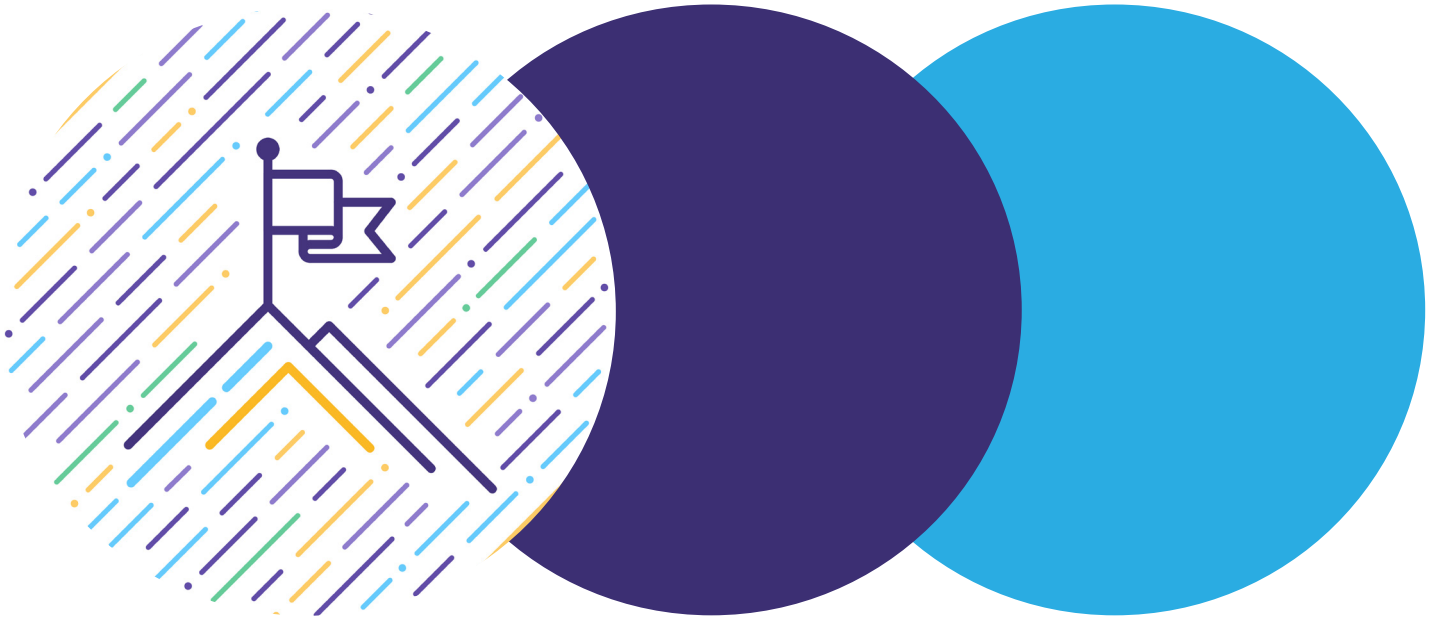
CRITICAL FOUNDATION

A framework for foundation doctors to gain exposure to Critical Care Medicine



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The Faculty of
Intensive Care Medicine

INTRODUCTION AND AIMS

This document is intended to provide a repository of ideas and information to allow you to support Foundation doctors working in or gaining exposure to critical care. In addition, it can provide information for making a business case or application for new posts to managers, Heads of School or Directors of Medical Education.

The educational opportunities offered in acute care, the supervision provided and the chance to work closely with consultants make the posts popular and valued by Foundation doctors. This is a unique opportunity to showcase our specialty at a time when trainees are making vital career decisions.

All the 'first-hand' experiences in this document illustrate the value of these placements and the vital role they play in helping doctors in the very early stage of their careers to choose intensive care medicine: this includes those who may not have previously considered ICM.

The intention is to illustrate ways in which intensive care units can support and encourage more newly qualified doctors to get exposure to ICM and develop their skills to assist in looking after ward patients.

Danny Bryden,
Chair of the Careers, Recruitment & Workforce Committee

1. What is the Foundation Programme?

The Foundation Programme is a two-year training programme at the start of medical training, that is '*intended to equip doctors with the generic skills and professional capabilities to progress to specialty training'* (UK Foundation Programme). It gives junior doctors the opportunity to develop and improve their clinical skills, judgement and decision making and allows participants to experience a wide range of specialties that will ultimately shape future interests and careers.

