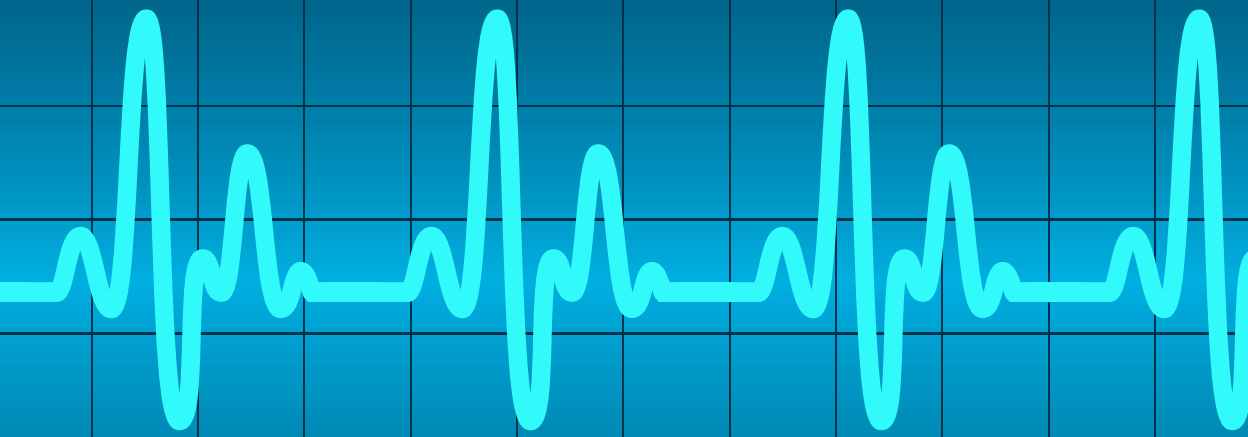


Critical Eye



Issue 12

Summer 2017

The Faculty of Intensive Care Medicine

Inside:

» NCEPOD

» Social Media in Training

» Women in Intensive Care Medicine

» Careers, Recruitment and Workforce

Welcome



Dr John Butler
Clinical Editor

Welcome to the summer edition of Critical Eye. The last few months has seen an unprecedented series of tragic national events ranging from acts of terrorism in Manchester and London, to the horrific fire at the Grenfell tower. Our sincere condolences go out to all those affected by these incidents and their families. The response from all the emergency services, including the multi-disciplinary teams working within Intensive Care units, was exemplary under very difficult circumstances. The NHS responded with bravery, professionalism and compassion and has rightly received widespread admiration for the care provided to the victims and their families. Undoubtedly there will be lessons to be learned from these events and our intention is to produce a number of relevant articles in the next edition of Critical Eye.

As the Faculty enters its 7th year work is already underway on the 2nd edition of GPICS. The board received an encouraging response to the recent request for comments regarding the next version of GPICS. Information on all these recent developments can be found in the subsequent articles. This edition also includes updates on the GMC implemented changes to curricula incorporating generic professional capabilities, the creation of the safety section on the FICM website to share learning from local safety incidents, the use of FOAMed in medical education and details of the new ICM trainees contract which starts from August this year.

In May the Faculty hosted the Annual Meeting entitled 'Hard Cases or Bad laws' in London. Topics covered included: death from the perspective of HM Coroner, overviews on the role of the court of Protection, mediation and its place within the clinical setting, and experience of clinical negligence claims. Baroness Illora Finlay outlined why care at the end of life matters and gave us further insight into why the House of Lords consistently rejects the assisted dying legislation. Thanks to Dr Bryden and her colleagues the event was a sell-out and a great success. I look forward to next year's event with anticipation. We welcome any ideas for future articles. Please send your comments to ficm@rcoa.ac.uk.

Contents

Dean's Statement	4
Recruitment & Workforce	6-7
Careers	8
Regional Workforce Engagements	9
Women in Intensive Care Medicine	10-12
Speech & Language Therapists	13
Advanced Critical Care Practitioners	14-15
What is NCEPOD?	16-17
NCEPOD: Acute Pancreatitis	18
Training in a Smaller Unit	20
Smaller & Specialist Units	21
Training & Assessment	22
Regional Advisors	23
Spotlight on KSS	24
Trainee Update	25
Transformation & Leadership	26-27
Social Media & #FOAMed	28
FFICM Examination	30-31
Professional Standards	32
AHP Competency Framework	33
Legal & Ethical Policy Unit	34
2017 Annual Meeting	35

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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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Dean's Statement



Dr Carl Waldmann
Dean

This is my 2nd article in Critical Eye since becoming Dean; the time has flown. Recent months have been overshadowed by the events in Manchester, London Bridge and Grenfell Tower. Our heartfelt condolences go to all those affected by these awful events. What these events did bring home is the amazing work of all the emergency services in an already overburdened system, including the staff of the numerous critical care units involved. Many of our colleagues working on the units that received casualties may never have seen such awful injuries before and would hope never to see such devastation again. I have recently received a letter of support from the Dean of the Joint Faculty of Intensive Care Medicine of Ireland, Jeanne Moriarty. She wrote *"As an intensivist working in a Burns Unit I really understand the months and years of work that will be required to try and return as many survivors as possible at least to a functional life. I do not know how patients, their families and the wider medical community caring for patients in these circumstances can ever return to life as it was before this horrific event. The resilience of Londoners I legendary. I have seen it at first hand there between the Westminster and London Bridge attached, but his is reminiscent of the Blitz."*

Many changes and announcements affecting us have been delayed until after the general election. It remains to be seen how the result affects plans for the health service. One announcement I can now make is the appointment of Anna Batchelor as GIRFT representative starting in September, so please expect a visit from Anna in the next year.

On 5th May I attended the ceremony for the award of Diplomats in Westminster Hall. 34 Successful candidates from recent FFICM exams received the

Fellowships; I was a very proud man standing on the stage in this great auditorium with the successful diplomats in front of their families.

The Faculty hosted a successful sell out Annual Meeting on Legal and Ethical issues. During this meeting we were able to honour the great work of Dr Chithambaram Veerappan, who received FFICM by Election in the presence of his family, and Dr Louis Plenderleith who received a Faculty Commendation for his work developing the ICM e-Portfolio. Dr Tom Gallacher was also awarded a Faculty Commendation at an FICM Board meeting earlier this year for his work setting up ICM National Recruitment.

The UK Critical Care Forum hosted its meeting at Birmingham University on 8th and 9th June and what a wealth of research projects were on show. This was followed the next day by the annual ACCP Conference, again a sell-out and a testament to the hard work of the ACCP Sub-Committee.

The work on Critical Futures is nearing completion and will be published shortly. It is a modern version of Comprehensive Critical Care published in 2000 and we look upon it as the Faculty's manifesto for the future of our speciality. We are also looking forward to the NICE Quality Standard on Rehabilitation after Critical Care being delivered in the autumn, and the multidisciplinary document on Maternity Critical care should follow soon after. GPICS Version 2 is being written as we speak with a publication date of summer 2018.

The Faculty is now in its 7th year and is well established and progressing; I cannot underestimate the excellent work of our Head of Faculty, Daniel and his colleagues. They are key to our future

2018 FICM Annual Meeting

Thursday 24th May 2018

MIND THE GAP

Venue: Royal College of Anaesthetists, London

Registration fee: £180 (£100 for trainees and nurses)

CPD Credits: 5 (anticipated)

Our 2018 Annual Meeting "Mind the Gap" focusses on health and wellbeing and how to sustain a lifelong career in Intensive Care Medicine. A number of topics have already been secured including:

- **Work life balance involving interesting hobbies**
- **Identifying stress related illness in health professionals**
- **Developing strategies to manage stress**

There will be a healthy debate after lunch and, once the programme is finalised, CPD points will be applied for. This is the start of what we hope will be an exciting project to explore different ways of working in our specialty.

Look out for updates at: www.ficm.ac.uk/ficm-events/ficm-annual-meeting



The Faculty of
Intensive Care Medicine

Recruitment and Workforce



Dr Daniele Bryden
Chair
Careers, Recruitment &
Workforce Committee



Dr Jack Parry-Jones
FICM Workforce Lead

“Physician, heal thyself” (Luke 4:23)

Do you cross the road when you see someone in the street with a clipboard, or immediately delete those “5 minutes of your time” surveys that pop up on webpages? We have, and while we’re at it we can confess to not having completed many of the assorted questionnaires mailed out to us at work. We believe however that the Faculty’s Workforce Census has to be different. We would encourage you to please think again, and spend

that little bit of your time completing it. We believe it is worth it, and hope that you too can see this from the recent summary of previous survey responses sent out from the Faculty. If you are concerned with issues like resident unit cover, increases in the amount of time you spend in work, and the effect on your health, then this census should really matter to you. It also matters for the future of those coming into

the specialty. In CRW we get a broad glimpse of the workforce issues but the data submitted to date is patchy at best. Since 2014, the annual Workforce Census has been completed by around 40% of you as registered Faculty Fellows. We appreciate there has been a growing frustration regarding the structure of the survey, and we want to do something about making it easier for you to give us information.

For CRW and the Faculty to be effective for you, we need to demonstrate what is happening to the critical care workforce. All specialities have their

own workforce issues so it isn’t enough just to say we have a problem in critical care when we compete for attention with Emergency Medicine, General Practice etc. If we want a bigger piece of the pie we need clear evidence of why when we put forward our case. This is especially so if we also don’t want to deplete Anaesthesia rotas of trainees as has been happening in some regions. We need robust data to support our arguments. CRW can’t work with you to produce solutions to problems which we can’t properly quantify for lack of data, especially when

other specialties can. The data alone won’t provide solutions but we believe it will demonstrate the scale of the issues, and provide a real and more effective impetus to implement effective change. We will seek to prioritise what you believe is critical for the workforce of the future.

“A career as an ICM consultant needs to be visibly sustainable, enjoyable and be a good lifestyle choice. The days of ICM as the preserve of the workaholic are gone...”

Regional workforce engagement events show that the issues are varied,

and you would welcome assistance from the Faculty with more detailed information on how others have solved the same problems that you too face. For example, CRW will shortly share with you some real, but anonymous workplace job plans through the Faculty website. We need to understand each other’s problems and solutions. Solutions that some have put in place (or felt compelled by circumstance to put in place) e.g. consultant resident on-call, Advanced Critical Care Practitioners (ACCPs), a non-anaesthetic trained junior tier, physician assistants etc may not all be

solutions may help others avoid some pitfalls and find workable solutions for themselves.

