fears, certainly in almost all meetings by the end we reach an understanding of your service, how it fits in your hospital and how we can help. A particular thanks to those we visited early in our programme, it has taken a while for the messages to sift through the mass of data but I think we are getting there.

Most of all I have felt the enthusiasm for critical care from everyone who works in it and the strength of our teams despite the problems you may face and that is very encouraging. I am enjoying GIRFT but I have discovered that wherever you want to get to in England, Newcastle is almost always the wrong place to start!

FICM SUPPORT FOR ACCEA 2020

Last year the Faculty of Intensive Care Medicine was for the first time able to provide support for ACCEA awards candidates as an ACCEA National Nominating Body. The exact dates of the 2020 National process are currently not clear, but we have been provided with an indicative timetable:- The opening date is 6th Feb 2020 and the closing date is 5pm 3rd April 2020.

If you would like to be considered for support by the Faculty for the 2020 process, please send a CVQ application including the main form A and any additional forms (D, E, F) to contact@ficm.ac.uk before 5pm on 7th February 2020. We are happy to accept 2019 forms if the 2020 versions are not available at that point.

There are some useful links on the FICM website: <https://bit.ly/2sYLSiX>

The ICS are also running a similar process and have produced a “top pointers guide” which is definitely worth looking at in conjunction with the National ACCEA guidance: <https://bit.ly/306Oh7t>

When sending us your application, please let us know the contact details of a colleague who would be prepared to write a citation for you on behalf of the FICM. They should not be from the same hospital/institution

Notice of FICM Board Elections

The FICM will be holding an election for **three** Board Members to commence their terms of office in July 2020 and November 2020.

Requests for nominations will be sent to FICM Fellows and Associate Fellows in March 2020 along with more information about the election process which will be entirely electronic.

Voting will take place in May 2020 (deadline 7th May).
Further information will be available on the FICM website

To ensure you will be notified when the process begins, please inform us of any changes to your postal or email addresses.



TRAINING AND ASSESSMENT

Dr Tom Gallacher

Chair: Training, Assessment & Quality Committee (FICMTAQ)

Following long discussion and consideration the committee have agreed that the new Intensive Care Medicine curriculum will be referred to as *ICM CURRICULUM: Supporting Excellence*. This name will facilitate its ready accessibility on common search engines and will be commonly referred to as *Supporting Excellence*.

To support the introduction of the new curriculum we will have a new eportfolio and work has commenced on this project.

Along with our new curriculum we must also submit the requirements a doctor must fulfill to become eligible for entry onto the specialist register via a non-training programme pathway – known as Certificate for Eligibility for Specialist Registration (CESR). I would like to thank Dr Sarah Clarke as lead author for all her work in producing this comprehensive piece of work.

The FFICM Examinations Sub-Committee (FESC) recently gave consideration to a proposal from the wider TAQ Committee that the FFICM final examination can be taken during Stage 1 ICM training. The proposal was unanimously rejected by

the FESC for the following reason. The examination is designed to be taken by a cohort of trainees who are at the level of knowledge expected of a trainee who has completed Stage 2 ICM training.

The standardisation process for the exam relies on trainees taking the exam being at the expected level of knowledge. If they are not, this adversely affects the exam pass rate and this, I am sure everyone will agree, is a highly undesirable scenario. We do not want to encourage attempts when people are not ready.

Our trainee survey this year asked for trainees' opinions on Advanced Critical Care Practitioners (ACCPs). Overall the responses were extremely positive with trainees feeling that ACCPs were a valuable addition to the multi-disciplinary teams. They enhanced patient care and lightened the workload of trainees, thus improving the training and learning environment.

Finally, we have produced an updated version of our Guidance for Training Units and this can be found on the FICM website.



TRAINEE UPDATE

Dr Richard Benson

Lead Trainee Representative

As I write this the clocks have just gone back, the thermals and headtorch are standing by for the commute and winter seems a lot closer. The year seems to be flying by. Things have certainly been busy.

We are delighted to announce the publication of a new resource that is designed to introduce trainees to a career in Intensive Care with direct information and links to online resources. Discover ICM can be found on the faculty website; www.ficm.ac.uk/sites/default/files/discover_icm.pdf

Alongside this resource we have a continuing Twitter hashtag of #DiscoverICM. We are a growing, diverse group of trainees and it is important that this is celebrated. If you work in critical care and are able to tell us what you love about your job then please email me or the Faculty at shall@ficm.ac.uk and we can tell you how to get involved.

Trainees who have completed their special skills year (SSY) will have recently received a survey. It has been designed to capture trainees' experiences of the year, provide real life examples of what can be done and inform others of how to maximise and support the development of SSY programmes at a regional level. Your help in completing this is greatly appreciated.

