



Critical Eye



Issue 7

Winter 2015

The Faculty of
Intensive Care Medicine

Inside:

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» Physiotherapy and the ICU

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» Defence Intensive Care Consultants tackling Ebola

Welcome



Dr John Butler
Clinical Editor

Welcome to the 7th edition of the Faculty newsletter, as we look forward to the opportunities and challenges that 2015 will inevitably bring. This winter has seen a nationwide focus on the pressures surrounding acute and urgent care. Through the Academy of Medical Royal Colleges the Faculty has been closely engaged with NHS England and its new Chief Executive in an attempt to find solutions to some of these issues. Further details can be found in the Dean's report which includes updates on the Shape of Training review and developments in integrated care.

This year sees the launch of the *Guidelines for the Provision of Intensive Care Services* (GPICS) document on behalf of the FICM/ICS Joint Standards Committee. This is a significant document for the specialty and is a major step towards developing a definitive reference source for the planning and delivery of UK intensive care services. GPICS is open to consultation until the 6th February so there is still an opportunity to make a contribution. Further details can be found in the reports by Gary Masterson and Simon Baudouin.

Our colleagues Stuart Dickson and Jeremy Henning provide us with a fascinating insight into the workings of the UK Defence Medical Services in the midst of the Ebola virus outbreak in West Africa. The UK response to the crisis is focused on Sierra Leone and the update in this issue highlights the excellent work being undertaken by our military colleagues in extremely challenging circumstances.

Having the appropriate levels of trained staff is critical to providing high quality Intensive Care Medicine. The Workforce Advisory Group (WAG) of the Faculty was formed in 2012 to provide information on the current and future workforce. In 2014 the first workforce census was conducted and in their article Dr Jack Parry-Jones and Dr Matt Wise outline the main findings of this interesting report.

As ever, the Faculty welcomes any suggestions for future *Critical Eye* articles. Please send your thoughts, suggestions and feedback 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: www.ficm.ac.uk/news-events

Update from the Dean



Dr Anna Batchelor
Dean

As I am writing this the Christmas decorations have gone, New Year celebrations (rather limited for me as I was on call New Years Day) are over and a whole new year beckons. My unit seems to have been even busier than usual over the holiday period and I'm not sure when the surgeons will get their beds back, they are full of medical patients. The College of Emergency Medicine has been keeping everyone up to date on the state of the nation's Emergency Departments which have been overflowing.

Many of you will be too young to remember the time when Intensive Care Medicine had its (pre-Twitter) 'media moment'. At the end of the 1990s patients were being shipped around the country in search of an ICU bed, matters came to a head when a child died whilst on, as I understand, his second transfer in a quest for a neurosurgical bed. This led to transformational changes in ICM and something similar will be required for emergency and acute care.

NHS England and its new Chief Executive Simon Stevens seem determined to address the problem and through the Academy we have had several meetings with Mr Stevens and Professor Sir Bruce Keogh. It is good that the medical profession is engaged in identifying the problems and trying to find solutions but it is a Herculean task. There seems to be a bewildering collection of attempted solutions in the community from drop in centres to polyclinics and 111. For most people (me included) there are GPs and hospitals, if the first cannot solve the problem, you try the second. A degree of rationalisation seems necessary.

We are engaged with the far right of the problem; there is no way a visit to a walk in centre or a review by an emergency care technician will prevent admission to ICU. But how many times have you

been to review a patient about whom you, and the referring clinician, know pretty much nothing apart from the current crisis? How good would it be if we had a joined up system so we could access information from the GP? You may have seen a proposal we signed up to on developing integrated care: <http://www.ficm.ac.uk/news-events/rcprcgp-joint-statement-integrated-care>. What if we could make this happen? The Faculty will be carefully considering these issues.

The Shape of Training Review rumbles slowly on and it is still not clear what will happen. As I write, the ministers of the four governments should have papers prepared by civil servants after the six seminars held in the autumn. We do not know what recommendations are being made so it is impossible to say if we can support them. The colleges are very reluctant to see shorter training times; if trainees have to be generalists as well as specialists it is difficult to see how that can be achieved in less time than at present. Trainees are concerned that they will be less experienced and competent at completion of training. The thrust of the review is good but as always the devil will be in the detail. The Faculty, as ever, remains closely engaged.

Many of you have heard about, pondered and maybe even consigned to the 'too difficult' box the implications of Deprivation of Liberty Safeguarding. Many ICU patients fit the acid test of being unable to leave and under constant supervision, so should we be notifying all these patients? The Law Commission has been asked to look at the implications for ICUs and other hospital patients, but as we know legal wheels grind quite slowly. FICM and ICS have established a joint policy group to review this and other legal and ethical issues and we will keep you updated.



Defence Intensive Care Consultants deploy to Sierra Leone in response to Ebola Outbreak

Surg Cdr Stuart Dickson FFICM, RN
Lt Col Tim Nicholson-Roberts FFICM, RAMC
On behalf of the 22 Field Hospital
Ebola Working Group

Col Jeremy Henning FFICM, L/RAMC
Consultant in Intensive Care,
Defence Medical Group

After a decade of leading advances in combat casualty care in Iraq and Afghanistan, no-one expected the UK Defence Medical Services to now be operating in the midst of one of the most complex humanitarian emergencies of recent times — the Ebola virus outbreak in West Africa.

The United Kingdom (UK) government response to the Ebola crisis in West Africa is being led by the Department for International Development (DFID) in partnership with various Non-Governmental Organisations, Public Health England (PHE) and the Ministry of Defence. The focus of the UK relief effort is Sierra Leone; a country with whom the UK has a close relationship. The UK is funding the construction of seven EVD treatment centres across the country which when complete will provide 700 beds for the isolation and treatment of victims of this deadly disease. The design, planning and construction of the treatment units is being led by British Army engineers in what is a massive logistical and engineering operation.

The first of the UK-funded treatment centres was opened in Kerry Town, an hour's drive south of the capital Freetown in early November 2014. The larger part of the site comprises an 80 bed facility run by *Save The Children International* for the treatment of Sierra Leoneans from surrounding communities with suspected or confirmed Ebola infection. A functionally separate DFID-funded 12 bedded tented treatment facility is co-located on the Kerry Town site and is currently operated by the British Army's 22 Field Hospital, normally based in Aldershot, with augmentation by specialist medical and nursing staff from all branches of the Defence Medical Services.

The military-run treatment facility in Kerry Town has a four bedded 'Suspected Ward' area, where patients with febrile illness are held in strict isolation and cared for by military medical staff wearing full personal protective equipment (PPE), pending the results of investigations including PCR for Ebola Virus. Those with diagnoses other than Ebola infection are treated appropriately and discharged from the 'Suspected Ward' area as soon as the diagnosis of Ebola infection has been confidently excluded. Those individuals with confirmed Ebola infection are transferred to the eight bedded 'Confirmed Ward' where patients are cohorted (rather than isolated) and receive ongoing supportive care.

The natural history of Ebola virus disease is typically heralded by the onset of a non-specific febrile illness. The illness characteristically enters a gastro-intestinal phase, approximately five days following the onset of fever. The vomitus and diarrhoea produced at this time results in marked volume and electrolyte depletion often rendering the patient prostrate. The highly infectious nature of body fluids during this and subsequent phase of the illness pose an extreme risk to anyone providing care, hence the high rate of infection affecting both informal and formal care providers which has characterised this outbreak. Haemorrhagic manifestations of Ebola infection are well described but seen only in a proportion of those infected. Progression to a severe encephalopathy with associated dehydration, acute kidney injury, electrolyte disturbance and sometimes haemorrhage are the typical precedents to death in this terrifying disease.

The military Ebola Virus Disease Treatment Unit (EVDTU), whilst small, offers a level of supportive care beyond that which can be typically provided in local healthcare facilities. The EVDTU is staffed by seven consultants and Specialist Registrars with backgrounds in Infectious Diseases, Intensive Care Medicine and General Internal Medicine. Nursing care is provided by 42 nurses, healthcare assistants and combat medical technicians. The clinical cadre

is supported by an operations team, logisticians, mortuary affairs team and laboratory personnel.

All clinical care in the EVD treatment unit is provided by staff wearing full PPE, comprising a fluid-resistant white protective suit with hood, wellington boots, two pairs of gloves, FFP-2 face-mask, surgical hat and face visor. Given the environmental conditions with typical daytime ambient temperatures of 30°C and humidity typically in excess of 70% (and often nearer 100%), the provision of clinical care must be carefully balanced against the inevitable physical degradation of staff. In an environment where the slightest mishap may result in a breach of PPE and subsequent exposure to body fluids containing Ebola virus, all clinical care must be carefully planned before entering the ward areas. Depending on the prevailing temperatures and humidity, staff typically enter the EVDTU for periods of 1-2 hours. On exiting the facility, the potentially contaminated PPE being worn must be removed with extreme care. All staff remove their PPE under the direct supervision of dedicated PPE monitors in a carefully controlled and well choreographed doffing procedure.