Staffing is complex and multi-factorial: the number of people on a rota and their competencies must be linked to local service demands. Encouraging trainees to take up ICM and ensuring they stay is vital: it is soul destroying providing high quality training on a unit only to be told that people won't apply for ICM because other specialties offer 'a better lifestyle'. For consultants facing an increasingly long career, the frequency of on-call, coupled with the nature of it and the impact on personal and family life is very important. A career as a consultant in Intensive Care Medicine needs to be visibly sustainable, enjoyable and be a good lifestyle choice. The days of ICM as the

preserve of the workaholic are gone, and the CRW and its 'Women in ICM' (WICM) Sub-Committee will lead the way in demonstrating sustainable alternatives to this model.

From 2018 the annual workforce census will be different. We plan to run with fewer, easier to answer generic questions but in addition we will target specific areas related to workforce wellbeing e.g. resident medical cover, fatigue, burnout, etc. Your comments are always very welcome but we specifically ask that you let us know those areas where you feel the CRW Committee should target future census questions. "Physicians, if not heal thyself - at least help thyself".

Consultations: Summary FICM Responses

NICE Quality Standard: Sepsis

April 2017

Extracts taken from comments sent to NICE

- Structured set of observations: There is no need to record an extra mandatory set of obs; clinicians will have already asked for a NEWS and it is all in the NEWS. In addition the over emphasis on skin changes and integrity comes at the risk of ignoring important abdominal/chest signs which are some of the most common causes of sepsis.
- Senior decision makers: It is unclear still who this might be. It refers to an Advanced Nurse Practitioner who may have prescribing responsibilities, yet all F1/2 trainees and all CT1/2 trainees have prescribing responsibilities.
- Antibiotic treatment in under 1 hour of identification: Whilst it seems intuitive and prompt antibiotics should be given, the prospective evidence available for outcome and timing of antibiotics does not suggest it has to be given within 1 hour, but merely within the first few hours. There is no mention in this section of blood cultures being taken – why is this? Surely it is an important part of this package of treatment and there is no mention of source control, which has a strong evidence base.

NICE Quality Standard: Trauma (Topic Engagement)

June 2017

5 key areas for quality improvement.

- Recognition of major trauma in the elderly: delays in recognition often result in inappropriate management, poorer outcomes and higher health and social costs.
- Management of major trauma in the elderly; Many elderly patients experiencing major trauma are managed at the hospital of first admission. Comparing the management of these patients in a Major Trauma Centre C vs a trauma unit would help determine whether such patients are best managed locally or transferred to a Major Trauma Centre.
- Delays in access to rehabilitation and inappropriate repatriation: Delays in access to rehabilitation units can lead to inappropriate occupation of acute beds.
- Access to pre-hospital medical care: There is a lack of quality evidence as to the value and cost-effectiveness of pre-hospital medical care. Increasing amounts of third sector funding and senior clinician time is committed to the provision of pre-hospital medical care.
- Prevention: Improvement in the quality and effectiveness of injury prevention programmes especially among the elderly are overdue. Without changes to the number of patients who sustain major trauma, the costs for associated healthcare are only going to increase.

Careers



Dr Jonathan Goodall
Careers Lead

In my last careers update I described how the FICM Careers Sub-committee, in its attempt to best support the careers of intensivists at all stages of training, had identified four key areas for career support. This work has now been moved to the newly formed 'Careers, Recruitment and Workforce' (CRW) committee. The new Committee quickly realised that these four key areas are only loosely associated with the stages of a career in ICM. As part of the overall strategy to work across a career in ICM, we have refined our initiatives to describe a plan which better aligns itself to the stages of a career in ICM. These stages are:

- Choosing a career in ICM
- Training in ICM
- Managing a career in ICM
- ICM Consultants and Professionals

Danny Bryden and I presented these ideas to Faculty Tutors and Regional Advisors at a workshop in March 2017. Our plans received very positive feedback, along with some ideas for what should be included. Taking this response as evidence we are on the right track, we have started to implement our plans. The careers section of the FICM website is being developed to mirror these ideas.

This is a big project which will take time: we want to have some things ready for use quickly, so we have had to prioritise. As we are rapidly approaching the time when trainees are considering the next stage of their careers (they'll be applying for training programmes in November and January) so we decided that preparing resources to help with 'Choosing a Career' should be one of our first tasks. This section of the website, which will 'go live' summer 2017, includes information to help those trying decide whether a career in ICM is right for them, along with resources

to support for those guiding them in their choice. This information will come under the following headings:

- What is ICM?
- Recruitment to ICM
- Career stories (from trainees and consultants in ICM)
- Making your decision - should I choose a ICM?

The information is presented in a variety of formats: written reports, 'bite-sized' presentations, links to other websites and papers of interest. Of particular note, we've been able to include a downloadable version of 'ROADs to Success'¹, an invaluable guide for trainees and those helping them to prepare for career choices and interviews, which has been made available to the FICM by KSS Deanery. I have used this book for many years, both to help the trainees, and to help me guide them effectively; I'd recommend it as essential reading for anyone involved in the training and career guidance of colleagues.

Other areas CRW is prioritising include those on well-being and burnout, the sharing of job-planning and consultant rota ideas, and the development of an 'on-line' career day for medical students and trainees. We hope that by the autumn there will be something to help all members of the FICM.

We can only judge if we have got things right (or if things are missing) by having your feedback and ideas for the future. Please have a look at the resources and let us know what you find helpful, if you would like anything else to be included or if you would like to see any changes. We want this to be a useful, current and appropriate resource so tell us what you think!

Regional Workforce Engagement: North West



Dr Sarah Clarke
Regional Advisor

After a year in the planning, Friday the 17th March saw the Regional Workforce Engagement Meeting come to the North West region.

The aim of the engagement events has been to involve and engage all stakeholders within a region, to explore their current and future workforce needs. This is in an effort to balance the service delivery requirements with provision of quality training and trainee numbers to ultimately produce the correct workforce of the future. But why? We already have national data, with the FICM Census, CfWI in-depth review and ICNARC reports. Well, the fact is that different areas of the nation have differing needs and particular local circumstance. An easy option would be to pluck out of the air in a 'guesstimation' exercise. However, with the help, support and plenty of cajoling and emailing by the Faculty, we painstakingly gathered some more harder facts, at least of our current position, and proposed individual units' needs and requirements for the future. Every unit submitted data prior to the day and a region-wide survey was repeated, centering on workforce needs 5 years hence; a staggering 80-100 new consultants required is the headline!

The North West region is now a 'super-deanery', with Mersey and North West LETBs combining; we now have two Training Programmes in one School of ICM, 85 trainees, and 30+ units spanning three Networks. I was delighted therefore, that

with super coordination and collaboration, we saw over 50 people attending, from almost every ICU in the region, including Faculty Tutors and Clinical Directors. There was representation from HR, workforce managers from Health Education North West, the Deputy Dean, Clinical Network Leads and Lead Nurses, and finally the two STCs, TPDs and RAs.

The discussions may not have yielded any light bulb moments, but with sharing and recognition of similar problems, local solutions, innovative rota ideas, and creative workforce strategies, I believe we emerged from our event in a stronger position. Particular lively debates included ACCPs, GPICS, centralisation of services and reconfigurations based on the Manchester Healthier Together framework, stress and burnout. A summary of the day concluded that we need to continue to go collaboratively forward, to attract and recruit, and to retain. Most importantly though, the recognition that locally, regionally and nationally, we cannot continue with traditional staffing strategies alone. For many, it was an additional ideal networking opportunity between our region's colleagues.

My thanks go to Jack, Dawn, Susan and Daniel at the Faculty for their determination and commitment to visit the North West, and enabling the whole event: I hope the respective journeys home saw better weather at the end of the train line!

YORKSHIRE & HUMBER

The 4th Regional Workforce Engagement Event took place in Leeds in November 2016. The report has been published on the FICM website and is available here: www.ficm.ac.uk/local-engagements/reports



Women in Intensive Care Medicine

In 2017 we will hold the first meeting of the WICM Sub-Committee. This group was created to provide representation of women in all areas of ICM and highlight any key areas of Faculty consideration and discussion. Below is an introduction to the Faculty's newest group.

Dr Daniele Bryden (Chair) Consultant in ICM and Anaesthesia, Sheffield

When I was elected to FICM Board last year I was the only woman standing for election, despite the fact that there are a significant number of women working in ICM in management, educational, research and leadership roles. Work from the corporate sector has shown that engaging women directly makes sound 'business' sense and the Faculty was losing out on valuable information that will potentially benefit the whole workforce. I'm delighted that Faculty Board fully supported this initiative which it's hoped will be the start of an additional form of engagement with Fellows and Members. I work in adult ICM in Sheffield, and as Chair of the Faculty's Careers, Recruitment and Workforce (CRW) committee will be providing support to the group as well as taking some of their suggestions through into other CRW workstreams.

Dr Stephanie Cattlin Locum Consultant in Critical Care, London

I am a locum consultant in critical care with a special interest in major trauma, at Imperial College Healthcare NHS Trust. I was one of the first trainees to complete the 'new' dual CCT programme in intensive care medicine (with anaesthesia). Outside of my clinical practice my primary interest is education. I am currently completing my Postgraduate Certificate in Medical Education, and am a founding faculty member of both the London FFICM course and ISA Final FRCA Viva Course. With the number of female medical school graduates at 60%, ICM currently has a trainee cohort that is only 35% female. Additionally we work in a specialty blighted by burnout. We need to encourage more women to join ICM, support our current colleagues and friends, encourage their development, and protect their mental and physical health to ensure the sustainability of our specialty – that or face a dearth of intensivists in the future.

Dr Rosaleen Baruah Consultant in Critical Care and Anaesthesia, Edinburgh

My name is Rosie Baruah and I am a consultant in critical care and anaesthesia at the Western General Hospital in Edinburgh. My interests include critical care ultrasound, medical law and ethics and I am our unit's Faculty Tutor. I joined the WICM Sub-Committee as I feel strongly that being a woman or having caring commitments should not be a bar to a successful career in ICM. As a member of WICM I would aim to promote ICM as a female-friendly specialty to women in all stages of their medical training, from undergraduate level upwards. I also hope to collaborate in the development of mentoring and networking opportunities for women in ICM, similar to those developed by the Women in Surgery (WinS) network.