The Foundation Programme Curriculum is a framework for educational progression in the first two years of professional development after graduation from medical school. Foundation doctors have to demonstrate that they are competent in a number of areas including communication and consultation skills, patient safety and team work as well as the more traditional elements of medical training.

Key generic Domains of the 2016 curriculum include:

- Clinical Care
- Safety and Quality
- Communication, Team Work
- Professional Behaviour

> I was one of the very first FY1 doctors in ICM. It came at a perfect time - my plan through medical school had always been surgery but I had thoroughly fallen out of love with it during my surgical job and was feeling a bit lost.
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> I loved every minute of working in intensive care. Watching physiology unfold in front of my eyes was a revelation, and the senior doctors I worked with were inspiring - nothing seemed to stress them and they always had time to teach and explain what was happening.
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> I am so grateful for the chance to do this job - it inspired a great love of the specialty in me and 14 years later I am working as a consultant intensivist and faculty tutor and hopefully encouraging the next generation of trainees to follow in my footsteps.
>
> ***Dr Tom Billyard, FICM Tutor, University Hospital Coventry***

2. Why is ICM well-placed to take an active part of the Foundation Programme?

The Foundation Programme is currently under review, and there will be 1500 additional medical school places in 5 years. As new medical schools produce an increase in the number of newly qualified doctors requiring Foundation Training placements there is a need to consider the types of posts offered and their location. Although there is a clear steer to encourage placements in areas that show shortages for the NHS (e.g. General Practice, Psychiatry), issues around supervision and preparedness for specialty training are part of that review.

ICM can make a strong case to be included in the expanded Foundation Programme on many grounds. The importance of being able to recognise and treat the deteriorating patient is important for all doctors and a placement in critical care will address these needs very effectively. The superior levels of ICM consultant supervision and support which make such placements popular, is another strength of a Foundation post in ICM for overall training.

Themes emerging from the Foundation programme review and trainee morale surveys indicate that when trainees leave Foundation, they wish to possess the necessary skills to apply for the training post of their choice. ICM can provide generic skills-based experience needed by many trainees in acute medical and surgical specialties, as well as for those thinking of general practice, e.g. team working, delegation and communication skills, managing end of life care and nutrition.

Intensive care medicine includes the 'full spectrum' of medical and surgical conditions so trainees get experience of clinical care that is wider than occurs in many other specialties. Many patients have chronic illnesses that need to be managed within the context of their acute admission, so trainees will develop an understanding of the complex interplay of chronic illness management with acute health changes and understand the role of decision making and MDT working to manage these.

Contact time with an ICM consultant is high in ICM and direct supervision and training can come from the wider multidisciplinary team in addition to medical staff: nurses, physiotherapists, pharmacists and others provide educational support and are examples of the role modelling of important professional behaviours.

In summary …

There is a need to provide enhanced career support and levels of clinical and educational supervision for the increased numbers of Foundation trainees working in the hospitals linked to the new medical schools. ICM specialists possess the skills to do this well and can make a credible case to have Foundation doctors working on their units.

> My four-month rotation on the intensive care unit as a foundation doctor was very helpful in a variety of different ways. For one thing, it taught me to apply physiological principles in clinical practice, and use these to develop my understanding of the management of critically unwell patients, which will no doubt be very useful for any future rotation, regardless of whether this is in a surgical, or a medical field. Working in a centre for neurosciences, I gained experience in the often very specific management of neurosurgical cases and emergencies. I was able to develop practical skills I had already gained in previous years of training, but also build on these by gaining experience in more complex procedures, such as the insertion of central and arterial lines. Finally, the placement gave me insight into the multidisciplinary approach required to manage critically unwell patients effectively, which will certainly be very helpful for my placement in future rotations.
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> ***Lisa Jachertz, FY 2, Salford Royal Hospital***

3. What are the benefits of your hospital offering Critical Care training exposure during the Foundation Programme?

Foundation Training has a significant influence on career choice. Medical students and junior doctors making career choices are influenced by what they have done, and who they have worked with. Medical students who train at medical schools where they spend a lot of time in general practice are much more likely to become general practitioners (Harris 2005, Wesnes 2012).

Junior doctors working with consultants who they identify as strong role models (and they describe consultants who are good teachers as being particularly important) are more likely to choose the mentor's specialty as

their own career choice (Ravindra 2012). Do not underestimate the role that the ICM team, especially consultants, can have in promoting ICM.