This all has to be carefully trained for. Every member of staff entering the unit, has undergone a 10 day

package in the UK at the Army Medical Services Training Centre in York. Here a replica of the EVDTU has been erected inside a hanger, and clinical staff spend time looking after simulated Ebola patients, in full PPE. The PPE training itself takes two days, and the effectiveness is tested in the replica unit – actors with simulated disease have UV tracer added to their simulated blood, vomit and other body fluids, which is then traced after the PPE is taken off. This has proven to be a highly effective way of providing assurance that the equipment works.

The clinical management of patients with early Ebola virus disease is typically limited to oral rehydration therapy and anti-pyretics. As the disease progresses and fluid and electrolyte losses occur, parenteral fluid and electrolyte replacement is initiated. Placement of a central venous catheter is undertaken early in the clinical course as patients begin to develop gastro-intestinal symptoms in anticipation of rising levels of viraemia as the disease progresses. Whilst placement of a central venous catheter is undoubtedly hazardous to the operator charged with it's placement, the benefits subsequently in being able to not only administer drugs, fluids and electrolytes but to avoid subsequent use of sharps for venepuncture and peripheral vein cannulation, undoubtedly justifies the initial operator risk. This procedure



The 22 Field Hospital Ebola Working Group

is only undertaken by clinicians with significant experience of central venous cannulation in their normal clinical practice. Whilst undoubtedly there is a risk of haemorrhage from central venous cannulation in those patients with a significant virus induced coagulopathy, the majority of patients tolerate this procedure without such adverse events.

Experience gained in managing trauma induced coagulopathy has allowed for the provision of blood products in the field. We are refining the indications for their use and tranexamic acid in the patients that develop coagulopathy related to EVD. Furthermore, patients are examined by focused transthoracic echocardiography. This provides a rapid assessment of circulatory status in unstable patients and is used to guide fluid resuscitation.

Whilst the military EVD treatment unit provides a higher level of care than is currently available elsewhere in country, it does not offer critical care interventions such as ventilation or renal replacement therapy which would be considered routine in UK critical care facilities, nor would it be practicable to do so. At this time in the outbreak, unproven investigational

drug therapies are limited in supply and are not available in affected countries. Despite these potential limitations, there is no doubt that aggressive supportive care alone can yield significant impacts on the current high case fatality rates. The evolution of a bundle of care comprising fluid and electrolyte management, management of coagulopathy and bleeding, adjunctive anti-infective therapy and management of encephalopathy is showing promising results in the military EVDTU at Kerry Town and will hopefully in time contribute to the evolution of effective EVD case management in both Africa and in western intensive care units caring for patients with imported Ebola infection.

The 22 Field Hospital Ebola Working Group are:

Surg Cdr PSC Rees MRCP(UK) RN
Lt Col C Ardley MRCP(UK) RAMC
Lt Col M Bailey MD FRCP RAMC
Surg Cdr S Dickson MRCP(UK) RN
Maj T Fletcher MRCP(UK) RAMC
Lt Col Hinsley FRCS(Orth) RAMC
Maj L Lamb MRCP(UK) RAMC
Lt Col TC Nicholson-Roberts FFICM RAMC

The Faculty of
Intensive Care Medicine



CRITICAL WORKS

A new two day meeting from the FICM featuring lectures on a variety of CPD topics and on political issues of interest to doctors practising in Intensive Care Medicine

Thursday 14 - Friday 15 May 2015

Full programme can be found on page 26 of this issue

Booking now open via www.ficm.ac.uk or www.rcoa.ac.uk

Professional Standards



Dr Simon Baudouin
FICM/ICS Joint Standards Committee Co-Chair

The creation of the first version of the *Guidelines for the Provision for Intensive Care Services* (GPICS) document has been a major activity of the FICM/ICS Standards Committee over the last year. The philosophy, structure and content of this document are detailed in a companion article written by my co-chair Gary Masterson. GPICS builds on our initial *Core Standards* and adds a number of additional recommendations.

Ideally every standard and recommendation in GPICS would have strong supporting evidence. This is particularly important where the adoption of a standard has major resource implications. Medical professionals, with their science orientated training, are also more likely to adopt standards if these are supported by strong clinical evidence. In the last 20 years or so an evidence-based medicine movement has grown up. This was partially in response to a growing information overload caused by an increasing number of published clinical trials and reports. It was also recognised that the quality of much of the clinical evidence used was very variable and that many trials and studies were flawed because of various sources of bias. These included the favouring by journals of positive trial reports, incomplete data and follow-up information, sponsorship conflicts (including the involvement of pharmaceutical companies in trial analysis) and other important issues. The evidence-based movement has developed various approaches. All these share a systematic methodology used to judge the value of an intervention or investigation. Several systems exist but the Scottish SIGN and the international GRADE approach have been widely adopted.

The FICM in collaboration with the ICS are developing evidence-based guidelines to complement the GPICS work. We have begun this

long journey by forming two guideline working groups. One will focus on therapies in Acute Respiratory Distress Syndrome (ARDS) and is led by Mark Griffiths. The other will look at aspects of delirium and is led by Mark Borthwick. Both groups have conducted initial scoping meetings. Following these it was decided to initially focus on developing methodology with the ARDS group so that we can ensure the process is secure and appropriate before instigating work on the delirium guidelines.

We had decided to use the GRADE approach to quality assessment and recommendations. This focuses on outcomes, usually of interventions, that are important to patients. Relevant randomised controlled trials (where available) are identified by a systematic literature search, predetermined outcome data is then extracted (for example 28 day mortality, quality-of-life at one year) and an estimate of effect size (using meta analysis) performed. Sources of possible bias are identified from the papers and finally a judgement is made on each outcome based on the quality of evidence available. Summary tables are created and the working group then makes recommendations based on an intuitive scale which can be summarised as either 'most patients would want this treatment', 'some patients would want this treatment' or 'patients would not want this treatment'.

This approach to guideline development is very time-consuming and it is clear that we can only support the production of a small number of guidelines at any one time. Evidence-based guidelines are not applicable in all areas of practice and we also plan to develop a series of guidance documents, for example in areas of medico-legal practice.

Guidelines for the Provision of Intensive Care Services (GPICS) 2015



Dr Gary Masterson
GPICS Co-Editor
FICM/ICS Joint Standards Committee Co-Chair

GPICS is a major step towards developing a definitive reference source for the planning and delivery of UK intensive care services, and is needed as ICM evolves into a standalone specialty in the UK. GPICS will be of relevance to clinicians involved in the management and design of critical care services; hospital managers; commissioners; Adult Critical Care Operational Delivery Networks; and the NHSE Adult Critical Care Clinical Reference Group. However, GPICS also includes clinical topics and will also be of interest to those who undertake clinical audit to improve their practice and for revalidation. Currently the FICM and ICS are co-developing an Audit Recipe Book and future editions of GPICS will link chapters to audit recommendations.

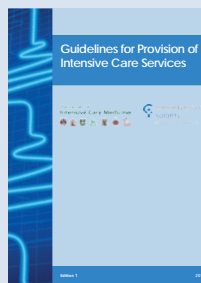
GPICS will be updated and will grow with the addition of new chapters. The recommendations in GPICS are, where possible, based on evidence. However, we acknowledge that in a number of areas the evidence base is incomplete. The FICM and ICS are addressing this gap by developing a portfolio of evidence-based guidelines. With time it is intended to obtain NICE guideline development accreditation to strengthen the authority of our recommendations and standards.

GPICS has been designed so that its chapters and sections are clear and readable. The sections have been written by recognised UK experts in their respective fields and each will have a standard format of an Introduction; Recommendations; Standards; Background; References; and Relevant On-going Research (where appropriate). Some chapters will also have an Additional Information section.

Recommendations will be statements of advice that the authors intend **should** be good practice in UK Intensive Care Medicine and which are endorsed by the both FICM and ICS. Stakeholder consultation is also important and we have consulted with all major UK organisations linked to Intensive Care Medicine as well as the general public. In time and where appropriate some Recommendations will evolve into Standards depending on both available clinical evidence and the consensus opinion of the FICM/ICS Joint Standards Committee.

In version 1 of GPICS, standards quoted by authors are already included in the 2013 *Core Standards for Intensive Care Units* document. These **must** be followed by UK Intensive Care Units and are the major resource for the Adult Critical Care Clinical Reference Group to make commissioning priorities. Both GPICS' recommendations and standards will be key to peer review processes by Operational Delivery Networks on behalf of commissioners and the Care Quality Commission.