Dr Helen Cole
Trainee in ICM and Acute Medicine, South West

Having trained through the ACCS Acute Medicine route and spent some time working abroad, I've now landed in the beautiful South West Region as a dual ICM and Acute Medicine trainee. I'm hugely excited to be a part of the WICM Sub-Committee and looking forward to representing trainees' needs. I'm keen to hear of the breadth of experiences and challenges encountered by female trainees and anticipate that LTFT training will be a particular area of concern. By setting up a mentoring scheme I hope that we can support female trainees through their careers, and encourage women to achieve their ambitions within ICM. I know that the WICM group is full to the brim with ideas for change, so it will be an exciting time to see what emerges and develops.

Dr Sarah Marsh
Consultant in Anaesthesia and ICM, Harrogate

I obtained a Joint CCT in Anaesthesia and Intensive Care Medicine in 2012 and my current job plan is full time, split between anaesthesia and intensive care. I am the Clinical Lead for our Critical Care Outreach Service and for Organ Donation within the trust. In addition to my clinical roles I have a great interest in medical education; I have been involved with teaching courses for the final FRCA for a number of years now, and am currently the course director for the FICM's exam preparatory course. I am also the Deputy Clinical Lead for e-ICM. Like most women in intensive care medicine, I work within a male dominated department. I am incredibly fortunate to work with the guys as they are supportive, innovative and industrious. Being female however, I hope that I bring something different to the table (or ward round). There aren't many of us, but it has been due to the help and guidance of few influential women in my professional life that I have been able to achieve what I have today. I owe them a deep debt of gratitude for advising, encouraging and supporting me throughout my career. From this I have developed a sense of responsibility and determination to pass this on to others, and becoming part of WICM is another stepping stone to achieving this.

Dr Nish Desai
Trainee in ICM, London

I am a ST6 single ICM Trainee in London, one of the first batch of us! My special interest is echocardiography in the critically ill and I enjoy mentoring an ever-growing list of colleagues to help them gain FICE accreditation. My other passion is Medical Education; I am involved in organising some fascinating meetings as a trainee representative for the Critical Care Section of the Royal Society of Medicine and a director for the 'Practical Introduction to Intensive Care' course at UCLH. In addition I am currently undertaking a Masters in Medical Leadership. I am also interested in widening access to medicine and volunteer with the Social Mobility Foundation, with whom I run a program for A-Level students. As part of an ever growing body of female physicians in Intensive Care I'm excited to be part of WICM. I'm proud to be part of a specialty that acknowledges the contribution of women to medicine and acknowledges the need to address issues that prevent it being a sustainable career path.

Dr Aoibhin Hutchinson
Consultant in ICM, Belfast

I have been a Consultant for seven years, working in the Regional ICU, and I have been Faculty Tutor for three years. I have an interest in ethics, legal aspects of medical care and safety. I am interested in working with the WICM group to help secure a strong future profession, which I feel means taking steps to engage young doctors early, both during undergraduate training and in the first few years practicing medicine. We need to continue to safeguard a high quality training programme in ICM, to continue to attract and retain the best trainees for our specialty. We need capable doctors to want to be part of ICM. Female Consultants are still a minority in our intensive care units and we need to address the reasons for this, both in terms of equality but also to secure a future workforce, as the majority of medical graduates are now female. Recruitment and retention of well trained doctors of all genders is essential to maintain high quality care in ICM and to develop the specialty in the future.

Dr Kathryn Naylor
Consultant in Anaesthesia and ICM, Oldham

I am a consultant in Anaesthesia and Intensive Care Medicine at The Royal Oldham Hospital, part of Pennine Acute Hospitals Trust. I am a member of our regional intensive care airway safety group and a Faculty Tutor. I have two daughters and spent three years of my training working less than full time so I understand how rewarding it can be. I believe all staff should have the confidence and opportunity to find a work life balance that works for them and adapt it as they progress through their careers. Over 50% of medical school graduates are women. Our workforce is by far our biggest asset as a speciality. I hope the WICM group will help us lead the way in career development to support doctors choosing ICM as their career.

Dr Manni Waraich
Consultant in Neurointensive Care and Neuroanaesthetics, Southampton

I was appointed a consultant in Neurointensive Care and Neuroanaesthetics at University Hospital Southampton in 2016, having trained at St George's and KSS. I left medicine for 10 years to raise my two daughters, moving from St Albans to San Francisco and finally Sydney. I worked for eight of those years in mergers and acquisitions and completed the Warwick MBA. When the financial markets collapsed in 2008, I could luckily return to anaesthetics and ICM to support my family. The senior female executives I worked with in Sydney, set up mentorship networks to support more junior female colleagues, as well as creating a platform for learning and collaboration. During my time as KSS ICM trainee representative, I used that spirit of support to encourage junior female colleagues to continue with their ICM dreams, citing my own rather unusual roundabout training pathway. I look forward to working with the committee to build on that spirit of support and develop a mentorship network for present and future women in ICM.

Dr Suzy O'Neill
Consultant in Anaesthesia and ICM, Newcastle

I am a consultant working in anaesthetics and intensive care at the Freeman Hospital Newcastle upon Tyne since 2009. I am the HEE-NE Training Programme Director for Acute Care Common Stem (ACCS) and Intensive Care Medicine. I am also a trained coach and facilitate resilience workshops for trainees. Outside of work I am a carer for my father who has a history of progressive multiple sclerosis, Parkinsonism and vascular dementia. My experience as both a carer and a full time consultant has been full of challenges! But it has also given me opportunities to learn what support is available for carers, raise the profile of carers' needs in the work place, and explore strategies to ensure my own well-being and delivery of safe patient care. Ideas I am keen to develop as part of WICM include an on-line platform for sharing of stories, experiences, resources; and establishing a mentoring network between colleagues.

Dr Nia Williams
Trainee in Anaesthesia and ICM, Wales

I'm Nia Williams, a dual trainee in Anaesthetics and ICM in Wales. I've been asked numerous times why I want to do ICM. Many people still believe ICM is male dominated and a difficult environment to work in. The reality is, ICM is an advancing, exciting and dynamic speciality. I'm lucky enough to work with incredibly supportive colleagues and seniors that go that 'extra mile' to teach and help me. However, there does seem to be a perceived gender bias associated with ICM. Myths that need to be dispelled! We strive for high-quality care for our patients and a good working environment. To facilitate this ICM needs to recruit trainees and consultants, male and female, who strive to improve the speciality. WICM could be an amazing opportunity to encourage and support women within ICM, and those hoping to pursue a career in ICM. Exciting times lie ahead!

Spotlight on: Speech and Language Therapy



Corinne Gaston
Specialist Speech and Language
Therapist

Speech and Language Therapists (SLTs) work within the multidisciplinary team (MDT) with patients of all ages who are experiencing swallowing (dysphagia) or communication difficulties. The broad aims of the SLT in critical care are to minimise the risks of dysphagia to the person, maximise the person's potential through rehabilitation and enable patient-centred care as a method of care delivery by supporting communication between the patients and those involved in their care.

Upper airway

The SLT has an advanced understanding of the upper airway. They are able to carry out Fibre Endoscopic Evaluations of the Swallow (FEES) which provides video images of the nasopharynx, oropharynx, hypopharynx and larynx. The patient's ability to manage their secretions can be observed as well as eating and drinking. Vocal fold movement can be visualised. These images can be used to support the weaning process, the maintenance of a safe airway, the introduction of oral intake and the identification of appropriate rehabilitation for the voice and/or swallowing. The SLT can also support the introduction of a speaking valve to maximise the person's communication opportunities.

Communication

The SLT is trained in carrying out complex communication assessments. These assessments can provide vital insights into a person's receptive and expressive strengths and weaknesses, supporting the implementation of communication therapy, identifying neurological changes, identifying opportunities for rehabilitating any cognitive deficits and information to support mental capacity assessment. Through this they can facilitate communication between the patient and their

family or team, providing practical tips and resources to enable them to communicate effectively.

SLTs can support short, medium and long-term communication impairments with a variety of communication aides.

Dysphagia

The SLT is able to provide a detailed clinical assessment of the swallow and formal assessments such as FEES and videofluoroscopy of the swallow. The videofluoroscopy uses fluoroscopy to gain images of the oral, pharyngeal and oesophageal phases of the swallow. This information can be used to reduce the risk of aspiration to the person whilst also minimising the impact on the person's quality of life. The assessments provide a foundation for dysphagia management and therapy.

Pre-existing conditions

People with pre-existing communication and dysphagia impairments can require additional support to enable them to cope with the critical care environment and to fully engage in their care. SLTs can help by meeting with the person and carers to help gain a clearer understanding of how best to meet their needs and to enhance patient centre care.

Audit and research

The role of the SLT continues to evolve within critical care to best meet the needs of the patient. There continues to be a need for greater understanding in the management of dysphagia, the use of speaking valves and facilitation of communication. The SLT can help to identify, design and participate in research to target these areas of need as well as playing a key role in auditing the ongoing changes in managing communication and dysphagia needs in critical care.

Advanced Critical Care Practitioners



Ms Carole Boulanger
Co-Chair
ACCP Sub-Committee



Dr Simon Gardner
Co-Chair
ACCP Sub-Committee

The 5th national ACCP Conference was held in London on Friday 9th June 2017. The event was an overwhelming success and sold-out for the 3rd year running. The conference attracted ACCPs from all around the UK and included excellent lectures on legal and ethical issues for ACCPs, difficult airway management in critical care, advances in renal replacement therapy, and FICE ultrasound accreditation. Attendees also participated in a series of educational workshops including advanced ventilatory management, platelets & platelet monitoring, CPD pathways and social media in medical education. Planning is underway for the next ACCP Conference which will be held in June 2018; the final date and venue will be confirmed shortly. We strongly advise early booking as the number of attendees is increasing on a yearly basis.



ACCPs as Teachers and Trainers

It is now almost five years since the first UK ACCPs were trained according to the 2008 Department of Health Framework. Since that time, the number of qualified ACCPs working in units across the UK has increased dramatically. As with all medical professionals however, the end of training does not represent the end of learning. The longer the ACCPs have been in post, the more knowledge and

experience they have accumulated and several ACCPs have also gone on to develop further skills via sub-specialisation in areas such as critical care follow up, ultrasound, arrhythmia management.

