CRITICAL EYE

Issue 15 | Winter 2019

Critical Care Rehabilitation Services at RSUH

End of Life Care

FICM Focus Group Project

Membership Update

ICM Curriculum Rewrite

The New ReSPECT Process

The Faculty of
Intensive Care Medicine

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https://www.ficm.ac.uk/news-events-education

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WELCOME

Dr John Butler
Clinical Editor

Welcome to the latest edition of Critical Eye. As well as our usual updates, we have a number of fantastic guest articles, including an overview of Royal Stoke University Hospitals experience of setting up a Critical Care Rehabilitation Service.

Activity at the Faculty continues at pace into 2019, with the launch of GPICS V2, the establishment of the Enhanced Care Working Party and the development of the new curriculum, in addition to many other projects outlined in this edition. The Dean provides an insight into meetings with the new Secretary of State for Health and Social Care, the CMO for Scotland and the Cabinet Secretary for Health and Social Services in Wales. It seems that capacity, staffing and technology continue to be areas of national focus for ICM.

Work continues on the rewrite of the curriculum to meet the new GMC standards. The overall process involves submitting the curriculum purpose statement to the GMC's Curriculum Oversight Group (COG), followed by a stakeholder consultation, and finally submission for full GMC approval. The Faculty is planning a GMC submission date this towards the end of 2019 with an aim of introducing the new curriculum in August 2020 however, the timeframe will be clarified after the first stage GMC/COG approval in early 2019.

The training update embraces the news that Paediatric Intensive Care Medicine has now been formally recognised as a sub-specialty of ICM, with the Royal College of Paediatrics and Child Health being the lead for the curriculum content; more details to follow. Furthermore, it seems that Intensive Care Medicine is now a mandatory module of the Royal College of Physicians Internal Medicine curriculum, which will replace the current Core Medical Training curriculum in August 2019. This development will increase the pool of doctors in training with exposure to what ICM has to offer. This is a welcome initiative and will be good for patients and for the specialty, though will not be without complexity during its phased introduction.

The Legal and Ethical Policy Unit provide an update on the government plans to replace DoLS with, what is currently called, Liberty Protection Safeguards (LPS). This issue is currently under Parliamentary debate so watch out for updates in the near future.

We welcome any ideas for future articles including any comments on the new format of the newsletter. Please send your comments to **contact@ficm.ac.uk.**

@FICMNews

MESSAGE FROM THE DEAN

Dr Carl Waldmann

Even though many of you have had a break during the summer, this Critical Eye details what has been a very busy time for the Faculty.

MEETING WITH THE NEW SECRETARY OF STATE FOR HEALTH

Since Matt Hancock took over the position of Secretary of State for of Health and Social Care, the FICM through the AoMRC, has managed to have two meetings with him. He was very keen to hear what it is really like on the shop floor. He was appraised of the challenges facing Intensive Care Medicine, including capacity issues. His plan for the future is three fold under the headings of Staffing, Technology and Prevention. Current issues in Intensive Care Medicine lend themselves itself very well to these three areas.

AoMRC Presidents meeting with Matt Hancock, Minister for Health

ACCPs

The ACCP role is a key solution to middle grade cover in critical care units, providing a stable and sustainable workforce able to maintain continuity of care on medical rotas. The FICM has developed a national curriculum, a national register and appraisal pathways for ACCPs and is working with HEE on the essential issue of regulating this new workforce.

As you may all know, the FICM is disappointed by the recent news that the ACCP role was not included for regulation following the recent Medical Associate Professionals (MAP) consultation. We believe there would be numerous potential benefits in expanding this role however, we remain engaged with the HEE MAP project, as further roles may still achieve regulation under this mechanism, and we will learn from the regulation of the PA and PA(A) roles.

MEETING WITH THE CHIEF MEDICAL OFFICER FOR SCOTLAND, JUNE 2018

On 17th June, we (myself, Danny Bryden, Daniel Waeland and Liz Wilson) had a very constructive

Carl and Jack Parry Jones meeting Vaughan Gething, Cabinet Secretary for Health and Social Services in Wales

meeting with Catherine Calderwood about the future of critical care services in Scotland. She is a proponent of the idea of 'Realistic medicine' and is very committed to helping realise the needs of critical care in Scotland.