GPICS will be published in early 2015 and we hope it will meet the expectations of intensive care colleagues and our patients.



GPICS draft edition is now available for consultation on the FICM website until Friday 6th February 2015.

Please visit <http://www.ficm.ac.uk/news-events/guidelines-provision-intensive-care-services-gpics-consultation> to provide your feedback.

Workforce Advisory Group



Dr Jack Parry-Jones
FICMWAG Member



Dr Matt Wise
FICMWAG Member

“The current provision of critical care is characterised by considerable variation in organisation and delivery, quality, funding and effectiveness ... it is compounded by difficulties in the recruitment and retention of necessary trained staff and in professional training and development that do not match the needs of the individual or the service...”

Critical care, as many of you are only too aware, faces a number of significant challenges. The pain that the current drive for reconfiguration of health care services brings faces most if not all of us. The drivers for reconfiguration may be couched in terms of better outcomes in higher volume centres, or in terms of financial economies of scale but for critical care it is first and foremost our workforce. We are a service entirely dependent on adequately trained nursing and medical staff. As the demand for critical care services rises with patient demographics, coupled with public and professional expectations, the ability to meet that demand with a supply of junior and senior medical staff is falling. If we have the necessary increase in beds without adequately trained staff the quality of care will inevitably fall.

“No amount of equipment can compensate for the lack of appropriately trained staff”

The FICM Workforce Advisory Group (WAG) was formed in 2012. Information about the current

and future workforce is paramount but has been sadly lacking to date. As critical care and staffing standards are agreed, unless we have detailed information about current and future workforce we have no way of knowing whether these standards are an aspiration which can never be met across all UK critical care units.

We conducted the first census this year with a view to an on-going annual census in the same way that the Royal College of Physicians have been doing for some time. We are very grateful to all 787 of you who completed the first census (40% return rate). A large amount of data has been collected from the census and cannot be presented in this short article but will be used as part of our future triangulation and modelling. However one question which stood out to us was “Do you find Intensive Care Medicine stressful enough to influence future career plans?” This is qualitative data but then choosing to stay in the speciality or choosing a career often is a subjective decision.

Reading through the often lengthy comments from 339 (43% of you) was illuminating. The top five biggest causes of stress were trainee numbers and their competencies, lack of beds and resources, the frequency of on-call commitment, poor patient triage and outcomes; and ability to manage up until retirement age. The overall picture is fairly bleak — increasing work load, increasing stress with many looking to drop critical care in later working life or seeking early retirement. On the other hand it is perhaps surprising how much many of you still enjoy the speciality despite these stresses, and how much desire there is to continue in it.

We need both the objective data from the census and the subjective impressions from additional comments so that we can harness as much support for the right solutions to improve the situation over the medium to long term. We also need as many responses as possible in future censuses from all regions of the country as the problems encountered in workforce vary considerably across the UK. It is very unlikely that one solution will fit all; we know that there are

significant differences in the ability to staff units at junior and consultant level across the country.

For some units there may be trainees available at a cost whereas for others there simply aren't any to employ, and for small isolated District General Hospitals separate critical care and anaesthesia consultant rotas are never likely to be possible. We will need objective data over a period of time to support solutions for all regions rather than a single solution suitable for only one region.

Finally the process of getting the questions right is not easy and your patience is sought. Our thanks again to all those who took

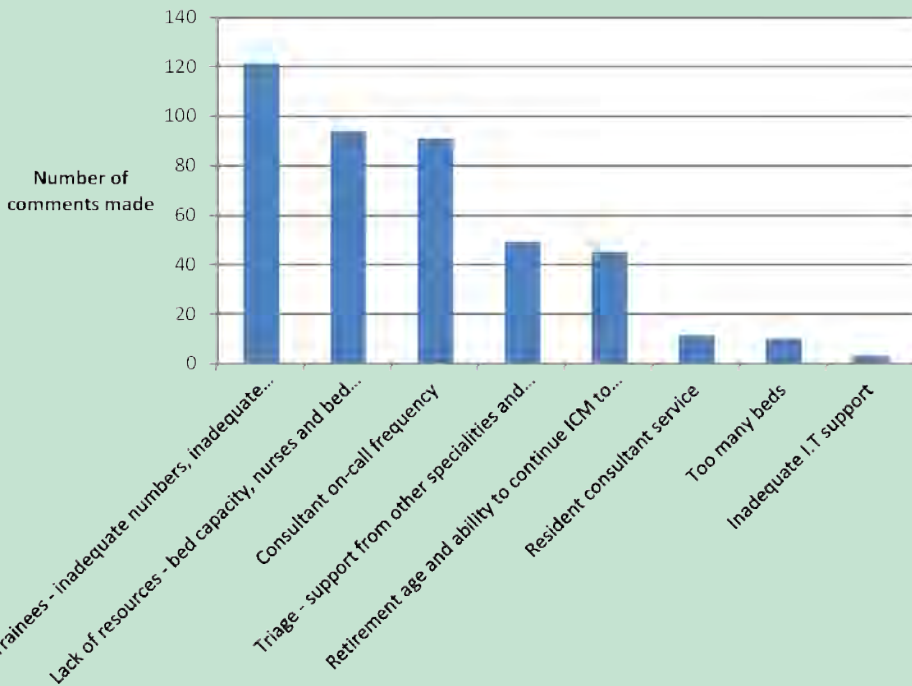
the time to respond last time and please continue to do so. Moreover please encourage as many of your colleagues as possible to contribute so that we can have more comprehensive data to inform our decisions.

“ It is very unlikely that one solution will fit all; we know that there are significant differences in the ability to staff units at junior and consultant level across the country ”

The quotes that appear throughout this article could easily have been written today but were in fact published almost 15 years ago as part of *Comprehensive Critical Care* (Department of Health, 2000). The fact that it is as true today as it was then demonstrates the need for us as a specialty to make the case for change armed

with robust data. Please complete the 2015 census when it arrives in your inbox.

Do you find Intensive Care Medicine stressful enough to influence your future career plans?



Physiotherapy and the ICU



Susannah Betteridge
Clinical Lead Physiotherapist in Critical Care
King's College Hospital NHS Foundation

Physiotherapists have long been an integral part of the Intensive Care Unit (ICU). Traditionally, the role of the physiotherapist on ICU is to treat respiratory complications such as secretion retention and atelectasis in the intubated and spontaneously breathing patient. However, with recent robust evidence demonstrating the long-term effects of Critical Care on its survivors, the role of the physiotherapist has evolved. The Critical Care Physiotherapy caseload is becoming more dynamic and complex to include the rehabilitation and respiratory weaning of patients along with the management of patients with acute respiratory care needs. A patient's course of illness on ICU can change rapidly and physiotherapy delivery needs to be modified accordingly to reflect this often unpredictable environment. Standardised treatment approaches should be avoided and replaced with responsive and flexible clinical reasoning focused on individualised patient care.

It is apparent that despite the challenges of an ageing population, critical care medicine is improving and the numbers of patients surviving ICU admission is increasing. The inevitable nature of critical illness leads to prolonged immobility and subsequent ICU Acquired Weakness (ICUAW). It is recognised that those that survive an ICU admission may suffer functional limitations and reduced quality of life for up to five years (Herridge et al 2011). Despite this knowledge, the early mobilisation of patients on ICU can be difficult and not without risk. There have however been a number of influential articles over the last 10 years demonstrating that early mobilisation in ICU is key to patient outcome (Schwieckart et al 2009, Needham et al 2010) and safe (Stiller et al 2004, Bailey et al 2009).

The pure nature of the ICU environment provides many barriers to the mobilisation of its patients. These barriers range from sedation, delirium, cardiovascular instability to a lack of resources. A multi-professional approach to the treatment and management of patients with ICUAW is essential and aims to reduce the barriers and facilitate rehabilitation on ICU.

The NICE CG83 Guidelines produced in 2009 aimed to improve the rehabilitation pathway delivered to patients suffering with critical illness; promoting goal setting, individualised rehabilitation prescriptions and the use of relevant functional outcome measures. The FICM/ICS *Core Standards for Intensive Care Units* (2013) also strived to further protect and promote the importance of the physiotherapist and other professional roles within critical care.

The ACPRC (Association of Chartered Physiotherapists in Respiratory Care) is a national body and clinical interest group of physiotherapists interested in respiratory care within the CSP (Chartered Society of Physiotherapy). The aims of the ACPRC are; to facilitate clinical excellence, health promotion, education and research in respiratory physiotherapy UK wide. Within the ACPRC there are key lead roles, critical care being one of these. The Critical Care Champion represents the ACPRC at the Critical Care Leadership Forum (CCLF). Given the continued development and emergence of evidence further reinforcing the importance of physiotherapy on ICU it is of paramount importance that as professionals physiotherapists are represented at this level and are part of the team responsible for moulding the future of Intensive Care.