Considering this expanding reservoir of knowledge and skills that qualified ACCPs represent, several hitherto unanticipated benefits have developed;

- Teaching and training nursing staff; the day to day presence of ACCPs on the critical care unit has enhanced nursing education in both formal ways (i.e. teaching sessions delivered by the ACCPs) and informal ways (bedside tutoring). What has become clear is that particularly junior nursing staff are far less intimidated by ACCPs (in comparison to consultants) and are therefore much more likely to ask questions and seek advice from ACCPs.
- Training the trainer; many units are now utilising qualified ACCPs in a 'train the trainer' capacity e.g. when a new piece of equipment, a new care pathway or a new treatment modality is introduced.
- Teaching and supervising medical trainees; qualified ACCPs have developed certain practical skills to a high level, including central and arterial line insertion. As such they are now capable of teaching and supervising medical trainees in the conduct of such procedures. This fact has been formally recognised by the FICM and RCoA

(through the FICM's liaison) in that qualified ACCPs are now approved to sign off practical competency assessments for critical care and anaesthetic trainees.

Competition for Training

As the ACCP programme has developed and expanded there have been occasional concerns raised about the possibility that ACCP training might interfere with or decrease training opportunities for medical trainees in critical care. Over the last three years our experience has demonstrated that the reverse is in fact true and the presence of ACCPs on a critical care unit actually enhances medical training. This is evident in the following ways;

- ACCPs take on a significant amount of the day to day clinical work on the critical care unit. This can, to some extent, free consultants from hands-on clinical duties, thereby providing the consultant with more time available for teaching.
- ACCPs can also 'free up' junior and middle grade doctors from the routine daily clinical activities in critical care (drug charts, daily clerking etc) and this allows more educational time for the medical trainees.
- ACCPs can instruct, teach and supervise medical trainees in a variety of practical procedures that the consultant might otherwise be too busy to oversee.
- ACCP can teach on critical care specific topics in which they have themselves become adept, such as Cardiac output monitoring, intra-aortic balloon pumps, renal replacement therapy etc.

Hub and spoke ACCP training

In terms of the origins of the ACCP programme, perhaps the single greatest driver for the development of the new ACCP role was a shortage of junior and middle grade doctors in critical care units. It has now been unequivocally shown that ACCPs are an effective, long term and high-quality solution to these staffing issues.

Nonetheless, medical staff shortages persist in units across the UK, and this problem can be particularly acute in some of the 'smaller' and/or more remote units. Thus far, many small units have effectively been precluded from training ACCPs on the grounds that they are not approved for higher-level ICM training and they cannot provide the full gamut of specialties that larger training units possess.

It has however always been the intention of the FICM that ACCPs could and should be an integral part of the critical care workforce in smaller units. As such the ACCP Sub-Committee has begun working towards a system by which smaller units could develop their own ACCPs via a 'hub and spoke' type training arrangement. We envisage the establishment of regional or sub-regional ACCP training centres, which in collaboration with a nominated Higher Education Institute, could provide seamless ACCP training that is undertaken both at the trainee's smaller base unit and also in the larger teaching centre.

LEARNING FROM PATIENT SAFETY INCIDENTS

Lessons from local incidents may not be shared widely and to improve wider patient safety, the Joint Standards Committee of the Faculty and the Intensive Care Society has created this forum to allow lessons from local investigations into adverse incidents to be disseminated to the intensive care community. We welcome you to share important safety lessons that have occurred in your own departments that may have general relevance. More information can be found, including other examples and the submission process can be found on the FICM website:

www.ficm.ac.uk/safety-and-clinical-quality/learning-patient-safety-incidents

What is NCEPOD?



Dr John Butler
FICM Representative
NCEPOD Board

The National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) is a well-respected national non-governmental organisation which aims to investigate patient outcomes and deaths in many areas of the healthcare system both within the NHS and independent sector. Over the last 10 years it has investigated and published its work on 21 separate areas from surgical conditions such as trauma, bariatric surgery and peri-operative care to medical practice such as sepsis, acute kidney injury, alcoholism and cardiopulmonary resuscitation. In April this year, the NCEPOD Steering Group voted overwhelmingly that the Faculty should be recognised as a member organisation of NCEPOD. This is another positive step in the development of the Faculty and will facilitate significant ICM involvement into future NCEPOD projects.

History of NCEPOD

The principle precursor to NCEPOD was a confidential and anonymous pilot study of mortality associated with anaesthesia (Lunn and Mushin, 1982). Its aims were to assess the perioperative information in order that the clinical practice of anaesthesia might be improved and to provide comparative figures between regions to facilitate this. In 1987 a joint venture between the surgical and anaesthetic specialities named the Confidential Enquiry into Perioperative Deaths (CEPOD) was initiated. In 1988 the NCEPOD was then established supported by government funding, and its first report was published in 1990. NCEPOD has moved away from reviewing the care of surgical patients only and now covers all specialities. This is reflected in the wide range of studies currently undertaken and the fact that death is no longer used as the only outcome to identify patients.

What does NCEPOD do?

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and making available the results of such studies. NCEPOD is supported by a network of local reporters and ambassadors at individual hospitals, in addition to case reviewers that analyse information from each study and clinical advisors that bring together all learning points from the study in order to formulate a series of recommendations.

Who's on the NCEPOD Steering group?

All Royal Colleges have a representative on the steering committee. In addition, there are representatives from the Association of Anaesthetists of Great Britain and Ireland, the Association of Surgeons of Great Britain and Ireland, the Faculty of Dental Surgery, the Faculty of Public Health Medicine, and the Lay Representatives. The Faculty is the latest member organisation to be recognised on the steering committee.

How does NCEPOD select studies?

Each year NCEPOD invites organisations to submit original study proposals for consideration as possible forthcoming studies. Proposals should be relevant to the current clinical environment and have the potential to contribute original work to the subject.

How do NCEPOD studies work?

Where clear standards can be defined then the studies can be defined as audit where the clinical questions are around whether a service reaches the pre-determined standard. However typically there

are not always agreed standards with which NCEPOD can compare current practice. In these circumstances NCEPOD will initially use techniques to identify the key components of a service and their clinical importance before reviewing the clinical cases.

How does NCEPOD disseminate its findings and recommendations?

A key role of NCEPOD is to make recommendations based on the findings of the reports produced. Many of the recommendations are for clinicians, but other are directed at service provision at both local and national level. NCEPOD recommendations are based on themes that emerge during analysis of the data collected. As well as identifying remedial factors that lead to less than ideal patient care NCEPOD also highlight examples of good practice. The objective is to encourage clinicians to change practice to achieve uniform standards of patient

care throughout the NHS. The intention is that the recommendations will provide a benchmark of quality of care and provide a useful negotiating tool with service providers. All reports are created as a full version and as a summary. On the day of publication, NCEPOD hosts a presentation of the findings of a report.

Improving dissemination of NCEPOD reports

The invaluable work of NCEPOD is available to clinicians to learn about via the published reports and newsletters from the NCEPOD website. NCEPOD aims to improve patient care by disseminating knowledge and publishing recommendations. It is particularly interested in targeting medical training grades and is piloting an NCEPOD championing scheme with the Birmingham school of Anaesthesia to promote greater engagement.

Faculty Calendar 2017

September	1st 21st-22nd	MEETING: EVENT:	FICM/ICS Joint Standards Committee FFICM Prep Course
October	2nd 5th 12th	MEETING: MEETING: MEETING:	FICM Careers, Recruitment & Workforce Committee FICM Training, Assessment & Quality Committee FICM Board
November	3rd 20th 21st	MEETING: MEETING: MEETING:	FICM/ICS Joint Standards Committee FICM Careers, Recruitment & Workforce Committee FICM Training, Assessment & Quality Committee

Notice of FICM Board Elections

The FICM will be holding an election for **seven** Board Members (six Consultant and one Trainee) to commence their terms of office in January 2018 and October 2018.

Requests for nominations will be sent to all FICM Fellows in September 2017 along with more information about the election process which, this year, will be entirely electronic.

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

NCEPOD: Acute Pancreatitis



Mr Derek O'Reilley
Consultant Hepatobiliary &
Pancreatic Surgeon

NCEPOD undertook a review into the care provided to patients treated for acute pancreatitis (AP) during a six month study period between 1st January and 30th June 2014. This included assessment of care at an organisational level, clinical level within hospitals and external peer review. From a random sample, 712 patients underwent hospital clinician review and 418 patients had peer review. Overall, we found that there was room for improvement in care in over 50% of patients with AP. Some of the key findings of particular relevance to ICM include the inconsistency and underuse of early warning scores (EWS); the overuse of antibiotics; and the need for multidisciplinary teams (MDT) and better regional network arrangements.

Although the initial patient assessment was deemed prompt in the majority of patients presenting to the ED, it did not include any form of EWS in 154/502 (30.7%) of AP admissions. On admission to a ward however, EWS was performed in 571/662 (86.3%) cases. Confusingly, the type of EWS used in the ED and the ward was not the same in 8% (22/285) cases. The value of using the EWS was clear in that when used, it often triggered a response; in 85/329 (25.8%) patients in the ED and in 23.9% (130/544) of patients once admitted to a ward. Crucially, this led to clinically important responses such as review by a critical care physician or member of an outreach team in the majority of instances. Effective responses must be both timely and appropriate. This review found that, while responses were almost always appropriate, they were not always timely.

In AP, there is strong agreement that intravenous antibiotic prophylaxis is not recommended for the prevention of infectious complications. The risks, of encouraging antibacterial resistance and opportunistic fungal infections, leading to even higher mortality

rates, outweigh any benefits. Despite this, antibiotics were prescribed in 439/712 (61%) patients. In one fifth of cases, antimicrobial management was not considered appropriate by both the clinicians and the case reviewers; the most common reason of inappropriate antibiotic prescription being that antibiotics were not indicated (60/72 patients). Healthcare providers should ensure that antimicrobial policies are in place including prescription, review and the administration of antimicrobials as part of an antimicrobial stewardship process. These policies must be accessible, adhered to and frequently reviewed with training provided in their use.