This year marks the 10-year anniversary for the Faculty. This is going to be a very exciting year with

essay prizes, events, podcasts and awards. One award that will have already taken place is the Trainer Recognition Award. We have all worked with a number of inspiring trainers who have shaped our careers and development. It is lovely to be able to recognise these individuals by saying a huge thank you from both myself and from the rest of the trainees.

I am excited to start working with the new Deputy Trainee Representative, Dr Guy Parsons. who will take up his post at the Board meeting in January. That does unfortunately mean that Dr Andrew Ratcliffe will be stepping down as the Lead Trainee Representative. It has been an absolute pleasure working with him. I wish him all the best as Consultancy looms and as appropriate I will give him the final word.

"As the twilight of my own training begins to set in and my time as Lead Trainee Representative comes to an end, I must take this opportunity to offer my sincere thanks to the Faculty for all their help and encouragement over the last couple of years; for the opportunity to sit on the Board and hopefully make some small positive contribution to our training; to Dr Gould (my predecessor) and Dr Benson for their ideas and guidance, and finally, but by no means least to the unwavering support from the secretariat who work tirelessly behind the scenes to make sure our training runs as smoothly as it possibly can. It has been hard work, but an honour to be your national representative over the last two years. I would encourage any of you with an interest to strongly consider applying for a Faculty position and help to continue to improve and further develop this great specialty. We are a small but rapidly expanding specialty and I look forward to the exciting opportunities that the next 10 years of FICM will undoubtedly provide." Dr Andrew Ratcliffe.



Dr Guy Parsons

Deputy Trainee Representative

Hello! I'm really looking forward to representing your interests as the Deputy Trainee Representative and working towards improving training and opportunities in our fantastic specialty. A little about me: I'm a single CCT ICM trainee in Oxford and an NIHR Academic Clinical Fellow applying computing advances to Big Data to address challenges in acute care. I grew up in a mixture of Australia, England and France and acquired an odd accent that occasionally still surfaces. I'm a big fan of languages, trivia and long-distance hiking and someday I hope to cross Europe from North to South. My inbox is open... contact me at guy.parsons@nhs.net



CURRICULUM UPDATE

Dr Tom Gallacher

Chair: Training, Assessment & Quality Committee

The proposed 14 High Level Learning Outcomes (HiLLOs) have now been agreed and can be found on the FICM website. We have also completed our Assessment Strategy which can also be found on the website. I would like to pay special thanks to Dr Chris Smith, as lead author, for his exceptionally hard work in preparing this very comprehensive strategy. Consultation on our new curriculum has now closed and we are very grateful to all those who took the time to reply to the consultation.

The GMC's new standards, which are outcomes based with a reduced assessment burden place a much greater responsibility on the Educational Supervisor. The lack of granularity inherent in the HiLLOs has raised some concern, amongst trainers and trainees alike, that it may prove difficult to know what evidence to provide and how much. I would like to reassure everyone that in preparation for the new curriculum there will be comprehensive supporting guidance made available and during our implementation and transition phases a diverse range of learning materials will also be made available - as well as in person and virtual familiarisation sessions. Some explanatory material has already been posted on our website.

The final curriculum (including HiLLOs, consultation process and feedback, assessment, transition, communication and implementation strategies) must be submitted to the GMC by February for consideration by them at their meeting in April.

The new Internal Medicine curriculum is now half way through its first year of implementation and this has raised some concerns as to the future of dual ICM training programmes with our medical partner specialties. The changes of note which affect Intensive Care Medicine training are twofold. Firstly, IM core training in our partner specialties is now 3 years as opposed to the old Core Medical Training which was 2. Secondly, our partner specialties must now dual train with Internal Medicine as part of the Royal College of

Physicians training requirements.

One of the goals of the above RCP changes is to increase the availability of Consultants in the future who can lead the acute unselected medical take. This means all acute specialties (including renal, respiratory and acute medicine) must complete 3 years of core training plus dual accreditation in Internal Medicine as well as their chosen medical specialty.

In order to accredit in ICM therefore, they would be required under the current system to triple accredit i.e. ICM, IM and either Renal, Respiratory or Acute Medicine. Currently, *if nothing were to change* all dual ICM programmes with medicine would not comply with the standards set by the GMC for new curricula in that the overall programme length would exceed the maximum recommended duration - by virtue of the additional year of training required to complete IM core training. In addition the GMC have some concern as to the ability of a doctor to revalidate in 3 specialties.