Advanced Critical Care Practitioners



Mrs Carole Boulanger
Co-Chair,
ACCP Advisory Group



Dr Graham Nimmo
Co-Chair,
ACCP Advisory Group

The Advanced Critical Care Practitioner syllabus, curriculum and assessment system are nearing completion. Following consultation with key stakeholders, the documents will be taken to the Royal College of Anaesthetists Council for final ratification. Once this has been achieved they will be released nationally and will be available on the FICM website. These documents provide a robust training and assessment programme which will lead to FICM Associate Member status for ACCPs. The intention is to provide a standardised nationally agreed programme with clear benchmarks for education, competency and practice.

There is steadily increasing interest and course provision from Higher Education Institutions

[HEIs] across the UK to provide courses. Details of appropriate programmes commensurate with the FICM curriculum are provided on the website along with contact information for units training and having ACCPs as part of their workforce. Information can be found at: <http://www.ficm.ac.uk/accps/unit-information>.

The Faculty Board has approved FICM Associate Membership for existing ACCPs who meet the requirements. This has been an important achievement to recognise the increasing number of ACCPs working in clinical practice. Membership is integral to the establishment of the role and association of the role as being commensurate with a clearly defined set of knowledge, skills, competence and practice level. Protection of the title ACCP is not possible in the current political climate where no new roles are currently able to be registered separately. For financial governance reasons, ACCP FICM Associate Member status will go to the RCoA AGM in March next year for final approval. Existing ACCPs will be able to apply for Associate Membership following this approval.

The 3rd Annual Advanced Critical Care Practitioner national meeting will take place at Churchill House on Friday 3rd July 2015. The programme will be published early in the new year.

The FICM ACCP pages provide useful information relating to the role and education provision, if anyone has information to add please contact us <http://www.ficm.ac.uk/accps/training>.

FFICM Examination Calendar July 2015 - July 2016

	FICM MCQ Examination		FICM OSCE/SOE Examination	
Applications and fees not accepted before	Mon 13 April 2015	Mon 19 Oct 2015	Thurs 13 July 2015	Thurs 4 Jan 2016
Closing date for Exam applications	Thurs 4 June 2015	Thurs 26 Nov 2015	Thurs 3 Sept 2015	Thurs 25 Feb 2016
Examination Date	Mon 13 July 2015	Tues 12 Jan 2016	Tues/Weds 13-14 Oct 2015	Tues/Weds 19-20 April 2016
Examination Fees	TBC	TBC	TBC	TBC

Training and Assessment



Dr Alison Pittard
FICMTAC Chair

Time passes quickly in the world of Intensive Care Medicine; it only seems like yesterday that I was writing the last Training and Assessment article for *Critical Eye* and here we are, Christmas a long distant memory and the whole of 2015 to look forward to. Shape of Training seems to have gone quiet for now. Its implementation would have significant implications for the way that training is provided and also on service delivery but the committee are poised to jump in to action where necessary.

There are a number of Special Skills modules in development to add to those previously approved by the GMC, including one on home ventilation and another on education. Hopefully these will be approved in this year's submission to the GMC. We are always happy to consider new modules but would advise early submission to the committee. We successfully lobbied the GMC for an earlier review date to last year so that curriculum updates can be approved prior to the start of the training year.

Other curriculum news includes the development of Core Ultrasound training in Intensive Care (CUSIC). A working party was convened to develop a practical approach to training in this area as current UK guidelines do not cover the areas where ultrasound is used in Intensive Care. The document outlines a training pathway to achieve accreditation in the use of ultrasound. Once there is adequate access to this with an approved mentor in each unit the core skills

will be incorporated into our curriculum. This accreditation will be administered by the ICS.

As we progress through the electronic age we have our ePortfolio established. Additional training days have been hosted around the country and more will be held if required. The ePortfolio group, masterfully led by Dr Louie Plenderleith, have responded to comments from users and refined the system. Any major changes take a little longer to incorporate e.g. including the Stage 1 completion certificate and a separate curriculum for the Top 30 cases. One area we are often asked about is the lack of a logbook. We deliberately do not include one as choice can

be very personal. What we will do is provide links on the FICM website to logbooks that are available. All that is required for the ePortfolio is a logbook summary therefore it is advisable to check what information is required for the summary prior to deciding which logbook to use. We will endeavour to only provide links to those that meet the ePortfolio requirements.

Finally I would like to take this opportunity to thank

Louie Plenderleith for his incredible contribution to ICM education and training over the years. He is retiring from clinical practice and attended his final committee meeting in November. He leaves a huge gap, in particular the upkeep and development of our ePortfolio and will be a difficult act to follow. I'm sure all the committee members will join me in wishing him a very happy retirement.

“ There are a number of Special Skills modules in development to add to those previously approved by the GMC. We are always happy to consider new modules but would advise early submission ”

Training in Point of Care Ultrasound in ICU



Dr Peter MacNaughton
FICM Board Member

Point of care ultrasound in ICU has come a long way in the last decade. Before the publication of NICE TAG 49 in 2002 that recommended the use of ultrasound to guide cannulation of the internal jugular vein, few intensivists would have considered using ultrasound and have predicted its development. In fact, the landmark NICE publication provoked considerable debate and criticism at the time. Twelve years on, ultrasound has become the standard of care for central venous cannulation and trainees are now almost exclusively taught ultrasound guidance in place of the landmark technique. Ultrasound machines have become widely available and the quality of the images and imaging capabilities have advanced considerably, as has the portability with machines now being available that are no larger than the latest smart phone.

Realising the benefits to patient care of ultrasound for central lines encouraged enthusiasts to use ultrasound to guide other procedures including pleural drainage, abdominal paracentesis and difficult peripheral and arterial line access. The move to peripherally inserted central catheters (PICC) for longer-term central access in ICU would not have been possible without the use of ultrasound. Point of care ultrasound performed by intensivists is becoming an important part of the initial assessment and management of critically ill patients. Focused echocardiography can play a pivotal role in the diagnosis and management of patients in shock. Thoracic ultrasound was initially limited to the assessment of pleural effusions and guiding drainage. However, a systemic examination of the lung by ultrasound has been shown to be more sensitive and accurate than the chest X-ray and in experienced hands has a diagnostic ability approaching that of a CT scan. Ultrasound is a rapid and sensitive way of assessing pulmonary oedema, ventilator associated pneumonia and excluding pneumothorax. Lung ultrasound examination can considerably reduce the need for chest X-rays in ICU.

The ability to use ultrasound in the roles outlined above is becoming a core skill for intensivists that has been recognised in the recommendations by a number of authorities in their call for it to be included in the ICM curriculum. Training and experience are key to safe and appropriate use of ultrasound in clinical practice: "A fool with a stethoscope will still be a fool with an ultrasound".

Ultrasound is now included in the undergraduate curriculum of some North American medical schools. Until recently, the UK guidelines for point of care ultrasound training did not include the range of practice relevant to ICU. This has been addressed with the establishment of a Focused Intensive Care Echo training pathway (FICE) and the recent development of a Core Ultrasound in Intensive Care pathway (CUSIC). These training pathways are endorsed by the Faculty, British Society of Echocardiography and Royal College of Radiologists and provided by the Intensive Care Society.

The challenge for the specialty is to ensure that we can deliver this training. Each unit needs to have an ultrasound champion with the expertise to lead and deliver training. Ultrasound is replacing the stethoscope which was first developed by Laennec nearly 200 years ago. At the time there was considerable doubt as to its practicality with one commentator at the time writing "I am extremely doubtful that it will ever come into general practice because its beneficial practice requires much time and gives a good bit of trouble to both the patient and the practitioner". Some may have similar concerns about ultrasound training but we shouldn't inhibit progress. We need to embrace this major innovation in the care of the critically ill and ensure we can deliver the training needed to ensure that ultrasound is used safely and appropriately for the benefit of our patients.

FFICM Examination November 2014



Dr Andrew T Cohen
Chair, FFICM Court of Examiners

In June 2014 I took over responsibility for the FFICM exam from Professor Nigel Webster. I first heard of the predecessor of the FFICM, the 'new' Diploma in Intensive Care Medicine, shortly after starting as a Council member of the Intensive Care Society in 1997. The Diploma's first sitting was in 1998 with Paul Lawler as Chair. Looking at early documentation it was made clear to trainees that although it would be a good thing for those keen on a career in Intensive Care Medicine to take the exam it was nevertheless optional.

Things have changed somewhat in 17 years; I find myself following a distinguished line of Chairs. Nigel Webster's role was to create the FFICM out of the old Diploma. The development of the FFICM was under the watchful eye of the GMC who insisted on the Faculty using the most modern assessment techniques rather than accepting those that may still persist in other colleges.