The treatment of AP has become increasingly complex and requires a multidisciplinary approach. Severe AP typically requires co-operative input from a core of surgical, gastroenterological, radiological and intensive care and dietetic specialists. Less than one-third of hospitals (51/172) reported having a MDT meeting where patients with AP were discussed. Regional networks are also necessary because of the limited number of hospitals that stated that they could provide the type of interventional, radiological, endoscopic or surgical procedures that are required for the modern management of the complications of severe AP. NCEPOD recommends that formal networks should be established so that every patient has access to specialist interventions, regardless of which hospital they present to and are initially managed in. Indications for when to refer a patient for discussion with a specialist tertiary centre and when a patient should be accepted for transfer, should be explicitly stated. Management in a specialist tertiary centre is necessary for patients with severe AP requiring radiological, endoscopic or surgical intervention. More information can be found at: <http://www.ncepod.org.uk/2016ap.html>.



Critical Eye

Coming January 2018

We're changing the look of Critical Eye. If you have any suggestions or would like to contribute we'd love to hear from you!

Please send any idea for articles, themes or responses to published articles to:

ficm@rcoa.ac.uk



Training in a Smaller ICU



Dr Sherif Ghabina
ICM Trainee

This is not going to be an article about how friendly small ICUs are and how you get to know all the staff. This is true but I think it's also true for most if not all ICUs.

At Core and Higher training level, I have trained in four district general hospital (DGH) ICUs in London and Lancashire as well as two tertiary ICUs in London. Intensive care training offers the wonderful opportunity to come to work every day and be presented with entirely unexpected challenges. Any hospital, which has acute medical wards and an accident and emergency department, offers this in abundance.

In my experience the pathology and challenges presenting to the emergency department in a district general hospital are extremely interesting and exciting. On the whole, DGHs are in areas where people live and patients that are likely to require intensive care admission are usually brought by ambulance to their nearest hospital. (There are exceptions, STEMI, Trauma etc.). Assessing patients at the front door of the hospital provides excellent training in intensive care.

Often small ICUs have single tier rotas with different training grades all on the same rota. At early stages of training this offers the opportunity to assess, make decisions and liaise with the consultant on-call directly which is invaluable experience irrelevant of future career plans. Depending on your level of experience this also offers exposure to transferring critically unwell patients to tertiary hospitals (commonly neurosurgical patients).

It is important to note that training experience really can depend on how the hospital on-call

system is set up especially whether emergency calls are covered by ICU or Anaesthetics. Some of the most interesting and challenging medical patients I have seen have been whilst on-call for Anaesthetics in DGHs.

I would say in my experience at some district general hospitals the role of the ICU trainee can be less defined and this can be a very positive thing. The opportunity to take part in the management of unwell paediatric patients, for example, can certainly be a benefit of training in a small ICU. The ward round, bed management and planning for procedures could be termed elective duties. Without the demand of multiple hospital specialties and external referrals, the supervising consultant on a small ICU can often allocate time for teaching on ward rounds, supervision of practical procedures or supporting quality improvement projects. In terms of quality improvement you could certainly argue that as a motivated trainee in a small ICU, you have a greater opportunity to instigate improvement and change than on a large ICU.

In my mind, the remaining benefits of training in a small ICU are associated with being in a small hospital. Often there will be consultants in parent medical specialties skilled in interventional procedures, ECHO, bronchoscopy who may offer training opportunities. Co-ordinating this at a larger hospital can sometimes be comparatively more difficult.

Certainly training in small ICUs has all the benefits I have outlined above and undoubtedly many more.

Smaller and Specialist Units Advisory Group



Dr Chris Thorpe
Chair
Smaller and Specialist Units
Advisory Group

The more observant of you will notice the name has changed and the group now includes representatives from two of the specialist units, specifically the cardiac and neurosurgical intensive care units. How do these unusual bedfellows come together?

The structure of the FICM has recently changed, and there are three standing committees - the Training, Assessment and Quality Committee (TAQ); the Joint Standards Committee (JSC) and the Workforce, Recruitment and Careers Committee (WRC). Preliminary work for the majority of FICM business goes through these groups and is developed into a working proposal before being presented to the Board for discussion and approval. Of necessity, arguments and detail on these issues are thoroughly worked through by the standing Committees prior to going to the Board and in the vast majority of cases approval is straightforward.

The specialist units have an interest in all of these areas, and therefore need access to the standing Committees in a variety of areas such as recruitment, workforce and GPICS. There is no guarantee that a relevant specialist Intensivist will be voted onto the Board and so it is vital that we have a mechanism for these specialties to provide expertise and input into the future of ICM.

The only group that spans all of the standing groups is the SSUAG, with the ability to sit on the different groups as required, allowing access to all areas of interest. This has proved helpful to both the SSUAG and the wider Faculty and has allowed exploration of various areas in which smaller units have a role to play. This wider remit seems the best fit for the specialist units. For example there is to be a new curriculum that will be developed by a working

party from the TAQ, Chaired by Tom Gallacher. This will clearly need a lot of work and input from specialist units will be essential. GPICS V1 contains areas that are difficult to be fulfilled by cardiac units and the development of GPICS V2 will need input from specialist units to find the right balance. This will take place under the auspices of the JSC, Co-Chaired by Pete McNaughton. Careers, recruitment and workforce also are an issue for specialist units. Simon Gardner has already begun working on strategies to address these issues on behalf of ACTACC (Association for Cardiothoracic Anaesthesia and Critical Care). This work will feed into CRW, Chaired by Danny Bryden.

SSUAG can work on issues and develop strategies that can then be taken to the various committees for further discussion; specifically the aim would be to come with potential solutions, or at least ideas on how to take things forward rather than just identifying difficulties. The structure has worked well for the SUAG. In addition to chairing the SSUAG I also am the deputy chair of TAQ and am a co-opted member of the JSC, which helps to ensure that the group is integrated into the system.

Input into the SSUAG is through the relevant specialist societies; Roger Lightfoot is representing the Neuroanaesthetic and Critical Care Society of Great Britain and Ireland (NACCSGBI) and Simon Gardner is representing ACTACC, joining the original SUAG members of Catriona Barr and Mike Fried from Scotland; Jon Sturmann, Jeremy Groves, Andy Ball and Ash Molokhia from England; Ronan O'Hare from Northern Ireland and me from Wales.

Training and Assessment



Dr Tom Gallagher
Chair
Training, Assessment and
Quality Committee

We are entering a period of significant change in how postgraduate curricula will be designed and delivered. The GMC have implemented a major change which requires that all specialties rewrite their curricula to comply with the new guidance.

The new standards call for fewer, but higher level, outcomes and the incorporation of generic professional capabilities (GPCs) into all curricula. The latter consist of nine domains which all doctors are expected to achieve, regardless of specialty, and are specifically designed to address shortcomings highlighted by the GMC's fitness to practice data. Achievement of these competencies will mean that all doctors will be equipped with the necessary GPCs to provide safe, effective and high quality medical care.

In addition, the new outcomes based curricula will reduce the burden of assessment. Whilst descriptors of the higher level outcomes, which will be known as capabilities in practice (CiPs), will remain to guide the trainer and trainee in what is required for sign off of the CiP, it will not be necessary to evidence every single descriptor. Rather, the educational or clinical supervisor will be able to make a professional judgement based on a sampling of the descriptors as to whether the trainee can be signed off for the relevant CiP and at what level.

The FICM and RCoA issued a joint guidance statement to clarify the dual counting of specialist modules in anaesthesia and intensive care medicine. In Stage 2 ICM/higher anaesthesia specialist modules (paediatrics, neurosciences and cardiothoracic) the time spent in the module can be dual counted towards both programmes. This is possible since trainees on a dual programme can pick up some of the competencies in either their anaesthesia attachment or an intensive care

attachment. Since many competencies are common to both programmes and can be acquired in theatre or on the intensive care unit, when they have been acquired in one programme they are automatically recognised in the partner programme. However, there are some competencies which can only be achieved in theatre and some which can only be achieved on the intensive care unit. Recognising this, it has been agreed by both the FICM and RCoA that Dual trainees, during their Stage 2/higher anaesthesia specialist modules should spend some time in both theatre and the intensive care unit. We have not specified a minimum time for either placement in order to allow each training programme the maximum flexibility in how they deliver the relevant competencies. It is recognised that different regions will adopt different models and the minimum time required in either theatre or the intensive care unit is that which is required to deliver the competencies which can only be delivered in that particular placement.

The major ICM curriculum rewrite will take quite some time. In the meantime we will continue to submit annual curriculum revisions; the GMC have requested that these are not significant in preparation for the major review. We have proposed to the GMC that from August 2017 we will remove the requirement for expanded case summaries from the curriculum. We will also replace the requirement to undertake an audit with the requirement to participate in a quality improvement (QI) project. The reading and writing skills formerly assessed in the expanded case summaries will be replaced with those required to participate in a QI project. The trainee will have to satisfy the ARCP panel that their participation in the QI project has been at a level relevant to their stage of training. Watch this space to see if it gets approved!

Regional Advisors



Dr Mark Carpenter
Lead Regional Advisor

This is my first article as Lead RA, so I would like to start by thanking Danny Bryden for all her hard work supporting the RAs throughout her tenure. I would also like to thank Sarah Clarke for taking on the role of Deputy Lead.

Since the last *Critical Eye*, 3 new RAs have been appointed. I would like to congratulate Sarah Irving (Sheffield and South Yorkshire), Frances O'Higgins (Severn) and Kevin Sim (North of Scotland) on their appointments and thank Danny Bryden, Jeremy Bewley and Paul Holder for their hard work during their tenure as RA.

One of the RA functions is to approve job descriptions and person specification for new consultant posts. With the advent of Foundation Trusts this became optional advice rather than a mandatory requirement, but we are pleased to say that a significant number of trusts are still asking for advice. The guidelines around minimum criteria have been changed to prevent exclusion of candidates trained in overseas training schemes, with the RAs continuing to be able to exercise discretion on the basis of local requirements and in discussion with the Trust. These update guidelines are here: <https://www.ficm.ac.uk/ras-fts/ras>.

The annual RA/FT (and increasingly TPD) day was held on 6th March 2017 at Churchill house. This was a sell-out for the second year with sessions on issues thought to be relevant both to trainees and trainers. A number of outcomes came from the day with the joint statement from the FICM and RCoA regarding specialty ICU for Dual trainees being a particularly important one. In addition we had session on 'the new FT', the Faculty workforce strategy and the work of the Smaller (now Smaller and Specialist) Units

Advisory Group. The day culminated in a session on the new trainee contract from ex ICM TPD and now guardian of safe working, Ros Tilley.

