



Critical Eye

Issue 9

Winter 2016

The Faculty of Intensive Care Medicine

Inside:

- » ICM and Shape of Training
- » The Faculty tackle the difficult questions
- » Bombs, Bullets, Blood and Bugs: What 15 years of Military Intensive Care can teach the NHS



Welcome



Dr John Butler
Clinical Editor

Welcome to the 9th edition of Critical Eye. This edition focuses on answering some of the difficult questions our specialty faces as well as addressing a number of themes highlighted by the recent 2015 Faculty census.

Predictably one of the recurring themes from the census related to the future of medical staffing. The recent changes to retirement age and the high profile ongoing contractual negotiations for both junior doctors and consultants, which may result in changes to the terms and conditions for doctors of all grades, have brought this topic into focus. Articles entitled 'Is ICM a career for life?' and 'Is on-call possible at 60?' highlight these areas giving possible avenues for us to explore in the future.

Undoubtedly ICM has made significant progress since it was given specialty status in 1999. One of the areas of considerable evolution over time has been the development of the training programme for ICM. The article by Dr Pittard gives an informative historical perspective on the progress made from the early days of the Joint Advisory Board on Intensive Therapy through to the approval of the competency based CCT programme in ICM and beyond. For the future development of the specialty it is essential to secure a competent and committed workforce. But does this mean that 'ICM is moving away from anaesthesia?'

Ongoing debate continues across the specialty about how critical care services should be delivered in the future. Articles exploring questions such as 'Who is setting the policy within the critical care community?', 'Are there models to run a sustainable effective critical care service in smaller hospitals?' and 'Are specialist units becoming so specialised that they are drifting apart from general units?' attempt to address some of these themes in a reasoned and balanced way. I am sure you will find the articles informative.

Please visit the News and Events section of the website for the latest news items at: www.ficm.ac.uk/news-events

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Dean's Statement



Dr Anna Batchelor
Dean

What a year we've had! A year when our trainees contemplated going on strike (and of course the contract discussions are still ongoing), when we all stood up for the NHS that we believe in, and when doctors became more vocal than I can ever recall. #IminworkJeremy, #notfairnotsafe and #ImworkingChristmas all featured on Twitter with the NHS being a surprise tweeting trend in 2015. But we have to throw into the mix less positive thoughts, a reduction in applications to medical school, an increase in the numbers who don't practice medicine when they finish medical school, an exodus of trainees and CCT holders to countries where the grass, for the moment, appears greener, and a background of trainees feeling undervalued, stressed and burnt out.

I thought this was a good moment to reflect on why I think that being a doctor and more particularly being an intensivist is the best job in the world. An Emergency Medicine friend described EM as the best 4 hours of everyone else's job, and for me with an adjusted time line ICM is the best few days of everyone else's job. Varied, unpredictable, time critical, team working, multidisciplinary, caring and communication skills are just some of the words needed to sum up what we do. Looking after a patient and their family at a time of crisis is an honour and a privilege as well as a challenge.

So if it is such a great job why is everyone not happy? I'm not entirely sure I know. Shift working, weekend working, emotionally draining, fear of making mistakes, fear of complaints, lack of consultant support (although I hope not), lack of support from nurses or other team members, worry about changes in training including the Shape of Training Review. I like to think (but I could be deluding myself) that trainees in ICM are happier than in some

other specialties. We have not had notable problems recruiting to our training posts and trainees rarely give up their ICM training number. The Academy and the Deaneries/LETBs are taking the issue seriously and have had a preliminary meeting and will be taking the work forward this year. Our trainees are the future of our specialty and our service and we need to ensure we create and sustain a supportive training environment and work place.

Women outnumber men at medical school but not in ICM, approximately 21% of FFICM holders and 37% of trainees in ICM are female. Only 3 FICM Board members are female. Is ICM seen as not female friendly? Some of the pioneers of UK ICM including Sheila Willatts, Gillian Hanson and Doreen Brown obviously felt it was a suitable job for a woman. Lets make 2016 the year we encourage more female trainees into ICM. There are elections to the Board later this year it would be great to see more women standing.

It was a pleasure to be asked to chair the Social Media plenary session at the ICS State of the Art meeting in December, we are fortunate to have a lot of high quality FOAMed (Free Open Access Medical Education) aimed at Intensive, Acute and Emergency Medicine, much from the UK, written by some very capable and enthusiastic clinicians. This is going to change the way we review and discuss papers and keep up to date. The democratisation of peer review maybe?

So a new year, new challenges and the best job in the world. Bring it on!

BOMBS, BULLETS, BLOOD AND BUGS -

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

1 July 2016

Royal College of Anaesthetists, London

Course organisers: Col Jeremy Henning & Lt Col Andrew Johnston

Although Military Intensive Care can probably trace its roots back to the Crimea War when Florence Nightingale cohorted the sickest patients together near the nursing station so they received a higher level of care, the first time a specifically equipped ICU was deployed to the Field was the Second Gulf war in 2003. The UK military has been manning a deployed ICU somewhere in the work ever since.

In this time, military Intensivists have become experts in the care of gun-shot wounds (Iraq), blast injury (Afghanistan) and most recently infectious diseases (Sierra Leone). As the initial care and resuscitation of these patients has improved, the severity of injury and illness presented to the ICU has increased exponentially. A casualty with bilateral traumatic amputations is now returned to the ward after their initial surgery in Field, hence the patient who comes to ICU has physiology on presentation that was previously thought unsurvivable. A patient with an infectious disease that was thought to have a greater than 80% chance of dying, can have a 70% chance of surviving given reasonable therapy. This presents unique clinical, ethical and moral issues.

Much has been written about the utility of 1:1:1 transfusion in acute blood loss, especially in the context of trauma. However, less is known about what to do after the 'big' bleeding has stopped and the patient is oozing on the ICU. The benefit of a pre-hospital team on early intubation of the IED victim has been described, but the issues of looking after the blasted brain, lung, heart and abdomen are less well known.

We now, for the first time since military Intensive Care was officially recognised, have all our ICM personnel in the UK. This is however not a time of rest. Not only do we have to prepare to respond to whatever the next emergency may be, we owe to it to our patients (those that survived and those that did not) to communicate our lessons learnt to anyone prepared to listen. They are lessons hard learnt, and history tells us we will learnt them again in the next conflict as we forget them in times of peace. However, this time it is different, conflict has the potential to affect us all. We remain lucky that a pandemic infectious disease has not hit this country. Maybe by making sure the whole ICM community hears our lessons, we can keep them alive to the benefit of both civilians and military. As the Royal Army Medical Corps Grace says:

Keep us forever mindful, it is not for ourselves, but for others we serve.

This meeting has been arranged to give an insight into what the military intensive care can teach the NHS. Topics will include critical care and Ebola, lessons for the next pandemic, training military personnel in ICM, blast injuries, ballistics and critical care air support teams. There will also be a demonstration of deployed critical care capability. For a full programme please see the link below.

Bookings now being taken:
www.ficm.ac.uk/ficm-events/ficm-annual-meeting

Is on-call possible at 60?



Dr Jonathan Goodall
Careers Lead

2015 may be recognised as a seminal year for the medical workforce in ICM and all other specialties. At the time of writing, contract negotiations that may change terms and conditions of working for a generation of doctors (in England at least) are underway. Whether the feasibility of being on-call during the later parts of a career will be addressed as part of these discussions is not certain. What is clear, however, is that ICM should not rely on external events and agencies to solve what is an increasing concern for many in the specialty.

Changing demographic

We're all increasingly aware that the demographic of our patients is changing. We provide more intensive care to older patients than we did a decade ago, and predictions suggest this trend will continue. Such patients are complicated, have challenging co-morbidities, and need experienced clinicians to manage them effectively. The Academy of Medical Royal Colleges report into Consultant Present Care, describes how 'patients expect treatment by competent clinicians and a parity of care irrespective of the day of the week'; the FICM/ICS Core Standards re-enforce the need for regular consultant input irrespective of the time or day.

We need to remember, however, that as doctors we are ageing too. Changes to retirement age and pensions means that consultants will be expected to work until their late sixties. We must ensure they are able to do so effectively and safely. How can we do this?

Alternative Ways of Working

A central tenant of rotas has usually been an 'equality of burden': that all contribute their

share of the work – often simply translated into a division of duties between those on the rota.

Is this the only way to work 'fairly'? Increasingly units have different arrangements for colleagues with particular requirements. I have an academic colleague who works 'excess' weekends to make time available for university duties during the week, a solution readily accepted as 'fair' by others on the same rota. Shouldn't we accept that alternative working patterns may be necessary for other demands, such as the over 60s?

Other Colleges are also exploring these issues. The RCEM is acutely aware of the need to keep consultants engaged and working, and suggests that the development of annualised job plans can help to 'embed safe and sustainable practice'. Similarly, the RCPCH has evaluated new ways of working, including the use of resident consultant on-call and 'twilight shifts', and describes how consultants may wish to transition through different models of working during their career. That the same report suggests its findings are applicable to other 24/7 specialties, and suggests future collaboration to develop future service models, should make us take notice.

Avoiding Burnout

'Burnout' is a big topic: a full discussion is out-with the remit of this article, but it merits consideration in this context. Although often associated with ICM there is in fact little evidence from the UK, although stress in UK intensivists has been described. Burnout in intensivists is more assumed than measured. A 'real time' survey I conducted using voting pads during a talk at the ICS's 'State of the Art 2015' meeting, suggested that audience (a self-selected

and highly unscientific sample!) were interested in the subject, but knew relatively little about it. They wrongly believed that burnout is most likely in older, male colleagues: it isn't - young, female doctors are the most affected group. The group also failed to recognise the impact that conflicts can have on burnout, though they did recognise the importance of being in control.

Conclusions

So is on call possible at 60? Is it necessary? We need to explore different ways of working, perhaps with annualised job plans, and working patterns tailored to suit the service and the individuals delivering it. By improving awareness of those work factors associated with burnout, we may allow intensivists to better protect themselves and avoid this problem – at any stage their career.

As a specialty we need to work together and with others to address these issues. After all, these are our careers.

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Faculty Calendar 2016

February	5th	MEETING:	FICM/ICS Joint Standards Committee
March	15th 23rd	MEETING: EVENT:	FICM Training & Assessment Committee Interviewers Training Day
April	27th	MEETING:	FICM/ Board Meeting
May	20th	MEETING:	FICM/ICS Joint Standards Committee
June	16th 21st	EVENT: MEETING:	Advanced Critical Care Practitioner Conference FICM Training & Assessment Committee
July	1st 13th	EVENT: MEETING:	Bombs, Bullets, Blood and Bugs: What the NHS can learn from 15 years of Military Intensive Care FICM Board Meeting

Is ICM a career for life?



Dr Daniele Bryden
Lead RA

Here's the thing; there's a perception that the most workable option for ICM as a career is from the position of a full time anaesthetist, able to step out of ICU when it all gets a bit too stressful. ICM has a reputation for not being a viable option for anyone who doesn't fit that mould.