So what are the features of the final FFICM exam? We have a machine marked test comprising of Multiple True/False questions and Single Best Answer questions with no negative marking; a Structured Oral Exam with independent marking by each examiner and no option for a single examiner veto and an Objective Structured Clinical Exam which is a flexible format used to test a wide range of skills including simulation and communication. In the structured oral exam examiners only ask a single question so each candidate is exposed to the

maximum number of examiners over the course of the exam, thus minimising any risk of bias.

Prior to the last sitting of the exam, 11 new examiners were appointed from a strong field. It is expected that it will be necessary to continue adding to the Court to make up for examiner retirements so there will continue to be further opportunities for those that wish to become FFICM examiners and be involved in the assessment of Faculty trainees. The Faculty provides examiner training for all examiners but

probably the most sought after skill in applicants for future examiners is prior experience of candidate assessment.

There are opportunities for those interested in the exam to visit (details are on the FICM website) but this is limited so I would stress that if you are offered the opportunity to visit please prioritise this commitment. It is not uncommon to find a visitor

fails to attend the exam thus denying someone else this opportunity.

The fourth sitting of the Final examination took place in October 2014. Our candidates are examined in cohorts, all of whom are presented with the same material at the same time. Over the course of the exam a wide range of topics from the syllabus were covered. A list is archived on the Faculty website. The exam standard is set using GMC approved techniques recognising that passing the exam is a requirement of progression to Stage 3 of the Intensive Care Medicine training programme.

“ There will continue to be further opportunities for those that wish to become FFICM Examiners and be involved in the assessment of Faculty trainees ”

The FFICM MCQ

The MCQ was held on 16th July 2014. 49 candidates sat the exam, of whom 34 passed (69.4%). The MCQ pass mark was 70.48%.

The FFICM OSCE/SOE

58 candidates attended the exam, 40 to sit both components, 11 OSCE only and 7 SOE only.

SOE

47 candidates sat the SOE of the 47, 35 (74.5%) passed the SOE component. 7 candidates sat the SOE with a previous pass in the OSCE. 6 from 7 passed giving an 86% pass rate for SOE only applicants.

All candidates	SOE	Total	47
		PASS (N)	35
		PASS (%)	74.5
	OSCE	Total	51
		PASS (N)	36
		PASS (%)	70.6
	Overall	Total	58
		PASS (N)	38
		PASS (%)	65.5

OSCE

51 candidates sat the OSCE, of the 51, 36 (70.6%) passed this component. 11 candidates sat the OSCE with a previous pass in the SOE. Of the 11, 8 passed giving a 72.7% pass rate for OSCE only candidates.

Overall

38 candidates from 58 (65.5%) passed the exam overall and achieved the Fellowship in Intensive Care Medicine. This compares with 63.2% in April 2014. Over the two days of examining 11 visitors attended the exam with a wide range of interests. On this occasion we had visitors involved in training and assessment from hospitals throughout the UK as well as a lay representative, postgraduate examiners from other colleges and an overseas examiner. Feedback was overwhelmingly positive with some

suggestions for change fed back to subgroup chairs. In general it was felt that the standard was as expected with some visitors suggesting the OSCE seemed at a slightly lower standard that they were expecting. It should be noted that the marking of the OSCE exam is done in such a way that neither an examiner nor observer are aware if a candidate passes or not so it is hard to interpret this observation!

On occasion after an exam the Court of Examiners highlight particular areas of practice that warrant comment. On this occasion it was noted that some candidates appeared to consider that they should concentrate only on areas within their own experience rather than the breadth of the syllabus.

That the exam remains a success is due to the hard work of many including the Examinations Department of the Royal College of Anaesthetists without whose considerable help and expertise we would not have been able to conduct the examination so smoothly. I would also like to thank Professor Nigel Webster (Vice Chair), the Chairs of the various parts of the exam – Mike Clapham and Jerome Cockings (Audit), Gary Mills (SOE), Jeremy Cordingly and Vickie Robson (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.

At its meeting in November 2014 the Faculty Training and Assessment Committee approved the creation of an Examinations Sub-Committee to oversee the running and future development of the FFICM. Historically this is of interest because as Honorary Secretary of the ICS in 2002 I was responsible for maintaining details of the ICS committee membership roles and responsibilities. This included a new ICS exams committee. Fortunately the society was able to work in a constructive way with those involved in training and assessment so there was never a need to activate the committee.

After a successful first sitting of the exam for me I now look forward to the future development of an exam which I have seen grow from its inception to become an essential part of the UK Intensive Care Medicine training programme.

Regional Advisor Update



Dr Chris Thorpe
Lead RA in ICM

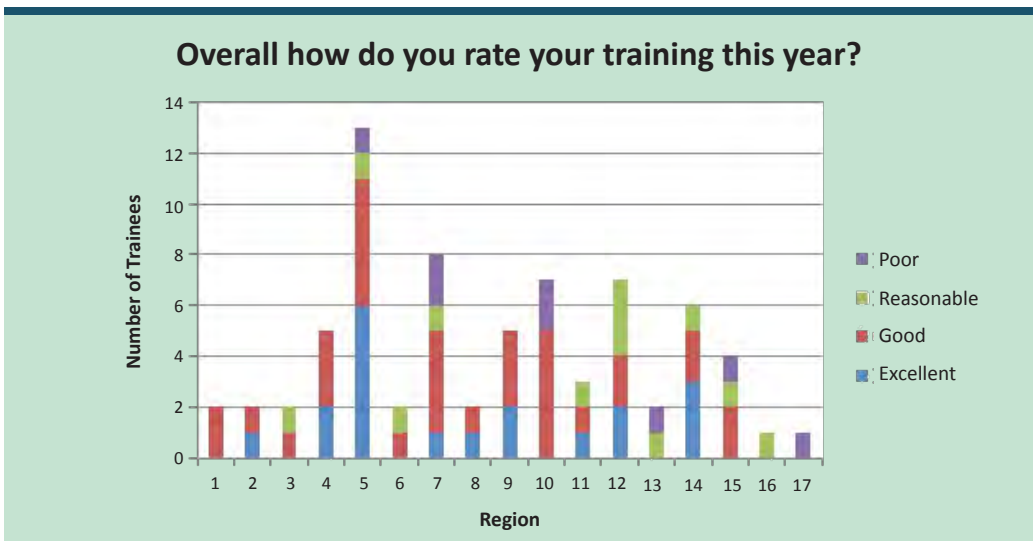
How do you know if your unit is good at training? Trainees' experience can vary dramatically and it can be difficult for a trainee to feedback difficulties they have had within a post. Obtaining feedback from trainees however is an essential part of quality assessment of training, even more so with medicine and anaesthetic blocks that are outside of our immediate control.

The FICM has just completed its second annual trainee survey. This drills down to individual attachments our ICM trainees have undertaken in the previous year. The survey is limited to ICM trainees undertaking the new CCT programme, and incorporates feedback from all attachments whether they are in the intensive care unit, in medicine or in anaesthetics. As opposed to the GMC survey, which collects data at only the one point in time, our survey collects detailed data on all attachments undertaken that year. We also do not have the GMC restriction of needing three or more responses before providing a report, which is

helpful as we do not have large numbers at present. The main beneficiary of the information is the regional training programme as the RA gets useful information about which attachments the trainee finds helpful, and those that are less than ideal.

Overall the training scheme is doing well but there is room for improvement. The most noticeable trend is for trainees to be dissatisfied with their medical attachments rather than ICM or anaesthetic attachments and information allows pressure to be brought on suspect posts.

The survey is divided into separate sections. The first section is an overall view of the year's training, which encompasses generic questions about the year. Out of 71 replies, 19 rated their training as excellent, 33 as good, 12 as reasonable and 8 as poor. As an example, the graph below separates out the responses to the question 'Overall how do you rate your training this year?' by region.



In order to target areas for improvement, the RA needs to know which particular aspects were good or bad and subsequent sections address each of the attachments separately. As almost all our trainees are currently in Stage 1, the separate attachments are in ICM, medicine and anaesthesia.

The question set is identical for each of the posts, allowing comparison to be made, with most responses graded along the lines of 'Poor' 'Reasonable' 'Good' or 'Excellent'.

As in 2013, trainees were proportionally happier with their training in anaesthetic and ICM blocks, with medicine having more 'poor' responses.

	Medicine	ICM	Anaes
Poor	34/112 (30%)	40/392 (10%)	30/408 (7%)
Reasonable	19/112 (17%)	86/392 (22%)	64/408 (16%)

The survey drills down further into specific aspects exploring consultant support, training ethos, appropriate responsibility, formal and informal teaching, achievement of training goals and ARCP support. One aspect that features highly in trainees concerns is support for ARCP documentation, with around 50% of trainees expressing some concern.