However, it must be stressed, that both the Faculty of Intensive Care Medicine and the Royal Colleges of Physicians are committed to the continuation of dual training programmes for those doctors wish to pursue a career in ICM combined with renal, respiratory or acute medicine following approval of all the relevant new curricula. We are in collaborative discussions with the GMC to try to find a resolution to this issue, but these discussions are at a preliminary stage and we will update you on their progress in due course. I would like to take this opportunity to reassure any trainee currently undertaking or planning to apply for a dual training programme that this will not in any way affect you. This issue will only affect dual training programmes when these have been agreed with the GMC and does not in any way affect the single ICM CCT training programme. Currently, any necessary changes are some years off as neither the new ICM nor any of the medical specialties new curricula have yet been approved.



REGIONAL ADVISOR UPDATE

Dr Sarah Clarke
Lead ICM Regional Advisor

So, what does the RA do I hear some of you ask? I like to think we are the 2-way lines of communication from trainees in units, to training committees, Deaneries and the Faculty. We are responsible for ensuring that training and education in ICM is appropriately delegated, organised and supervised and fulfils the requirements of the CCT curriculum and is accessible to all trainees. The role carries significant responsibilities, and the Faculty relies on our activities, to provide robust assurances that its objectives are being delivered. My sincere thanks to all of the RAs who have completed their terms since the last RA article in Critical Eye, they set a very high bar, and a successful legacy for our future.

Our main meeting is the newly named (formerly the RA/FT day) Training Leadership Annual Meeting - TLAM 2020 is on 24th February. We now (as with last year) welcome the TPDs into the Faculty's education arena. We never underestimate the job and role of the TPDs, in their implementation of our training scheme, given we have multiple routes of entry and hence a complicated curriculum. As ever this year's TLAM programme will cover pertinent issues (highlighted from the RA survey and the autumn RA forum), including reports from the Chairs of Faculty Committees, and we will be privileged to welcome the new Dean, Alison Pittard, to open the day. This year will include a workshop on the 'What Makes a Good Great Faculty Tutor?' alongside the successful RA/TPD facilitated session. We have a guest speaker to give us 'oldies' understanding of the Millennials. There will be insight on the differential attainment of trainees, and the transition to being a new Consultant. No doubt a big focus will be the session discussing the implications and implementations of the new curriculum, imminently to be submitted to the GMC. And we will close the day with the popular 'Question Time'.

Recruitment season is always a busy time for the RAs, TPDs and FTs, and in March we return to The

Hawthorns in West Bromwich to recruit our colleagues of the future. As we aim to attract the brightest and best doctors to our specialty, you might be interested in the superb new resource for potential applicants, compiled by two trainees Richard Benson & Zoe Brummell on behalf of CRW. Just check the Faculty website for 'Discover ICM', or social media #DiscoverICM. This will help you direct and advise on the specialty, on recruitment and how the selection process works. Further information is also available on the Faculty and icmnro.wm.hee.nhs.uk websites. For anyone who has not been involved in recruitment before then please contact us if you would like to be involved. We need a large number of consultants to run the selection centre (and importantly from across the U.K.) and will welcome you to join the established cohort of recruiters. Of note, it is also another opportunity to network with like-minded colleagues, and sample some of the local delicacies and beverages. We have an Interviewer Training Day at the Faculty on the 25th February (the day following TLAM 2020) and it is always easier to advise trainees if you know what recruitment looks like.

I'd like to draw your attention to another recently published Faculty document: Critical Foundation. It provides a framework of real-life scenarios, ideas and information to support Foundation doctors working in or gaining exposure to critical care. It might help your Units in making a business case or application for new posts to managers, Heads of School or DMEs.

As Lead RA I must finish by saying a huge thanks and my gratitude to the 25 other RAs, who have not only supported me for the last year, but served their regions, their trainees and the Faculty so well. As always, we are keen to hear about any issues relating to training in ICM or education in general. Please get in touch, either contact your own RA or myself directly, details on the Faculty website.



SPOTLIGHT ON TRAINING: YORKSHIRE AND HUMBER

Dr Helen Buglass
Regional Advisor

The Yorkshire and Humber region offers excellent training experience to trainees in critical care. There are currently 67 trainees in the region, with a fill rate of >90%. The majority are dual trainees with anaesthesia, but an increasing proportion dual with other specialties. There are a few single stream trainees, who are well supported by the Deanery. There are several less than full time trainees. The FICM survey feedback on the training in Yorkshire is consistently excellent.

Intensive Care training in Yorkshire and the Humber is pan-Deanery. Trainees are allocated a base in the West, South or East of the region, but will spend a period of time in one of the other locations. This allows greater exposure to specialist training in Intensive Care. The exact allocations are decided on an individual trainee basis after discussion with the TPD, and every effort is made to accommodate individual circumstances.

All trainees are allocated an educational supervisor for the whole of their training. Many of the supervisors are new consultants who have gone through the current training programme, enabling them to offer practical support on negotiating the portfolio and rotations. We are very proud of our Intensive Care training programme, with colleagues participating in many national bodies. Of note, the current Dean and Vice Dean of FICM are practising intensivists in Yorkshire.