So now it's time to hear other viewpoints. And yes, as an unmarried, childless, career committed anaesthetist, I'm suggesting that we need to support an environment of wider working choices as a solution to an ICM career for life. So let's start by shifting the stereotypes of what a doctor working in critical care is or the personal values they hold.

Those who want to train less than full time and those coming from a minority career background are quite clear that when they finish they will have highly valuable skills and are taking the risk that there will be consultant jobs for them. Feedback I've had from LTFT trainees about the environments they train in is mixed, but all report that the decisions they've made have been the right ones for their work life balance and all have an admirable commitment to ICM as a long term career that makes them want to continue. Why can't a decent work life balance be relevant for more of us?

Non anaesthetic trainees recognise that they come with a different set of skills but question whether some hospitals can address the challenges of rotas where not all ICU consultants will have advanced airway skills and finance for new posts usually comes from an anaesthetic budget. Many hospitals already do accommodate non anaesthetic ICM consultants, but we need to work to create jobs not financed on the back of theatre productivity

and recognise that whilst commitment to ICM may be equal, patterns of delivery may vary.

All the groups I've spoken with feel they contribute to ICM and are looking at ICM as a career for life, and those of us already in post need to respond by questioning the perceived local barriers to recruitment and retention. Inclusivity regardless of career background and a need for less than full time working will apply equally well to those coming to the end of their careers as at the start. People do move into areas like management for new challenges but that's a natural part of a medical career and not a universal symptom of doing ICM and being 'burnt out'.

ICM can be a career where an individual's contribution may wax and wane. After a particularly traumatic bereavement 14 months into my present job, I had 12 months off work, 18 months of phased return and long ago recognised I am unable to revisit some areas of my previous anaesthetic practice. ICM was and is a constant part of my identity as a doctor but there have been times in my personal life when my commitment has inevitably not been as great as it is now. I'm looking at finishing my career far more committed to ICM working than when I started.

The facts of everyone's working lives are that family, illness and other life events intervene and we have to find a way to function that doesn't assume we'll all need to jump ship at the end. We have generic skills and individual contributions that are vital for the health of the specialty and for ourselves as we progress through our careers. We must find a way to make this work for all our sakes.

Why we moved away from the joint CCT: The truth



Dr Alison Pittard
Chair
FICMTAC

We have come a long way in the last five years and we now have a curriculum, fit to equip trainees with the knowledge, skills and attitudes to treat today's critically ill, and a recruitment process that selects the best.

Initially ICM training was very much an 'add on' to other, mainly anaesthetic, programmes. In 1999 ICM was given specialty status, meaning the Specialist Training Authority (STA, now incorporated within the GMC) could award a CCST in ICM and record it on the specialist register. However a new training programme needed to be developed. This was approved in 2002 allowing trainees in the specialties of anaesthesia, medicine, emergency medicine and surgery to gain joint CCST's.

However our regulators, the Postgraduate Medical Education and Training Board (PMETB) and, from 2010, the General Medical Council (GMC), didn't really appreciate that our curriculum wasn't entirely independent. In order to achieve a dual CCT it should be possible to achieve each single component individually. In all honesty I think we just kept our heads down and tried not to draw attention to this misconception! Of course our joint CCT was not a stand alone programme and when the GMC took over the role it insisted that a single specialty CCT in ICM be established. An impossibly short timescale was given but, after much negotiation, a competency based CCT programme was approved, with some conditions, by the GMC in March 2011 with recruitment the following year.

It was never the intention of the Faculty to separate ICM training from that of other specialties but it was told to do so by the GMC. Our specialty has always prided itself in its generalist nature and

the importance it places on working with other acute specialties. Therefore it was expected that the majority of trainees would continue to train in more than one specialty, which has been borne out in subsequent years, but there is the option to train solely in ICM if desired. The latter is not as popular at present due to the uncertain job prospects but as our specialty continues to develop who knows what will change in the future. Market forces will dictate the career choices made by trainees in the future and we will need to be prepared to adapt accordingly, as we have always done.

Although the instigation was forced, having our own CCT programme brings with it many opportunities. It gives credibility to our specialty and our patients can be confident that they will be treated safely, to the highest quality and by highly trained clinicians. We described the attributes required of a consultant in Intensive Care Medicine and created the curriculum accordingly. Our assessment system, both in the workplace and by examination, ensures that high standards are achieved and is open to scrutiny. Of course organising the training programme at local level can be problematic and the Faculty appreciates this. We were mindful when planning the programme that we shouldn't be too prescriptive about its delivery as there would be different solutions to the same problem depending on the local environment. In some ways I think people would have liked things to be more black and white in this area but hopefully we can learn from each other to make things work. I think we do and I hope you agree that we have a curriculum to be proud of. The ugly duckling has transformed into a swan and will continue its journey with the partners it has made.

Is ICM moving away from anaesthesia?



Dr Anna Batchelor
Dean

This is a question I'm often asked. The questioner is usually hoping for one of the two obvious, clear answers: yes or no. Yes *and* no doesn't seem to cut it, but it is where we are.

ICM received specialty recognition in 1999 and the UK is one of a select band of countries including Australia and New Zealand, Switzerland and Spain where training in just ICM is possible. Until 2010, despite specialty status, training remained an add on to another programme with of course anaesthesia being the most popular. Now there is the option of ICM alone or in dual training with anaesthesia, acute, respiratory, renal medicine or emergency medicine. At present dual training with anaesthesia remains the most popular option but the other dual programmes and single CCT are a not insignificant proportion of the total.

So what does this mean for the future?

I hope it means we are developing a secure, competent and committed workforce in ICM who will assure the future development of the specialty and most importantly deliver a safe, high quality, continuously improving service to critically ill patients.

Do I want to cut anaesthetists out of ICM? Of course not. Do I want to go back to the time when ICUs were sometimes run by those who didn't feel an enthusiasm and passion for intensive care, because someone had to do it? Well that's a no too. Do I think anaesthetists should train in intensive care? Absolutely. I would like anaesthesia trainees to spend much longer in ICM, not because my rotas need to be filled but because the experience feeds into peri-operative

medicine, shared decision making, care of high risk patients, membership of trauma teams and so much more. Do I want that experience to also be available to trainees from medicine and emergency medicine? Of course, it can only be good for patients if clinicians understand what ICU admission can and cannot do.

Is there a place for the consultant anaesthetist on call covering the ICU as well as theatres and possibly labour ward? In an ideal world I would say no, and particularly not unless they also had fixed day time sessions in ICM. Regular participants, not as one of my long departed colleagues used to say "garaging" patients over night or even worse over a long weekend. Patients deserve better. But, I hear you saying, what about my small hospital? We cannot run separate rotas. This is where I think we need to start to have some honest conversations. In most areas of medicine the volume effect is now being recognised. How many of us would honestly chose a surgeon who does one or two gastrectomies a year for our loved ones? This is not at all to say small hospitals should not have ICUs but we do need to consider which patients should be in there. It is difficult to imagine a hospital with medical take and emergency surgery without a facility to manage patients who require a higher level of care. But we already regionalise head injuries, major trauma, burns, severe pancreatitis I could go on. If you are not able to devote all your attention to a critically ill unstable patient should you consider transferring them to a unit that can provide that level of input ?

Does the Faculty want only single CCT holders working in ICM? No. ICUs are run by teams, a

mix of skills makes for a healthy team. I am often asked “what else” will a single CCT holder do? Somehow this is not a problem for neonatologists or PICU consultants, but we are so used to the model of anaesthesia and intensive care that we sometimes struggle to see past it to a different way of working. At times its almost as if we are still apologising for taking time away from theatre to run our ICUs where we treat the sickest patients in the hospital. I remember as a registrar the consultant for the week still doing their usual lists whilst also being available 24/7 for the unit. Is it any wonder we talk about burn out ?

And now for the future, does the Faculty want independence from the Royal College of Anaesthetists? I do not know where a future Dean will want to take the Faculty. I do know that after a long period of gratefully received support from the Royal College of Surgeons that the Faculty of Anaesthetists wanted and needed to move on. It was and is a specialty in its own right not the handmaiden of the surgeon. I hope and believe that in the fullness of time Intensive Care Medicine should and will also make that step. Not a divorce but an amicable separation, a move to a new more equal partnership, a recognition that ICM will have come of age.

4th Annual ACCP Conference

Thursday 16th June 2016

Northern General Hospital, Sheffield

Cost: £45

Lecture topics will include:

- Post resuscitation cardiac care
- Intensive care for haematology & oncology patients
- Multiple trauma
- Delirium: recognition, assessment & treatment
- Legal and ethical aspects of end of life care

Workshops will include:

- Organ donation
- Thoracic ultrasound
- CPD
- Social media as an educational tool
- Setting up an ACCP programme

Abstracts are invited from trained ACCPs or ACCPs in training in any of the following areas; clinical, audit, quality improvement, education, research and patient safety. More information can be found on the FICM website.

**Booking and abstract information can be found at:
www.ficm.ac.uk/ficm-events/accp-conference**

Separation Anxiety: Are specialist units and general units drifting apart?



Dr Carl Waldmann
Vice Dean

In previous editions of *Critical Eye* we looked at the evolution of specialist critical care units for cardiac surgery and neurosciences.

The past decade has witnessed an exponential increase in the use of echocardiography (a core skill in CCU) in the management of critically ill patients. Furthermore, CCC units have a larger proportion of patients in cardiogenic shock that require invasive therapies such as intra-aortic balloon pump. General intensivists may wish to incorporate these in their ever increasing armamentarium of skills while dealing with critically ill patients. For the future we need to find out whether there is a formula to marry the expertise of those who have specialised in NCC and CCC with those who have developed an expertise in general critical care.

The impact of the Shape of Training, the role of the generalist, credentialing and the NHS England specifications for commissioning are yet to be properly digested and put into the formula.

If centralisation takes place, the marrying of skills and experience of general and specialist intensivists will naturally evolve; having general, cardiac, and neuro units geographically co-located can only be a win-win situation providing all support services are available and early transfer of patients into these units can be safely guaranteed.

The downside of centralisation can be the social implications for the family unit of having a loved member of the family being looked after at a distance. Centralisation of key specialist services including single speciality critical care units was the subject of Lord Darzi's review in 2007. It was argued that increasing the volume of cases in

larger centres would result in an expansion of the therapies available which would be more cost-effective to provide in a smaller number of regional, specialist centres than a large number of low-volume institutions.

Increasingly intensivists are developing skills such as ECHO, expertise in the running of rehabilitation programmes during and following a stay in critical care. There is no doubt that intensivists can master skills such as intracranial pressure monitoring and extracorporeal technologies.

I foresee that general intensivists will expand their repertoire and be more than capable of managing the critically ill in all subspecialty areas. The big issue to grapple with will be how we move forward from an organisational point of view. At present in many NCCs admission to their units is via neurosurgeons whereas in the general intensive care units the intensivist is in charge. There is still a lot of work to do within regions moving patients to NCCs.

In answer to the question whether there is a separation anxiety brought about by the specialist areas such as neurocritical care and cardiac critical care drifting apart, my inclination is that this is not happening but they are at present starting to think about and engage in a constructive dialogue around how we will work together, when and if centralisation takes place. There are far fewer differences than there are similarities in the capabilities of specialist critical care specialists and general intensivists. However there is one question that is difficult to answer which is what do we do in the short to medium term?