As a specialty ICM is uniquely placed. Currently we have no dedicated core training programme, but trainees from other training schemes spend time working in critical care. Traditionally all anaesthetic and ACCS trainees have spent between 3 and 6 month placements in intensive care medicine. From August 2019 medical trainees will also spend time in ICM during the new Internal Medical Training (IMT) programme. We need to use these placements to full effect, both to provide the clinical skills to improve patient care, but also to sustain and increase recruitment into ICM training.

> My Foundation Year 1 job in Intensive Care was invaluable in guiding my career choice of ACCS Anaesthetics. Having been interested in managing critically unwell patients since medical school, I purposely chose a post in Intensive Care at Whipps Cross Hospital to confirm my commitment to the specialty. Key learning points included a basic understanding of organ support and practical skills which have subsequently proven invaluable.
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> ***Ben Stretch - ACCS Anaesthetics, Royal London Hospital***

In summary …

Promoting ICM to all trainees, irrespective of any current interest they possess in ICM, will convert some into choosing a career in ICM and leave many others with a better understanding of our specialty and its role in patient care as they progress with their own careers. Promoting ICM within the Foundation programme is of benefit to the trainee, the specialty and ultimately our patients as more doctors will understand what an admission to critical care means for our patients and their families.

4. Is my unit suitable to provide ICM training exposure during the Foundation Programme?

Most likely yes. There is no evidence to suggest that Foundation placements are best sited in certain types of hospitals. The experiences for trainees are generic and are able to be optimised with the right support irrespective of the type of hospital.

In summary …

The first person accounts in this document illustrate how exposure can be managed in larger and smaller hospital environments.

> Throughout University and my Foundation Year One I particularly enjoyed assessing and managing the acutely unwell patient and working as part of a large team. I had always envisioned my future career to incorporate this, whether that being in the Emergency Department or Critical Care. It was very important to me to spend one of my Foundation placements in Critical Care. I felt this would allow me to experience the day to day running of a busy Intensive Care environment that could potentially shape my future interests and career. This placement would also allow me to develop my skills around the assessment and management of critically unwell patients as well as gaining the opportunity to site invasive devices. Critical Care consists of one of the largest and most diverse multidisciplinary teams. I hoped my foundation placement would allow me to develop my non-technical skills and integrate into this large team. These skills would be invaluable for the future, regardless of the setting.
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> My Foundation placement consisted of 4 months split between a large 19 bed Intensive Care Unit and a 12 bed High Dependency Unit. Clinical work involved reviewing patients on a daily basis and presenting them to the consultant on-call; admitting patients; inserting invasive devices and communicating consistently with a wide range of different multidisciplinary team members. Non-clinical work involved participation in Quality Improvement projects; active involvement in the Critical Care Research Group; attending weekly Journal club meetings; writing local protocols and receiving excellent teaching through a structured, Critical Care focused programme. This placement increased my desire to pursue a career in Critical Care and Anaesthetics. I was able to spend time in both an Intensive Care and High Dependency environment which gave me an invaluable insight into both the specialty itself and what life as a trainee would involve. Importantly, the non- clinical aspects of the placement allowed me to gain specialist knowledge while participating in various projects that enhanced my interest in the specialty and helped with future applications.
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> ***Dr Charles Flanders, Edinburgh***

My placement on Critical Care has been the hidden gem of the Foundation Programme options. I applied for this placement as an FY2 to explore Critical Care as a career option, however I ended up with a far more rounded experience.

Currently I work in a busy Critical Care. We host a large range of different specialties on site. Consultants closely lead every decision and this creates a safe environment knowing there is large, easily accessible senior input.

Going forward from this placement I am now far more experienced to deal with acute issues on other wards. The close input from seniors allows for greater exposure to trickle-down learning opportunities. I will be leaving with far greater knowledge on managing basic conditions. I can now tackle ward-based problems with a developed perspective on who is concerningly ill and who I can just monitor, one of the more difficult skills being new into clinical practice. My skills set has also expanded exponentially, from difficult cannulas to drains and lumbar punctures.

Overall, I think a critical care environment is a great place to create a broad foundation training placement. Going to a medical job next, I feel I am taking a huge clinical skill set with me. The exposure to all specialties has developed my clinical knowledge more than any other placement. Finally, it is my confidence in dealing with acute situations that has developed the most.