Overall satisfaction with ICM blocks is good, with positive feedback for consultant support and for appropriate responsibility. Within the ICM blocks themes of concern were with paperwork, with formal teaching and with achieving expected training goals. There is still concern that consultants are in places not yet up to speed with paperwork and the ePortfolio however I suspect this will improve by next year as the eportfolio becomes established. Formal teaching suffers from having small numbers of trainees and the RAs are addressing this within their regions, for example by implementing regionalised teaching.

As is often the case, the free text comments are illuminating and flesh out specific problems: examples are shown below.

“My ICM placement at this hospital wasn’t up to the standard. It lacks structure and training benefit for an ICM trainee.”

“The training experience was excellent. I had a good level of responsibility and had good exposure to the wards and Resus. The consultants were keen to teach and supported my clinical development with enthusiasm.”

“Fantastic placement, excellent support especially coming from a medical background. Couldn’t have asked for a better rotation.”

“No protected teaching time. Consultants in charge of FICE and lung ultrasound refuse to train, [with] a particular consultant [it] seems as if there is prejudice against anaesthetic trainees.”

“The department offers excellent teaching but the consultants are not particularly engaged with recent training requirements e.g. the need to complete ePortfolio.”

Of course one comment does not necessarily represent the whole story, but a picture can be obtained over time and interestingly one comment can be all that is necessary to instigate a change. If a negative comment is made about a specific aspect of teaching in your department do not be surprised if the initial reaction is denial, plus dismay and a touch of irritation. Despite this, however, the annoyance generated by the comment can focus the mind onto the alleged problem and the following year you may find the problem has magically disappeared from the survey, replaced with enthusiastic and glowing accounts of your departmental brilliance and wisdom.

On a separate note, this will be my last update as Lead RA for ICM. The very best of luck to my successor and thank you to all the trainees, consultants, Tutors and RAs for your commitment in developing our training scheme in ICM, which thanks to your hard work is developing into the excellent programme we all hoped it would be. Hwyl Fawr!

Spotlight on Intensive Care Training in London



Dr Angela McLuckie
RA South East Thames & TPD

The last few years have seen radical changes in the format and administration of ICM training within the capital. The Joint CCT programme closed to new entrants in July 2013 and recruitment to the new standalone and dual programmes began in earnest in August 2012 under the leadership of the West Midlands' HE. Coinciding with these changes, the London Deanery was dissolved and three new Local Education and Training Boards (LETBs) were established in central and north-east (HENCEL), south (HESL) and north-west London (HENWL), with Guy's and St Thomas' Hospital being awarded the contract as lead provider (LP) for ICM.

During this somewhat turbulent period, the continuity provided by myself and the other London Regional Advisors (Peter Shirley – NE, Julian Howard – NC, Susanna Price – NW, Phil Newman – SW) has been vital in supporting trainees and ensuring a smooth transition to the new regime. The system has also been strengthened by the appointment of additional TPDs to specifically manage Stage 1 (Ros Tilley) and Stage 2 (Gary Wares) of the new programmes. Whilst trainers would like to see ICM training continue to operate on a pan-London basis that ensures maximum flexibility and equity of access to specialist posts, there is increasing central pressure for the programme to be split into north and south sectors. I doubt it will come to a referendum but watch this space!

Looking to the future, the number of trainees in the Joint CCT programme (currently 78) will progressively decline and the posts in that programme will transfer across to the new standalone/dual programmes. Managing this transition whilst trying to maintain, or ideally increase, the output of ICM CCT holders to

meet the growing demand for ICM consultants in the region is extremely challenging. With our current levels of annual recruitment to the new programmes (19 clinical plus 2-4 ACFs), output of ICM CCT holders is set to fall significantly over the next four years (Table 1). Although it would seem logical to increase recruitment rates to address this problem, it's far from clear as we move to population based workforce calculations that London will be allowed to pursue this option.

With the introduction of the new training programmes, the diversity of partner specialties has also been reduced (Tables 2, 3). This is something which I personally hope will be addressed as the dual programme matures, particularly for those specialties such as gastroenterology, haematology and clinical pharmacology that currently have a number of Joint CCT trainees in post. It is worth noting that some of the trainees who are currently 'standalone' may be appointed to dual CCTs in the future.

Although the capital already offers high quality, and in some areas unique training experiences, there's always room for improvement. Gary Wares is planning an exciting range of Stage 2 Special Skills modules, including Echocardiography, Neurology/Neurosurgery, Liver, SIM, Education and Infection/Microbiology. Mandatory training half-days for London ICM trainees have evolved over time into full-day 'Core Topic' sessions. These are now publicised and hosted by the ICS and attract trainees and consultants from across the country. Andy Jones has put together another excellent schedule for the New Year, covering a broad range of topics and featuring many internationally recognised speakers. I'm sure demand for these days will be high, so do register early and enjoy your time in London!

Year	Projected output Joint CCT	Projected output Standalone/Dual	Projected output combined
2015	32	0	32
2016	25	1	26
2017	14	6	20
2018	6	14	20
2019	0	21	21

Table 1: Projected CCT output from London training programmes

	Clinical Trainees	Academic Trainees	Total
Standalone	22	3	25 (44%)
Dual Anaesthesia	25	1	26 (46%)
Dual AM	4	0	4 (7%)
Dual Respiratory	1	0	1 (2%)
Dual EM	1	0	1 (2%)
Trainees Total:	53	4	57 (100%)

Table 2: Partner specialties London Standalone/Dual ICM trainees (Dec 2014)

	Clinical Trainees	Academic Trainees	Total
Anaesthesia	53	1	54 (69%)
Respiratory/GIM	6	0	6 (8%)
Renal/GIM	5	0	5 (6%)
AM	5	0	5 (6%)
Gastroenterology	3	0	3 (4%)
Clinical Pharmacology	2	0	2 (3%)
Haematology	2	0	2 (3%)
Emergency Medicine	1	0	1 (1%)
Trainees Total:	77	1	78 (100%)

Table 3: Partner specialties London Joint ICM trainees (Dec 2014)

ICM National Recruitment



Dr Tom Gallacher
Recruitment Lead

We are seeing a gradual increase in ICM posts made available by LETBs year on year. In 2012 National Recruitment round we had 72 ICM posts available across England and Wales and in 2014 we had 112 posts available across England, Wales and Northern Ireland. National Recruitment to Intensive Care Medicine attracted 277 applications in 2014 and in an attempt to accommodate as many interviews as possible we added another day of interviews, which increased our capacity from 160 to 240 interview slots. In 2014 we filled 96% of all available ICM posts in the National Recruitment round and this compares very favourably with other training schemes indicating that ICM appears to be growing in popularity year on year.

For the first time, we are delighted that Scotland will be submitting posts into the National Recruitment Round 2015, which will make it a truly national process for the first time since the introduction of the ICM CCT programme. Scotland will be offering posts to be recruited through both the National Recruitment Round and through their own Scottish Medical Training (SMT) process. They will be offering a number of posts in national recruitment that will be single ICM CCT posts. These will be recruited to in exactly the same way as all other ICM posts in National Recruitment (i.e. they can be offered to either single or dual CCTs trainees and partnered with any of the five ICM partner specialties).

In addition, all Scottish deaneries will recruit to training posts in dual ICM and anaesthesia in the same recruitment round through coordinated processes. Recruitment to ICM posts for partner specialty NTN holders will also take place in Scotland and this will be coordinated by SMT.

For previous recruitment rounds there was no upper limit on when a trainee could enter a second specialty within training. Following consultation with our partner specialties this will change in National Recruitment round 2016. From August 2016 onwards, trainees will not be able to apply for a dual CCTs programme if they are beyond the end of ST5 in their initial specialty of appointment at the time of interview for the National Recruitment round 2016.

Initially, the Recruitment Sub-Committee and partner colleges considered setting the upper limit as the end of ST5 by the time of commencement of the second CCT programme i.e. August 2016. However, this could have the unintended consequence of preventing anyone commencing ST6 in August 2016 from applying, effectively placing the upper limit for recruitment at ST4. Therefore, contrary to any previous discussions, the upper limit for appointment to a dual CCT programme from 2016 will be the end of ST5 at the time of interview not commencement of post. The August 2015 intake remains, therefore, the last opportunity for trainees who are beyond the end of ST5 in a partner specialty to apply for a dual CCTs programme with ICM.

Comprehensive information regarding Intensive Care Medicine regional training programmes and the training opportunities offered by specific trusts can be found on the Faculty's website at <http://www.ficm.ac.uk/national-recruitment-icm/regional-information>.

Recruitment will once again be via the National Recruitment website <http://icmno.wm.hee.nhs.uk>, where a number of valuable resources including detailed applicant guidance can be accessed.