GPICS: Is it too far and how will it be implemented?



Dr Gary Masterson
Co-Chair
Joint Standards Committee



Dr Simon Baudouin
Co-Chair
Joint Standards Committee

Guidelines for the Provision of Intensive Care Services (GPICS) was published in April 2015 and is an expansion of Core Standards for Intensive Care Units published in 2013. This definitive reference source for both the planning and delivery of UK Intensive Care Services was necessary because of the transformation of Intensive Care Medicine into a stand-alone specialty in the UK.

GPICS was designed primarily for clinicians involved in the management and the design of critical care services, however it is also directly relevant to hospital managers, commissioners, Adult Critical Care Operational Delivery Networks, and the NHS England Adult Critical Care Clinical Reference Group. GPICS also includes clinical chapters, and will therefore be of interest to clinicians who undertake clinical audit to improve their practice and for revalidation purposes.

This first version of GPICS was the start of a long journey to compile a comprehensive index of recommendations and standards to build a clear picture of how Intensive Care Services should work in the UK. Over time it will be updated, and will grow as new chapters are added. The standards and recommendations in GPICS were, where possible, based on strong evidence. However, we acknowledge that in a number of areas, the evidence base is incomplete. The Faculty and the Society are addressing this 'evidence gap' as a joint initiative by developing a series of evidence-based guidelines. It is our intention to obtain NICE accreditation to strengthen the authority of GPICS' standards and recommendations. Of course this process will take some time and should be seen as a long term project.

GPICS is divided into six large chapters which themselves are subdivided into sections and subsections. Chapter One is an introduction which describes the service. Chapter Two describes in detail the structure of the service, including physical facilities and staffing. Chapter Three details the process of the service with a focus on the patient's pathway. Chapter Four describes the activity of the Critical Care service, including aspects of disease management and prevention as well as specialised critical care. Chapter Five contains other additional key components of the service, ranging from operational delivery networks to resilience planning. Finally, Chapter Six is a duplication of Core Standards 2013 in which the same numbering system used in the original document is kept to help avoid confusion.

GPICS was designed so that its constituent chapters and sections are clear, concise and readable. The sections were written by recognised UK experts, and after Chapter One, each has the standard format of Introduction, Recommendations, Standards, Background, References and Relevant Ongoing Research (where appropriate). Some chapters also have an Additional Information section.

Advice statements in GPICS are made in two ways – as Recommendations or as Standards. Recommendations should be routine practice in UK Intensive Care Medicine and these are endorsed by both the FICM and ICS. Stakeholder consultation was also important, and we have consulted with all major UK organisations linked to Intensive Care. GPICS has also undergone public consultation. For units where Recommendations are not currently met there should be a clear strategy to meet these as soon

as possible. However, it is appreciated that some Recommendations will take time to be implemented. Standards can be quoted by authors only if they are already included in the Core Standards 2013 document. Standards must be followed by UK Intensive Care Units and are considered absolutely essential to good critical care practice in the UK. 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.

Frequently Asked Questions

Will GPICS drive centralisation and close my unit?

This feedback has been made on a number of occasions. GPICS has always been about improving the quality of service we deliver to our patients as well as improving working conditions for our multiprofessional staff team members. It is true that a number of the staffing standards and recommendations will be easier to achieve in larger units but it is not the intention of GPICS to discriminate against smaller units. In fact, the intention is to support small units by directing attention to commissioning priorities in such units.

Does GPICS set unachievable standards?

All of GPICS' standards are realised in a number of UK units already. When designing a standard, the intention was to choose a certain level which would drive service improvement forwards and would also be achievable. It is accepted that this is not always easy, particularly for some smaller units but with local operational delivery network and commissioner engagement it should in all cases be possible to formulate an action plan to move towards meeting all of GPICS' standards.

Why is GPICS not evidence based?

GPICS is evidence based as much as it can be. A strong evidence base does not exist for much of UK practice and therefore in those circumstances case expert consensus opinion was used. When it comes to standards and recommendations for staffing levels it is appreciated there will always be some who will disagree. However, such standards and recommendations have been selected to protect patients and staff members and not to inconvenience some units.

What is the difference between GPICS' Standards and Recommendations?

A set of standards was published in 2013 as Core Standards and to avoid confusion by publishing a completely new set of standards within such a short time it was decided that GPICS would have the same Standards set as the Core Standards 2013 document. All other statements of advice in GPICS version 1 are therefore Recommendations. In general terms standards must happen and must be commissioned against whereas recommendations should happen and may or may not be commissioned against. The next version of GPICS will have different sets of standards and recommendations informed by developments (i.e. new evidence).

Why is GPICS not representative of all types of critical care unit?

GPICS is meant to apply to all types of critical care units including stand-alone level 2 or high dependency units, single speciality units (e.g. cardiothoracic or neuroscience units) as well as units of all sizes. It is accepted that meeting GPICS' standards and recommendations will be harder for some types of units than others. For instance where workforce shortages make the achievement of some GPICS' standards difficult to achieve in the immediate future, this should be built into the action plan.

Is GPICS representative of the UK?

GPICS applies across the entire UK. Some geographically isolated units will find it challenging to meet some of GPICS' standards and recommendations and again this should be included in the action plan as above.

Does GPICS cover other types of "critical care units" such as Non-Invasive Ventilation Units or stand-alone renal high dependency units?

GPICS covers units which are commissioned as critical care units and does not apply to units such as Non-Invasive Ventilation Units, Extended Recovery Units or stand-alone Renal High Dependency Units which should have separate commissioning arrangements.

Why was GPICS written by London ivory tower academics?

Neither of the GPICS Co-Editors work in London. One is not an academic and the other has never lived in an ivory tower. The GPICS author base is a healthy mix of experts from district general hospitals and teaching centres from around the UK. In version 2 of GPICS we will be seeking greater author representation from the devolved nations which are currently relatively under-represented.

Why is GPICS not multiprofessional in nature?

GPICS aims to support all members of the critical care multiprofessional team and there are sections representing all team members. It is planned to enhance the multiprofessional nature of GPICS in future editions. The list of endorsing organisations helps to demonstrate this breadth of engagement.

Why does GPICS not take the patient's perspective into account?

The patient's voice is very important in GPICS and there is a section devoted to the patient and relative perspective.

My unit's SMR is low so why do we need GPICS?

SMR is but one measure and in itself there is little evidence to suggest that a low SMR necessarily reflects a high performing unit. GPICS is about improving both processes and outcomes.

Implementation of GPICS

There is absolutely no point in compiling a list of theoretical standards and recommendations unless serious consideration is given to how these can be implemented on the shop floor. The implementation of GPICS' standards and recommendations will have a number of different but complementary drivers:

Personal Performance Setting

As GPICS has been endorsed by all UK bodies who are involved either directly or indirectly in critical care medicine, it is expected that all UK critical care units will take it upon themselves to use GPICS to drive their units forwards. It is hoped that units will perform a Gap Analysis certainly for GPICS standards and perhaps also recommendations to help identify gaps in service. This will lead to the construction of an action plan and the identification of commissioning priorities.

National Service Specification (D16)

NHS England's National Adult Critical Care Clinical Reference Group has constructed a national service specification which is about to be published. All of GPICS' standards are incorporated into D16 and will be formally included in NHS England baseline commissioning contracts in the very near future. It is expected that similar processes will take place in the devolved nations.

Critical Care Operational Delivery Networks

In England, Wales and Northern Ireland all regions now have adult critical care operational delivery networks although their levels of maturity vary. One of the networks' key functions is to perform annual service specification and peer review visits to its constituent units. The networks will incorporate D16 into their visits as from late 2015. In this way the standards from GPICS and indeed many recommendations will be reviewed by the operational delivery networks.

Care Quality Commission

The ICS/FICM Joint Standards Committee has worked closely with the Care Quality Commission over the last 18 months to build GPICS' standards into the Care Quality Commission critical care assessment tool. This is now in routine use due to the structure in place. Although much of the above is focussed on England, we hope that the experience here can be helpful across the UK.

Audit Recipe Book

The ICS/FICM Joint Standards Committee are developing a national Audit Recipe Book which will consist of standardised audit packages against the clinical sections in GPICS. Although this is at an early stage of evolution the expectation is that this will drive national comparative audit against the implementation of GPICS' standards and recommendations.

Summary

Version one of GPICS is the start, not the end. It is about improving the service we deliver to our patients and about looking after our staff. We hope this short article helps reassure the doubters.

Ivory Towers and the Coal Seams: Are smaller units being ignored?



Dr Chris Thorpe
Quality Lead

How is policy formed within the critical care community? Are consultants from large teaching hospitals setting the agenda for how critical care should be delivered in all hospitals? Did the Core Standards for ICUs, and subsequently GPICS simply reflect what large hospitals already do? Are critically ill patients best cared for in tertiary centres? Are there other models to run a sustainable effective critical care service in smaller hospitals? Should all acute hospitals have an Intensive Care Unit? Is 'stabilisation and transfer' a realistic prospect for acute hospitals? Is teaching better in bigger than smaller hospitals? What is a smaller hospital anyway? Does SMR matter and can we use it to compare hospitals? And how on earth can we get more trainees, residents, consultants, nurses, beds in this time of financial constraint?

In reality we are all at the coalface. Speaking to colleagues in different hospitals I certainly do not get the impression that either bigger or smaller units have the monopoly on hard work. In fact the overriding consideration appears to be when demand outstrips supply – when the dose of critical care expertise available is not enough. This critical factor seems to dominate most units and there is certainly not enough 'dose' to go around, and we are stretched beyond sensible workload. We have made substantial inroads over the last 30 years and obtaining resource locally has been aided by high profile national campaigns that have raised awareness of ICM as a cornerstone of acute care. The FICM and the ICS have therefore been essential voices to establish our specialty. Combining national support with local pressure has helped improve resources for all sizes of units. We are still behind the curve though.

So is there a separation between big and small hospitals? There is no doubt that there is a cohort of consultants who feel that ICM should be delivered in centralised units, perhaps supported by stabilisation and transfer services in smaller hospitals. It is probably of no great surprise that these voices emanate from bigger rather than smaller hospitals. While they are obviously committed to developing ICM they do have an inherent bias, as of course do we all. Can someone working in a large hospital really represent the needs of a smaller DGH? Partially, of course – in the same way that someone in a small DGH can understand the problems in a large teaching hospital – but clearly all are influenced by their own experience.

Does GPICS favour big hospitals over small hospitals? We must bear in mind that development of Intensive Care Medicine as a specialty in its own right has been a battle fought over an extended timescale. It has been an essential part of the battle to draw a firm line in the sand to distinguish what makes up properly delivered Intensive Care Medicine. This line in the sand has developed over the years and finds its way into recommendations and standards that clarify to all the perceived essentials of the specialty. Use of standards and guidelines are a way of exerting pressure for change and are very helpful but there are risks. One risk of standards is when they are formed by a group who look inwardly at what they already do and use this as a template for what all should do. While this has advantages of clarity, it loses an aspect of Darwinian evolution – other potential models are closed off. Standards have also been used for self-interest since medieval times when the Guilds used them to put

competitors out of business. So yes, they do favour big hospitals. Many units will struggle to meet the standards and it remains to be seen how this will be addressed. It is worth looking beyond the black and white of standards however and exploring the discourse accompanying the GPICS headlines, for example Gould and Danbury's section on Consultant Staffing helps to provide context.