Daniel Law, Foundation Trainee, Wales

As a medical student I enjoyed high acuity specialties such as emergency medicine, obstetrics and surgery. With my interests stoked, my foundation training choices were based on those that offered rotations in anaesthetics and/or intensive care. I wanted to confirm my interest in the specialties and get involved with projects to aid application to further training.

The four-month rotation I undertook in critical care was my last of FY1. Based in a small district general hospital, the unit had a 4 bed high dependency and 11 coronary care beds. There were two FY1s on the unit most of the time, however we would cover the ward alone during annual leave or zero hour days. Coronary care patients were reviewed daily by a consultant cardiologist, and high dependency patients would be reviewed by their parent team on the daily round. It was our role to undertake the level two daily review, support the ward round, perform routine clinical and administrative duties and escalate deteriorating patients. We would often liaise with tertiary specialties in central hospitals for management advice and coordinating transfer if required. The mixed specialty HDU exposed me to post-operative surgical patients, non-invasive ventilation, management of invasive lines and the basics of organ support; whilst in coronary care I witnessed DC cardioversion, unexpected cardiac arrests and insertion of pacing wires. The learning experience was brilliant, I felt I was exposed to the most interesting patients in the hospital, and unlike other FY1 jobs I had more time and resources to learn from the patients before me.

Dr Ally Rocke, Foundation trainee, Greenock

WAYS TO DEVELOP ICM EXPOSURE WITHIN FOUNDATION TRAINING

1. Bridging the Gap days

Bridging the Gap (BtG) days are training days that foundation year 2 (F2) doctors can tailor to meet their learning needs. The days are designed to give trainees the flexibility to select a course approved by HEE relevant to their desired career interest. It is mandatory to attend one full BtG day with the option of an additional day. The Bridging the Gap days broadly fall into 2 categories; 'Skills Themed' days that help with practical skills and 'Speciality Themed' days that provide support, training and advice about developing a career in that speciality. Offering to provide a programme for a Bridging the Gap day in ICM is a way for units/hospitals with few or no foundation doctors working in critical care to provide some exposure to interested trainees. They may also be of benefit to trainees in providing additional evidence they can put in their portfolios in applications for core training.

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In Sheffield there are approximately 200 hundred foundation doctors across FY1 and FY2. 30 trainees have rotations which have critical care within them. We run a careers day for all trainees at which there is an anaesthesia and critical care interactive station with advice on the specialities from both trainees and consultants. Significant numbers of foundation trainees request to spend 'taster days' (5 can be taken across F1 and F2) within anaesthesia and critical care: these are facilitated through the year.

It became apparent that anaesthesia and critical care were popular potential career choices for foundation trainees, but many did not have exposure to the specialities. In that context we set up a critical care and anaesthesia skills day. The day involves a series of focused lectures on clinical skills, practical physiology and careers followed by an afternoon of practical skills stations. These include echocardiography, central venous access using ultrasound, lumbar puncture and airway techniques, including fibreoptic and front of neck practice. The deanery funds the cost of training equipment. The day ends with a simulation suite trauma scenario using interactive mannequins and treatment of a pneumothorax/ pericardial effusion. There is also focus on human factors as well as team working. The day is very oversubscribed and run once per year, the limiting factor to more sessions being the high faculty ratio. The day has been the top ranking BtG day in the last 3 years and receives excellent feedback. This year we have some senior trainees coming from another deanery to look at the course with a view to setting up a similar day in their region.

Ajay Raithatha, Foundation School Training Programme Director, Sheffield

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2. A ‘taster week’ with Critical Care Exposure

The Blackburn Experience

At East Lancashire Hospitals NHS Trust, we have more than 70 Foundation doctors in each year of the Foundation Programme. One of the Foundation Year 1 tracks includes a very popular 4-month post in Critical Care & Anaesthesia, and the Trust has had increasing competition for this rotation.
As a result, our department experienced significant pressure on time, administration and resources as Foundation Doctors requested ad-hoc ‘Taster Weeks’ in Anaesthesia & Critical Care. The variability in demand, greatest around the time of applications for core training programmes meant that the experience for trainees and trainers became unsustainable. Following discussions with the Postgraduate Department and rota teams, an initial pilot year followed, where all F1s rotating through their surgical placement would spend a week in Critical Care & Anaesthetics. This was rostered into their timetables, attendance was compulsory, and feedback obtained.