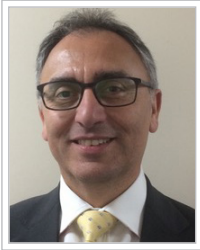
The content of the next RAFT day is being planned, but the date is fixed on the 5th March 2018. We will be continuing to address issues that trainers tell us are important, and will aim to cover most if not all of the GMC domains for educational supervisors during the sessions.

It is fair to say that we have been through a turbulent couple of years in terms of trainee morale and satisfaction. This general feeling of dissatisfaction has unfortunately for ICM as a specialty coincided with the major change in training that was the advent of the Single and Dual ICM curricula. We have now had our first CCT in ICM and have increasing numbers of trainees in each of the stages of training. Stage 2 and the impact of Dual curricula have been major themes for the RAs and TPDs both in terms of designing rotations but also helping trainees through two curricula, two sets of competencies etc etc.

A feature of the RAFT meetings as well as our work on the TAQ and CRW has been to look at how the regions and devolved nations are managing these changes. Trainees, FTs and Educational Supervisors can be re-assured that we are keen to ensure that training is fit for purpose to train a future of intensivists to tackle the changes in healthcare that undoubtedly lie ahead.

If you have any comments about any of our workstreams, any ideas about how we can improve things or, have issues that need to address in your region please do not hesitate to get in touch. The RAs page on the website contains all of our contact details.

Spotlight on: Kent, Surrey and Sussex (KSS)



Dr Cas Barrera Groba
Regional Advisor
Kent, Surrey and Sussex

KSS is a large geographical area along the South Coast with 16 hospitals, organised within nine NHS trusts. While all hospitals deliver Stage 1 ICM training, only six trusts are involved in Stage 2 and Stage 3 ICM training. This large geographical area, matched with inadequate transport infrastructure from East to West, is a real challenge to our training organisation; unbelievably, London is still the most accessible point from all Trusts in the South East. Our HEE office has been recently relocated, together with HEE London, to form HEE London & the South East (LaSE).

The ICM TPD and Faculty Tutors are enthusiastic, approachable and supportive. As trainees enter the ICM training programme at various stages of their careers and from various specialties, we provide a training programme that is carefully tailored to the educational needs of each individual trainee. Wherever possible, personal and social circumstances are taken into account when planning the rotations. This flexibility is only possible because various Trusts offer different parts of the complementary and ICM training and the TPDs skill in pairing trainees with posts. Brighton and Sussex University Hospitals (BSUH) NHS Trust is the regional level one trauma centre, sitting in the picturesque South Downs area on the South Coast, but not very well connected to other areas by road or train. The hospital is currently going through a major development on teaching, training and trauma programme to deliver a state of the art care and training with 55 ICM bedded unit. It provides a specialist year for most ICM trainees; although, some of those with dual specialisation in Anaesthesia and ICM may also train in London. The Royal Alex Children Hospital in Brighton lacks a level 3 unit; therefore,

paediatric ICM experience is provided at the Evelina London Children and Great Ormond Street Paediatric hospitals.

The educational programme has expanded and progressed immensely. Trainees attend the national ICM training days in London, providing an excellent opportunity to network with ICM trainees from around the country. In addition, regional training days are organised by trainees as part of their personal and professional development. FICE and FFICM courses are available for the most advanced trainees and BASIC and ALERT, for the novice, are also offered in the region. Trainees have given very good feedback to the programme although, there are still some issues, which need to be resolved including lack of funding for teaching programmes and HEE office support which is still stabilising after recent reconfiguration.

Furthermore, KSS offers approved training opportunities to develop special interests in echocardiography, education, leadership and high fidelity simulation. Some of these posts can be part of the training programme for a maximum of one year or be done as OOPT, subject to prior approval. The training flexibility shaped in the region supports trainees who wish to undertake some of their training overseas or in specialised units within the UK.

Lastly, we give trainees a strong voice at the Specialty Training Committee and at the local faculty group in each hospital. Trainees from any of the partner specialties are all treated equally and fairly at all stages of their training. Currently, we have trainees who are training in ICM alone and dual in ICM with renal, acute and respiratory medicine, emergency medicine and anaesthesia.

Trainee Update



Dr Jamie Plumb
Trainee Representative

Greetings fellow ICM trainees. We hope that you're getting to enjoy some of the long summer evenings and not sweltering too badly. Most intensive care units have air-conditioning right? (Can you tell this was written in the unusually hot June 2017?)

As all ICM trainees will be on the new contract in August this year we hope that people will be hot on exception reporting, and engaging with the guardians within their workplaces. I had an email from my local DME informing me that I have two hours of SPA each week! Time will tell if I actually get offered this! However, this is greatly welcomed.

The work of the trainee representatives at the Faculty has been focused on a number of things over the last few months but our main focus has been around ensuring that the countless emails I received about the burden of assessment did not go unheard.

There will be some changes being made (awaiting GMC approval) to the curriculum which should be live very soon. We will keep you updated. As many of you know the GMC have started a review of all postgraduate medical curricula to update standards, the mood music seems very positive regarding the general ethos of trying to reduce the overall burden. For anyone interested the link is below: http://www.gmc-uk.org/05_Initiating_the_Standards_of_curricula_including_assessment_review_SCAR_.pdf_65118471.pdf. The Faculty wants to use this opportunity to review our curriculum to make sure these new requirements are met and address assessment burden.

We will shortly be releasing a document that offers guidance on how to approach 'getting competencies signed off' we hope that this document will bring



Dr Richard Gould
Trainee Representative Elect

about a national standardisation to this process which at times as been quite regional/unit dependent.

This is also the time of year that we begin to here about the successful applicants of the national recruitment round held in Birmingham. I'm sure we will all look forward to working with an ever-increasing number of enthusiastic trainees who share our passion for intensive care medicine. The Faculty will be in touch with the new-starters shortly to help them get up-to-speed with the programme before August, and we can all do our bit by sharing our amassed 'tips and tricks' locally.

As ever please do not hesitate to get in touch with us as many of you have done regarding anything that you feel needs to be discussed by the Faculty.



TRAINEE EYE

Coming September 2017

Submit article ideas to us at:
ficm@rcoa.ac.uk

Training in Transformation and Leadership



Dr Robert Gatherer
ICM Trainee

I'm an ST7 Dual trainee in Anaesthetics and Intensive Care Medicine currently undertaking a fellowship in Transformation and Leadership. The fellowship is a partnership between King's College Hospital, Deloitte and Health Education England. It is 21 months in duration with 6 months counting as OOPT. The initial 12 months involves secondment to Deloitte as a Healthcare Management Consultant, followed by 9 months working on transformation projects within King's College Hospital.

This is a new fellowship and was engineered with HEE as a driving force and the RCoA closely involved, therefore arranging OOPT/E was easier than it could have been. The advert came out in late June, the interview was in July and the Fellowship started in November, so the rules were bent a little to make it work. I must thank Gary Wares (ICM) and Kate Prior (Anaesthetics) for being fantastic TPDs and the RCoA for being supportive too.

Post FRCA I undertook an Education Fellowship at Guy's and St Thomas'. As part of the fellowship I was enrolled on a PgCert in Medical Education with King's College London. My tutor for the PgCert, Chris Holland, is also an ICM consultant. His passion for Medical Education sparked a fire, making me challenge my perceptions in ways forgotten since being an angst-ridden teenager. Education is problematic to research using randomised control trials and traditional quantitative methods, so it's necessary to understand and explore qualitative

research methods. Just critiquing a qualitative research paper requires an entirely different approach. But I began to see the potential for application of this different perspective in Intensive Care Medicine.

Studying Medical Education gave me a great theoretical framework, but I felt there would be problems in translating my ideas into practice. I see this current fellowship as an opportunity to develop skills to resolve this concern. In the FRCA we learn how an osmometer works, the triple point of water and the principles of Infrared spectroscopy. I take no issue with learning these things, but what we don't learn is how a hospital is funded, what the

political pressures are, how one goes about writing a business plan, and what the likely obstacles are to the practical delivery of such a plan. Some of our colleagues will tell us these things are of no relevance, because they are not 'clinically' important or that 'they are only interested in the welfare of their patients, not wasting time talking to managers'. But if we understand how the hospital works, where the different influences lie, we are better able to effect change to benefit our patients.

In the current climate, clinical leadership is especially important. I have heard that most UK hospitals are running above 95% occupancy and most ICUs are at or nearing 100%. The outcome is; operations are cancelled, there is a resultant morbidity and potential mortality impact because of these delays. With the hospital full, unable to complete elective

“ If we understand how the hospital works, where the different influences lie, we are better able to effect change to benefit our patients ”

surgery, it is starved of the associated income. This has a cyclical effect; the worse the flow of patients through the hospital, the worse its financial position and the harder it is to fix the problems with flow. No amount of understanding of absorption spectra of Carbon Dioxide will help with this, but the job I am currently doing will.

Our language, or rather our vocabulary, shapes our thought processes. When one starts Medical school, there is an entirely new language to learn. Any medic who has taken a non-medical family member to hospital, knows the power of being fluent in that language. Business, finance and management are no different. Once you know the language, people treat you differently and you understand the world differently. It opens possibilities that didn't exist before you knew the language.

Deloitte has allowed me to develop the ability to assess a Trust, combining the interpretation of finances, political motivations and clinical insight, to judge where they would benefit from support and development. I have been given awareness of the processes that go into thinking about the future of healthcare. From managing the impact of the current funding issues for Acute Trusts and CCGs, to how STPs might be implemented and what the various roles of NHSE, NHSI and the DoH are. Furthermore, realising the private sector; Google DeepMind, IBM Watson and Apple Health, all understand the opportunity for innovation in healthcare, especially given that our current model for delivery is based on a pre-industrialisation approach. But most powerful of all has been the development of a rich network of people I would never otherwise have had access to as a clinical trainee.

I, like most, was taught medicine from a positivistic perspective and this epistemology dominates our approach to knowledge seeking. Positivism suggests knowledge can only be derived through sensory experience or interpreted through logic. It seeks an objective truth, generalisable laws that apply in all situations, with an aim to predict any eventual outcome. This principle has provided a great deal of success to human civilisation, medicine being one of the greatest; raising itself from a medieval craft into a scientifically rigorous discipline and saving millions of lives in the process. But there are limitations to the

positivistic approach, not least of all within medicine. The human system is incredibly complex and many attempts to reduce aspects of it to bench-top studies have seen failure when attempting to return in vivo.