Is this important? Despite our progress we are still a young specialty, and as such it is essential that all units and staff feel supported by the national bodies. We need a strong, cohesive base to build over the next decade. The FICM has no intention of positioning itself as a national body that supports only big units. The number of smaller units within the UK is surprisingly large. Furthermore there is little evidence that larger hospitals provide better outcomes in the UK. Support from national bodies must therefore be pitched at a level that is helpful rather than a hindrance to our wide base of units. Start with a broad base, and build tall. Chop your base down at the start, and watch it all topple down around your ears.

Training is another area of contention. Clearly trainees need a programme that gives them the opportunity to sample the variety of units that serve our hospitals. Most trainees end up in hospitals where they have spent time during their training, and it makes sense to give them a broad exposure. Trying to centralise training to just a few units when a large amount of work goes on in other units is a strategy that supports the few at the expense of the rest. There is no evidence that training is better in big hospitals, and there are substantial benefits of having training as part of your unit's activities. Large units are particularly valuable for higher-level trainees, but the DGH can give a great combination of individual mentorship and experience at earlier stages. One of the differences between big and small units is that bigger units tend to need enough trainees to staff complete tiers and are therefore 'trainee hungry' whereas smaller units use multiple sources for their resident rota of which trainees may contribute 2 or 3 slots. Of overwhelming importance is the ethos of the unit.

Are there other models for delivering critical care?

Yes, without a doubt. Given the scarcity of resource perhaps the time has come to be more open about other models of delivering effective care in smaller hospitals. Following a template used by big hospitals can be constraining and potentially not sustainable. Having a workable structure that grows over time is more important. The truth is that we do not currently know how best to deliver cost effective Intensive Care and while it may turn out that big centralised hospitals are best it might equally well turn out that this is not the case. I suspect that both bigger and smaller units can be equally effective and outcomes depend more on the quality of the staff than a given size per se. Let's explore what is out there at the moment and see what lessons can be learned.

So what next? There is within the Faculty a growing understanding that we need to understand and work with smaller units to ensure broad based expertise feeds in to national committees. There are many aspects of working within a DGH that may not be accurately represented in the working groups that make up the FICM. This is something that the FICM takes seriously, and there is now a plan to develop a smaller units working group. The remit of this group will be to inform the board of successes and difficulties in providing critical care services in smaller units, to comment on relevant documents produced by the FICM and how they fit with current and projected care within smaller units and to provide a conduit for smaller units to access advice and practical guidance.

So in drawing all this together – we are taking steps in the right direction and standards and guidelines have been helpful in this. We are moving at a fast pace ideologically within the FICM but resource is slow to back up ambition and there will be inevitable gaps. There has been a preponderance of large unit input into national bodies, and the Board is keen to address this potential bias by the formation of a smaller units working group to inform and discuss issues that affect these units. Both Larger and Smaller units can deliver safe, effective critical care but we need to openly explore sustainable models in more detail.

Workforce: Iron Hammers Not Silver Bullets



Dr Andrew Rhodes
Chair
FICM Workforce Advisory Group

Ensuring that the Intensive Care Medicine (ICM) workforce is adequate in both size and competence is a topic that all of us hold close to our hearts. There is nothing worse than starting a night on call worrying whether there is sufficient cover to cope with the demands about to be placed upon it. Ensuring that there are plans for an appropriate workforce for the coming year, but also for the foreseeable future, is highly complex and is contingent on a number of external factors, many of which we are unable to influence.

I am writing this article soon after returning from Wales for the Faculty's Workforce Advisory Group's (FICMWAG) first regional pilot assessment of workforce demands and pressures. Although the formal report has not yet been written, it was highly re-assuring to see how engaged clinicians in Wales are in tackling the problems they face in ensuring that the clinical service is covered with a sufficiently trained workforce.

What is immediately obvious is that there are some challenges in Wales that are different to other parts of the UK. In particular it is obvious that the geography and demography of North and South Wales are very different and this has major impacts on service configuration and the ability to attract adequate numbers of trainees and consultants to the different regions. The recent publication of GPICS has only served to exacerbate this further and may not be immediately achievable in all hospitals.

There is an urgent need to find creative solutions to a lack of middle grade cover, the possibility of a number of consultants either retiring early or changing practice to another specialty and to provide an elective and emergency service in

isolated areas that may never be able to acquire the GPICS standards.

At the end of November, the government published its Comprehensive Spending Review (CSR) for 2016-2020. Whilst this brought to the NHS some much needed comfort in terms of increased resource (an extra £8 billion applied to NHS England's by 2020/21), there were some areas that should raise concern. Although the NHS health budget has been relatively protected, other areas of health spending have not. In particular the budget for Health Education England (HEE) (currently around £4.9 billion per year) will reduce significantly. Figures from the Treasury suggest that there may be a £1.5 billion reduction in the annual budgets that include training for doctors and nurses. This is in an area where we were already getting pressured and the much needed expansion in training posts has been slow to materialize.

Recent estimates from both ICNARC and the Centre for Workforce Intelligence have predicted that there will be a significant shortfall in the numbers of trained consultants in ICM as compared with the likely need over the next 10 years. This shortfall may be of a material dimension. It is thus of the utmost importance that we are able to develop a greater number of ICM training schemes. The numbers of these schemes, however, are dictated (and funded) by HEE. We have therefore been lobbying HEE in order to ensure they are fully aware of the likely future skills gap in our speciality but at present they are prioritising the additional training places to the 'pressured' specialties of emergency medicine, psychiatry, general practice and radiology. This reduction in their overall budget

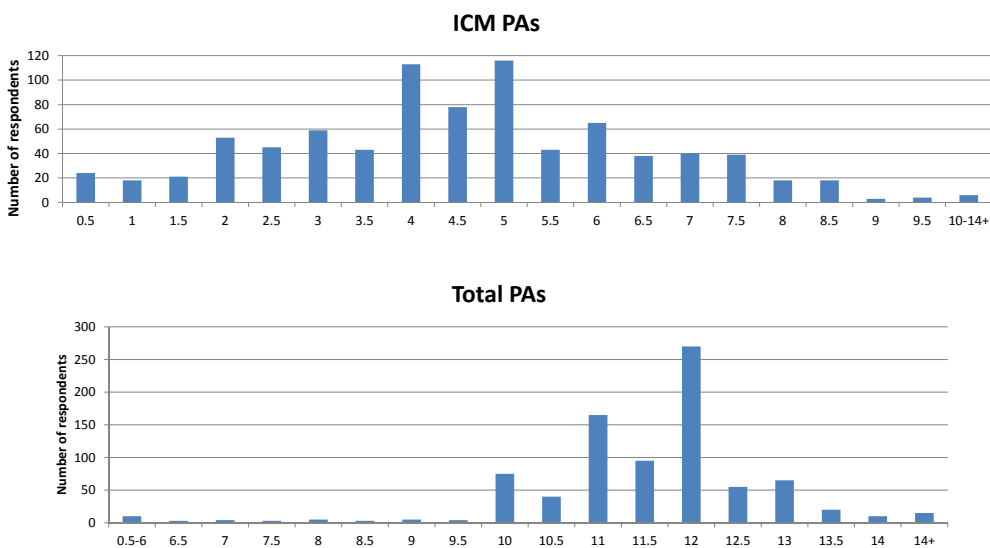
is unlikely to improve our position. A significant danger is that we will see a move to increase ICM training numbers at the expense of anaesthesia. This is of concern in many parts of the country where the two specialties remain closely linked. Recent recruitment data suggest that the proportion of trainees choosing dual CCT programmes with anaesthesia remains stable (70% Anaesthesia Dual, 20-25% Medicine Dual, 5% EM Dual and a very small number of ICM Single CCT trainees (5%)). It seems untenable, therefore, in the longer term to increase ICM numbers purely

at the expense of anaesthesia and it maybe that internal medicine also has to share the load.

With these challenges surrounding us on all sides, the Faculty has no silver bullet in its armoury, but with the CfWI findings, the early data outcomes from ICNARC, our annual census data and the series of reports that will be generated by the local workforce engagements started in Wales, ICM as a specialty finds itself in one of the best starting positions to hammer home our very justified case for workforce.

2015 FICM Workforce Census

The graphs below highlight the number of ICM PAs and the total number of PAs worked by the 861 respondents of the 2015 census from the 2015 census; more information will be published on the website shortly. The 2016 Census will be circulated on 24th February 2016, we appreciate you taking the time to complete this short survey to assist with future workforce planning.



We are looking for new members to join the FICM Workforce Advisory Group

The FICMWAG is tasked by the Board to develop and implement the Faculty's workforce strategy including monitoring the ICM workforce using the annual census and engaging with external organisations to assist with national planning.

If you would like to be considered, please email a summary CV and supporting statement (no more than one A4 page) expressing your interest in the role, your experience and your capacity to undertake any work generated to Dawn Tillbrook-Evans at dtillbrook-evans@rcoa.ac.uk.

The deadline for submissions is 1st April 2016.

What is the point of Advanced Critical Care Practitioners?



Ms Carole Boulanger
Co-Chair
ACCP Advisory Group



Dr Graham Nimmo
Co-Chair
ACCP Advisory Group

What is an ACCP?

In practical terms ACCPs are experienced individuals with clear training, assessment and supervision arrangements which enable them to work as a permanent member of the critical care team. ACCPs are not transient and will be cornerstones in ensuring the consistency of high quality of care delivered to your patients. The ACCP role is one which works across occupational barriers and has patient care at the focus of practice. Patient safety is a key issue and the well defined training for, and supervision of, the role both for trainees and trained has this firmly at the core.

Who can be an ACCP?

To date we have only critical care nurses and physiotherapists trained and in training. This role as a progression for operating department practitioners (ODPs) makes perfect sense however it will require legislative change to allow them to become non medical prescribers, an integral skill for the role. This is a situation we are well aware of and are equally frustrated by and are doing all we can to influence a statute change.

A cheap way to cover the medical rota shortfall?

A way to cover the shortfall certainly, but cheap not. Most ACCPs train on at least a Band 6 on Agenda for Change and qualify on a Band 7 minimum with progression to 8a for many. So not a cheap solution as two years supernumerary training in conjunction with a university brings significant on-going costs.

Competitors for Junior doctors?

Skills training in an ICU environment will bring with it competition but regarding ACCPs the skills standard required is the same which means common ground. It is worth the time investment for consultants to

train them to the highest level; trained ACCPs are currently supporting skills acquisition in junior trainees on their ICU attachments relieving the pressure on ICU consultants. They can also afford to be aware of the learning needs of the junior medical staff on short placements. There has been a long held concern that ACCPs will take jobs from medical staff but this has not proved to be the case. In reality ACCPs are covering junior and middle tier medical rotas for ICU which makes the rota compliant and increases the cover, especially out of hours. So in fact the role is a support for the trainees rather than competition. ACCPs are highly unlikely ever to be in the situation where a doctor is in direct competition for a permanent senior position.