The advantage for the department is that Foundation trainee exposure is now a timetabled, structured and manageable process. All trainees receive an introductory lecture as part of their induction programme, electronic instructions and details of their week, which is all coordinated through the departmental secretariat. On completion of their week, formal, anonymised feedback is sought, and a certificate of attendance then issued.

The attachment is now mandated by the Director of Medical Education, is a local Foundation ARCP requirement and has the full support of The North West Foundation Programme. The feedback obtained is used to guide the quality and suitability of allocations and contributes to the Trust’s overall Postgraduate Education Quality Report. It is also used by individual trainers for Medical Educator revalidation. Importantly, the feedback from trainers is positive, as the regularity and structure of the programme has become ‘embedded’ in the department, with high levels of satisfaction and acceptability.

> “It was clear to see how well their experience and the learning they undertook mapped to their curriculum and as a result we rolled it out as a one-week placement for all F1s to undertake in the first or second placement (prior to ARCP) in their F1 year. This allows them to sign off core procedures and undertake case-based discussion for areas of the curriculum for which they may otherwise have limited exposure to. In addition, supervision tends to be delivered directly by Consultants, and the reported discussions and higher-level, deeper learning as a result develops areas of the hidden curriculum such as emotional intelligence and self-awareness. The feedback by trainees from this week is overwhelmingly positive and has become standard in the Foundation training programme at our Trust.
>
> ***Miss Suzanne Gawne, Director of Medical Education,***
> ***East Lancs Hospitals NHS Trust***”

The week includes a detailed welcome and guidance email, with timetabled allocations, expectations clearly outlined, and Foundation Programme Competencies and Core Procedures which can be mapped against objectives and opportunities. Not all of the learning outcomes below can be mapped in one week, but providing a list allows Foundation trainees to identify where their individual knowledge and skills deficiencies are and to focus on those.

Intended Learning Outcomes for the Week	Suggested Mapping to Foundation Programme Capabilities (FPCSs)
Work in the Critical Care & Theatre teams, & appreciate the roles of each member in patient care	1,2,3,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20
Observe consultations with patients & families about management decisions, & appreciate the views of the patient are central to every decision	2,3
Understand the importance of communication skills in complex situations or with difficult decisions	3,10,11,17
Appreciate the importance of patient safety check lists & protocols in Theatre & Critical Care	1,2,3,19,20
Take part in MDT ward rounds on Critical Care	1,2,3,4,7,10,11,13
Assess patients for surgery under supervision	1,2,3,7,18
Participate in the consent process required for procedures & interventions	1,2,3,6,14
Exposure to medical devices & equipment used for general anaesthesia and in critical care	14
Improve skills of airway management & managing the acutely unwell patient	1,2,4,5,14,15
Opportunity to manage patients with abnormal physiological parameters & improve knowledge of managing organ failure	2,7,14,18
Improve knowledge of the management of the unconscious patient	2,3,4,7,9
Manage pain	1,2,3,13
Manage sepsis	1,2,3,9,13
Recognise and understand strategies for managing the critically ill patient, including prescribing	1,2,3,9,11,12,13,19
Understand the principles and take part in discussions regarding end of life care and DNAR decisions	2,3,4,6,7,10,17
Appreciate the importance and anticipate the impact chronic disease can have on treatment choices	2,3,7,10,13,16
Understand the importance of addressing nutritional needs in critically ill patients	2,10,13
Improve investigative & interpretation skills including blood results, ABGs, CXR, ECG, PFTs	2,9,10,12,14,19
All 15 Core Procedures attainable	14

An EWTD/Junior Doctors compliant timetable is populated according to availability and activity within the department. Flexibility is paramount and coordinated by the day-day Duty Consultant and secretary. Below is an example of a taster week combining intensive care medicine with anaesthesia. It is also possible in larger units to swap out Anaesthesia sessions for time on the High Dependency Unit, with Outreach staff or in ICU Follow-up clinics.

	AM	PM
Monday 08:00-17:00	Theatre	Theatre
Tuesday 08:00-17:00	ICU	ICU
Wednesday 08:00-17:00	Acute Pain or Acute Care Team	Acute Care Team
Thursday 13:00-17:00	Rest	F1 Teaching
Friday 08:00-17.0 08:00-17:00	ICU	ICU

Embarking on a supervised taster week in intensive care is a unique opportunity to get an understanding of the staff working in a department as well as the patients and their families on this journey. Are the consultants in the specialty who you would like to become in the future? Outwardly they are high achieving polymaths with several extra-curricular interests, but the truth may be that it helps them to have some reason to be off the unit. This may be devoted families, casual caffeine and exercise addictions, academia or even another specialist interest. Intensive care is enough for anyone. It's that it may be too much at times, without an escape from the most rewarding specialty in the hospital.