The Yorkshire and Humber Deanery can offer all of the options for the Special Skills year, with the exception of ECMO (although this can be supported if requested). In particular, the liver and renal transplant programme in Leeds is one of the largest in the UK. Pinderfields Regional Burns Centre in Wakefield provides all levels of adult burn care for a population of 3.5 million across Yorkshire and Lincolnshire.

There is bimonthly pan-deanery teaching, with all trainees being released for the day. This rotates around all the units offering stage 3 training Bradford, Doncaster, Leeds, York, Hull, Sheffield and Wakefield. Over a 2 year programme, the teaching covers all areas of the curriculum, and comprises a mixture of lectures, simulation and exam preparation.

Yorkshire is a beautiful region to live in, with a very competitive cost of living. Should you wish to visit other areas, there are good travel links including high speed rail to London, a comprehensive motorway network, and easy access to airports. However, there is plenty to keep you occupied within the region.

For the adventure enthusiast, there is climbing and caving in the Peak, walking in the Yorkshire Dales, and ultra-running across the North York Moors. Cycling has always been popular, but since the 2012 Tour de France and subsequent legacy of the Tour de Yorkshire, it is becoming ever more popular. The Brownlee brothers are from Yorkshire, and a significant proportion of ICM consultants and trainees take part in triathlons, including a number competing at national standard.

Yorkshire also has a strong cultural heritage. David Hockney was born and bred in Yorkshire, and many of his works are displayed in Yorkshire galleries. The Yorkshire Sculpture Park offers stunning walks through beautiful countryside, with installations including works by Henry Moore and Barbara Hepworth. The Northern Ballet is based in Leeds, and there are regular touring national theatre performances. Sheffield and Leeds Arena are venues for most major band tours. There is a wide variety of high level sporting fixtures, including cricket, football, both rugby codes, and horse racing.

For more information about the opportunities we offer, please contact any of the RAs or TPDs. Welcome to Yorkshire!



FICMLEARNING

Dr Peter Hersey

Chair: FICM Education Sub-Committee

On behalf of the Education Sub Committee (ESC) I'm delighted to announce that FICMLearning (www.FICMLearning.org) will launch on Monday 3rd February. As the hub for Faculty education, the site will serve several purposes. These include:

- To provide a location for our new podcasts, blogs and 'cases of the month'.
- To signpost other useful resources. The meteoric rise of free and open access medical education (FOAMed) has led to the production of an incredible array of quality resources. The FICMLearning project fits into that space so it seems very appropriate to highlight other providers. We also signpost useful books, and resources for those preparing for the final FICM examination.
- To give e-ICM a stronger Faculty identity. The partnership between the Faculty and e-learning for healthcare is a strong and productive one, but the programme wasn't as clear as it could be within the Faculty structure. By including e-ICM within FICMLearning, it should increase the accessibility of the

programme and highlight Faculty ownership.

- To make pre-existing educational resources easy to access. Various committees and groups within the Faculty have been producing excellent resources for a long time, but we know that they weren't always easy to locate on the Faculty website. FICMLearning is now the place to look!
- To provide a central registry of national educational events. We are asking for anyone organising an educational event to tell us so that we can advertise it on FICMLearning. If we can capture most events, planning CPD activity should be made that little bit easier.

This launch is just the beginning, and we fully expect that FICMLearning will evolve. In order to make FICMLearning as useful and valued as it can be, we need your suggestions and ideas.

As well as the work on this project, the ESC is working on the programme for the 2020 Annual Meeting, which will take place on Monday June 15th – save the date!

FICM Blog – Brian Pouchet, Blog Editor

The new FICM Blog is an opportunity to share ideas, updates and opinions with the wider critical care community. Initially with about one post per month, it will include interesting views and discussions on various topics pertinent to current critical care practice.

The content will be modulated by feedback from the readers, so your input will help us develop the blog into the one you find most useful. Equally, if individuals or groups wish to contribute to the blog, please get in touch.

Podcasts – Martin Huntley, Podcast Lead

It's easy to wonder why there is a need for another educational podcast series, especially when several excellent alternatives are already on offer. With this in mind, we have devoted considerable time to evolving a concept for the FICMLearning podcasts that is both engaging and relevant to the potentially diverse audience.

Whilst the contribution of evidence-based medicine to advancing critical care practice shouldn't be underestimated, it is often the assimilation of this with professional experience and a degree of pragmatism that transforms the care of our patients. As a result, we have chosen to focus on a narrative-based learning style through engaging key clinicians in conversations that frame their opinions in a way that helps us to gain a greater depth of understanding on a range of topics. We'll be starting with some truly inspirational stories from Alison Pittard, Segun Olusanya, Matt Morgan, Sarah Marsh and Rosie Baruah on what resilience means to them and how we can strive towards becoming effective and well-balanced intensivists.