Bottom line challenges

ACCPs keep their baseline registration as either a nurse or a physiotherapist as legislation currently will not allow registration of any new professions. The GMC taking on our registration has been mooted however this too requires a legislation change. A quick and easy solution does not exist making this the key challenge, focus and frustration going forward. The role is probably not for every unit; it is one workforce solution to consider in future planning. A lot is dependent on your flow of trainees, the culture and environment of your unit and the vision for your unit going forwards.

Is the future bright for ACCPs?

We believe so as each of the barriers are removed and workforce planning and training are focused on patient needs rather than occupational boundaries. The hierarchical structure in ICU has always been more linear than other areas and this role is evidence of that demonstrating the fact that care for the critically ill is most effective as a team game.

Critical Futures



Dr Peter Nightingale
Chair
Critical Futures Steering Group

I would like to take this opportunity to thank all those who contributed to the recent survey on how those actually delivering the service felt it should develop. When the survey was closed to further comments there had been 512 postings, which I felt was an extremely good figure from which to gauge opinion from. Although most were from individuals or those representing their hospitals and Critical Care Networks I am especially grateful to the following for their input:

- Association of Cardiothoracic Anaesthetists
- British Association of Critical Care Nurses
- Faculty of Intensive Care Medicine
- Intensive Care National Audit & Research Centre

The geographical spread of responses can be seen to the right; I will leave you to draw your own conclusions as to what this data might be telling us.

With 30 direct questions and 512 responses the magnitude of the task of analysing the data is really quite daunting but with the help of the Steering Group I would hope that we could be looking at our first draft in mid-2016.

Indicate the geographical region in which you practice		
Answer option	Response Percent	Response Count
Defence Medical Services	0.9	3
East Midlands	5.1	17
East of England	3.6	12
KSS	7.6	25
London	16.2	54
Mersey	6.6	22
North Western	10.6	35
Northern	6	20
Northern Ireland	0.9	3
Oxford	1.8	6
Scotland	9	9
Severn	3.9	13
South West	6.6	22
Wales	5.4	18
Wessex	4.2	14
West Midlands	10	33
Yorkshire & Humber	6	20
Answered question		331
Skipped question		181

Examination Calendar 2016

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications and fees not accepted before	Thursday 4th January 2016	Monday 11th April 2016
Closing date for Exam applications	Thursday 25th February 2016	Thursday 2nd June 2016
Examination Date	Tuesday 19th April & Wednesday 20th April 2016	Tuesday 12th July 2016
Examination Fees	Both: £570 OSCE: £315 SOE: £285	£470

Just Say Sepsis: A summary



**Dr Alex Goodwin
on behalf of NCEPOD**

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) published 'Just Say Sepsis' in November 2015. This study set out to identify and explore avoidable and remediable factors in the process of care for patients with known or suspected sepsis.

This year, international consensus definitions of sepsis will be amended to focus on physiological changes of organ dysfunction, including hypotension, tachypnoea and altered mental state. Sepsis is already recognised as difficult to diagnose and it can only be hoped that a new definition will be of assistance to clinicians. However, whichever definition is used it is the wider consideration given to sepsis by healthcare professionals that is important. There is an increasing focus on sepsis from health and political organisations with a will to improve the care of patients with sepsis. NHS England has identified tackling sepsis as a clinical priority for improving patient outcomes for 2015/16. Sepsis has been linked to a new Commissioning for Quality Innovation (CQUIN) in England and NICE are currently developing sepsis guidelines.

The NCEPOD study population included adult patients, ≥ 16 years old, identified as being seen by the Critical Care Outreach Team or equivalent, or who were admitted directly to critical care with a diagnosis of sepsis, based on the presence of infection, documented or suspected during the study period.

From the cases identified, the reviewers were able to assess 551 cases. This study confirmed that there is huge variability in the clinical presentation of sepsis. Patients seen in the community present diagnostic dilemmas and whilst the difficulty is

recognised, it was of note that there was poor recording of clinical observations by both primary and secondary care providers.

In the Emergency Department (ED) 40% of patients did not have a timely review by a senior clinician against the standards used. The importance of source control is often overlooked and it was noted that a possible source of infection was only recorded at triage in 46% of patients admitted via the ED. In those patients in whom a source was amenable to control, that control was delayed in 43% of cases, which could have affected the outcome in 26/41 patients.

Following admission to hospital, a consultant did not see 20% of the patients in this study within 14 hours. In view of the fact that 61.5% patients had changes made to their care following consultant review, it is paramount that the resources are in place to ensure prompt consultant review.

One quarter of the patients in this study acquired their infection whilst in hospital. In half of these patients the infection was diagnosed following an invasive procedure. In 10/88 patients with hospital-acquired infection, the Reviewers felt that the infection was preventable.

The Reviewers considered that there was a delay in identifying sepsis in 182/505 (36%) cases, severe sepsis in 167/324 (51%) and septic shock in 63/193 (32%), and identified that good documentation of sepsis was associated with more timely diagnosis.

Despite the presence of protocols, investigations considered essential in the diagnosis of sepsis were missed in 39% of patients and delayed in 39%.

Management on a care bundle reduced delays in the treatment of patients with sepsis. However, only 39.4% of patients were started on a sepsis care bundle. Only 55/215 (25.6%) acute hospitals used standard proformas to identify and monitor patients with sepsis, and less than half (90/204; 44%) audited the timely treatment of severe sepsis against their own protocols.

Critical Care Outreach Teams (CCOT) were only available 24/7 in 49% of hospitals. Consultants were part of the team in 28.4% of hospitals. The reviewers considered that the CCOT arrived promptly when summoned in 88.8% of cases.

Antimicrobial stewardship is important not only in the management of sepsis but also in the broader environment of healthcare. It was of note that a microbiologist was consulted on the suitability of therapy in only 52% of patients. Senior microbiological input is essential in the management of patients with sepsis to aid the appropriateness of antimicrobial therapy.

Morbidity following sepsis is common and 22% patients had evidence of complications at discharge. There was little evidence of information being given to sepsis patients or their relatives on the disease and its consequences.

For those patients who died, an autopsy was only performed in 12.1% of cases. Sepsis was only included on the death certificate in 40.8% and only 63.8% of cases were discussed at mortality and morbidity reviews, missing opportunities to learn from the care provided.

Throughout the patient pathway areas for improvement were identified and the Reviewers were of the opinion that good care was delivered in only 36% of cases. Early recognition, better documentation and prompt treatment of sepsis would all lead to improved care for this group of patients. Using the word 'sepsis' as soon as it is considered would also raise awareness amongst healthcare professionals and patients.

The reports principal recommendations were:

1. All hospitals should have a formal protocol

for the early identification and immediate management of patients with sepsis. The protocol should be easily available to all clinical staff, who should receive training in its use. Compliance with the protocol should be regularly audited. This protocol should be updated in line with changes to national and international guidelines and local antimicrobial policies.

2. An early warning score, such as the National Early Warning Score (NEWS) should be used in both primary care and secondary care for patients where sepsis is suspected. This will aid the recognition of the severity of sepsis and can be used to prioritise urgency of care.

3. On arrival in the emergency department a full set of vital signs, as stated in the Royal College of Emergency Medicine standards for sepsis and septic shock should be undertaken.

4. In line with previous NCEPOD and other national reports' recommendations on recognising and caring for the acutely deteriorating patients, hospitals should ensure that their staffing and resources enable:

- All acutely ill patients to be reviewed by a consultant within the recommended national timeframes (max of 14 hours after admission)

- Formal arrangements for handover

- Access to critical care facilities if escalation is required; Hospitals with critical care facilities to provide a Critical Care Outreach service (or equivalent) 24/7.

5. All patients diagnosed with sepsis should benefit from management on a care bundle as part of their care pathway. The implementation of this bundle should be audited and reported on regularly. Trusts/ Health Boards should aim to reach 100% compliance and this should be encouraged by local and national commissioning arrangements.

ICM and Shape of Training



Dr Alison Pittard
Chair
FICMTAC



Mr Daniel Waeland
Head of the FICM

Firstly, let us remind ourselves what Shape of Training is. The initial review, by the core group under Professor David Greenaway, resulted in a report published in November 2013. This gave a series of high level recommendations, many potentially positive and some with concerning interpretations. One of the latter was that Shape was designed to shrink the years of training, producing more generalist doctors in a shorter timeframe. The BMA, a number of trainee groups and the Academy of Medical Royal Colleges (AoMRC) actively countered this interpretation noting that the outcomes of Shape should not hold the reduction of training lengths as a prerequisite. The Shape Steering Group agreed that the emphasis of Shape was on ensuring a flexible and well-trained workforce and not about accelerating throughput. The Shape project then moved into a series of smaller meetings and discussions groups for the months between the summers of 2014 and 2015.

Then in July 2015, the Steering Group requested the AoMRC to conduct a mapping exercise. This exercise gave each Faculty and College an opportunity to detail how they would see their specialty programme(s) operating in a post-Shape training world. The Faculty submitted a full response to the Academy request in October 2015. The core of our response is that ICM is a relatively young specialty, and this comparative youth has allowed the specialty to anticipate many aspects which Shape has rightly seen as essential cornerstones of medical training. We grouped the rest of our formal response into five final sections which are summarised for your reference.

So what happens next? The Academy's Shape group will consider the submissions and send a formal

response to the UK Steering Group by December. We will then await future engagement.

1. Introduction

The ICM curriculum is designed around the tenets of flexible entry from multiple core programmes; dual training; experience across the acute sphere of the hospital; basic and essential experience in specialist areas of ICM; and the provision of basic research training and integration of higher levels of academic training for aspiring research-active NHS consultants or career clinical academics.

This reflects the role Consultant Intensivists have as the generalists of the hospital, managing adult (and in some cases paediatric) patients from all specialty areas whilst also being specialists and experts in the management of acute organ failure.

2. The Future of Critical Care Service

Through a number of data sources, it is clear that there will be a greater need for ICM specialists in the future.

One key solution to this greater demand is to ensure patient centred acute management across specialty boundaries and earlier intervention preventing deterioration rather than responding to it. The flexibility of the current curriculum aids this vision and the inclusion of ICM experience in other programmes (for example Core Medical and Core Surgical Training) would help further.

3. The Benefits of a Broad Based Curriculum

Intensive Care Medicine embodies cross-specialty working within the modern hospital. The curriculum, based upon the European-wide Cobatrice competency framework, is designed to equip doctors at CCT level to manage acute and emergency patients.

Many critically ill patients benefit from cross speciality working and a major role of critical care is to act as care co-ordinator as well as delivering critical care. The curriculum (particularly in Stage 1), allows intensivists to become familiar with multiple acute scenarios and have a broad understanding of patients' wider needs.