The practice of medicine as purely a 'find a diagnosis', 'focus on the numbers', 'clinical' pursuit is to practice in vitro, and ignores the complex whole of patient wellbeing and healthcare. While there is obvious comfort from that 'clinical' precision approach, it may not reap the greatest rewards for our patients. Some colleagues have been cynical towards both my interest in qualitative research and undertaking of a 'management' fellowship. I think those responses come, in part, from the esteem we attach to the champions of positivism. Certainly, there were colleagues asking me why I would take such a strange approach? While the clear blue skies of basic science research remains very appealing, the curious child in me is currently driven to get down in the muddy understanding of how we 'practice' Intensive care.

The time at Deloitte has given me the space to look at things from a different perspective. If I can bring back what I have learnt, and apply it successfully within the NHS, it will have been worth the effort and the funny looks. I am aware I need to get back to my training, and CCT, before my TPDs lose their patience! Some of those cynics mentioned earlier have asked if I will come back to the NHS or will I be lost to corporate greed? I point out, I have never left. The fellowship involves a secondment to Deloitte, as such I remain on an NHS contract. Working here has served to remind me of the privileged position we have as doctors, and how it remains the job I love. However, these are interesting times and I would rather be informed and resilient, so I can most effectively help direct the future of the NHS and healthcare, rather than keeping my head down and watching the numbers.

“**Deloitte has allowed me to develop the ability to assess a Trust, combining the interpretation of finances, political motivations and clinical insight, to judge where they would benefit from support and development**”

Social Media and #FOAMed in ICM Training



Dr Thomas Price
ICM Trainee

The last 15 years have seen an explosion in the use of social media within medical education. Blogs and podcasts in critical care and emergency medicine have increased in number from 3 to 183 between 2002 and 2013 and medical education resources have shifted from traditional textbooks to a vast array of easily accessible online content. With 74% of internet users spending time on social media networking sites, it is of little surprise that these platforms have risen to such prominence in medical education.

[Free Open Access Meducation \(FOAMed\)](#) is an online community that provides medical education through a variety of social media platforms. Within critical care these platforms include microblogs, such as Twitter, knowledge aggregation websites and numerous other podcasts and blogs.

Twitter is at the forefront of the FOAMed movement. Its use within critical care and emergency medical education has grown rapidly since its launch in 2006. Free to access, Twitter can provide the user with professional networking and expert discussion, allows dissemination of research, facilitates crowd-sourcing for answers to clinical questions, exposes regional variation in clinical practice and promotes translational research. Conferences are engaging in Twitter, allowing audience interaction with speakers, live streaming of talks and rapid dissemination of educational topics. Whilst Twitter has brought undeniable benefits to the FOAMed movement, caution must also be applied when viewing the material posted online. The quality of content can sometimes be questionable and the lack of formal peer review can occasionally lead to the consumption of poor quality information, which can be unreferenced, incomplete and prone to bias. The short tweets (140 characters) may also lead

to over-simplification of complex topics that often require more thorough discussion. However the FOAMed community does provide a degree of real-time peer review, allowing users to debate, critique and rebuff posted content.

Knowledge aggregation websites such as Critical Care Reviews, The Bottom Line and Life in the Fast Lane, allow users easy access to vast amounts of peer reviewed literature, critically appraised landmark papers and information on common ICU conditions. They are invaluable resources for anyone preparing for the FFICM exams. Podcasts available from sites such as the Intensive Care Network and EMCrit offer huge breadth of high quality educational material from international expert speakers.

Social media does however pose potential problems for healthcare workers with most content being freely accessible for public consumption. In response to this, the GMC released guidance entitled 'Doctor's use of social media' in 2013. Particular emphasis is placed on online patient confidentiality and maintaining patient and public trust in the profession, and it is vital all doctors using social media are familiar with the guidance.

Training in critical care continues to offer new challenges as the speciality grows. The need for continuous lifelong learning is essential to keep up to date and provide the best care for our patients. Social media will play an expanding role in this, allowing real time connectivity to the ever changing world of ICU. Whilst it is vital that we embrace, engage in and promote social media, caution must be exercised in its extrapolation to everyday practice and its place in medical education must continue to lie alongside traditional teaching in ICM.

FFICM Examination Prep Course

Thursday 21st September
&
Friday 22nd September

Day 1:

Lectures & Workshops including: Ethics, the law and ICU, Radiology, Nutrition in ICU, Burns, Organ Donation, ECG interpretation, Fluid analysis, the Sick Child*

Day 2:

OSCE and SOE Practice with experienced FFICM Examiners

Venue: Cloth Hall, Quebec Street, Leeds LS1 2HA

Registration Fee: £270 for both days

Please note: it is not possible to attend only one day of this event

To book online please visit:

www.ficm.ac.uk/ficm-events/fficm-prep-course



#FFICMPREP

*Please note: the programme may be subject to change

FFICM Examination



Dr Andrew Cohen
Chair
Court of Examiners

The FFICM exam is now in its 5th year. The exam replaced the UK Diploma in Intensive Care Medicine which was generally taken late in training or once training had been completed. The oral component of the diploma comprised of five vivas in a one day marathon. The numbers of candidates presenting for this were small, typically less than 30 at a sitting.

The FFICM exam is an integral part of the assessment of training and is a requirement to complete the Intensive Care Medicine training programme. Candidate numbers at the structured oral examination (SOE) are slowly rising with over 80 in the last few sittings. Increasing candidate numbers means the exam is now run over two days and may soon have to spread into a third day.

The Faculty is about to give warning of a future change to the FFICM which is to increase the number of Single Best Answer questions in the FFICM Final MCQ examination. SBAs allow testing of the application of knowledge in clinical scenarios rather than just factual recall. The increase in SBA questions will be associated with a fall in Multiple True False (MTF) questions, the written exam remaining 90 minutes in duration.

Candidate performance is discussed regularly at examiner meetings. Despite repeated guidance examiners continue to report that problem

areas for candidates in the SOE stubbornly remain around presenting structured answers to questions and in the interpreting and presentation of images and ECGs.

As the training programme has become more established so have resources for candidates. Online searches will reveal various blogs and textbooks giving advice to trainees, which they can use alongside their more formal training. The Faculty website also has a number of resources

for candidates including detail of Free Open Access Medical Education (FOAMed) and detail of the popular FFICM Exam Prep Course which is being held for the third time in Leeds at a new venue on Thursday 21st and Friday 22nd of September 2017.

The data in the tables and pie charts shows a summary of the success rate of candidates in various parts of the exam over the last two sittings. It

should be remembered that not all candidates sit all components of the exam in each sitting; for example, if a candidate passed one of the OSCE or SOE, they would not need to re-sit that component.

Examiners are aware that passing the FFICM exam while also juggling commitments at home and working is a challenge and congratulate all of those who have been successful. This year the Court of Examiners have recommended awarding a prize to the candidate who has excelled in all components of the exam this academic year.

“ Examiners are aware that passing the FFICM while also juggling commitments at home and working is a challenge and congratulate all of those who have been successful ”

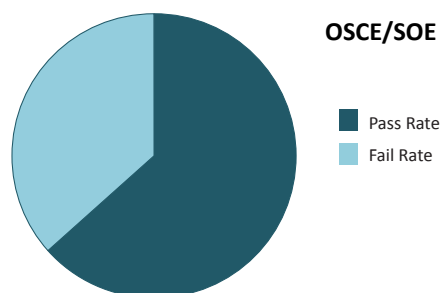
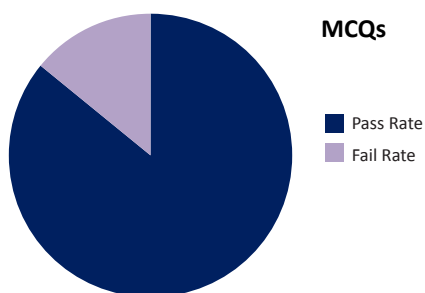
I would like to congratulate John David Rae from the North of Scotland Deanery for his outstanding performance and wish him all the best for his future in Intensive Care Medicine.

Organising the exam is becoming increasingly complex. My thanks goes out to all those that keep

it running so smoothly. These include members of the exams department and examiners who in addition to assessing candidates, spend time writing questions, attending meetings and in standard setting.

MCQs	Jul 2016	Jan 2017
Applications	73	86
Withdrawn	1	2
Absent	0	0
Pass	60	74
Fail	12	10
Total	72	84
Pass Rate	83.33%	88.10%

OSCEs/SOEs	Oct 2016	Mar 2017
Applications	85	104
Withdrawn	3	3
Absent	0	0
Pass	49	67
Fail	33	34
Total	82	101
Pass Rate	59.76%	66.34%



FFICM Examination Calendar 2017-2018

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications not accepted before	Monday 10th July 2017	Monday 16th October 2017
Closing date for Exam applications	Thursday 31st August 2017	Thursday 23rd November 2017
Examination Date	Tuesday 10th October & Wednesday 11th October 2017	Tuesday 9th January 2018
Examination Fees	Both: £570, OSCE: £315, SOE: £285	£470

Professional Standards



Dr Peter Macnaughton
Chair
Professional Standards
Committee

The work to produce GPICS V2 is now underway with an expected publication date of summer 2018. GPICS V1 was published in 2015 and was a fantastic achievement by the previous editors (and Co-Chairs of the Joint Standards Committee) Simon Baudouin and Gary Masterson, who brought together this very important document for our specialty in a short time frame. The aim of GPICS was to produce a definitive reference source for the planning and delivery of UK Intensive Care Services. The breadth of the document is very impressive and at over 200 pages in length, I must admit it took me some time to read it as a whole! The first edition of GPICS was seen as the start of a journey to build a comprehensive index of recommendations and standards for how UK Intensive Care Services should work and we hope to develop this in V2.

The majority of intensive care in the UK is delivered outside of teaching hospital units and some may have perceived that the authorship of GPICS was not representative with too many authors working in 'Ivory Towers'. It is an FICM aim to include an appropriate range of authors in GPICS V2 from both teaching and non-teaching hospitals in addition to ensuring all the home nations are appropriately represented, as this is a UK wide document.

