

Critical Eye



Issue 10

Summer 2016

The Faculty of
Intensive Care Medicine

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Welcome



Dr John Butler
Clinical Editor

Welcome to the 10th edition of Critical Eye. This summer has seen a number of new national leadership appointments, most importantly of course, within the Faculty Board itself. Elections have taken place for the posts of Dean and Vice Dean and I would like to congratulate both Dr Carl Waldmann and Dr Alison Pittard on their appointments as the new Dean and Vice Dean. Their new roles will commence in November 2016 at the next Board meeting.

The Faculty's Annual Meeting was held on 1st July in collaboration with the Defence Medical Services. Entitled 'Bombs, Bullets, Blood and Bugs' the meeting was an opportunity for the whole ICM community to see what the NHS could learn from the last 10 years of military Intensive Care Medicine. Featuring demonstrations of a deployed critical care unit and critical care air support as well as real-life insights into the problems associated with working in the 'red zone' during the Ebola crisis this was a thoroughly educational and enjoyable day.

This edition includes information on all the key developments relating to our specialty including updates on the eportfolio, an insight into the focus of the Quality, Recruitment and Careers Sub-Committee, a doctor's experience of the CESR equivalence process and news of the development of the first school of ICM in the North West region. In addition, an article from the Legal and Ethical Policy Unit written by Dr Danbury describes the latest opinions surrounding the use of Deprivation of Liberty Safeguarding (DoLS) orders in ICM and explains how the up and coming Law Commission ruling, due in December 2016, may clarify some of the confusion. I hope you enjoy this edition.

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

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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>

Dean's Statement



Dr Anna Batchelor
Dean

The last year has been dominated by the junior doctors contract negotiations which have served to reveal that trainees are very unhappy. I think all of us in 24/7 specialties were bemused with a contract offer that wanted to reduce rewards for unsocial hours without recognising the impact this might have on recruitment and retention or indeed morale. Even worse to do this without having the conversation that recognises the financial difficulties facing the economy and the NHS and seeking our professional help in formulating a way forward. Every cloud has a silver lining, trainees are now more politically aware, many have shown great leadership, and the causes other than money for unhappiness have leapt to the fore. Social media is a great way of raising and discussing problems but can also create more heat than light. The Faculty will be looking to take forward some work on this area imminently.

There seems to be a desire to have more opportunities for LTFT training, OOPE or OOPT, more flexible training with trainees able to get off the tramlines and become "the doctor you feel you need to be". This is in direct conflict with the aspiration of many to get to the end of training ASAP or indeed the potential aim of the Shape of Training review. How do we find a balance between doing what I and many of my contemporaries did of wandering about accumulating a broad range of skills and expertise which we brought to our consultant posts and the aims of Deaneries to get everyone through training with as little hindrance as possible? Please always feel more than welcome to come and tell us about this or anything else. We are part of an HEE working party looking at how to improve training and your views are important to represent there.

So to the other referendum, 'Brexit'; I was on call that night, calls from the unit didn't keep me awake but repeatedly checking the BBC news update with rising horror did. It seems likely that rather than bringing extra money into the NHS it will cost us in many ways, perhaps the most concerning of which is Europe wide research groups and funding. The UK is a net gainer earning more in research funding than we pay into the fund. There are already anecdotes of changes in relationships which have been built up over many years. The Faculty will be raising this at the Academy and with government and supporting our research community which is in the healthiest state it has ever been. The UK Critical Care Research Forum had a successful meeting in Newcastle and the enthusiasm from trainees to build research and quality improvement into training bodes well for the future.

The latest recruitment round was very successful, 142 trainees will be starting ICM training this year and despite the contract misery we achieved a 90% fill rate. Unfilled posts were region specific and reflect recruitment difficulties across specialties. As we had the largest ever number of posts to fill this is a very positive and encouraging outcome. The Faculty is the fastest growing membership group at the RCoA. We have almost 3000 Fellows, Members and Trainees with a 10% growth rate this year.

I am coming to the end of my tenure as Dean. Carl Waldmann has been elected as my successor and Alison Pittard as Vice Dean and they will be taking up office at the November Board meeting. It has been an honour to be Faculty Dean and to have played a part in the continued development of our specialty.

Careers Update



Dr Jonathan Goodall
Careers Lead

An intensivist's lot is not an easy one. This sentiment was certainly reflected in the tone of many of the articles included in the last edition of *Critical Eye* (Jan 2016), which described the challenges facing the specialty as it matures and develops. Yet, despite these challenges (directly quoting the Dean's Statement from the same edition), I whole-heartedly agree that being an intensivist is 'the best job in the world'.

Our specialty has to ensure that medical students and trainees are attracted to choose a career in Intensive Care Medicine. At the same time, we have to preserve the well-being of current intensive care doctors; we have to ensure that the current ICM workforce are able to meet the demands of working in a high pressure specialty for many years, and give individuals the knowledge and resources so they can develop their career as they move through their working life.

Late last year I was asked to become the Careers Lead for the Faculty and was delighted to accept this challenge. Provision of effective careers guidance has been recognised as an essential part of the development of a doctor for many years. *Modernising Medical Careers – The Next Steps (2003)* highlighted the importance of 'rigorous and realistic' career advice and how such guidance should be used to support doctors as they progress through training programmes. Despite such initiatives, many doctors still feel that appropriate careers advice difficult to come by. We need to make sure that this is not true for intensivists, at any stage of their working life.

So, what role can the Faculty play? How can we ensure that we attract the very best, most suitably motivated medical students and core trainees into

the specialty, and do so in sufficient numbers to meet the ongoing workforce needs of ICM? What can we do to help colleagues balance the challenges of working longer (and potentially harder) in times of fewer resources, and in less certain circumstances? How do we support colleagues during 'pivotal periods', such as the transition from trainee to consultant? What resources are available to help colleagues plan for their life after a career in ICM?

These and similar issues are now discussed during the careers section of Quality, Recruitment and Careers Sub-Committee meetings, which are held quarterly. Over the coming months this group will develop a career strategy for the Faculty, which aims to develop guidance around recruitment of medical students, foundation and core trainees into the specialty; helping ICM trainees make effective and appropriate career choices; resources and advice for those giving career advice to trainees; support and mentorship for newly appointed consultants; burnout and stress in ICU and new ways of working in intensive care.

The new FICM website now has a 'careers page', which the Sub-Committee will use to communicate its work, where career related resources (for both trainees and trainers) will be available, and which will include links to other career-related websites. It is hoped that in time it will be also be used to share career stories and areas of good practice.

As with all new projects, the development of 'FICM Careers' will be an iterative process: if there is anything you feel should be included in our remit, please contact us. I hope that this project will help to ensure that - although not easy - an intensivist's lot will remain a satisfying and productive one.

Trainee Update



Dr Ian Kerslake
Trainee Representative

So much has happened since the January update that I don't quite know where to start. Whenever I sit down to write this update it seems like a new drama is unfolding and with the referendum result there is no let up! I'd like to start by congratulating Carl on becoming the new Dean of the Faculty and look forward to working with him during the remainder of my time as Trainee Representative. On behalf of all trainees, I'd like to say an enormous heart felt thanks to Anna Batchelor for her tireless work on our behalf. During the very difficult past few months, Anna has been dedicated to our cause throughout, both in and out of board meetings, as well as publicly on social media, I have felt that we have had nothing but absolute support from her. Thank you for your thoughts and advice.