Morale is bolstered by the daily ritual of campfire camaraderie discussing the patients of the day. The ward rounds march on with the resonance of human endeavour at every bed-space. The afternoon calls for an arsenal of procedures from central venous catheters to percutaneous tracheostomies and bedside ultrasonography. However, "Bed Number Six" is never reduced to the diagnosis of a cavitating pneumonia. "Bed Eight" is not simply the hypothermic drowning from the Scottish Firth of Forth. Each diagnosis carries a human face and you could not forget this with so much of the job involving communicating with families. I find it more comforting to remind myself that four out of five times these conversations do not ultimately end with having to break bad news.

There are obvious reasons to do a taster week in intensive care. It will help you work out whether you like the job, let you care for some of the most interesting and unwell patients in the hospital, make connections, get involved in a specialty related project or simply demonstrate speciality interest at interview. Above all, try to understand the patient and their families' journey from admission and not only to discharge but through the following months of rehabilitation. Attend a charity funded ICUsteps meeting or some form of follow-up for these patients. Intensive care changes patients and their functional status. A taster week gives you a realistic idea of the motivation behind the day to day heroism in intensive care, how the care impacts patients' lives, and the life commitment entailed in this career path.

Dr Fabian Cook, ACCS2 Anaesthetics, Edinburgh

3. Maximising the experience for ICM interested trainees

Some trainees may be undecided between specialties or unable to attend for more than a day or two. Although a brief point of contact, this may be a vital opportunity to engage with a trainee. Encouraging trainees who wish to spend a day or two on critical care can be an important point of first contact in offering an undecided trainee an insight into ICM as a specialty.

A major role of the Foundation Doctor is often contributing to the safe and successful care of the acutely unwell patient. Trainees must therefore be able to understand and perform the basic elements of care required to assess and manage acutely ill patients. Furthermore, they have to be able to summarise their findings and actions to communicate this succinctly to senior colleagues. The ICU is an ideal place to learn these skills and practice them repeatedly in a supportive environment. The diverse nature of patients and problems will help to reinforce the idea that certain basic principles in the care of the unwell patient are generally applicable (i.e. A-E assessment, fluid challenge, oxygen therapy).

Trainees should be encouraged to identify their own priorities for learning and making the best use of a short period of time can be difficult.
Dr Tim Holzmann from Salford illustrates how they maximise this period of exposure:

> It can be helpful to have a prepared set of objectives that the Foundation doctor should achieve. For example, generic principles of the management of the acutely unwell patient, applicable to clinical areas outside the ICU.
> - Structured assessment of the acutely unwell patient - this will usually be through an A-E assessment.
> - Theoretical knowledge of basic steps in the resuscitation of an acutely unwell patient - this should include basic airway manoeuvres, application of oxygen, iv fluid therapy including fluid challenge as a diagnostic tool and management of hypoglycaemia.
> - Structured presentation of assessment and management of the acutely unwell patient - this should be assessed on the consultant ward round.
> - Review of new admissions and referrals, to gain a basic understanding of what critical care can offer. This may be best achieved by working 1-2 evenings as the majority of admissions occur at this time
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> Additional objectives are more specific to Intensive Care Medicine can be flexibly adapted to the students' interests and abilities.
> - Organ support on the ICU - this can include basics of respiratory, cardiovascular and renal support.
> - Career options including ICM - interested students can be provided with basic careers advice (see links to FICM career materials at https://www.ficm.ac.uk/careers-recruitment-workforce).
> - Practical procedures - these can include venous cannulation, arterial lines, urinary catheters, an introduction to bedside ultrasound etc.

4. Foundation Doctors Contributing to the Critical Care service

Early exposure of trainee doctors to the sickest patients in a hospital in a safe and supervised manner has huge benefit to the individual trainee doctor and ultimately to the wider patient population. Embedding a Foundation doctor in the unit can be of benefit to patients and staff and as the following accounts illustrate can operate in tandem with growing the ACCP workforce.