4. Aspects of Training in ICM

Core training: ICM does not have its own core programme but welcome trainee from multiple cores. The generic nature of a programme like ACCS allows the development of doctors with a well-rounded understanding of medicine and anatomy, who are then able to work across the acute sphere of the hospital. The Faculty would support the expansion of a common acute core programme.

Dual training: The FICM remains supportive of the value of dual training, which allows greater workforce flexibility, a broader basis for experience and the completion of two elements of training in less time than it would to train in them independently.

Subspecialty training, special interest and credentialing:

ICM is a parent speciality to Pre-Hospital Emergency Medicine and Paediatric ICM. Whilst both may be suitable credentials, whilst the definition of credentialing remains so obscure, it is not possible to comment on the relative pros and cons of such an outcome. Specialist interests within the ICM curriculum (i.e. the Special Skills Years and specialist ICM) are designed to aid generalist learning and are not curriculum designed to create independent consultant practice in those areas.

Academic training: Research training is an essential component in creating a high quality specialist workforce for the speciality and many ICM training centres offer basic research skills training. The Faculty's academic training strategy has been

developed by research active trainers and conforms to recommendations of the Walport Report and the NIHR Integrated Academic Training (IAT) Programme.

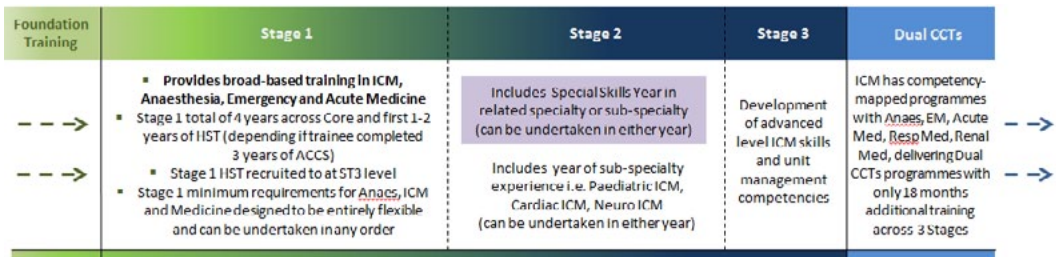
Overall length of training: Within the limits of the current models of service provision (of which trainees remain a notable component) and the European Working Time Regulation, the FICM feels the current training programme length, which was only codified in 2011, is necessary. Although competency based, ICM requires experiential learning, which can only be acquired with time. Over 90% of the trainees confirmed that if training was shortened, they would find a way to extend their training outside of the CCT (i.e. with a post-CCT Fellowship) to ensure they were appropriately trained before starting a consultant post.

5. Foundation and Undergraduate Training

The ICM curriculum recognises that 'common competencies ... are as important as the clinical competencies' and suggests that they should be attained 'seamlessly alongside clinical skills during training. The CCT in ICM builds upon the knowledge and skills of foundation and undergraduate training.

Our response went on in detail to note the 'continuum' of core experience that a trainee develops through undergraduate, foundation and then ICM specialist curricula. It covered the areas of Professional Behaviour & Trust; Communication, Teamworking & Leadership; Clinical Care; and Safety & Quality.

We summarised the training programme in the diagram below.



Training and Assessment



Dr Alison Pittard
Chair
FICMTAC

We have reached another milestone; we recently held the Faculty's first FFICM Examination Preparation course, skillfully developed and coordinated by Dr Sarah Marsh. Some of you will have attended, some may have been unsuccessful securing a place. Demand was extremely high and I have no doubt this will remain the case. This two day course will be held once a year, just before the Autumn oral exam and allows candidates to experience OSCEs and SOEs. A prep course for the written exam is in consideration.

We have appointed a new e-portfolio lead, Dr Andrew Gratrix, supported by Dr Peter Hersey. The e-portfolio is evolutionary and will develop in response to user feedback. Some changes are easier to make than others so please be patient. We have secured funding for an e-learning programme for ICM and will be looking for authors so if you are interested please contact the Faculty.

For those busy writing Expanded Case Summaries, a new FOAMed resource is being developed. Summaries assessed as an acceptable standard will be posted at www.casesummaries.com and will be mapped to the curriculum. They will be edited to remove any risk of patient identification and there is the usual reference to plagiarism.

The GMC have published *Promoting excellence: standards for medical education and training* which comes into force in January 2016. There are ten standards around five themes and highlights what Trusts need to do to meet these standards. It is well worth reading.

If you are passionate about an area of ICM, feel that it could be covered in more depth/breadth by

interested single CCT trainees and you would be able to provide the training then write a proposal for a special skills year and submit it for consideration. It is worth looking at modules already approved on the website and use these as a template. The module should last for 12 months and have clear, achievable objectives that cannot be gained during the course of general training. Once approved by the GMC and agreed as part of the curriculum any unit who feels able to deliver the content can offer a module to potential single CCT trainees.

Finally I would like to clarify some concerns that have been raised about the specialist ICM year in stage 2, particularly the cardiac, neuro and paediatric modules. The competencies in each block can be achieved in any location. It doesn't have to be in the ICU. For example in the paediatric ICM module the aim is to provide the trainee with opportunities to gain knowledge and skills, allowing them to stabilise a sick child and manage them for a short period until they are transferred to a specialist unit. We are not trying to train specialists in PICU. In some programmes the best solution will be for the trainee to be placed for the full 3 months within a PICU. Other areas may find that the optimal local solution is for the competencies to be acquired within a theatre setting. For the dual trainee with Anaesthetics the latter may be the best option as this allows the 3 months to double count towards both CCTs. In fact this was the initial plan to limit the duration of training to an acceptable length.

The next momentous occasion will be the award of our first CCT from the new programme on 2nd August 2016. I look forward to wishing this trainee every success in their future career.

Trainee Update



Dr David Garry
Past Trainee Representative

You will all doubtless be aware of the current situation regarding the proposed changes to the junior doctors contract. The message filtering up through Faculty channels is consistent with my discussions with trainees (and consultants) in my region and with other trainee groups – people are worried. I hope that you are all cognisant of the immense support that you have. There have

been numerous statements from the Faculty, the Royal College of Anaesthetists and the Intensive Care Society. Additionally the Academy of Medical Royal Colleges' Trainee Doctors Group have released a statement of support that myself and Ian have signed. Amongst all this please do look after yourselves, and do not hesitate to get in touch with any questions.

I will soon be stepping down as Trainee Representative and this is my last trainee update for Critical Eye. I would like to thank you all for your support during my tenure - it has been a privilege. Please do give a warm welcome to Ian who up to now has been working hard behind the scenes as the Trainee Representative Elect. And finally, my best wishes to you all in your future ICM career.



Dr Ian Kerslake
Trainee Representative

I'd like to start by saying a huge thank you to David for all of his hard work over the past year, so much work goes on behind the scenes and we are all very grateful to him. I am taking over the 'Lead Trainee Representative' reins at what is an exceptionally turbulent time for us. Looking around the hospital here in Bath, I have never seen so much palpable uncertainty and worry amongst the trainee group.

My email inbox is filled almost daily with work and letters written on your behalf from the AoMRC trainee doctors' group; all of which have unanimous support from their respective Royal Colleges.

When times are tough, I think it's important to try and recognise some of the positives. I'm immensely proud of the medical profession, and of junior doctors in particular, for the way in which they have come together as a force to be reckoned with. I'm proud of the unfailing dedication to our patients, in trying to secure a future for our NHS that can care for our families and the public in their time of need. It goes without saying that I hope this gets sorted soon, so we can all get back to worrying about whether or not we'll get through the next ARCP, rather than having visions of widespread NHS collapse!

In the next few weeks a new Deputy Trainee Representative will be elected and I look forward to welcoming them to the job. It has been highly rewarding and I hope whoever you are, you will find it as enjoyable as I have. That only leaves me to say that you are always welcome to get in contact about issues you would like me to raise, one of my primary roles is to facilitate the lines of communication to the Board from you all. I've actually succumbed to getting a Twitter account (@ikerslake) seeing as Anna Batchelor has one, so either email or tweet me (which I will be particularly excited about)!

Recruitment



Dr Tom Gallacher
ICM National Recruitment Lead

In 2015 the Faculty were delighted that for the first time, Scotland was able to offer posts via the National Recruitment process and thus with all four nations involved for the first time the process was truly national.

The overall fill rate this year was 88% which was slightly lower than the 96% fill rate of 2014 recruitment. However, this is likely to be a consequence of the relatively small numbers of ICM training posts and the need for trainees who wish to undertake a dual training programme to have both specialty training programmes in the same deanery. This can be demonstrated by the fact that several regions had candidates appointable to Intensive Care Medicine but to whom we were unable to offer a post since all posts were filled whilst others had unfilled posts. Of the 137 posts available, 120 were subsequently filled.

In order to maximise the number of successful trainees who are offered a post the QRC Subcommittee have modified the veto process which has been used in previous years. For 2016 a trainee who has attained a sufficiently high score to be deemed appointable will now only be vetoed from the selection process if they are awarded a score of zero by two examiners independently in a single station. A score of zero awarded by a single examiner in 2 different stations will not result in a veto but will clearly make it very difficult to achieve the minimum appointable score.

We have concluded our recent discussions with the GMC and the latter have agreed to remove the '18 month rule'. There is no longer a requirement for a trainee to commence training in their second specialty of a dual programme within 18 months

of commencing their first specialty in order to be awarded dual CCTs.

The Faculty and our partner Colleges have agreed that no trainee will be permitted to commence a dual training programme with ICM if they will have commenced ST6 before the date of the national interviews appointment to their second specialty training programme. This has been well publicised in advance in order to avoid any trainee wishing to dual train being prevented from doing so.

The GMC have also recently released guidance concerning dual training programmes. This is a generic document covering all specialties but the GMC have agreed this can be modified by specialties to suit their individual needs if required. The document states that a trainee who wishes to apply to a dual programme first needs to resign from their single programme. This clearly would not be compatible with ICM recruitment and the Faculty have written confirmation from the GMC that we can continue to recruit using our current process. Thus, any trainee who wishes to undertake a dual training programme with ICM does not have to resign from their first specialty programme in order to apply for a dual programme. This applies whether the trainee is applying to ICM for a dual programme or an ICM trainee is applying to one of our partner specialties for a dual programme.

2016 Recruitment Dates

Application window: **10am on Tuesday 16th February - 4pm on Wednesday 9th March**

Interviews held: **12th-14th April**

Regional Advisor Update: A View from the Bridge



Dr Daniele Bryden
Lead RA

Every September the Regional Advisors meet to discuss priorities for the new academic year. We base discussions on reports submitted to the Faculty by each RA in July to give a picture of ICM training from the viewpoint of local hospitals and regions. I've always found the September meeting extremely helpful. At times it can be quite worrying as an RA giving guidance to a region where local arrangements don't quite fit the central templates. No one wants to be the only region doing things differently from everyone else.