When I wrote a first draft of this article, we were still voting on the new contract. Having read the new proposals, and having attempted to draft a new ICU rota based on the new rules, there are still a number of hurdles we will need to overcome to make this work for everyone. Now junior doctors have voted to reject the new contract, the coming months will be challenging.

Welcome to Jamie Plumb as Trainee Representative Elect. Jamie has been thrown in at the deep end and is doing brilliantly. Between the two of us we sit on most committees and working groups and we are really keen to put your views across. I'd really like to try and facilitate easier lines of communication, as currently it is very difficult to keep up with you all, as emails change and new people start. It would be useful I think to set up a closed group on social media and I'm looking into this as a possible way of doing that. Any other ideas about improving this would be most welcome. Once we've managed it, I'll need you all to spread the word to get people using it.

On a final note, I am personally interested to hear your experiences over the summer of the ARCP process. In particular, how easy has it been to navigate the ePortfolio with your educational supervisors? Have you managed to get things 'looking green' on your sign off? Have there been issues that you think we need to look at centrally? As ever, you are all welcome to email with any training related issues and both Jamie and I, will do our best to address them on your behalf.

Faculty Calendar 2016

September	22nd & 23rd	EVENT:	FFICM Prep Course
	23rd	MEETING:	FICM/ICS Joint Standards Committee
	27th	MEETING:	FICM Training & Assessment Committee
November	9th	MEETING:	FICM Board
	22nd	MEETING:	FICM Training & Assessment Committee
December	16th	MEETING:	FICM/ICS Joint Standards Committee

Training and Assessment



Dr Alison Pittard
Chair
Training & Assessment Committee

There have been some changes since my last update; new leaders, more disputes and finally new agreements.

There are more changes coming with respect to curricula in general and that means we are in the throes of a major rewrite. The first reason for this is the requirement to embed Generic Professional Capabilities (GPCs) into curricula just like we already do for Good Medical Practice. These are broad skills that cross specialties, such as communication, leadership and team work etc, which are essential for the provision of safe and effective patient care. Information about this can be found on the GMC website. As we select for these skills during recruitment and already have them in our syllabus all we need to do is map our competencies to GPCs. The Academy is working closely with the GMC to provide guidance on how best to do this. It is likely that new assessment tools will be developed to ensure that these are being achieved and we will keep you informed.

The second reason we need to change our curriculum is the GMC's desire to make curricula more 'outcome' based. The GMC are consulting on a new standards document for curricula and assessment and is likely to publish this early next

year. Within the document there will be guidance on how to assess these outcomes. The idea is to move away from a tick box exercise and look more holistically at the outcome. If it is felt by a multi-disciplinary panel that the trainee has achieved the outcome at the appropriate level they will have completed this requirement. However, if they have not achieved the outcome, it will be broken down into smaller parts to establish why the outcome has not been achieved and this area will be focussed on. This will be quite a significant change to the way we currently assess trainees in the workplace and of course we will work closely with trainers and trainees to ensure we get it right. We will have 2-3 years to make the required changes but have started work already in anticipation of publication.

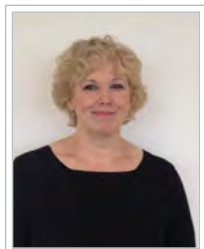
Shape of Training carries on in the background. It is recognised that it will be a major change, not only to the way we train but also to the way the NHS works. Any change will be slow and implementation gradual over many years.

Finally I would like to thank those of you who voted for me in the FICM Board Election. I feel privileged to be able to continue in my role and hope that, with all TAC members, we can successfully navigate the stormy seas.

FFICM Examination Calendar 2016

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications & fees not accepted before	Thursday 14th July 2016	Monday 17th October 2016
Closing date for Exam applications	Thursday 1st September 2016	Thursday 24th November 2016
Examination Date	Tuesday 11th October & Wednesday 12th October 2016	10th January 2017
Examination Fees	Both: £570, OSCE: £315, SOE: £285	£470

Regional Workforce Engagements: West Midlands



Ms Angela Himsworth
Midlands Critical Care Network
Manager

The Midlands Critical Care Operational Delivery Network (CCODN) hosted a Regional Workforce Engagement on Friday 20th May on behalf of the Faculty of Intensive Care Medicine. This event was the second one to be run by the Faculty but the first run in England. The pilot meeting was run in Wales in November 2015.

Medical Leads and Faculty Tutors were invited to attend the day from all organisations within the West Midlands Deanery. Daniel Waeland (Head of the FICM) opened the day which was followed by presentations given by Dr Andrew Rhodes (FICM Workforce Lead) and Dr Zahid Khan (Network Medical Lead). The presentations provided some background and data which detailed the issues that the profession is facing; these included changes in the national commissioning of junior doctor placements/ training schemes in ICM.

The main aim of the day was to facilitate information gathering on the current medical workforce working within critical care across the region and to focus on what the future requirements are likely to. This was achieved through direct contact and dialogue with the Medical Leads and Faculty Tutors as well as providing the opportunities to discuss any immediate concerns / issues.

Data was collected from the provider Trusts through the Faculty prior to the meeting on unit demographics, current medical and nursing workforce along with what future predications might be for the same services within the next five to ten years.

The day had two break-out sessions which provided quality time for group discussions; the first

session focussed on current gaps and immediate concerns and the second on mapping the future. Representatives from the 13 organisations present who covered 20 critical care units were asked to consider the consequences and implications of separating critical care and anaesthesia rotas, morale as well as possible effects of future service reconfigurations within the region. The first break out session focused on capturing each unit's medical workforce, working patterns and gaps in each unit whilst providing a valuable insight in to challenges being faced by individual units, creative solutions adopted to deal with shortfalls and gaps along with impacts made to the speciality following service reconfigurations within some organisations.

The second breakout session concentrated on what life might look like in the future five to ten years hence. New models of working and other staffing options were debated and discussed in an effort to address some of the areas predicted to be problematic, especially in relation to reduced junior doctors rotations and replacement of experienced consultants approaching retirement.

Common themes and challenges from both of the break-out sessions were identified and incorporated into a detailed report which reflected information pertaining to each organisation represented, findings from the day and potential solutions.

For more information on the engagements and how to request a meeting, please visit the new FICM website:

www.ficm.ac.uk/workforce/local-engagements

Smaller Units Advisory Group



Dr Chris Thorpe
Chair
Smaller Units Advisory Group

Smaller units are generally situated in smaller hospitals, exceptions being specialised units. Withdrawal of critical care services to these hospitals is clearly a non starter and so we are left with two options: either the hospital should close and amalgamate with another to form a bigger acute hospital, or we look at how best to deliver the critical care to the hospital as it stands.

As we do not work in isolation, we need to make sure we see the wood clearly through the trees. The population is getting older and there are an increasing number of elderly, frail patients requiring hospital care. This group benefit from having care as close to home as possible. Quite apart from the difficulty for relatives and partners once a patient is admitted, there is evidence for a distance decay effect where patients are less likely to utilise care with increasing distance. This effect is particularly seen in vulnerable groups such as people on low incomes, the elderly and those with disabilities.

The Nuffield Trust has an active campaign at present challenging the accepted view that 'bigger is better'. The Academy of Medical Royal Colleges and the Nuffield Trust recently held a meeting which looked at services in smaller hospitals and geographically remote locations. The meeting was attended by a surprisingly large number of the great and good and the conclusions of the day were overwhelmingly in favour of supporting these hospitals and exploring ways in which effective care can be delivered, accepting that models may be different from those in larger hospitals. The King's Fund published a paper in 2014 looking at evidence for reconfiguration and found no evidence that there were any financial savings in reconfiguration, and that increased quality was

limited to a very small number of specialties such as vascular and trauma care.