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In 2008, there was a large expansion in critical care beds and the challenge of how to safely staff the department from a trainee medical perspective. We couldn’t expand our number of airway trained doctors to cover the whole clinical area so we had to constructively look at less experienced trainees to assist with the safe medical staffing. As a result, we subdivided the department into different areas of acuity. It was perceived there would be advantage in exposing F2s to Intensive Care Medicine early in their medical careers to help look after a deteriorating patient, understand the advantages and disadvantages of offering Intensive Care to a sick patient and to help guide future career choices.

We arranged for the 2 tiers of airway trained doctors to staff the 16 Level 3 beds and the 2 tiers of non-airway trained doctors (an ACCS and F2) to staff a 16 bedded mixed level 1+ /level 2 facility. Initially, there was nervousness within the existing nursing/ medical staff about the suitability of using less experienced medical staff in the department. These fears were allayed by regular discussions with staff beforehand explaining the qualities and skills the F2s could offer and ensuring the patient case mix was appropriate for each facility and robust medical escalation plans were in place for the deteriorating patient.

A dedicated F2 rota was constructed and an educational programme and educational supervisors were put in place. The F2s soon became part of the established medical workforce and thrived. Rotations were 4 monthly and whilst their out of hours’ service commitment was primarily to the level 1+/ level 2 beds they were part of the on call team and often got involved in the admission of sick patients to the level 3 facility. Furthermore, they were rostered into a set number of training days which allowed them to gain confidence and consider future career options. Training days included protected time in theatres with Anaesthetic Consultants, dedicated time on the ICU in a supernumerary capacity looking after level 3 patients for practical procedures and to shadow the Outreach team and SpR on emergency referrals. In addition, they attended the Pre-Op Anaesthetic Clinics and the Acute Pain Ward Round.

The programme has subsequently become one of the most popular F2 rotations in the hospital. The rotation has consistently offered dedicated time with consultants, plenty of exposure to informal and formal teaching and the opportunity to conduct worthwhile service evaluation and audit projects. In addition, the programme constantly receives excellent trainee feedback allowing a CV worthy stepping stone.

The STH Critical Care F2 rotation has now been running for 10 years and some of those original F2s are now substantive consultants in Intensive Care Medicine or Anaesthetics.

On reflection, the F2 rotation to the Critical Care Department in STH has been a very positive experience for all involved.

Dr Andy Temple, Clinical Lead, Sheffield Teaching Hospitals

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I am an Advanced Critical Care Practitioner (ACCP), currently working between two tertiary referral teaching hospitals. I started this role in 2009 in the first cohort of practitioners to complete the FICM accredited MSc programme. My background had been in nursing and over a 10-year period I had worked up to the level of junior charge nurse and had gained clinical experience in a variety of Intensive Care Units in the UK, Australia and New Zealand.

In my post I undertake the daily assessment of patients in critical care, diagnose and treat their health care needs. This includes patient transfer, referral to speciality services, prescription of organ support therapies and medications, in addition to practical skills such as central venous access and ultrasound. The ACCP role has diversified significantly since our group completed their accreditation and we have been supported to expand our skill set within individual areas of interest. For me, this has included point of care ultrasound (FICE and CUSIC) and tracheostomy management. Other specialist interest areas have included clinical facilitation, quality improvement and development of a regional special interest group.

There were many challenges with this role in the initial stages, such as competition for skills acquisition and training opportunities, compounded by the misconception that the role was implemented to replace medical staff. However, now that the role is well established, an essential element of my practice involves the training and supervision of junior doctors new to critical care. This also includes supervision of certain training competencies recognised by FICM, such as DOPS and MiniCEX.

Pete Thomson, ACCP, Edinburgh

STANDALONE POSTS IN CRITICAL CARE –THE 'FY3' OR CLINICAL FELLOW YEAR

Improving Junior Doctors' Working Lives has identified the need to support doctors at the post foundation or pre-specialty training level looking for a more flexible approach to their career progression.

In 2018, only 38% completing Foundation went directly into core training, but 55% of those who did not remained working within the NHS, usually in service orientated posts. Reasons for this are complex but include uncertainty over career choices and a desire to improve competitiveness for their chosen posts and rotations by enhancing their CVs and portfolios.

90% of foundation trainees eventually come back into training within 3 years of completing foundation (UK Foundation Programme Office). Health Education England provides access to the Horus e-portfolio so doctors who have completed Foundation training but who haven't yet embarked on an identified core programme, can continue to record their experience and competences gained in this interim period.