This year's meeting illustrated the variety of solutions being developed for the ST5 year where trainees rotate through specialist modules gaining neuro, cardiac and paediatric competences. Dual anaesthetic trainees have a lot to cover in these modules as they need to complete a significant number of anaesthetic and ICM competences and RAs have identified it as a potential 'choke point' of delivery for the dual ICM/anaesthetic trainees if we aren't going to extend their training further. Paediatric arrangements appear to be a particular challenge and as ICM and Anaesthetic TPDs are working together on this, a certain degree of 'horse trading' is taking place to manage individual regional arrangements. We will be very keen to see how these arrangements have worked out in next year's RA reports.

RAs are however extremely positive and upbeat, reporting that the delivery of the new ICM CCT curriculum is working well whilst still training a number of joint trainees on a different curriculum. We've come a long way since the new curriculum was first developed. The complexity of all this training is now being worked out with the benefit of greater numbers of ICM TPDs and

enhanced Deanery/LETB support. Local solutions to diverse trainee needs are being worked out using social media, websites and regional teaching programmes, and funding that has been found for some new posts is allowing RAs to bring in new training centres. The high quality of ICM applicants is creating a positive buzz for the future and it feels like a good time to be involved in training, even though, as I've outlined previously, 40% of trainers aren't getting the support they need from their employers. My region has, for the first time ever, created a pan Deanery ICM specialty training committee that includes trainee representation: it has strengthened the role of the RAs and TPDs by allowing all of us to speak with one voice to our parent school.

Of course there are still ongoing challenges, and the e-portfolio is a significant source of comment. The Faculty has identified logbooks which produce 'ARCP friendly' outputs, and is creating a resource of free open access ICM education websites, the complexity of the e-portfolio at ARCP time was noted and several RAs reported that outcome 5s were given as trainees appeared to be unfamiliar with what is needed.

If you have any comments or queries, to feed them back to either to me directly, Mark as representative on the Training and Assessment Committee or your local Regional Advisor.

FFICM Exam Preparation Course



Dr Sarah Marsh
Course Organiser

It's been a long road for ICM in the UK. We are a relatively new specialty having come to the world's attention in the 1950s following a polio epidemic in Copenhagen. If we compare this with the 14th century origins of the Royal College of Surgeons, you can see that we really are quite new.

Training in ICM in the UK was formalised in 1996 with the creation of the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM), and the first ICM exam was sat in 1998 (Diploma in ICM). The IBTICM and the DICM have now been superseded by the formation of the Faculty of Intensive Care Medicine (FICM) in 2010 and it's own exam in 2013 (Fellow of the Faculty of Intensive Care Medicine (FFICM)).

FFICM exam

The first sitting of the FFICM was held in the January and April of 2013, and had an overall pass rate of 85%. The average pass mark for all six sittings to date has been approximately 70%.

Why produce an exam course?

A new exam precipitates an automatic appetite and seemingly visceral need from trainees for a pre-exam preparation course. There is little quantitative evidence to prove that attending an exam course increases one's chances of passing an exam, however anecdotally attending one does seem to help. Perhaps the more motivated and organised candidates are the ones that sign up to such a

course but were actually destined to pass anyway. Perhaps attendance at a course gives you that extra edge to hopscotch your mark above the pass-fail line. All this aside, there is a ferocious demand for exam courses and the FICM wanted to respond to trainees' needs by delivering its own affiliated course.

There are a number of excellent existing regional exam preparation courses, mainly in the southern half of England. With that in mind as well as economic viability, venues outside of London were considered. In view of its central position and good transport links, Leeds was then selected to host the first course in October 2015 at The Rose

Bowl Conference Centre.

How was it done?

A faculty was established across different regions, with founding members from

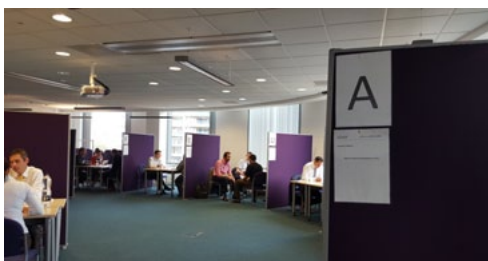
South Yorkshire to Scotland. The exam was visited to assess the standard required and to get some organisational tips for the day itself. Using a successful template created for a national FRCA exam course (Leeds Crammer), a two-day program was then developed.

The course was held one week prior to the exam to ensure candidates were at the top of their exam preparation trajectory. Day 1 comprised of lectures and small group tutorials based on areas of poor performance in previous exams. Twelve consultants from eight different specialties delivered these teaching sessions, which included



subjects such as ECG interpretation, radiology, ethics and the law, and renal medicine.

The aim of day two was to provide as much exam practice in an exam setting as possible. Due to demand we expanded the course to accommodate 32 candidates from the 16 originally planned. The morning comprised of two OSCE rounds of eight stations each, with the candidates being examined in pairs (one examinee, one observer). The SOEs were examined in the afternoon with two examination rounds of four stations containing two questions, as in the exam. To facilitate such a large cohort of candidates 18 Consultant Intensivists gave up their time to examine as well as four faculty members and two administrators from the FICM. All questions and answers were provided for the examiners, a feat which took months of preparation including new question generation and quality control. Topics were wide ranging and incorporated specific areas mentioned in the Chairman's exam report.



OSCEs in motion

Attendees

Candidates came from the length and breadth of the country. Of the 32 candidates 18 were joint trainees, 11 were dual trainees, and 2 were training solely in ICM. There were also 2 affiliate trainees. The majority of the candidates were training in combination with anaesthetics (24 out of 32). The remaining 8 were training with emergency medicine, acute medicine, respiratory medicine and cardiology.

Pass rates

Of the 32 candidates that attended, 30 sat the exam with 80% passing both components. Furthermore, 90% passed the OSCE section overall and 83% passed the SOE. This was in comparison with an overall pass rate of 70% (with 80% in the OSCE component and 75% in the SOE component) in the

actual exam. The cohort therefore appeared to perform well when compared with the candidate population as a whole.

Feedback

Feedback was requested immediately after the course and then following the exam. Comments were overwhelmingly positive stating that the course was excellent, was of an appropriate level and that it helped them to pass. Candidates also stated that they would recommend the course to others. Some candidates did however feel that the course was too close to the exam (which will be addressed for the next sitting) and would have preferred fewer candidates with more exam practice in general. However as the course was oversubscribed in addition to the extent of consultant involvement, this may not be possible to achieve.

Future developments

The course will run again immediately prior to the October 2016 Final OSCE/SOE exam sitting. In addition, an MCQ/SBA will be developed at a later date. New questions written by any non-examiners for either course would be gratefully received!

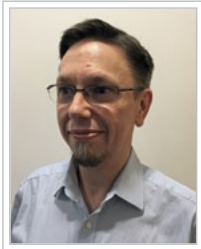
Thanks

First and foremost huge thanks go to the founding faculty members – Dr Jane Howard, Dr Tim Wenham and Dr Martin Hughes without whom none of this would have been achieved. In addition thanks also goes to all the consultants who gave up their own time to attend and ensured that the course was expertly delivered. Lastly may I personally thank Susan Hall, the FICM and the Training and Assessment Committee for all their help and support over the last year.



Workshop session

Spotlight on ICU Steps



Peter Gibb
Chief Executive
ICUsteps

Over the last decade, it has been increasingly recognised how distressing intensive care treatment can be for patients, and how long lasting are the consequences. Often the need for admission is an emergency, with no time for patients or relatives to prepare or understand what is about to happen. While in ICU, patients can experience awareness under light sedation (but not understand where they are or what is happening); inability to communicate; delirium; paranoia; confusion and disorientation; sleeplessness and distressing interventions.

For those that survive critical illness, leaving hospital is only the beginning of a long road to recovery. It is likely they will be very weak physically, perhaps with a new disability to come to terms with, as well as the psychological impact of ICU treatment. Patients and relatives can experience flashbacks and distress about what happened in hospital, some developing PTSD. Many of the issues patients encounter during their recovery are common, but it is unlikely they will know anyone who has had intensive care treatment, and they can feel isolated and alone. Many units do not offer follow up support and patients and relatives have no one to ask for help or advice; often their GP is the only link to services, but GPs can have limited knowledge about what intensive care patients experience and what support is required.

Mo Peskett, a Senior Sister at Milton Keynes General Hospital, was responsible for the hospital's follow up clinic and saw first-hand the legacy of intensive care treatment. In 2005 we established ICUsteps to set up the first support group for intensive care patients and relatives. The idea was to provide a place for patients and relatives to come where people truly understood, sharing

'empathy not sympathy', with those further along the journey of recovery supporting those just beginning it. It is hard to overstate just what this means, hearing from others who have been there and had similar experiences, learning about what helped them and that recovery after critical illness is possible.

Since that beginning, it has been quite an extraordinary journey. We now have 18 affiliated support groups across the country. We believe that good quality information is vital for patients and relatives, and since our information booklet 'Intensive Care: a guide for patient and relatives' was first printed in 2008, we have distributed 135,000 copies to UK hospitals. It's available in fourteen languages on our website, and we get requests from around the world to adapt it. In 2013 we held our first conference, attended by over 200 healthcare professionals. Last year, our website had 21,000 visitors. We are involved in strategic work, ensuring the patient and relative voice is heard at all levels, for example, at NICE, National Outreach Forum and the Critical Care Clinical Reference Group, as well as advising researchers. We are proud of our achievements, not least because we have no paid staff; our charity is run by patient, relative and healthcare professional volunteers.

As patients and relatives, we have immeasurable respect for intensive care staff and for their skill and dedication which saved our lives. But it is the aftercare and rehabilitation that is so often lacking; patients and relatives need help to recover after critical illness, they cannot do it alone. We have achieved a great deal in partnership with healthcare professionals, and we look forward to seeing where the next ten years will take us.

Spotlight on Training in Mersey



Dr Mark Hughes
Regional Advisor

Mersey is undergoing a period of change. We have recently merged with the old North Western Deanery to form Health Education North West (HENW), although we remain a single unit of application for national recruitment, and a distinct training area.

The region is relatively compact geographically; commutes are never too strenuous, and trainees are able to easily stay in touch with what's going on across the region and with each other, as well as readily access centrally organised events.

Training in ICM occurs in two University Teaching Hospitals: Royal Liverpool University Hospital and University Hospital Aintree (which houses the trauma centre); two large District General Hospitals: Wirral University Teaching Hospital (Arrowe Park) and St Helens and Knowsley Teaching Hospital (Whiston); and three standalone specialist referral centres: Alder Hey Children's Hospital, Liverpool Heart and Chest Hospital and Walton Centre for Neurosciences, all of which have excellent reputations. ICM presently sits within the HENW School of Anaesthesia, but we are looking to develop a separate School for ICM in the future.

The last three Joint CCT trainees are due to finish in 2016. We currently have 15 trainees on the new CCT schemes, with all but one in dual programmes. The trainee demographic is mixed. 60% are currently dual training with Anaesthesia, while the others are additionally training in AIM (20%), EM and Respiratory Medicine. We have very good links with our partner specialties and they are all very supportive of the programmes. In order to come more into line with our workforce requirements, we are looking to increase our trainee intake to six for the forthcoming recruitment round in 2016.