With the background of wider support for local hospitals to retain acute care, we have to provide sensible support to those patients who either present with critical illness or develop it once in hospital. It is not financially or logistically realistic to provide this to tertiary centre standards, and this is a conundrum for us. All care should be provided to the same standards, which is reasonable as long as those standards are causally linked to outcomes. In many smaller, or medium sized, hospitals they come up shy of one or two standards but outcome measures are good.

So to the Smaller Units Advisory Group (SUAG); we tried to define a 'smaller unit' which led to quite a wide-ranging discussion. We found a lot of the issues we are looking at affect many medium size DGHs as well. The discussion to date has resonated with specialist and military units who also have also contacted us. It is a term therefore used loosely to include any unit that feels they need support and although perhaps aimed principally at DGHs initially, it is clearly a broad church.

We have reviewed the GPICS document and looked at areas of difficulty for smaller hospitals. We have heard from a number of hospitals and units with a variety of problems and potential solutions. Our next step will be to work with the Joint Standards Committee to explore how these units can help by contributing to further editions of GPICS.

Thanks to the group for their input which has been refreshing and edifying. We are all very keen to hear what is happening at the grass roots level. Do get in touch if you want to discuss things.

ePortfolio Update



Dr Andy Gratrix
ePortfolio Lead

Just over 12 months ago I saw an advert asking for expressions of interest for the position of FICM Lead for ePortfolio. Louie Plenderleith had done a fantastic job of initiating the ePortfolio project, developing it from the ground up and then seeing it go live. I thought it would be an interesting project that I could see myself being able to assist with, and potentially influence something that was a necessity for ICM trainees but was not looked upon favourably.

Much to my surprise some six weeks or so later I received an email from the Faculty stating that I had been successful. What had I got myself into? The one saving grace was that the Faculty had also appointed a deputy lead in Pete Hersey. This has been a successful combination as I come to this as a RA with a significant interest in education and Pete as a FT, also with an educational background but also his significant IT and website skills. We also have a fantastic team at FICM which includes Susan Hall, Anna Ripley and Daniel Waeland without which none of this would be possible. Thank you.

The ePortfolio was in good shape but needed to develop further as trainees were now progressing through the curriculum. We asked RAs and trainees for comments and questions regarding what they would like to see and how could the portfolio be changed or improved. Responses came flooding in, along with our own opinions from our own experiences, which gave us quite a long list of things to discuss!

We had our first meeting in September 2015 and thankfully Louie was able to attend and give the team a detailed presentation of the ePortfolio to date. This was very informative in not only educating us about some of the parts of the portfolio we had

not experienced, but also gave us a unique insight into what had already been achieved, what was outstanding and significantly clarified some issues. An action plan was devised for the months ahead.

So, what have we achieved? Well, in nine months quite a lot. As I'm sure you can imagine some changes are easy to make and can now be done by the Faculty but some are more complicated and require discussion with NHS Education for Scotland (NES) and may or may not require funding, and some are impossible.

Some of the most significant changes made so far are:

- Role specific user guides for RAs, TPDs, FTs, ESs, ARCP assessors and trainees all accessible through the ePortfolio and FICM website
- ARCP assessor role added
- Electronic Stage 1 and Stage 2 training certificate forms
- Five additional stage 1 curricula along with the one in use at the moment which will be selected as appropriate when the trainee account is created. This will change the competencies that have been achieved from core training depending on their entry route i.e. ACCS EM, ACCS AM, ACCS Anaes, CAT, CMT
- Top 30 cases curriculum
- Changes to the educational agreement form from a single form to an individual form for each initial meeting, interim meeting and final meeting
- Special Skills Year completion form
- Education session at the RA/FT/TPD education day

Areas under discussion and potential challenges in the future include:

- Area for logbook summary to be uploaded
- FICM logbook
- Training Videos
- Adapting the e-portfolio for new FICM curricula
- New NES e-portfolio platform affecting all NES portfolios

We have also engaged with the trainees and selected two trainee representatives to join the

development group. Dr Hywel Garrard and Dr Dafydd Williams have been selected and are very welcome. We hope they bring a different perspective and many new ideas to the group representing their trainee colleagues.

Can I once again thank all of the team as without their hard work and dedication to the project none of this would be possible. We hope to make the use of this system educationally beneficial to the trainees but also as user friendly as possible for all. Any questions or suggestions for improvement please get in touch.



e-Learning for Intensive Care Medicine

NOW AVAILABLE!

Only just launched, e-ICM is a joint venture between the Faculty of Intensive Care Medicine (FICM), e-Learning for Healthcare (e-LfH) and the Department of Health (DH). The program will provide 10 modules of resources (e-learning sessions, open access review articles, guidelines and self-assessments) covering the FICM syllabus.

Whilst the resources will be particularly useful for trainees undertaking Stage 1, they will also be of interest and use to anyone caring for the critically ill or preparing for the FICM examination.

Please keep an eye on the FICM website as further modules are launched.

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

Regional Advisor Update: Silence is not golden



Dr Daniele Bryden
Lead Regional Advisor

I've just attended the RCoA College Tutors Meeting by invitation of the Lead RA in Anaesthesia, Darrell Lowry. Questions at the workshops I ran were focussed on how we make the detail of the dual CCT programme in ICM and Anaesthesia operate within a region, something the RAs in ICM have been working hard on locally.

In the past year, it has felt like all the effort many have put in to establishing and supporting ICM training previously is really starting to come to fruition. There is a recognition amongst trainers that a national training template might need some local tweaking to be deliverable and the ability in terms of local training structures and committees to now do it.

The relative dark cloud on the training horizon is trainee morale and welfare, particularly amongst those engaged in dual programmes. Contract uncertainties may have impacted on the number of people applying for ICM training this year, but not the quality of applicants. We must do our best to hold on to and support them in their training. In the RAs meeting in September we will be paying particular attention to Stage 2 ICM training, looking at ARCP outcomes, exam performance and curriculum delivery in the blocks of paediatrics, cardiac and neuro. We must be sure that what we ask of trainees is deliverable, as well as being mindful of the desire to develop ICM training to reflect the future needs of the specialty. To this end we are also planning to look at echo and ultrasound training in the regions and establishing how widely this is being delivered as well as any barriers that may exist to expansion of training. We know that 40% of Faculty Tutors and some RAs are not getting support for their roles in terms of SPA or duty leave, and are in effect doing

the work 'pro bono'. Does a similar barrier exist to the development of echo and ultrasound skills?

Worryingly the NHS Practitioner Health Programme has demonstrated a reduction in the average age of those accessing their services, reflecting the pressure felt by senior trainees and those in the early years of consultant practice: the rate of referral for those under 35 is proportionally twice as high as those over 45 [1]. Burnout and anxiety are growing complaints in the younger groups. I'm keen that the RA system can provide a structure to flag up any local issues that may be contributory. My impression is that the RAs in ICM have always had a far more clearly defined role than our equivalents in our partner specialties, and we are very fortunate that as a result we have tried to maintain a strong and clearly defined voice locally.

One LETB, North West Deanery, is now establishing the first School of ICM that I'm aware of, with a specific Head of School and support from Sarah Clarke and Mark Hughes as Regional Advisors. This is an interesting development and another means by which we can potentially exert the influence that may be needed on the trusts that are not valuing educational support as well as improve opportunities and support for trainees in ICM training.