All this makes a standalone post a viable career development option after completing Foundation: one in which the trainee can settle on their specialty and enhance their applications and CVs for their

chosen specialties as well as possibly take time out travelling. This is frequently referred to as taking 'an F3 year'.

Units carrying gaps in rotation allocations can convert these to standalone posts although there will be an additional financial costs in terms of paying for both the in hours and out of hours' work (normally the basic 40 hours' salary is paid by the Deanery or LETB). However, the added costs of daytime payment can be partially offset by the reduction in locum payments and improved quality from a more permanent member of staff. Whilst it may be preferable to have a clinical fellow with core or some degree of specialty training experience, such individuals may not be available and more junior Clinical Fellow posts may be easier to fill.

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The critical care unit at Musgrove Park Hospital, Taunton currently consists of 14 beds. A new theatre and critical care build due to be completed by 2023 will have capacity for up to 22 beds. The present resident critical care rota is staffed by a mixture of Acute Care Common Stem (ACCS) and Foundation Year (FY) doctors while the out of hours rota is bolstered by other trainees from anaesthetics. Even with ACCP training and recruitment planned from 2019 to mitigate against an obvious future shortfall in medical staff, there is still a need to increase the current pool of resident doctors to create a safe and sustainable rota.

An interesting opportunity to reinforce the junior rota arose when the Trust was approached by the University of Bristol with funding for 20 hours of teaching a week for undergraduate students. This funding was then matched by the directorate for 20 hours of clinical work each week. The directorate was able to fund these posts from within budget as not all specialty doctor posts in the directorate are filled.

This post can be filled by any grade of trainee however it seems to hold most appeal to those trainees who are post FY. FY trainees often enjoy their attachments on the unit and several have returned to locum over the years before embarking on ACCS or specialty training. This is a pivotal time in their careers, and they are motivated and keen to build their CV during the post. This results in engagement with Quality Improvement, often tackling issues that they have identified during their period on the unit as a FY. They have fresh perspective and energy, and more time (12 months) during their attachment to complete these projects. Recent trainees have presented high quality projects at national meetings.

In summary the clinical fellow/ teaching post has been a definite success for our unit, and early feedback from trainees is also encouraging.

Dr Richard Gibbs, Taunton

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The Royal College of Physicians is currently promoting core medical posts in hard to recruit areas by offering trainees 1 day per week focused on their portfolio development. This may include time exploring the role of clinical informatics in health care, medical education, quality improvement or research. Standalone F3 ICM posts can be enhanced by offering similar additional experience.

> I was offered a clinical fellowship in critical care and joined the junior tier rota of a busy critical unit with 19 level 3 beds and 11 level 2 beds, with one day per fortnight of protected development time. It was my first exposure to ventilated patients and the first few weeks were daunting, however I was not overwhelmed and very well supported by the clinical team. My confidence and willingness to adopt responsibilities grew quickly, and I began to review critical care referrals, understand new complexities of pathophysiology and site invasive lines. I have attended the SICS trainee and scientific meetings, a critical care research methods course, FICE and CUSIC courses. With consultants in the department I am working on a quality improvement project and a systematic review article.
>
> Throughout the year I have developed my teaching skills through the excellent, easily accessible Clinical Educator Programme. Integrating with trainees and consultants has also given me an insight to potential future training pathways, academic opportunities and the diversity of consultant job plans.
>
> ***Dr Ally Rocke, Edinburgh***

CONCLUSION

Themes emerging from the Foundation programme review and trainee morale surveys indicate that when trainees leave Foundation, they wish to possess the necessary skills to apply for the training post of their choice. ICM can provide that generic skills based experience needed by many trainees in acute medical and surgical specialties, as well as for those thinking of general practice e.g. team working, delegation and communication skills.

There is a need to provide enhanced career support and levels of clinical and educational supervision for the increased numbers of Foundation trainees working in the hospitals linked to the new medical schools. ICM specialists possess the skills to do this well and can make a credible case to have Foundation doctors working on their units.

Promoting ICM to all trainees, irrespective of any current interest they possess in ICM, will convert some into choosing a career in ICM and leave many others with a better understanding of our specialty and its role in patient care as they progress with their own careers.

Promoting ICM within the Foundation programme is of benefit to the trainee, the specialty and ultimately our patients as more doctors will understand what an admission to critical care means our patients and their families.

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