The region prides itself on providing high quality training and having excellent trainee/trainer relationships. The trainees have a well established support and social forum and have indeed produced their own website to share important information. (www.merseyicm.com). There is an established regional teaching programme, backed up by excellent courses, particularly around echocardiography and simulation. We have a number of FICE mentors and are able to support FICE accreditation. The research profile of the region is on the rise, with most units actively contributing. We are also looking to develop local academic training and are about to appoint our first ICM ACF.

We are exploring exciting new opportunities for education and training with our counterparts from the former NW Deanery, which should further improve trainee experiences across both patches. We are developing a strong working relationship together, and share a common approach and vision for the future, including maintaining our separate identities.

Liverpool is also an exciting and vibrant area to live in with significant developments in the city following the success of the European Year of Culture. It has an international reputation for arts and sports, and offers other excellent recreational activities. There is easy access to beautiful countryside and several nearby National Parks. The transport links are also excellent, and London is only two hours away by train.

If you are interested in training in HENW-Mersey then please get in touch with either myself, or Dr Tom Williams, who is the TPD.

Professional Standards



Dr Simon Baudouin
Chair
FICMPSC

The production of the GPICS document and the continuing work on the ARDS guideline and NICE accreditation are two of the major JSC work programs. In an accompanying article Gary Masterson and myself discuss the implications and implementation of the Core Standards and GPICS documents. In this article I will therefore highlight some of the other issues that have engaged the JSC in the last year.

The JSC has constituted a Legal and Ethical Policy Unit (LEPU) under the able leadership of Chris Danbury. This working group, which has both medical and legal representation, will help advise the Faculty, Society and its members on changes and implications of legislation that is likely to impact on critical care practice. One piece of legislation that is causing some concern is the recent Deprivation of Liberty Legislation. The LEPU has drafted a very helpful response to the Law Commission's report and this has been fully endorsed by both the Faculty and Society. Their commentary highlights areas where there are specific issues of applying legislation to the critically ill in a sensible and proportionate manner.

Critical Care in the United Kingdom has always been at the forefront of robust data collection and has

a long and successful history of collaboration with ICNARC to produce comparative standardised mortality information. Measures of hospital mortality continue to dominate headlines. However the use of Standard Mortality Rates as a quality measure is not without problems and controversies and the JSC intends to produce a review on the uses of SMR as a quality measure.

The work to obtain NICE accreditation for guideline production continues to progress. We recently attended a very useful meeting with representatives from the NICE accreditation team. They are prepared to review our current documentation and manuals and give us feedback on our progress. We have completed both our process manual and GRADE guide and will submit both these documents. Their feedback should be very valuable in terms of ensuring that our final application is as complete as possible and therefore likely to succeed on the first submission.

Finally, the trainee representatives continue to provide very useful input into the committee. Currently they are developing an audit recipe book with the ultimate aim of producing off-the-shelf audits that can be used in conjunction with the Core Standards and GPICS documents.

We are looking for new members to join the FICM Professional Standards Committee

The FICMPSC has responsibility for the creation and maintenance of standards for the specialty and holds joint meetings on a quarterly basis with the ICS, which you would be expected to attend.

If you would like to be considered, please email a summary CV and supporting statement (no more than one A4 page) expressing your interest in the role, your experience and your capacity to undertake any work generated to Dawn Tillbrook-Evans at dtillbrook-evans@rcoa.ac.uk.

The deadline for submissions is 1st April 2016.

Legal and Ethical Policy Unit



Dr Chris Danbury
Chair
Legal and Ethical Policy Unit

This year a clear theme arose for LEPU. That theme was Decision Making. The decision in *Aintree v James* has been widely discussed in a number of meetings across the country. The Courts seem to be taking the view that although clinicians are experts in medicine, families/friends are experts in what the patient would want – ‘best interests’. Therefore, in cases where there is dispute as to the ‘best interests’ of the patient, the Court increasingly prefers the family’s argument. The most recent example of this was heard earlier this year, although may be being appealed.

These disputes are concerning to all involved. Getting a judge to make a decision doesn’t mean that the problem goes away. The day after the case, the family, and clinicians still have to look at each other by the bedside of the patient on ICU. There may be perceived ‘winners’ and ‘losers’ and feelings are likely to run even higher. The implications may run on long after the patient has left ICU.

My colleagues on LEPU discussed who the decision maker is in the last edition of *Critical Eye*. Since then we have had the opportunity to hold a Seminar to consider an alternative way of resolving disputes without going to Court. On the 15th October a seminar was held at Churchill House jointly hosted by LEPU, 39 Essex St Chambers and the Medical Mediation Foundation. It was Chaired (in a personal role) by the Court of Protection judge, The Hon Mr Justice Hayden. We heard from PICS colleagues, who have been considering these issues for years. Sarah Barclay from the Medical Mediation Foundation gave a fascinating talk about the development of the Evelina Resolution project. I gave a talk on how this is starting to creep into adult ICU practice.

There was an audience of over hundred doctors, solicitors, barristers and mediators. The consensus of the evening was that the Court should only be a last resort after all other avenues have been exhausted. Mediation is a good alternative and can be tried in a number of different ways. Informally, within a team it may be that changing who communicates with the family will resolve the issues. If this does not work, then there may be mediators within the organisation who can facilitate a solution. Alternatively, clinicians and families could choose to go to formal mediation with an accredited mediator and legal representation.

Moving to other areas of the law, there have been other interesting decisions in the last year. We saw the findings of the judicial review in *Tracey*. This in itself mandated the discussion of DNACPR with patients and their families. Combined with the Supreme Court ruling in *Montgomery v Lanarkshire* this potentially means that we will spend more time explaining lots of treatment options. LEPU is planning a work stream to examine this area, and will to issue some advice (not guidance!) next year.

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.

Breaking Bad News and Trainee Welfare



Dr Anthony Eiden
ICM Trainee

From my personal experience of breaking bad news on the ICU, I recognise the effect it may have on all ICM trainees. As a result of this reflection I decided to research the implications on the emotional wellbeing of other ICM trainees, to find out what, if any, support is available and to explore if any improvement is needed.

Method

After undertaking intensive online research to see if this issue had been explored previously, I created an online survey which was distributed to all ICM trainees registered with the Faculty of Intensive Care Medicine (FICM) via the FICM trainee representative. The survey was open over a period of two months (March-May 2015). The results of each question were analysed using simple statistical analysis.

Outcome

110 responses were collected from 446 registered trainees (24.66%). Respondents to the survey were in various stages of their training, which in rank order were: (91.81%) Specialty trainees, (5.4%) Consultant (it must be assumed that these consultants were relatively new in post as they were contacted via the FICM Trainee Representative), (2.73%) Core trainees.

Respondents were then asked how they felt after breaking bad news, the responses were; (70%) sad, (45%) calm, (38.18%) emotional, (18.18%) upset, (14.55%) stressed, (13.64%) indifferent, (12.73%) nervous, (8.18%) relaxed.

Over a quarter of respondents (25.4%) stated breaking bad news had impacted on their personal wellbeing. This question was analysed further to produced the following responses: 25.55% stated

breaking bad news had impacted on their work life, 16.36% stated breaking bad news had impacted on their family life, 10.19% stated breaking bad news had impacted on their social life.

When asked if any training had been provided on breaking bad news and how to deal with its emotional consequences a significant number (46.36%) had never received training. In addition to this, an even higher number were not aware of any formal support from their department (76.36%), hospital (78.18%) or deanery (71.19%). When asked if formal support had been accessed after breaking bad news a relatively low number had done so (3.64%). 58.18% of respondents thought more support was needed for trainees in this matter.

Conclusion

The data shows that a significant number of trainees had experienced various negative impacts on their emotional wellbeing as a result of breaking bad news. 14.55% of respondents stated that they experienced stress after breaking bad news. This is a compelling percentage if this is extrapolated across the whole trainee body and could have long term implications on mental health and wellbeing.

In addition to this, 25.55% stated breaking bad news had impacted on their work life. I would recommend this is investigated in further detail as well as explore the implications on staff productivity.

It is clear to see from the results that the trainee body feel that more support is needed. We need to explore ways of improving formal support mechanisms and pushing trainees wellbeing further up the agenda for change.

FICM Fellows by Election 2015

Professor Peter Hutton

Peter Hutton graduated from medical school in 1978 and undertook his postgraduate training in anaesthesia in Bristol. After four years as clinical lecturer he was appointed Professor of Anaesthesia at the University of Birmingham moving to the NHS from this post in 2010. In 1994 he was appointed medical director to the Trust. In 2000 Peter was elected President of the Royal College of Anaesthetists and negotiated the process along with the Royal College of Physicians and Faculty of Accident and Emergency Medicine for the new ICM training programme to become a 'supra-specialty' and from which the Board eventually developed into the UK Faculty of Intensive Care Medicine. Peter has held many posts of national importance, notably Hospital Consultant Advisory to both of the Francis Mid-Staff enquiries, chairing reports into the storage of DNA samples for criminal investigation and vice chair of the Long-Term Conditions Alliance for which he became an Honorary Ambassador to National Voices linking the charitable sector to the NHS. He has also established a company advising the public and private sectors on quality and cost-effectiveness in medicine.

Dr Paul Lawler

Qualifying in 1969 from Oxford with degrees in Human Physiology and Medicine Paul took up a consultant post in anaesthesia in South Tees Hospital Middlesbrough in 1979. He established the first Intensive Care Unit there and for many years ran this single handedly. Paul along with David Ryan set up the North of England Intensive Care Society in 1994 bringing together clinicians and nurses from all the regions units to regular meetings, a Society which is still in existence and thriving. Elected to the Council of the Intensive Care Society Paul served as its President from 1997-9 a time when there was a desperate shortage of intensive care beds which Paul wrote about in the BMJ. Paul was a member of the expert group which produced Comprehensive Critical Care and played a significant part in managing the publicity and media attention at this time. Paul was an examiner for the FRCA and elected to College Council in 1999. He had been Regional Advisor for training in Intensive Care Medicine in the North East and was Chair of IBTICM setting up the Diploma in ICM the forerunner of FFICM and was chair of the examiners. Throughout his career Paul published extensively, he was an early investigator of endocrine issues in critically ill patients. He served as medical director of his trust a large and complex organisation from 2002-5 by which time he had established a team of colleagues to run "his" unit.

Dr Joe Stoddart

Joe Stoddart is one of the founding fathers of ICM in the UK. Trained at the University of Durham medical school he returned to the Royal Victoria Infirmary in Newcastle after completing his National Service as 1st Assistant in the University department of Anaesthesia; a post equivalent to a senior registrar. The duties included responsibility for the intensive care patients being treated in ward side rooms. Joe was appointed to a consultant post in ICM and anaesthesia and, in 1967 became one of the first consultants to have formal sessions in ICM. The Intensive Care Society was established in 1970 and Joe became its second President. He was on the scientific committee when the society organised the 1st World Congress of ICM in London in 1974. Not content with running a unit single handed for several years, and establishing ICM training he published extensively especially on respiratory physiology and aspects of unit organisation. He thought everyone should maintain a second specialty to return to when burnt out in ICM but ignored his own advice dropping anaesthesia and continuing ICM until his retirement.

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