Without a voice, we will not be heard. Make use of and maintain contact with your Regional Advisor so we know what the issues are.

[1] Gerada C et al. Young female doctors, mental health, and the NHS working environment. <http://careers.bmj.com/careers/advice/view-article.html?id=20015983> accessed 10 June 2016

Spotlight on Peninsula



Dr Mark Sair
Regional Advisor for Peninsula

Four years ago the South West region divided along historical deanery boundaries into two distinct geographic areas. The north of the region became Severn and in the south the 'Peninsula' was born. The Peninsula consists of arguably three of the most stunning counties in the UK namely Cornwall, Devon and large parts of Somerset.

Training is largely delivered by four acute trusts (South Devon in Torquay, the Royal Cornwall Hospital in Truro, the Royal Devon and Exeter Hospital in Exeter and Derriford Hospital in Plymouth.) All trainees rotate through Plymouth in Stages 2 and 3 as Derriford has nearly all major specialities on site and is the regional neuro/cardiothoracic/trauma centre. One exception is paediatric intensive care which is provided in Bristol (in Severn) at the Children's Hospital and our trainees are lucky enough to spend three months in PICM regardless of their partner speciality. All of our ICM trainees are training, or plan to dual train, in a partner speciality. Most come from an anaesthesia background but roughly a quarter are from acute or emergency medicine.

The Peninsula has a smaller ICM programme than many other regions, but in some respects this is one of its strengths. We produced 4 CCTs per year in the old 'Joint' system and for now continue to recruit this number through the national recruitment process. Naturally, we would like to see more expansion in training numbers but as with all new developments the rate limiting factor is finding new money!

The training environment is busy with perhaps a slightly older demographic in parts of the region. There is a varied case mix and outcome data is amongst the best in the UK. There is a long history of supporting ICM training with supportive trainers

and diverse educational opportunities in each Trust. These range from lively journal clubs to the latest in simulation technology, computer apps or hyperbaric chamber in the Tamar Science Park. There are numerous courses aimed at all levels of experience. The basic Intensive Care Medicine course has been run successfully for a number of years in the Peninsula. There are also twice yearly Core Ultrasound Skills in Intensive Care and Focused Intensive Care Echocardiography courses and what has become an annual bronchoscopy workshop. Echocardiography and lung ultrasound are increasingly performed 'in-house' and in Derriford there is a weekly echo review meeting to discuss the most interesting ICU cases. Historically the region has achieved excellent examination results and there is monthly protected teaching aimed at the ICM curriculum with a venue that rotates between Trusts. All the units contribute to local and national research projects and many of our trainees are involved with the highly successful and much lauded regional trainee research network (SWARM). Our regional society, the somewhat questionably named SODIT (Society of Devon Intensive Therapists), holds a highly regarded summer meeting (usually somewhere near a beach) and this is always a very popular event with trainers and trainees alike!

The Peninsula is a great place to live and work. From seemingly endless coastline, to rolling hills, national parks and vibrant towns and cities, the Peninsula has much to offer. I could wax lyrical about quality of life, work life balance and professional satisfaction, but in the South West it really is possible to have the best of both worlds. If you are interested in training in the South West feel free to contact myself or my colleague and TPD, Dr Rob Jackson.

FFICM Examination



Dr Andy Cohen
Chair
Court of Examiners

The nature of the FFICM continues to evolve. New trainees coming through the system will see the exam as part of their training, the gateway to ST7. Candidates are now able to look through examples of exam questions on the website and after each exam they can see a breakdown of topics covered and comments made by the examiners about current issues with candidates, weaknesses or strengths. The numbers of candidates presenting for the exam are slowly rising year on year with the overall success rate falling slightly.

The aim of a training scheme should be for only suitable applicants to be enrolled and for them all to be trained to the appropriate standard. This would mean that when they present for an exam as part of the assessment of training the pass rate should be close to 100%. Training does not work like this because trainees are people and sometimes things do not go to plan, nevertheless our aim is to run a fair exam. The pass rate is not set by the Faculty, it is a function of how many candidates reach the standard set by the examiners. Various techniques are used to ensure that the exam is fair, such as objective methods of standard setting, exposure of candidates to large numbers of examiners and the use of auditors and visitor feedback during the exam sitting.

FFICM examiners are subject to regular training and updates including equality and diversity. They also undergo appraisal and regular audit of their role as examiner.

Being a postgraduate examiner involves commitment both during and between exams. Despite this we are regularly approached by those interested in becoming new examiners. This year we have advertised again to increase the cohort. The increase

in numbers is to deal with retirements and to allow us to accommodate increasing numbers of candidates. Those putting themselves forward will typically have had experience in education, training and assessing trainee intensivists and have showed an interest in the work of the Faculty.

The exam is designed to test all parts of the curriculum. Successful candidates can feel proud that they have demonstrated their skills to the satisfaction of more than 20 examiners they will have met personally as well as others involved in the written part of the exam. This year I was invited to attend the Diplomates Day to introduce the prize winners from the first few years of the FFICM exam. This was held at the impressive Westminster Hall within walking distance of Buckingham Palace and Big Ben. The day was celebrating those who had been successful in all of the exams run at Churchill House, including Anaesthesia and Pain Medicine. The FFICM prize winners were those selected to win the prize for each academic year the FFICM exam has run, currently 2012 to 2015, with the prize winner for academic year 2015-2016 still to be approved by the Board. They were: Dr John Henry Glen, Dr Allan Gerald Howatson, Dr Michael Peter Ward Jones and Dr Fiona Anne Wallace, all of whom truly deserve to be rewarded for their notable effort. To win the prize candidates have to perform at the highest level in all parts of the exam at their first sitting. I met with our current prizewinners after the ceremony and they noted that all of the winners of the FFICM prizes originate from Scotland, although there had been some movement South since birth. I could not help feeling they were challenging the rest of the UK to break their run. Since becoming Chair, after each exam I have published a list of topics covered in the exam in addition to my report. As the numbers

of candidates rise we need to use larger numbers of questions which means my list becomes larger. This tends to reduce the value of the increasingly long list of topics published as so many are covered I may as well just refer to the syllabus. It would be useful to know from readers if publication of topics covered in each FFICM is valuable. If there is little call for it I will stop the practice.

Visitors to the exam remain enthusiastic about the process and generally consider the standard is about right. They are often more hawkish than the examiners. They provide valuable feedback and their comments are always relayed to the Court of Examiners at the evening call-over. Lay representatives amongst the visitors help ensure that the exam remains suitably patient centered.

After previous exams I have had to feedback about poor candidate performance in some OSCE stations such as imaging and ECGs with particular reference to a practical, structured approach. It seems things might be getting marginally better but examiners still advise that candidates should

consider spending some time with clinicians with a special expertise or interest in these fields to hone skills before the exam. More pleasing is the good impression the lay visitor got of candidates he observed in the communications station.

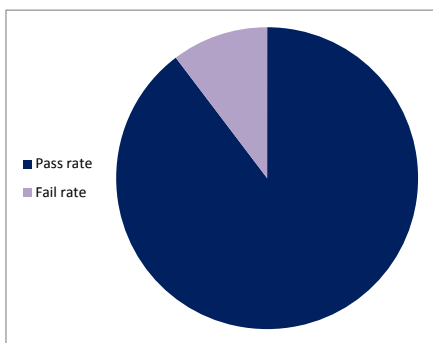
The data in the tables and pie charts shows a summary of the success rate of candidates in various parts of the exam over the last two sittings. It should be remembered that not all candidates sit all components of the exam.