Trainee Update



Dr David Garry
FICM Trainee Representative

A big welcome to the new trainees who started in August; you are joining our specialty at an exciting time. Trainee numbers have increased this year, and this trend looks set to continue. There are many interesting developments in the pipeline — I would like to focus on three of them.

FFICM Examination

Congratulations to all those (38/65) who passed the latest FFICM Final examination. Future candidates will have the opportunity to attend a FFICM Final revision course organised by the Faculty. The first one should take place later this year in Leeds, details to follow on the website and through *Trainee Eye*. It will cater for the OSCE and SOE components in the first instance. Keep your eyes peeled, places will be tight and it will be first come first served!

Trainee Eye

You will have received the second edition of *Trainee Eye* in September. It is a very useful e-newsletter for news and events. The style for future issues will be reformatted and the Faculty want to have more trainee involvement. This will start with critical appraisals of recent ICM articles of interest submitted by Intensive Care Medicine trainees – more on this to follow.

Special Skills Training

With the recent update to The CCT in Intensive Care Medicine trainees can now train in a 'Special Skill' during their Special Skills Year (SSY) as part of their Stage 2 training. *The CCT in Intensive Care Medicine* has a new *Part V: Special Skills Training* giving a complete outline of all currently recognised Special Skills, with more on the way, such as education and home ventilation. The curriculum also states that Special Skills modules beyond these will be considered as long as training programmes obtain prospective approval from the FICM and the GMC. It

should be noted that the approved process requires considerable lead up due to the consultation and approval periods.

Broadly speaking the rules stipulate that the Special Skills Year will be counted as part of Stage 2 training. For those trainees undertaking dual CCTs it is expected that their SSY will take place in the other specialty (such as Anaesthesia or Respiratory Medicine). Dual CCTs trainees could potentially develop an additional Special Skill, but this would extend training so they would need prospective approval from their postgraduate deanery/LETB, local trainers and the FICMTAC. The FICM secretariat should be kept informed of any planned Special Skills training for all ICM trainees as it must be approved by the Faculty to count towards CCT.

I had the opportunity to extend my training for 12 months as a Fellow in Critical Care Echocardiography in a fellowship that was structured in a very similar way to the Echo Special Skills module. It was (and remains) a very enjoyable and worthwhile experience, and it has been wonderful to gain another string to my bow. As I approach the end of my training and start contemplating the daunting task of obtaining a consultant post, it is becoming apparent that my 'Special Skill' will form an integral part of my future career. When I look down the list of current modules there are many that would catch my eye if I were coming up to Stage 2 Training. So all that is left for single CCT trainees to decide is what takes their fancy, and how they would like to shape their career in ICM! The choice of SSY modules is based on local capability.

Many thanks to those trainees that have already been in touch — please do email myself (davidgarry2000@yahoo.co.uk) or Ian Kerslake (ikerslake@me.com) if you have any questions.

Special Skills Module	Aim
Academic Research	<ul style="list-style-type: none"> • Contribute to high quality recruitment to the Specialty • Enrich the professional lives of trained clinicians • Ensure continuous improvement of the care that we deliver
Cardiac Intensive Care Medicine	<ul style="list-style-type: none"> • Equip individuals with competencies required to work as a consultant in a specialist Cardiothoracic Intensive Care Unit
Echo	<ul style="list-style-type: none"> • Advanced Critical Care Echocardiography Accreditation • Knowledge, skills and attitudes to be Clinical Lead for Echocardiography on a Critical Care Unit
Extra-Corporeal Membrane Oxygenation (ECMO)	<ul style="list-style-type: none"> • Knowledge and skills to provide ECMO as part of a team in a specialist Critical Care Unit
Neuro Intensive Care Medicine	<ul style="list-style-type: none"> • Central role in Neuro Intensive Care Unit • Collaboratively lead the provision of Neuro Intensive Care
Paediatric Intensive Care Medicine (PICM)	<ul style="list-style-type: none"> • A further block of Paediatric Intensive Care Medicine • <i>Note:</i> PICM is not currently recognised as a sub-specialty of general adult Intensive Care Medicine
Pre-Hospital Emergency Medicine (PHEM)	<ul style="list-style-type: none"> • Sub-specialty accreditation in PHEM
Quality Improvement (QI) in Healthcare	<ul style="list-style-type: none"> • Develop skills and a portfolio of QI activity that may support application for further experience in a national leadership fellowship/programme
Transfer Medicine	<ul style="list-style-type: none"> • Enhance training in transfer and retrieval medicine • Competencies derived in part from the PHEM curriculum

Faculty Calendar 2015

February			
	6	MEETING:	FICM RA and FT meeting
	23	MEETING:	FICM/ICS Joint Standards Committee
March			
	17	MEETING:	FICM Training & Assessment Committee
April			
	23	MEETING:	FICM Board
May			
	14-15	EVENT	FICM Critical Works
	26	MEETING:	FICM/ICS Joint Standards Committee
June			
	9	MEETING:	FICM Training & Assessment Committee

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.

NICE - Draft Scope - Care of the Dying Adult August 2014

- Annually, 28000 patients who are admitted to intensive care die on ICU (figures from ICNARC 2012/13). Therefore, 5.6% of the annual deaths in England occur on intensive care. Therefore, we consider that the consultation should consider the deaths occurring in ICU as a separate group within the overall guideline.
- In the intensive care setting, there can be disagreement between the treating clinical team and family members. It would be helpful for the NICE guidance to address this issue.
- In relation to “recognising dying”, the fact that this is intimately related to decisions about withdrawing or withholding other elements of care (e.g. antibiotics, disease modifying drugs such as chemotherapy, organ support on intensive care) or to failure to respond to such treatment seems to have been omitted. This is of importance as these broader care decisions are related to judgements about the balance of benefit (improvement in the duration or quality of life) and harm (adverse effects of the interventions or associated care). Therefore the exclusion of prognostic tools from this guideline may be a mistake as such tools may be of importance in guiding such decisions.
- We are of the opinion that the guidance should address whether cardiopulmonary resuscitation should be delivered to patients who are actively dying, and if so identify why? If a patient is successfully resuscitated after cardiopulmonary arrest, then they would require multi-organ support on ICU. If they have been identified as dying, then all that has been achieved by resuscitating them is that their dying process has been prolonged. In our opinion the need/requirement for resuscitation needs clear guidance.

NHS England - Proposed Congenital Heart Disease Standards - November 2014

- The aspirations of this report may be difficult to achieve.
- Clinical leadership will be fundamental
- The current system has suffered from planning blight, competition and in some cases enmity; it is not clear how this review will overcome these problems. Whilst individual team members (particularly surgeons) are discussed, the fact that good results are delivered by competent and effective teams does not appear to be sufficiently emphasised. Networks will need to become effective teams and have leaders (not necessarily surgeons) who can engage all members in developing an outstanding regional service.
- It difficult to understand how the costs of reorganisation will be absorbed without impacting on the revenue available for patient care.
- Services are currently provided by a variety of different models, in different areas of the country. Reorganisation will be time-consuming and costly.

JMMC - Consultant Working Environments November 2014

- Consultants in Intensive Care Medicine should not cover other services when on duty for critical care. Data suggests that approximately 30% of UK units do not comply. Attempting to cover other services in addition to critical care is not consistent with a safe and high quality working environment for consultants.
- In Intensive Care Medicine a wide range of allied healthcare professionals are vital. Now that rehabilitation is accepted as an essential component of critical care from the point of admission, the need for AHP support is even more evident. Currently most units have some provision for Physiotherapy, Pharmacy, Dietetics and Speech and Language therapy, whereas few units have adequate provision for Occupational Therapy and Clinical Psychology.
- Stepping patients down from critical care to a ward environment is frequently delayed. This results in poor patient experience as well as delayed admissions.