MATERNAL CRITICAL CARE DOCUMENT

In September, the interdisciplinary guidance was at long last published. This was the result of a working group comprising of the FICM, ICS, RCM, OAA, RCOG and RCoA. Our congratulations go to Audrey Quinn for leading this important piece of work and to Ravi Mahajan and the RCoA for helping us complete and successfully publish the document.

MEETING WITH CABINET SECRETARY FOR HEALTH AND SOCIAL SERVICES IN WALES, NOVEMBER 2018

Jack Parry Jones, Daniel Waeland and myself met up with Vaughan Gething. He understood the need for more critical care staff, and beds in the right place, and promised to look at developments very closely to ensure critical care is high on the agenda. We have agreed to liaise with his review in the areas of workforce data, enhanced care and end of life, among others. We appraised him of the importance of outreach, rehabilitation and the need to encourage the growth of ACCPs in Wales. We discussed centralising the funding for ACCPs amid concerns that ACCPs might be trained in one hospital but, force of circumstance, may lead them to have to move to another hospital.

UPDATE ON DEVELOPMENTS IN PAEDIATRIC SERVICES

In the last issue of Critical Eye, we discussed our recent interaction with NHS England and Peter Wilson on the question of capacity issues in our regional Paediatric Intensive Care Units. This is a long-term project that would have a huge impact on both medical, nursing and allied health professional staffing, as well as educational resources. Our engagement process is continuing but, we have considerable concerns which we have highlighted to them. These are shared by the stakeholder organisations from other specialties.

PROFESSOR TIMOTHY EVANS

Tim was the Faculty's first Vice-Dean, and with Julian, was instrumental in getting the Faculty off to such an excellent start. It was our pleasure to be able to welcome Tim and his lovely wife Emer to our Board meeting on the 31st October and be able to honour him with the Faculty Gold Medal. Julian Bion wrote a fitting citation for the occasion. This was made all the more poignant by the sad news that came the following week that Tim had sadly passed. Our thoughts are with Emer and his family.

Professor Julian Bion and Professor Tim Evans

FICM Annual Meeting

END OF LIFE MATTERS!

Thursday 13th June 2019
Churchill House, London

This year, the FICM Annual Meeting will coincide with the launch of our guidance on End of Life Care in the Intensive Care Unit. We have some exciting speakers lined up who will discuss various aspects of End of Life Care:

- **HELP! I need somebody** | The patient/relatives' perspective
- **Trust me, I'm a doctor** | Decision making in End of Life Care
- **Weak at the knees** | Frailty assessment
- **How many deadly sins?** | Legal considerations in End of Life Care
- **Getting it right everytime** | FICM guidance on End of Life Care
- **Home is where the heart is** | Getting home to die
- **Forensic Pathology: the Book of (some) Revelations** | Views from a pathologist
- **The customer is always right** | Public Engagement in End of Life Care
- **Aftercare** | Views from the Bereavement Centre

ONLINE BOOKING IS NOW OPEN!

VISIT THE FICM WEBSITE FOR MORE DETAILS.

PLEASE NOTE: programme is subject to change

END OF LIFE CARE AND ICM

Dr Joe Cosgrove

Chair: FICM End of Life Working Party

The FICM End of Life Working Party (EoLWP) has now drafted work, aimed at providing best practice templates, in several aspects of care at the end of life and advance care planning. In addition to an executive summary, the document will include an introduction that traces the evolution of ICM and how developing treatments and technologies have simultaneously improved survival, while creating uncertainty and concern that interventions could create inappropriate and disproportionate burdens for individual patients and those close to them. This section will also provide the reader with an overview of how ethics and the law structure discussions, communications and decisions. An easy to read '*Key Themes'* section will outline the main recommendations for effective provision of care, factors that contribute to good decision-making and the rationale for advance care planning. It will also provide a series of vignettes from the core group as to how they use techniques and phrases to approach difficult conversations. Additional in-depth information will then be reviewed in the rest of the document, and there will be key references (traditional and hyperlinks) and recommendations for further reading and additional resources.