I would like to thank the RCoA Examinations Department who continued to run the exam in an extremely professional manner, allowing examiners to concentrate on the assessment of candidates while being very well supported. I would also like to thank Dr Vickie Robson (Deputy Chair), the Chairs of the various parts of the exam – Jerome Cockings (Audit), Gary Mills (SOE), Jeremy Cordingly (OSCE) and Jeremy Bewley (MCQ) – as well as all of the Court of Examiners – for all their hard work in setting and running this examination.

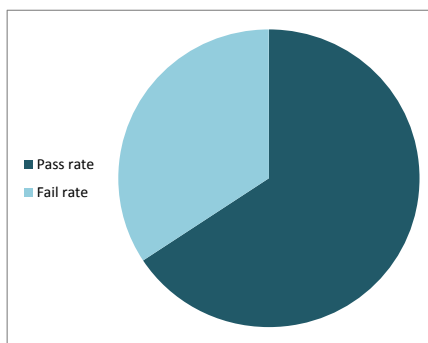
MCQs	Jul 2015	Jan 2016
Applications	74	90
Withdrawn	2	7
Absent	0	0
Pass	65	74
Fail	7	9
Total	72	83
Pass Rate	90.28%	89.16%

OSCEs/SOEs	Oct 2015	Apr 2016
Applications	91	91
Withdrawn	5	2
Absent	0	0
Pass	60	55
Fail	26	34
Total	86	89
Pass Rate	69.77%	61.80%

Annual Pass Rate: MCQs



Annual Pass Rate: OSCEs/SOEs



FFICM Examination Prep Course

Thursday 22nd September
&
Friday 23rd September

Day 1:

Lectures & Workshops including: Ethics, the law and ICU, Microbiology, Neurointensive care, Burns, Organ donation, ECG interpretation, Fluid analysis, Trauma

Day 2:

OSCE and SOE Practice with experienced FFICM Examiners

Venue: The Rose Bowl, Portland Crescent, Leeds LS1 3HB

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

CESR and Equivalence of Training



Dr John Butler
CESR Assessor

In order to work in a substantive consultant post in the UK, doctors must be on the Specialist Register of the UK General Medical Council (GMC); this can be achieved by attaining a CCT or a CESR (Certificate of Eligibility for Specialist Registration). A CESR is awarded to doctors who have completed all or some of their training outside of a UK training programme and whose training and experience is assessed against the current UK CCT training programme.

Equivalence procedures are the responsibility of the GMC and are covered under Article 14 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. All CESR applications are made directly to the GMC and not to the Faculty.

A candidate must be able to demonstrate that they have the equivalent level of knowledge, skills, qualifications and experience outlined in the CCT curriculum. Applications will be judged against the GMC-approved Specialty Specific Guidance for ICM CESR applications, as well as the GMC's generic guidance of evidence to support a CESR application.

Candidates are required to provide substantial documentary evidence in order to support their application (usually 800-1000 pages). Applicants are required to demonstrate possession of an acceptable test of knowledge; previously accepted examples include the European Diploma for Intensive Care and the Fellowship of the College of Intensive Care Medicine of Australia and New Zealand. The GMC will then assign an advisor and request structured reports from the candidate before checking the evidence provided and issuing a checklist to the applicant.

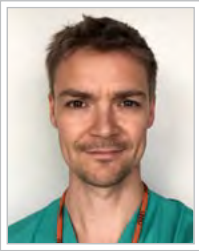
Once the GMC has collected what it considers to be a satisfactory range of evidence, it will send the application to the Faculty for consideration. Applications are assessed by the Faculty's Equivalence Assessors against the most recent GMC approved curriculum under the four domains of Good Medical Practice. It is necessary to demonstrate competence at level four (expert) in most of the competencies outlined in the curriculum. A recommendation report is then submitted to the GMC. This is a recommendation rather than a decision as the GMC do not have to agree with the Faculty's recommendation and can issue their own decision (although they have always agreed to date). The GMC then has a statutory obligation to issue the applicant with a decision within three months.

If the application is approved then the doctor will be added to the specialist register. If the application is unsuccessful then the GMC will outline a series of recommendations on how the doctor can address these deficiencies in a clear and specific way. These recommendations will be divided into two parts: a description of the further training needed and the evidence required to support this. Unsuccessful applicants have the options to reapply once they have gathered the evidence to show they have met the recommendations or to appeal the initial decision.

Applications for a CESR involve a considerable amount of organisation and structure. Applicants should be aware that most weight is placed on evidence gained in the last five years and that all of the submitted evidence will be considered by the assessors.

Further information can be found on both the GMC website www.gmc-uk.org and FICM website www.ficm.ac.uk/faqs/cesr-and-equivalence-queries.

CESR: a title of imperial character



Dr Lee Allen
ICM Consultant

A Certificate of Eligibility for Specialist Registration (CESR) is a route for overseas Consultants, Specialty Doctors, Staff and Associate Specialists and others to gain entry to the specialist register, usually in order to apply for a UK Consultant post. Not one to do things by convention, this is the (lesser trodden) path I chose to take.



CESR application ready for posting

Firstly, applying for a CESR involves a considerable amount of work and the time this takes should not be underestimated. I say this not to discourage but to highlight the fact that this is a marathon not a sprint, so prepare and pace yourself. I would highly recommend speaking to someone who has experience of the process for tips and advice before starting.

It was my determination to pursue a career as a dedicated critical care doctor (combined with the lack of funded ICM training posts in Scotland) that led me to take ownership of my own 'training' as a Specialty Doctor. Gathering evidence is relatively easy, yet its importance cannot be overstated. A CESR application is simply a demonstration that you have adequately covered the current specialty curriculum. The GMC suggests an application

should be around 1000 (single sided!) A4 pages. Any less than this and the evidence is probably insufficient, but much more than this and you probably haven't exercised due diligence in refining your application. I found the GMC website guide a useful reference, and the equivalence advisors were helpful to talk to. I also contacted the Faculty of Intensive Care Medicine for advice, and would suggest this to anyone preparing a CESR application.

After many months of blood, sweat and tears I had amassed a significant bundle of evidence and was ready to submit my application. However a contents list of all evidence needs to be uploaded to the website, separated into 13 domains set out by the GMC. It takes some time to divide 1000 pages into the relevant sections, and I would advise printing

out the dividers early in the process to make the life easier. Payment is made at this final stage, but officially the application is 'open' from the day it is started online. I would recommend collating as much evidence as possible prior to this since applications only remain active for six months.

“ I found the GMC website guide a useful resource, and the equivalence advisors were helpful to talk to. I also contacted the FICM for advice and would suggest this to anyone preparing a CESR application ”

If by this time it has not been completed and submitted then the contents are lost and a new application is required. I submitted my application, and after three long months (plus five ink cartridges, one whole tree, £17 in postage and two tipp-ex mice) was unsuccessful. Disappointed was an understatement. However I received feedback from the Faculty that clearly laid out those areas where my application was felt to be insufficient. As much as I was deflated, this felt like a glimmer of light at the end of the tunnel. I had 12 months to complete the recommendations in order to re-submit the additional evidence under the same application. (It is worth noting that this re-submission also incurs a fee, payable over and above the initial application cost.)

The toughest challenge I encountered was arranging three and six month placements necessary for me

to fulfill the curriculum, (PICU, Acute Medicine), as a 'non-training' doctor the Trust had no

obligation to release me from my post to another specialty whilst continuing my salary. Furthermore, with staffing difficulties there was reluctance to agree to an unpaid sabbatical. Fortunately, my consultant colleagues were supportive and I eventually succeeded in negotiating time out for the necessary placements. There is an SAS development fund that can be accessed for such placements (See BMA website for

details). This support can cover salary payments during unpaid leave taken to complete 'top-up' training for a CESR application.