Membership Update July 2014 - January 2015

FFICM

Sharon Lisa Moss
 Mohammad Rajaa Abdul Rahim
 Kevin Paul Morris
 Shruti Agrawal
 Andrew James Baldock
 Norman Main
 Daniel Henry Lutman
 Pamela Ann Dean
 Louisa Ellen Anderson
 Tariq Husain
 Christopher Stephen James
 Michael Bernd Schupp
 David Balthazar
 Neil Harvey Crooks
 Phillip Hyde
 Ziad Mohammed Saeed
 Vimal Grover
 Livia Shirin Malanjum
 David Morgan Griffith
 David Welburn Popple
 Felicity Jane Elizabeth Clarke
 Jon Christopher Hopper
 David Patrick John O'Callaghan
 Simon William Malcolm Scott
 Joanna Lucy Catharine Wheble
 Sandra Anne Walsh
 Sachin Bharatbhai Shah
 Yat Wah Li
 Alexander James Trimmings
 Lucy Ann Hogg
 Imelda Margaret Galvin
 Matthew Craig Faulds
 David Thomas Ashton-Cleary
 Kyra Dingli
 Karthik Somasundaram
 Malligere Kumaraiah Pathanjali
 Prasanna
 Matthew Derman Christopherson

Rana Hafiz-Ur-Rehman
 Paul William Bush
 Laura Jane Walton
 Gordon Thomas Bird
 Marina Sashika Selladurai
 Muhammad Shakeel Riaz
 Nikunj Shah
 James Henry Charles Wilmott
 Thomas John Trinder
 Ronan O'Leary
 Andrea Lavinio
 Simon Paul Wood
 Simon Roy Sparkes
 Thomas William Lawson Holmes
 Suzanne Clare Dean
 Suresh Kumar Gopala Pillai
 Jennifer Scarth Scarth

FFICM (by Examination)

Timothy James Williamson
 Dawes
 Birte Feix
 Peter David Frank
 Charles Edward Stuart
 Gibson
 Christopher Michael Johnson
 Claire Victoria Leech
 David Thomas Edward
 West
 Katrina Ellen Bramley
 Peter James McDermott
 Prashanth Nandhabalan
 Nicola Jayne Pawley
 Pradeep Shanmugasundaram
 Michael David Spiro
 Anthony Joseph Wilson
 James Campbell MacBrayne
 Daniel Simon Owens
 Najwan Abu Al-Saad

John Matthew Kelly
 Abigail Helen Ford
 Russell Morton Allan
 Helen Elizabeth Ellis
 David Fahed Fallaha
 Matthew James Jackson
 Clinton Alexander Lobo
 Patrick John Morgan
 Christopher Paul Newell
 Joanne Elizabeth Petrie
 Thomas Edward Poulton
 Gunchu Supreet Kaur
 Randhawa
 Brendan Donal Robert Sloan
 Clare Michelle Windsor
 Michael Puntis
 Adam Revill
 Thomas Alexander Williams
 Eleanor Jane Galtrey
 Andrew Denne Holder
 Ben Felix Richard Singer
 Claire Catherine Tordoff

AFICM

Khalid Jiwad Khalid
 Mruga Diwan
 Amer Majeed
 Peter Robert Evans
 Mary Bernadette White
 Ewa Zasada
 Pawel Michal Arkuszynski
 Tiina Tamm

MFICM

Mahmoud Elsayed Noureldin
 Pietr Du Preez
 Deeptarka Roy

FACULTY OF INTENSIVE CARE MEDICINE

CRITICAL WORKS

14 — 15 May 2015

RCoA, London

Thursday 14th May

Sepsis: anything new in the definition

Dr Mervyn Singer

What's the ProMISE in Sepsis?

Professor Kathy Rowan

Faculty Honours

FICM Updates

Ethics of emergency trials: PARAMEDIC Study

Dr Gavin Perkins

Deprivation of Liberty

Dr Chris Danbury

Update on ARDS

Dr Luigi Camparota

What's new with Commissioning?

Dr Jane Eddleston

Friday 15th May

Emerging Infectious Diseases: implications for critical care

Dr Bob Winter

Cardiovascular support: new drugs or new roles

Dr Tony Gordon

The role of the Coroner in Critical Care

Mr James Adeley

Nutrition in 2015

Professor Richard Beale

Paediatric Intensive Care: the future

Dr Peter Wilson

ECMO

Dr James Cordingly

Annual Faculty Lecture

Dr Clifford Mann, President of the College of Emergency Medicine

The Faculty of
Intensive Care Medicine



Fee: £295 full (£155 for trainees and nurses)

CPD Credits: 10 (Anticipated)

Availability: Places available

Event code: F33

Bookings now being taken via:

www.ficm.ac.uk www.rcoa.ac.uk

Event organiser(s):

Dr C Waldmann and Dr A Rhodes

The UK TEAM (Training in Emergency Airway Management) course

**Dermot McKeown, David Ray, Jerry Nolan,
Gavin Perkins and Jonathan Benger**
On behalf of the UK TEAM Course National Steering Group

Emergency airway management can be difficult and challenging; doctors are often required to work in unfamiliar environments under conditions of stress and uncertainty, and techniques acquired in elective anaesthesia may require modification. Individuals must practice within the limits of their competence, and work collaboratively with experienced clinicians from several disciplines to deliver optimal care. Failure to do so is associated with increased complications.

In 2002, the need for a national training course covering the core skills of emergency airway management outside the operating room was recognised, and in the following year a process of development began. This led to the creation of the UK TEAM (Training in Emergency Airway Management) Course.

UK TEAM teaches the foundations of the knowledge, skills and attitudes required to manage the airway safely in an emergency, and has proved ideal for doctors 3-4 years after qualification who are pursuing a career in Anaesthesia, Emergency Medicine, Intensive Care Medicine or Acute Medicine. TEAM focuses on airway management in the emergency department, but also considers inpatient wards, radiology and links with pre-hospital care. Although TEAM is aimed primarily at doctors in the early years of training, it has also proved very useful for more senior doctors involved in acute care.

The course and its content have been approved as suitable for trainees by both the Royal College of Anaesthetists, the College of Emergency Medicine and the FICM. This collaborative approach is reflected in the course instructors and candidates. The course comprises workshop-based tutorials, application of clinical skills including basic and advanced airway techniques, rapid sequence induction, explicit decision-making in situations

where tracheal intubation is difficult or has failed, front of neck access, and post-intubation management. A series of clinical scenarios using mid- or high-fidelity simulators emphasise all the principles of emergency airway management.

Since 2003 more than 50 UK TEAM courses have been run in centres throughout the UK and the Republic of Ireland. The course, and its supporting materials, was completely revised and updated in 2014. Currently there are five courses planned for 2015, to run in Bath, Birmingham, Edinburgh, London and Wrexham. Teaching faculty are established consultants in anaesthesia, Emergency Medicine and critical care who have an active clinical role in emergency airway management. Feedback from candidates who have attended the courses has been universally excellent, with anaesthetists and Emergency Medicine doctors both enjoying the teaching structure, and recognizing the benefits of attending the course for both disciplines.

The course is now of even greater relevance with consolidation of Acute Care Common Stem (ACCS) training. Single-stem training in Intensive Care Medicine enables trainees from medical backgrounds, who may not have acquired competent airway skills, to enter an area of specialist training where emergency airway management is considered a core activity. Management of the airway in Emergency Departments in the UK is also widely variable with models where anaesthetists or Emergency Medicine doctors deliver sole care, or more commonly a joint and collaborative approach is in place. The UK TEAM Course therefore contributes much to improving the consistency of approach to emergency airway care outside the operating room throughout the UK.

The UK TEAM Course is formally endorsed by the Royal College of Anaesthetists, the College of Emergency Medicine and the FICM.

RCN Critical Care and In-Flight Nursing Forum workshop

The changing face of
flight nursing

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Showcasing the very best of flight nursing, this workshop will explore the current advances in this specialty by discussing in-flight medical emergencies, developing Standards for air ambulances and looking at the public health implications for air travel.

The workshop is aimed at flight nurses of all grades and sectors. It will also be of interest to all healthcare professionals working in patient repatriation and retrieval.

For further information and to book your place please visit www.rcn.org.uk/F15

Saturday 25 April 2015

RCN HQ, 20 Cavendish Square, London W1G 0RN

Registration from 10.30am conference starts at 11am and finishes at 3.30pm

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NURSINGSTANDARD

The Intensive Care Society Calendar of Events

FEBRUARY

23 **FICM Exam Prep**
Churchill House, London

MARCH

5-6 **BASIC Assessment & Support in Intensive Care**
Churchill House, London

13 **Trainee Day**
St Giles Hotel, London

23 **Core Topics for Training & Revalidation in ICM- Sepsis & Infection in the ICU**
Churchill House, London

APRIL

27 **Core Topics for Training & Revalidation in ICM- Gastroenterology and Nutrition/Ethics in the ICU**
Churchill House, London

MAY

12 **FICE Echocardiography**
Churchill House, London

28-29 **Radiology**
Churchill House, London

JUNE

11 **Law & Intensive Care Medicine *NEW***
Churchill House, London

18 **Core Topics for Training & Revalidation in ICM**
Churchill House, London

27 **Snowdon Xtreme Challenge**
Snowdonia

SEPTEMBER

25 **Core Topics for Training & Revalidation in ICM**
Churchill House, London

30 **Chest Ultrasound**
Churchill House, London

NOVEMBER

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

16 **ICM Career Day**
Churchill House, London

DECEMBER

7-9 **The State of the Art Meeting**
London ExCel, Docklands



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www.ics.ac.uk/events



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