Advance Care Planning: This section outlines principles and processes which use shared decision-making in advance of acute illness and loss of capacity, aimed at better guiding healthcare professionals in making *Best Interest Decisions*. The likely context of pre-emptive discussions will involve patients with significant frailty and severe, deteriorating chronic organ dysfunction. It could also include certain patients who have survived intensive care and are close to discharge.

Decision Making: This section highlights the difficulties faced by everyone in the acute setting and advises circumstances and strategies whereby decision-making can be improved. It suggests using honesty, empathy and clarity of communications supported, but not necessarily delivered, by senior members of staff.

Provision of Care: This section relates to guidance on delivering effective physical and holistic care when patients are dying. It deals with symptom relief, meeting patients' wishes (including spiritual and religious needs) and supporting patients and those close to them. It is made very clear that, whilst generic guidance can be provided to aid teams in the delivery of care, this is not a proscriptive process. Intensive care teams should aim to provide highly individualised care on a case-by-case basis.

The work was presented to a wider stakeholder group at a workshop in November 2018. Attendees included medical, nursing, patient and lay representation and the content was well-received. Overarching themes that emerged from the day were:

- The need for training in dealing with these difficult situations, including an aspiration to include such training in undergraduate and postgraduate curricula for all healthcare professionals.
- Improved psychological and emotional support for staff involved in difficult decisions and appreciation that a lack of this support is associated with a high incidence of burnout.
- Determining outcome measures and research priorities.

The EoLWP is now reviewing commentary from the stakeholders and updating the documentation. We will reconvene in late February 2019 and finalise amendments by early spring. A public consultation period will follow and, if current momentum is maintained, we will be ready to launch at the FICM Annual Meeting, June 13th 2019.

ENHANCED CARE

Dr Alison Pittard
Vice Dean

It is now just over a year since Critical Futures was published and a mere six months since we established a working party to develop guidance on Enhanced Care. This is an area that the Critical Futures survey respondents identified as requiring development, along with being one of the 12 recommendations in the report. At the first meeting of the Enhanced Care Working Party (ECWP), we determined the need to evaluate services already being provided. Initially, we focused our data collection on the perioperative patient (as an easily defined population) but plan, ultimately, to extend our remit to encompass other areas such as maternal care and medical patients. We developed and circulated a questionnaire to 249 hospitals in the UK and, with the help of the Perioperative Intensive Care section of the ESICM, around Europe and beyond. The European section of the survey has not yet closed however, in the UK we have had 141 respondents across all four nations with the majority (62%) coming from District General Hospitals. Of the 141, 80 said they have an Enhanced Care Service of some kind. We asked 46 questions about these services to establish the reasons for implementation, explore common themes and identify examples of good practice.

The second ECWP meeting occurred two weeks after the UK survey closed; there was little time to analyse the data in detail, however it was clear that there was wide variation in the drivers for development, what the services were called, how they were funded and how they were delivered. There were also significant differences in what the current services looked like. Most respondents said their service managed between two and four patients but, there was a range from one to more than ten. Two thirds have both a nursing and medical lead with care routinely delivered by nurses at Band 5-7 in over 90% of cases. The grade and specialty of medical cover appears to depend on the location and objective of the service. For example, patients managed within, or co-located with, the operating department tend to be covered by the surgeon and perioperative anaesthetist. Where the enhanced care is delivered in a designated area of the ward, it is more likely to be covered by junior surgical staff with input from an intensivist. Unsurprisingly, intensivists provide the care when it is delivered within a critical care facility with input from surgical teams. Most have admission and discharge criteria but again, they appear to be specific to service objectives and the level of monitoring/ physiological support that can be provided. Although most services collect activity data there is little evidence of their impact.

> "THE OUTPUT OF THE ECWP WILL BE ENABLING RATHER THAN RESTRICTIVE, ACKNOWLEDGING WHERE VARIATION EXISTS, YET STILL PROMOTING SAFETY, QUALITY AND EQUITY OF ACCESS.