Finally, having fulfilled the Faculty recommendations I re-submitted my application and felt confident that it would now be approved. And luckily for me it was. Actually no, strike that. Luck played no part; just hard work and determination.

“ I received feedback from the Faculty that clearly laid out those areas where my application was insufficient. As much as I was deflated, this felt like a glimmer of light at the end of the tunnel ”

MY TOP CESR TIPS

- Keep evidence of everything
- Be organised from the outset: It is much easier than trying to catch up on paperwork retrospectively
- Match your evidence to the current curriculum
- Arranging secondments from a service-provision post can be hard, but it is possible.
- Anonymise & redact ALL identifiable information from your evidence – check and check again. (See GMC rules for what this applies to.)
- Don't lose heart – perseverance will pay off

VISIT THE NEW FICM WEBSITE
www.ficm.ac.uk

Professional Standards



Dr Simon Baudouin
Co-Chair
Joint Standards Committee

The role of external inspection in the drive to improve clinical standards has become a fact of life in the modern NHS. The most recent iteration of this process are the Care Quality Commission visits to English Trusts with similar inspections occurring in Scotland led by Health Care Improvement Scotland. A significant number of these visits have now been performed and we invited Claire Land, Senior Designer for the Acute Policy Team at the CQC, to a recent JSC meeting to update us on both the process and the outcome. The CQC inspections of critical care services have been informed by GPICS produced by the Faculty and Intensive Care Society and the CQC has acknowledged the importance of this document in their process.

Critical care, as assessed by the CQC, is in general a high performance area within the NHS and many of their visits judged the units to be either good or outstanding. This is a great credit to the critical care community and should be a cause for celebration. However, we should not become complacent as not all units reached this level. The JSC intends to work with the CQC and the Clinical Networks to identify areas where further improvements could occur and to offer advice and assistance to units that would benefit from external advice or assistance.

The Acute Lung Injury evidence-based guideline is finally moving towards completion. Whilst guidelines are useful as a source of information it is their implementation that is important. The guideline will contain implementation tools but the development of a national acute lung injury audit would be a very useful method of ensuring that these standards of care are being delivered in the NHS. We hope to develop such an audit based on recommendations produced in the guideline.

All successful committees need renewal and the Joint Standards Committee is no exception. We advertised for, and appointed, three new members to the committee as Faculty representatives and they will shortly take up post. Both Tim Gould and I will step down and I would like to thank Tim for his hard work and input into the committee over the years. Finally, I would also like to acknowledge the Faculty administrative team who have been a fantastic support to myself and the committees. Daniel, Anna, Dawn and James (the last of which has gone on to pastures new) have been the backbone that has made the Faculty such a successful organisation. My thanks go to all of them.

If you would like to contribute to Critical Eye we'd love to hear from you!

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

ficm@rcoa.ac.uk

Legal and Ethical Policy Unit



Dr Chris Danbury
Chair
Legal and Ethical Policy Unit

We welcomed Dr Rosie Macfadyen from Edinburgh onto LEPU this year to provide some much needed perspective on Scottish Law. Rosie has a Masters degree in Healthcare Law and Ethics from the University of Dundee and wrote her dissertation on ethical and medicolegal aspects of defining futility in the ICU in the context of withholding or withdrawing life-sustaining treatment in the ICU.

I discussed the theme of 'Decision Making' in the ICU in the last Critical Eye; LEPU have commissioned a paper exploring the ethical and legal issues in this area. Hopefully this analysis will be available for publication sometime next year. There continue to be cases reaching the Court of Protection where there have been disagreements between clinicians and family. The general view is that Court helps very few; it is expensive, prolonged and potentially increases tensions between clinicians and the family. LEPU would encourage mediation as an alternative; this has been piloted successfully by the NHS Litigation Authority, who said 'we evaluated the pilot with positive results with a view to extending and expanding mediation as a way of resolving disputes without going to court.'^[1] We understand that similar discussions are also going on at the Department of Health.

Another major interest of the Intensive Care world is Deprivation of Liberty Safeguarding (DoLS). It is a really important topic and has huge implications throughout healthcare, not just our specialty. Jules Brown has written about the potential impact on Intensive Care Medicine in JICS. However, the issue hasn't gone away: the case of F has been appealed ^[2], and the Court of Appeal will hear the case by the end of 2016. The Faculty and the ICS are considering requesting permission to enter the

case as interested parties. Everyone agrees that the current system is not working as intended, but there remain considerable differences of opinion as to how to deal with DoLS.

However, the whole issue of DoLS may disappear before too long, as the Law Commission is pressing on with its review of the law. They published an interim statement ^[3] on 25 May 2016 and plan to publish a draft bill in December 2016. Early indications coming from the Law Commission suggest that they are very aware of the problems we have in acute hospitals and want to deal with them, but have to do so in a way that is lawful.

In other areas, the Faculty has also convened two new working parties as a result of discussion with the organ donation community; the working parties are focused on Devastating Brain Injury and End of Life Care. Dr Macfadyen will be the LEPU representative on the End of Life Care Stakeholder Group and we look forward to their reports.

Finally, in LEPU we want to respond to any Legal and Ethical issues that you come across, so please do contact us through the Faculty. We are also looking for people to help us with the reviews, so again please let us know who you are and what your legal/ethical interest is.

^[1] NHS Litigation Authority Business Plan 2016- 2017

^[2] R (on the application of LF) v HM Senior Coroner for Inner South London [2015] EWHC 2990

^[3] http://www.lawcom.gov.uk/wp-content/uploads/2016/06/mental_capacity_interim_statement.pdf

Advanced Critical Care Practitioners



Ms Carole Boulanger
Co-Chair
ACCP Advisory Group



Dr Graham Nimmo
Co-Chair
ACCP Advisory Group

Another busy period for the ACCP Advisory Group with increasing numbers both in training, qualifying and achieving FICM Associate Membership. The ACCP CPD document is about to go live to provide a clear framework for CPD/appraisal for trained ACCPs and is available to download from the website. The Advisory Group will also be reviewing the ACCP curriculum which has reached its first anniversary.

We also held our 4th ACCP National Conference hosted in Sheffield in June. This event sold out for the 2nd year in succession. We were fortunate to have three members of the Faculty Board supporting the day with sessions, plus excellent local speakers. The feedback has been very good with a great deal of enthusiasm looking towards 2017. The event will be held on 9th June at the RCoA building in London.

Significant challenges going forward for the group centre around maintaining and assuring a national quality standard for ACCP training and practice. Regulation and registration remain a key agenda item with the prospect of ACCP registration with the GMC a key discussion area. Associate Membership remains the benchmark of achievement, post the 2015 ACCP Curriculum centring on meticulous alignment to that curriculum. We are producing a Higher Educational Institution (HEI) checklist to ensure programmes meet these standards. Some of the key points to note on this are here.

ACCP trainees must:

- Be registered as a healthcare professional, with recent experience of working within critical care and able to demonstrate evidence of appropriate continuing professional development.