We hope you will listen in, and continue to do so, as we embark on this exciting project aimed at supporting your learning and continuing professional development in ICM.

Case of The Month – Sarah Marsh, ESC Deputy Chair

Spare 5 minutes with your phone in your hand? The case of the month can be found in the 'useful resources' section of FICMLearning. Whilst primarily aimed at candidates for the FFICM examination, these short articles can be used as 'quick CPD' by anyone. Each article is essentially a summary of a topic. They're not review articles but provide the key points in an accessible format. If writing a case of the month is of interest to you, please let us know.

e-ICM – Pete Hersey, e-ICM Lead

e-ICM will take such a prominent place within FICMLearning and the wider educational strategy of the Faculty. Launched as part of a collaborative project in 2016, e-ICM has expanded as a learning resource for intensivists of every grade. Focus is not just on the basics, although it is mapped to the FICM curriculum, but also the hard to reach parts of the ICM curriculum. There are specialist topics including Medical Law and Research, and new sessions to come, such as Human Factors in ICM. e-Learning for Health also provides links to open access journals. Importantly, e-ICM isn't just a resource for trainees in ICM, but for all. We have recently launched learning paths designed for specific learner groups (e.g. nurses, ACCS trainees), and are considering how e-ICM can better fit the CPD needs of consultants.

The quality of the sessions is high and the content is comprehensive, providing knowledge and learning in an interactive and enjoyable way. The process of producing a session ensures consistency, and the content is provided by authors within their area of expertise. Although e-ICM cannot be as responsive to trending events as podcasts, blogs etc due to the development timeframe, we are always open to feedback should someone want a particular topic session or collaboration.



FFICM PREP COURSE

Dr Sarah Marsh
FFICM Prep Course Lead

Autumn came around quickly this year. Not long after the success of hosting the first London based FFICM exam preparation course in the Spring, it was time to head up to Leeds for the second course of the year.

This was the 6th Preparation Course to be held by FICM for the FFICM exam, with the event continuing to grow in popularity and success – this sitting was fully booked prior to the release of the MCQ results demonstrating a voracious appetite for help with exam preparation.

Day 1 saw new hot topics discussed alongside valued core subjects. We were delighted to host experts across a broad base of ICM to discuss the topics, which included the law pertinent to ICM, 2 radiology sessions and poisoning. Day 2 was a busy affair with 2 OSCE rounds and 2 SOE rounds spread across the day. Mirroring the “real” exam, candidates faced questions on ECGs, radiological images and data interpretation interspersed within clinical topics spanning the syllabus. Questions ranged from vascular access to mass casualties, and intestinal failure to the mental capacity act (meaning some great CPD for the examiners too).

The September sitting saw a drop in the pass rate overall for the FFICM exam from 60% to 51.6%. Our candidates had a pass rate of 57% overall with 69%

in the OSCE and 76% in the SOE (compared with 54% and 74% respectively from the national cohort)¹.

Candidates felt that the course was value for money (89% Excellent or Good) and well organised (96% E or G). Comments included “Excellent and elaborative course, fitted into 2 days. Good exam orientated exposure” and “Excellent! Comprehensive workshops and great exam practice”.

Work is now starting on the Spring 2020 sitting (April 2/3rd) to be held at the RCoA building. Topics for us to focus on will include those mentioned as requiring improvement in the latest Chairman’s report, including further work on ECGs, basic radiological reporting, lactate physiology and heart-lung interactions¹. Huge thanks go to Anna Ripley and Lucy Rowan from FICM for overcoming adversity of the highest order caused by the event venue over the 2 days, and to all the speakers and examiners without which there would be no course! Special thanks also to Paul McConnell, Jane Howard, Steve Lobaz and Sharon Moss for their tireless efforts into producing and organising fantastic resources, which make the course what it is.

1. Robson V. FICM Examination Report. October 2019. https://www.ficm.ac.uk/sites/default/files/documents/fficm_-_chair_report_-_october_2019_0.pdf

FFICM EXAM CALENDAR 2020

| | FICM OSCE/SOE Examination | FICM MCQ Examination |
|---|---|----------------------|
| Applications & fees not accepted before | Monday 6th January | Monday 6th April |
| Closing date for Exam applications | Thursday 20th February | Thursday 4th June |
| Examination Date | Tuesday 21st April & Wednesday 22nd April | Tuesday 14th July |



FFICM EXAMINATION UPDATE

Dr Vickie Robson
Chair: FFICM Examiners

The final FFICM examination has been held twice a year since 2013, and continues to be an integral part of the assessment strategy of the stand-alone ICM CCT programme, and is mandatory for all single and dual ICM trainees prior to entry into stage 3 training. It consists of a Multiple Choice Question paper (mcq), followed (if successful) by an Objective Structured Clinical Examination (OSCE) and Structured Oral Examination (SOE). I am Chair of the Board of Examiners, who set and revise the examination questions and are also responsible for the standard setting and examining in the face-to-face component. They are well-supported by the Examinations Department. At this sitting, seven new examiners joined the Board, after a full day of training. These replaced examiners who had recently retired from examining.