As part of the process for identifying those areas of GPICS in need of revision, we recently sent out a survey to all FICM and ICS Fellows and Members. The response rate was very encouraging and much of the data still needs collating but there are some clear themes from an initial review. The overwhelming majority of respondents found GPICS very useful and an important document that has assisted the development of local critical care services. The sections on staffing standards and service

provision are considered the most useful. In terms of additional subjects for consideration in V2, one clear theme is the challenge faced by small and specialist units in achieving all the standards whilst delivering good outcomes. This has already been recognised by the Faculty Board and the JSC with the formation of the Small and Specialist Unit Advisory Group and a plan to include a section in GPICS V2 on the challenges and solutions faced by these units. Other suggested topics for consideration include guidance on working patterns; both for optimal patient care and avoiding staff burnout and guidance regarding the optimal relationships between tertiary centres and referring units.

On a lighter note, one area where we do not have standardisation within our specialty is terminology. When I first started it was intensive care or intensive therapy units (the latter was a term I personally never used) and now we also have the additional terms critical care, high dependency, Level 2 and Level 3 used at times. I'm not convinced that many outside of our specialty understand what is meant by critical care. I always introduce myself as an 'intensive care' consultant and that is also the name of our specialty and Faculty however, the term 'critical care' is gathering momentum. Should we stop using all the other terms to describe our departments, units and specialty? I would welcome your views.

Finally, I would like to highlight that the patient safety section of the FICM website has been set up as a resource to share learning from adverse incidents. Please forward any lessons from local safety incidents that would be useful to highlight to other units using the generic SBAR form that can be downloaded: www.ficm.ac.uk/safety-and-clinical-quality/learning-patient-safety-incidents.

AHP Competency Framework



Mr Craig Brown
Lead
AHP Framework Project

The FICM has partnered with the ICS to work on an exciting joint venture supporting the career development of four key Allied Health Professions (AHPs) working in critical care. Historically the Nursing, ACCP and Pharmacy professions have developed extensive competency frameworks to demonstrate safety and effectiveness. However, the wider AHP communities have yet to reach a national consensus to develop either profession specific or baseline generic frameworks for critical care.

Initially the focus for this work will be with the four largest professional groups in critical care but lack any nationally agreed framework, namely Dietetics, Occupational Therapy, Physiotherapy and Speech and Language Therapy.

This ambitious and unique project has the backing and endorsement of the Chartered Society of Physiotherapy (CSP), the Royal College of Occupational Therapy (RCOT), The Royal College of Speech and Language Therapy (RCSLT) and the British Dietetics Association (BDA). The writing team brings together experts from each of these four professions to work collaboratively in this development. The team come from a range of critical care units around the UK, all of whom are leaders in their field, they are:

- Lucy Morgan and Ella Segaran (Dietetics)
- Gareth Cornell (Physiotherapy)
- Lauren Maher (Occupational Therapy)
- Corrine Gaston (Speech and Language Therapy)

The project team have excellent support and guidance from a range of stakeholders including the UKCCNA, the Royal Pharmaceutical Society and the ACCP Sub-Committee, and all of these providers

have extensive experience and expertise in this area. Using the best of the Nursing, Pharmacy and ACCP developments we are ensuring that this new framework, which will span all four professions has a consistent approach.

A recent publication on the national 'Critical Care Non-Medical Workforce' clearly identified that there are workforce gaps, for example only 14% of Critical Care Units have access to an Occupational Therapist, and only 30% can identify a Speech and Language Therapist (CC3N 2016). There are also potential gaps in knowledge and skills, for example, 20% of units reporting that Dietitians had no form of senior supervision (CC3N 2016).

This discrepancy in workforce development for professions who are essential to patient recovery and rehabilitation is likely to have long term consequences. The critical care nursing community identified this risk in 2008, particularly the lack of consistency across post-registration education (CC3N 2012). This same issue faces the AHP community currently working in critical care, and whilst the individuals are all accountable to the Health Care Professions Council (HCPC), there are currently no nationally agreed frameworks in place to ensure patient safety, quality assurance and professional development opportunities for these staff working in critical care.

The long term aim of this project is that this framework may inform curricula development with the potential to develop both undergraduate and post-graduate programmes, thereby ensuring high quality practice and patient safety. We are aiming for the initial draft framework to be ready by December 2017.

Legal and Ethical Policy Unit



Dr Chris Danbury
Chair
Legal and Ethical Policy Unit

"... if a decision is made that a patient needs life-saving surgery, they should be transported immediately to their local [tertiary referral] unit. This may mean that a critical care bed would have to be found for that patient thereafter – even if that requires extensive 'bed-juggling' by critical care doctors – or in extreme cases, treatment post-operatively being offered elsewhere. The proposal is that this should cover all types of life-saving surgery... This is clearly vital for patients whose priority is life-saving surgery... The decision as to whether proposed surgery is 'life-saving' or not should be a matter for the consultant surgeon..."

This was written in the Section 28 report by the Nottingham Coroner in January of this year. Section 28 letters arise from Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. As the Chief Coroner says, "These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say 'his death was tragic and terrible, but at least it shouldn't happen to somebody else.'

Following this letter, the Faculty has been asked to ensure that Fellows are aware that the coroner considers a lack of an ICU bed in a receiving institution is not an acceptable reason to prevent the transfer of a patient for surgery; neurosurgery or any other specialist surgery. This is likely to result in some different conversations in future. It remains to be seen what sanction will apply to tertiary units who fail to heed the coroner's instruction.

In other news, LEPU intervened in the Ferreira case, and we have recently learned that the Supreme

Court has refused leave to appeal. Therefore, we infer that most ICU patients are not being deprived of their liberty and we can get back to helping patients rather than filling in quite so many forms. Do remember that there will still be some patients where DoLS still applies.

If you are aware of any coming case where there might be a general policy implication on ICM, then do let the FICM secretariat know. LEPU discusses these cases as they arise to ensure that the specialty's voice is heard. I have had feedback from a number of legal sources who tell me that our interventions have been appreciated so far. Naturally this will come with significant financial risk so are only taken up where it is argued we can make a lasting different to a key legal precedent.

My regular plug for mediation: The Faculty has agreed to host a medical mediators database. If you are CMC registered, up to date with your mediation CPD and have insurance in place, please let the secretariat know if you want to be included. It's up to the individual mediator to confirm these details and keep them current. Do ask me if you want more details.

Finally, my thanks to Dr Bryden for organising a fantastic, sell-out meeting in May. It was great to meet so many of you and do let LEPU know if you would like a repeat event.



2017 FICM ANNUAL MEETING

Hard Cases or Bad Laws?

Event organiser: Dr Daniele Bryden

Find out what you missed ...

How do you follow a successful meeting showcasing knowledge learnt from the military? Start with a pithy title, some great speakers and ensure plenty of time for debate and questions. The shocking bombing in Manchester two days previously brought focus and poignancy to a day where every speaker was on top form, arguing their case or illustrating why it's not just the latest clinical developments we need to know about if we are to do our jobs to the best of our ability. An eclectic group of speakers were united in speaking to the audience with good humour and clear messages, even as they all chastised me as organiser for giving them awful lecture titles!

Chris Dorries, HM Coroner for Sheffield gave us insight into death from his perspective: reassuringly he sees intensivists as 'the good guys', able to provide a balanced overview of hospital care. Rebecca Fitzpatrick from Browne Jacobson gave an overview of the role of the Court of Protection illustrated with specific cases she had been involved in and Chris Danbury spoke of the role of mediation in helping to negotiate difficult clinician family relationships without recourse to the legal process.

Many speakers were asked to challenge us and make us think; Dominic Bell took issue with the sidelining of medical clinicians from speaking with families about organ donation; Rosie Baruah illustrated why defining futile can be, well, futile; Rehana Iqbal illustrated how we can still be responsible for others' actions even when we're not physically present and Rachel Elliott presented a wake up call for ICM to get its act together and ask the right research questions. Star billing in the afternoon went to Baroness Illora Finlay who illustrated why care at the end of life matters and gave a spirited defence of the House of Lords consistent rejection of assisted dying legislation. The day ended with Andy Cohen's 'festschrift' of all the ways in his career he has encountered clinical negligence claims for ICM care.

Amidst all the talk of law and ethics, the Faculty chose to recognise the contributions of two individuals who have supported training and education, Dr Louie Plenderleith and Dr Chithambaram Veerappan. In a day focusing on what happens when things go wrong or get difficult in ICM practice, it was good to see people honoured who have focused on ways to deliver better patient care.

DITCH THE REPEATS: TRY SOMETHING NEW



STATE OF THE ART 2017: OPEN TO ALL WHY LET INTENSIVISTS HAVE ALL THE FUN?



peri-op medicine & ICU: the interface
all-new, all-day trauma track
new concepts in medical frailty
is there a place for standalone HDUs?
robotics in healthcare
new ideas in bedside imaging
human factors, design, ergonomics
acute cardiology: new guidelines
how to get your patient into the cath lab
new respiratory guidelines
interactive Research Clinic – bring your ideas
infection: novel imaging, emerging diseases
pain, sleep and psychology in critical care
critical care education & knowledge transfer
and much more

new venue: voted Best UK Conference Centre 2017
more interactivity
RCoA CPD codes for every session: target your portfolio
panel debates & pro-cons
social media integration
new-generation e-posters with zoom & video
no all-male panels!
parent & infant facilities
two drinks receptions
final night after-party

INTENSIVE CARE SOCIETY ACC LIVERPOOL DEC 4-6TH

NOW OPEN FOR REGISTRATION & ABSTRACTS
15 CPD (RCoA – pending)
SOA.ICS.AC.UK #ICSSOA2017



Edinburgh Radiology Course for ICM

Thursday 22nd & Friday 23rd February 2018

Edinburgh Training and Conference Centre, St Mary's Street, Edinburgh

Course fee: £350*

*£350 early bird registration; £400 after 5th January 2018



Topics Include:

- Basic Principles of Radiology
- Indications & Limitations of Different Imaging Modalities
- Interpretation of CXR & AXR including tubes & lines, CT Chest & Abdomen/ Pelvis including venous & arterial phase and angiography
- CT Head & C-Spine including Neuro-Interventional Radiology, Pan CT Trauma including common injuries & fractures.

REGISTER YOUR PLACE NOW!

For more information and to register online please visit:

<http://edin.ac/2pZYT80>

OR

Contact Dawn Campbell: **Email:** dawn.campbell@ed.ac.uk **Tel:** 0131 242 6395



This meeting has been approved for
10 CPD credits by the Royal College
of Anaesthetists





The Faculty of
Intensive Care Medicine

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