- Be legally allowed to become Non-Medical Prescribers (NMP); this includes those registered with the NMC or on the appropriate section of the HCPC register. .
- Have a bachelor-level degree or be able to demonstrate academic ability at degree level .
- Be in a substantive recognised trainee ACCP post, having successfully met individual Trust/Health Board selection.
- Be employed in a unit recognised and approved for, at a minimum, Stage 1 and 2 ICM level training by the Faculty. All clinical training should occur in this setting.
- Be entered into a programme leading to an appropriate Postgraduate Diploma/Masters degree with a HEI, including NMP.
- Be entirely supernumerary during their training.
- Acquire 60 academic credits per year via the completion of HEI modules. The acquisition of NMP is pivotal to the success of the individual ACCP in practice and their full integration into the critical care team. The NMP module is nationally set and counts for 40 academic credits.
- Be in training for a minimum of two years and this should be full time.
- Be awarded a PgD/MSc by the HEI but the full assumption of the role of ACCP requires successful completion of assessment of clinical competence by consultant trainers in ICM.

ACCPs who have satisfactorily **completed** training to a minimum of PgD level with successful completion of ACCP competencies can apply to become an Associate Member of the Faculty. Associate Membership will *only* be granted to those meeting the set criteria. We acknowledge

that we cannot mandate this, and in effect units may set up their own programmes which might include training those who are not eligible, in current statute, to be non medical prescribers. It is essential to state that whilst we understand and share the frustrations around this, it remains the view of the ACCP Advisory Group that NMP is integral to the role in clinical practice. Also worthy of note, ACCPs in practice would in all likelihood be benchmarked against Associate Members in the event of an issue. We continue

to lobby at every level to influence statute change in relation to NMP to support our colleagues who are working or training and who would not currently meet our requirements.

The Advisory Group would like to thank Graham for all of his hard work; Graham has now stepped down from the group but assures us he will remain involved in ACCP training in Scotland.

4th Annual ACCP Conference: Sheffield 2016

‘Valuable subjects relevant to current practice. With emphasis on current research. Interactive workshops brilliant’



‘Excellent content. Very well prepared and informative lectures. Found the workshop on CPD/ appraisal particularly interesting’

‘Very good value for money considering the high quality speakers and catering’

‘Well selected presentations. Wonderful to see the support from our medical colleagues’

‘Excellent standard - fantastic to meet other ACCPs’

‘Looking forward for the next ACCP conference’



**The 5th Annual ACCP Conference will be held on Friday 9th June 2017 at the RCoA in London.
More information coming soon!**

BOMBS, BULLETS, BLOOD AND BUGS

What can the NHS learn from 15 years of Military Intensive Care

Course organisers: Col Jeremy Henning & Lt Col Andrew Johnston

The Faculty's Annual Meeting was held at the Royal College of Anaesthetists on 1st July. After an address by the Dean, the day started along its theme of seeing if the NHS could learn anything from the last 10 years of military intensive care on operations.

The first session looked at the UK Government's response to the Ebola crisis in West Africa last year. Lt Col Christian Ardley outlined the chronology of events and Lt Col Andy Johnston described the clinical course of the disease. Both talked very elegantly about the problems of working in the 'red zone', not only coping with personal protective equipment in extreme heat but also the ever present danger of getting infected. Dr Bob Winter then outlined what happened in the UK over this time. It is clear that not only were there real ethical issues felt by all, but also that communication with the public had to be handled carefully for the disease to be managed well.

After this the next session looked at organisational aspects. Col Jeremy Henning described the development of military Intensive Care over the years, claiming that Florence Nightingale had run the first ICU in Crimea when she cohorted the sickest patients together near the nurses station to allow higher nursing ratios. He then went on to describe how echelons of care delivered elements of ICM far forward in austere environments to ensure the patient arrived in the base ICU in the best possible state. He proposed that this integrated system of care was one of the major factors in the success seen on recent operations. Lt Col Chris Gibson followed showing how the military validation system of exercises honed over years of trauma care had to innovate and change at pace to provide the same (if not better) levels of assurance for the predominately medical operation in Sierra Leone. This inspirational presentation showed how even big organisations can change focus within days to ensure the best outcome for patients. Many in the audience were left wondering how to do this in the NHS.

The afternoon was dedicated to more traditional military aspects of trauma care. Surg Cdr Tim Scott started the session with a presentation on primary blast injury. It was salient to note it's not just the lung that is affected – blast abdomen and blast effects on the brain have both also been well described. Col Paul Parker then braved the audience, as an orthopaedic surgeon he was well and truly 'thrown to the Lions', but still gave a fascinating talk on ballistic injury. True to type he overran, but the audience were well entertained. Surg Cdr Sam Hutchings followed with a paper about the end points of resuscitation. By the end of his session, we were all convinced (if not already) about how poor blood pressure is as a measure of organ perfusion, and we were all impressed with his data looking at the micro-circulation. We all look forward to his prospective multi-centre study – MICROSHOCK. The final session was delivered by Wg Cdr Dan Roberts who showed us the amazing work of the Royal Air Force Critical Care Support Teams, who can evacuate seriously ill level 3 patients across continents within hours of being called.

At the end of the day, the audience had been thoroughly entertained, had learnt a whole lot about military ICM and took away their own thoughts as to what they could implement. Perhaps the most important lesson: Military time keeping – the first Faculty meeting to finish a few minutes early!

Consultations – FICM Responses

Full versions of the responses to these and other consultations can be found on the FICM website. The below are summaries only.

GMC: Confidentiality **February 2016**

The FICM agreed that this was an improvement on previous guidance in some areas (such as conversations with relatives). Some specific comments can be found below:

Paragraph 66: There will shortly be legislation in Northern Ireland about capacity.

The FICM would invite the GMC to confirm that they have run the guidance past a specifically Scottish-qualified lawyer as there is an entirely different jurisdiction north of the border. We would want the GMC to be sure that they can actually apply the ‘best interests’ test here. Further, paragraph 72 is England-specific and this comment also applies to the legal annex.

The FICM understand that the SRA is shortly to issue guidance about disclosing information in circumstances where a patient reveals to a solicitor that they may be about to self-harm. We would advise that the GMC contact the SRA about their draft guidance (if this has not already been done).

The FICM were unsure of the helpfulness of paragraph 77 – are doctors actually allowed to disclose information in such circumstances or not? The FICM felt that the term “not normally” was insufficient.

NICE: Sepsis **February 2016**

We would first like to congratulate the NICE team on producing a high quality, very comprehensive, evidence based review. We are pleased that they acknowledge different levels of risk and different treatment strategies based on this risk stratification. However, we are aware that the new international sepsis definitions are due to be published this month and include risk stratification too. In order not to confuse clinicians it will be vital to ensure that the various trigger thresholds align so that uniform guidelines can be implemented in all hospitals.

We think that a separation of the paediatric and adult guidelines would greatly simplify the presentation of the information in the document. Currently there is significant replication in the sections and it is often difficult to find the relevant sections of adult v paediatric practice.

Treatment algorithms are very useful. However there are also the sepsis six algorithms which have been widely adopted in adult practice. It would be helpful for a single, national algorithm to be proposed by the various organisations to avoid possible confusion and overlap. In particular the use of lactate as a treatment stratification tool is unproven and the single lactate threshold approach of the sepsis six bundles may be simpler to use in clinical practice.

NICE: Care of dying adults in the last days of life **June 2016**

- Improve communication skills of key staff, and subsequently family feedback.
- Documentation of end of life treatment plans should be explicit.
- Treatments, patient and family experience should be broadly similar in the end of life care for patients being withdrawn from life sustaining therapies (organ support) regardless of location.
- DNACPR documentation should be completed using nationally agreed standards.
- Consideration of organ donation, and appropriate referral to the specialist nurse for organ donation, should occur in all cases of withdrawal of life sustaining therapy.