In July 2019, the most recent sitting of the FFICM MCQ paper, 72 candidates presented for the exam of which 79% passed. The MCQ paper continues to contain both true-false multiple choice questions and single best answer (SBA) questions, and is developing towards only SBA questions (at the request of the GMC).

The face-to-face examinations in October 2019 saw 97 candidates, of these 28 had passed one component on a previous occasion. Candidates are required to take both components on the first sitting, but if successful at one component, only need to re-sit the other.

The Objective Structured Oral Examination (OSCE) which consists of 13 stations (including one test station which does not contribute to the total mark) had 84 candidates, of whom 54% passed.

The Structured Oral Examination (SOE), which consists of 4 sets of two questions, had 82 candidates, 72% of these passed. The overall examination pass rate was 51.6% which compares to

60% in March 2019.

The standard of the examination is set at the end of stage 2 training, and the examination aims to test as wide a range of the ICM CCT stage 1 and 2 curriculum as possible, so includes those more specialist areas of curriculum within stage 2 eg cardiothoracic ICM and paediatric ICM. Relevant basic science is also tested, as well as relevant practical skills, where possible, and professionalism. Candidates can expect to be examined on some of the very wide range of conditions which might present to an ICU doctor, from those seen commonly to more rare conditions. Some candidates appear unprepared for the breadth of knowledge required; the curriculum can be used as a guide, and there are sample question on the FICM website. Chair of Exams reports on previous exam sittings (also on FICM website) highlight areas where a number of previous candidates have struggled.

Nine visitors (all UK ICM consultants) were present at the October oral examination. They watched examinations in progress, and were able to observe questions being asked and answers being scored. They commented on the fairness of the exam, and the standard of questions was as they expected. Visitors appreciated seeing how the exam is run, and felt this would help when guiding their trainees and their presence is part of the openness of the process.

In September I represented the Board of Examiners at the Diplomates Day, where recent successful FFICM candidates were awarded their diploma and presented to the Dean. I was delighted to present Stephen West, the winner of the FFICM 2018-19 prize, and to congratulate him on his achievement.

The next exam is Spring 2020 when we expect to need to utilise three days for the face-to-face component, as the number of candidates in Spring has increased year-on-year.



PROFESSIONAL AFFAIRS AND SAFETY

Dr Peter Macnaughton

Chair: Professional Affairs and Safety Committee

As mentioned in the last update, an audit tool is being developed for individual units and organisations to undertake a self-assessment against the standards and recommendations contained within GPICS Version 2. To ensure consistency in response between units, it is essential that there are clear criteria that define compliance with each of the standards. It is planned that the audit tool will be available early in the New Year and we hope that units will allow their data to be shared anonymously, in order that we can build a picture of compliance with GPICS nationally. This will be important information that will inform future changes to GPICS.

Work is continuing in a number of projects relating to airway management in ICU. Recognising the increasing and key role of ACCPs in the staffing of many units, the Faculty supports the principle that ACCPs should be able to gain advanced airway skills. The committee will be working with the ACCP subcommittee to develop an optional training framework to gain these skills as an additional module.

At the last meeting of the committee, it was clear from those present that there are significant

variations in local airway management such as the use of subglottic drainage tracheal tubes and in the conduct of extubation. It was felt that these would be appropriate areas to develop evidence/consensus based guidance. To assess current practice nationally, a survey is being planned, the results of which will be used to guide the development of any future guidelines. I would encourage all units to contribute in order that we get a true picture.

In this edition of Critical Eye, the key lessons from a death that occurred during the transfer of a critically ill patient are shared (see page 44). The Faculty became aware of this incident through a coroner's regulation 28 letter. We are keen to share more lessons from adverse incidents and not just from those that have resulted in a death and have been highlighted by a coronial investigation. We plan to develop a regular safety newsletter and would encourage units to submit a summary of the outcome of any investigation into a local incident that has lessons that may be relevant to all.

A FRAMEWORK FOR IMPROVED COLLABORATIVE WORKING BETWEEN EM AND ICM: 6 MONTHS ON

Dr Liza Keating

Working Group Chair

As we move into winter, the new season brings with it:

- a new Dean here at FICM and a new President at RCEM.
- the completion of the joint project aiming to achieve a more consistent standard of care for the sickest patients in the Emergency Department.