Membership Update 2016

FFICM by Assessment

Abhishek Basu
 Aditya Rungta
 Alice Kim Carter
 Alistair Ronald Meikle
 Alla Mohamed Belhaj
 Andrew James Soppitt
 Andrew McDonald Johnston
 Benjamin David Lakin
 Christopher Flannigan
 Christopher Watt
 Hawthorne
 Clare Elizabeth Hommers
 David John Golden
 David Peter Stanley
 Deborah Louise Horner
 Dominic Joseph Janssen
 Ganesh Kumar Ramalingam
 Gordon Murray Flynn
 Hassan Ahmad
 Helen Louise Tyler
 Hoon Seong Teo
 Iain Donald Macintosh
 James Taylor
 Jenny Townsend
 Jeremy Tong
 Jill Nicholson
 John Kenneth Baillie
 John Paul Lomas
 Joseph Jijin Chackuvail
 Justine Barnett
 Kiran Manjula Prabhakar
 Salaunkey
 Laura Tulloch
 Madhu Shankar
 Balasubramaniam
 Mamoun Mohammad
 Abu-Habsa
 Mark Edward John
 Davidson
 Mark Terris
 Martin John Platt
 Matthew Gaughan
 Meera Subash Bryant
 Michael John Griksaitis
 Nageswar Rao Bandla

Natasha Louise Lawrence
 Peter Anthony Delve
 Peter Brendon Sherren
 Peter Orton Beaumont
 Rahuldeb Sarkar
 Ronan Haughey
 Rose McRobert
 Saibal Ganguly
 Sonia Arun Sathe
 Sridhar Reddy Nallapa
 Reddy
 Stewart Reid
 Suhas Santhosh Kumar
 Susan Kim Dashey
 Syed Muhammad Ali
 Tahsin John Kilic

FFICM by Examination

Aditya Krishan Kapoor
 Alexandra Belcher
 Amy Louise Morgan
 Andrew Chadwick
 Anne-Marie Amphlett
 Anthony David Lewis
 Cochrane
 Benjamin James Greatorex
 Caroline Elizabeth Ferguson
 Caroline Frances Burford
 Chian Chyn Khoo
 Clare Morkane
 Cristian Salbaticu
 Dassen Ragavan
 David Jonathan Cain
 David Richard Helm
 David Robert Palmer
 Ehsan Ahmadnia
 Gemma Caroline Dignam
 Hannah Ruth Brown
 Hazem Lashin
 Iain James Carroll
 Idrisu Odekoyejo Sanusi
 Jason Gittens
 Jennie Rose Stephens
 Jennifer Louise Danielle
 Briggs
 Jian Wen Chan

Jodie February Smythe
 Jonathan James Rivers
 Julian Douglas Wijesuriya
 Kate Anne Sarah Crewdson
 Kathryn Flavin
 Khaled Osman Mohamed
 Elnady Ellisly
 Kieran David Donnelly
 Manohasandra Majuran
 Mark John William McPhail
 Matthew John Martin
 Michael Patrick Dias
 Mohamed Shahparan
 Ahmed
 Mohammed Asif Arshad
 Norfaizan Ahmad
 Pamela Catherine Elizabeth
 Eakin
 Paul Robert Gamble
 Pauline Alison Austin
 Richard Gordon Paul
 Richard Siviter
 Ricky Kevin Bell
 Robert Edward Charnock
 Sarah Louise Jarvis
 Scott Grier
 Stephen Mark Copplestone
 Tahir Ali
 Timothy George Martindale
 Victoria Louise McCormack
 William John Clayton
 Sutcliffe
 Rachel Louise Wadsworth

Associate Fellows

Aoibhin Bernadette
 Hutchinson
 Luidi Geraldo Forni
 Milena Georgieva
 Najaf Ali Khoja
 Omubo Ariwerisobia Davies
 Peter Csabi
 Timothy David Walter
 Mawhinney

Members

Ahmed Sabry Abdelfadeel
 Mohammed
 Anil Kumar Arenahalli
 Neelakanta
 Anita Jónás
 Anshuman Singh
 Deepak Madhukar Mane
 Ganapathy Subramani
 Janardhanam
 Hermant Deshpande
 Lorinc Zavorszky
 Mandeep Dhankar
 Masood Mohammed
 Nicholas John William
 Bolton
 Pamela Louise McGibbon
 Rahul Dimber
 Stephen Richard Stamatakis
 Vallish Kumaraswamy
 Bhardwaj

Associate Members

Alexandra Gatehouse
 Janet Pugh
 John Williams
 Luke Sargent
 Marion Palmer
 Mark Griffith Thomas
 Peter Sewell
 Rachel Mander
 Sadie Diamond-Fox
 Steven Simpson
 Tracy Owen



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ICS State of the Art 2016

5-7 December, ExCel, London, UK



The UK's critical care meeting – rebooted

You told us you wanted something new. We listened.

Welcome to Year 2 of the all-new State of the Art!

It's 2016, when major studies are published as open access and picked apart on social media within 24 hours. Nobody needs a list of pale, male and staid speakers in suits at lecterns with 2 minutes for questions at the end. A conference should be an event, it should be fun, it should be engaging and give you the chance to talk to the people you're paying to see. We made changes. It worked.

Last year: we changed everything - we listened to your feedback and we gave you

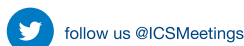
- Exciting new faces and a diverse faculty
- UK rising stars as well as big international names
- Imaginative clinical content - new science and emerging technology, along with the practical information and opinions you need for your day to day practice
- Controversies and pro-cons
- Panel debates, pop-up talks, interactive sessions combining live mic and social media
- Year in Review on key topics
- Shared best practice from international and British units
- Multidisciplinary focus and new workforce models
- Strong social focus with two drinks evenings, restaurant guide, and London helpdesk
- Open access to all conference materials - see soa.ics.ac.uk for access to podcasts, blogs and slides

This year: now is your chance to plan for Dec 5th - 7th 2016 - save the date and book your leave!

Come and meet, debate, and network with your colleagues from around the country and a host of speakers including Peter Brindley, Danny Bryden, Kevin Fong, Adam Hill (McLaren Applied Technologies), Karin Imrein, Jack Iwashyna, Kath Maitland, Louise Rose, Mervyn Singer, Catherine Snelson, Yoanna Skobrik, and Jean-Louis Vincent.

Dec 5th – 7th soa.ics.ac.uk #icssoa2016

listen to last year's talks: soa.ics.ac.uk/podcasts



SICS Scottish Intensive Care Society

26th Annual Scientific Meeting

SICS AGM, Annual Dinner & Ceilidh

Thursday 26th & Friday 27th January 2017

Fairmont Hotel, St Andrews



Guest speakers include

D Needham, G Bellingan, K Brohi, P Shirley, B Winter, C Calderwood, D Wade, R Das, A Plunkett, D Griffith, A Lee, J Payne

Topics Include

Rehabilitation and Post-ICU Recovery, The role of Psychologist in ICU, ARDS: Pathophysiology and Future Therapies, Trauma: Managing Penetrating Injuries and Major Incident, Learning from Excellence and from Complaints, How do I manage: Acute Hepatic Failure, Acute Heart Failure in ICU, Realistic Medicine

Poster and free paper presentation abstract submission deadline: Friday 7th of October at 5 p.m.

For further details please see the SICS website or contact Julie Fenton:

Email: Julie.Fenton@luht.scot.nhs.uk

Tel: 0131 242 1186



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