Six months on from the launch of the working party to undertake this piece of work we are almost there having reached a consensus on a number of important issues. It is readily apparent that the need for such a document has not gone away.

Winter pressures are very much upon us; declining hospital performances around ED targets are now the norm. Some might say that the unrelenting pressures never really went away and indeed 12-hour bed breaches seem to have become commonplace. Never has there been a more appropriate time to provide some guidance in the management of the care of patients in the resus room.

Having reviewed the literature the working party have reached consensus in a number of key areas. The document is divided into three sections: processes, staffing and training, and equipment. The focus is very much on looking in some detail at the process of care for critically ill patients in the resuscitation area. The team have concentrated on matters relevant to patients, their families and the teams looking after them using GPICS 2 as the foundation for the framework.

With processes being targeted, the team have arrived at relevant best practice recommendations on the need to minimise delays to definitive treatment and promote timely admission from

resus to the ICU. The focus is very much on the patient and their families, emphasising the need for a clear communication and patient centred care.

The document stresses the need for senior staff to be involved with decisions around transfer of patients at both ends of the journey. A number of recommendations have been made with regards to the training needs of the staff along with the need for greater governance around the process. Indeed the need for greater scrutiny and shared learning for both the EM as well as the ICM team around the care of this group of patients has been highlighted.

Perhaps more controversial are the recommendations made around both medical and nursing staffing levels in the resus room. Although in the light of recent reports recommendations may well not be currently achievable, it may be hard to argue that such staffing levels and seniority are not required for the undifferentiated spectrum of patients presenting to the resus room.

The final section focuses on equipment and highlights the need for standardisation of kit between the resus room and the ICU. As it draws to a close the report stresses the need for training in the use of such kit and emphasises the need for such kit to be maintained by appropriately trained staff.

As this document enters the final stages and is about to go out for stakeholder review it is important to remember that whilst some of the recommendations maybe aspirational and currently unachievable few will deny such a document is required.

References

https://www.rcem.ac.uk/docs/Workforce/RCEM_NHSBN_Staffing_Report_09-2019.pdf (accessed 26/11/2019)

INCIDENT ALERT - OXYGEN CYLINDER DISCONNECTION DURING TRANSFER



Prof Gary Mills

FICM Professional Affairs and Safety Committee, Safety Lead

Critical care patients who are being transferred are at potential risk from many sources. A recent incident involved the disconnection of a ventilator from the oxygen cylinder which was being used for the transfer. This may have been due to a failed insertion of the oxygen probe into the supply. The disconnection was not detected even though capnography was in use and alarms were set and the staff involved were senior and had received transfer training. This resulted in desaturation, followed by a cardiac arrest leading to a fatality.

The ICS/FICM guidelines on the transfer of the critically ill patient and GPICS V2 both discuss transfers of the critically ill^{1,2}, emphasising the need for visibility of ventilators and monitoring. It is essential to check that all is functioning correctly, especially when a change has been made. The coroner in this case highlighted the need for a tug test when changing cylinders and oxygen connections³. The local network checklist now includes an explicit check: “Transport ventilator securely connected to portable oxygen supply and adequate ventilation confirmed.” The staff involved raised the potential risk of using capnography within the ventilator in situations where the screen might not always be prominent enough and

suggested that some separate capnographs might be more visible and would have a separate alarm. The incident illustrates the need for consistent and systematic observation and rapid response to issues, even in difficult or unfamiliar situations and in this case ensuring that oxygen is always flowing.

Although not key features in this case, the need for adequate reserve and preparation in all airway, oxygen and ventilatory aspects is vital for a safe transfer. This includes a suitable supply of oxygen with enough capacity to more than comfortably cope with complexities and delays. An alternative means of ventilation including a self-inflating bag and suitable connections are also essential as is immediate access to equipment to deal with a loss of airway⁴.

Key points:

Tug test, alarms set and audible, clearly visible screens, alternative means of ventilation immediately available. adequate oxygen supplies.

References:

1. Guidance on: The transfer of the critically ill adult. FICM and ICS. 2012
2. Guidelines for the provision of intensive care services. Edition 2. GPICS 2 June 2019. <https://www.ficm.ac.uk/standards-research-revalidation/guidelines-provision-intensive-care-services-v2>
3. Checking anaesthetic equipment 2012 AABGI safety guideline. Anaesthesia 2012; 67: 660-68. <https://anaesthetists.org/Home/Resources-publications/Guidelines/Checking-Anaesthetic-Equipment>
4. Major complications of airway management in the United Kingdom. 4th National Audit Project of the RCOA and The Difficult Airway Society. March 2011.





QUALITY IMPROVEMENT

Dr Irfan Chaudry

FICM Professional Affairs and Safety Committee, QI Lead

The quality improvement recipe book from the Royal College of Anaesthetists is to be published later on this year. Previous editions of the audit recipe book included suggestions on topics for audit in intensive care.

The focus for this year is on quality improvement projects using specific techniques in QI. The recipe book starts with a useful chapter in QI methodology and I would highly recommend it for those that are new to QI techniques. The Faculty was invited early in the year to oversee a chapter dedicated to QI topics in intensive care medicine. As part of the process suggestions for topics were invited from faculty members and edited to a standard template. The intention is that each topic is relevant to our daily practice in intensive care up and down the country. Each project should be easy to understand and perhaps more importantly practical to complete on a busy intensive care unit. I would encourage all colleagues to incorporate QI as part of "business as usual". The ICM section in the recipe book will provide a useful resource to help start projects and also provide suggestions for further improvement topics. A huge thank you must go to all the contributors who took time out from their busy clinical schedule.

It became clear very quickly that there is a huge depth and breadth of QI projects of interest to faculty members. Unfortunately not all project suggestions could be included in the recipe book due to the sheer volume.

The FICM Professional Affairs and Safety Committee is planning to provide an online QI resource for all clinicians and the wider multidisciplinary team within ICM. This would include an online library of suggested QI topics relating to day-to-day practice within intensive care units. The suggestion for topics and the library will be an ongoing process

contributed to by the wider critical care community including nursing and AHP colleagues. We would like to include individual units' stories on how they complete QI projects with 'top tips' and any pitfalls encountered. This could be provided in the form of written stories or as video blogs. The QI resource will be within the current FICM webpage and have links to various patient's safety groups and examples of QI initiatives from other relevant industries.

We will be looking shortly for contributors to build the QI library and your input will be essential. Further instructions on how to contribute will follow.





LEGAL AND ETHICAL POLICY UNIT

Dr Chris Danbury

Chair: Legal and Ethical Policy Unit

We have welcomed Drs Sonya Daniel, Monika Beatty and Ian Thomas onto LEPU. We're sad to see Dr Rosie Baruah step down, but delighted to see her still at the Faculty, on the Women in Intensive Care Medicine Committee (@WomenICM). LEPU wish her all the best.

The Midnight Law series has commenced since the last Critical Eye. This can be found on the FICM website. It is not intended to be legal advice, but it is hoped that Fellows will find it useful when presented unexpectedly with a tricky situation relating to legal or ethical matters. We have decided to limit the content of each topic to 1 side of A4 only. This should make the key points easy to locate. If more reading is needed on any of the subjects there is a great deal of available material available from your hospital library, or local School of Law. So far we have published:

- **Relatives Recording Conversations**
- **Disagreement on Best Interests (England and NI)**
- **Disagreement regarding the treatment of patients who lack capacity (Scotland)**
- **Police Access to Critical Care Patients**



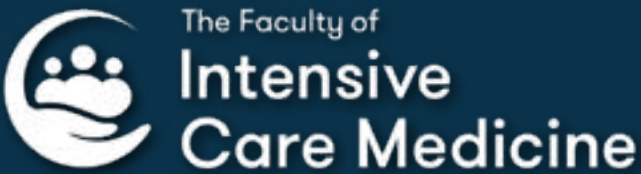
We're keen to develop this series further, so please let the Faculty know of any suggestions. Also, this could be a project for Registrars. All submissions will be reviewed by FICM before publication, to ensure usefulness and accuracy.

Anything longer than 1 page will be politely declined with suggestions how to edit down!

Finally, as there are no major cases to discuss, a few thoughts on decision making on ICU. Emergency treatment is an exception from the otherwise absolute requirement to have a patient's consent. Question is: Where is the boundaries for emergency treatment? When is it no longer an emergency setting / when is consent needed? This is not clear – is the resuscitation period the emergency or the entire ICU stay? When the emergency is over, then following the Mental Capacity Act 2005, we have become used to the concept of making decisions in the 'best interests' of our patients. But is that the correct metric? In my experience, we often conflate medical best interests with a holistic approach to the patient's best interests. Best interests, as a concept, are frowned upon by the United Nations Committee on the Rights of Persons with Disabilities¹, the expert body that oversees the Convention on the Rights of Persons with Disabilities (UNCRPD), a convention which the UK ratified some 10 year ago. The Committee says that states, including the UK, must take action to develop "*laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences.*" So should we be discussing will and preferences rather than best interests? For my part, I find this an easier concept and recent case-law suggests that we may be moving in that direction. I would recommend reading Lucy Series Blog on the subject.

References:

1. <https://thesmallplaces.wordpress.com/resources-on-legal-capacity-and-the-united-nations-convention-on-the-rights-of-persons-with-disabilities/new-to-the-un-convention-on-the-rights-of-persons-with-disabilities/>



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