The output of the ECWP will be enabling rather than restrictive, acknowledging where variation exists, yet still promoting safety, quality and equity of access. The next step is to hold a focus group meeting in 2019, in order to learn from organisations who have successfully developed enhanced care services. We are currently developing a draft report, based on the survey findings, to facilitate these discussions. By exploring their experience in greater depth we hope to incorporate the findings as vignettes or

short narratives in a report containing guidance and recommendations rather than explicit standards for this service.

A number of Scottish Boards responded to the survey and this data, along with the SICSAG report shows Level 1/enhanced care being delivered, to some extent, in intensive care and high dependency units (1). Development of enhanced care services may reduce the degree of strain on critical care and release much needed capacity. This is in line with the Scottish Government's 2020 Vision (2) focusing on prevention, anticipation and delivering patient- centred care to the highest standards of quality and safety. It also sits nicely with the Chief Medical Officer for Scotland's 'Realistic Medicine' vision, as it aims to reduce variation in the availability of services and outcomes.

A Healthier Wales establishes the case for change and innovation and, recognising the importance of critical care, the Cabinet Secretary of Health and Social Services in Wales announced new recurrent funding to target an expansion in capacity. The RCoA Welsh Advisory Board are leading a group looking at post anaesthetic care and we are working with them to ensure any developments are concordant with the FICM work stream. We had responses from Northern Ireland however, there does not appear to be any provision for enhanced care outside of the critical care environment.

Development of Enhanced Care is a perfect example of how the National Audit Office's 'Invest to Save' programme can be used to promote change, improve service delivery and efficiency, and to enhance working across specialty boundaries. There is evidence from multiple sources that, nationally, there is insufficient critical care provision to meet current and future demand. This is due, amongst other things, to the changing patient demographic and developments in surgical and medical interventions. Critical care is an expensive resource and expansion of the current model of delivery may not be the most cost-effective way of addressing this unmet need. Gap analysis has identified patients within critical care who do not actually receive organ support, but require a level of monitoring and/or intervention that cannot be provided on a general ward. This then limits the availability of beds for the critically ill patient or may result in early discharge. Investing in the development of enhanced care will facilitate the management of the 'at risk' patient in an appropriate environment. It will avoid admission to critical care, or enable earlier discharge, thereby realising an increase in critical care capacity at a reduced cost. In the longer term, this represents an overall saving, an example being that this extra capacity will support throughput of elective surgery.

The next ECWP meeting is scheduled for March 2019. We hope to put the finishing touches to our report in time for internal consultation, commencing in May. We still need to establish how such services will be commissioned and managed regionally; discussions are underway with the Critical Care Networks and Adult Critical Care Clinical Reference Group. External stakeholder consultation will then follow with a view to publish the final document by the end of 2019. There may be some agreed slippage in this timescale, for positive reasons, but we will keep you informed of developments via the website and our various news outlets.

(1) SICSAG Report: http://www.sicsag.scot.nhs.uk/publications/_docs/2018/2018-08-14-SICSAG-report.pdf
(2) Scottish Government 2020 Framework for Quality, Efficiency and Value: http://www.qihub.scot.nhs.uk/media/607430/2020framework_12062014_final.pdf
(3) A Healthier Wales: our Plan for Health and Social Care: https://www.basw.co.uk/system/files/resources/180608healthier-wales-mainen.pdf

"INVESTING IN THE DEVELOPMENT OF ENHANCED CARE WILL FACILITATE THE MANAGEMENT OF THE 'AT RISK' PATIENT IN AN APPROPRIATE ENVIRONMENT. IT WILL AVOID ADMISSION TO CRITICAL CARE, OR ENABLE EARLIER DISCHARGE, THEREBY REALISING AN INCREASE IN CRITICAL CARE CAPACITY AT A REDUCED COST.

PROFESSIONAL AFFAIRS AND SAFETY

Dr Peter Macnaughton
Chair: Professional Affairs and Safety Committee

The first meeting of the FICM Professional Affairs and Safety Committee (FICMPAS) took place in December. This committee has replaced the Professional Standards Committee which in recent years had met as joint committee with the ICS standards committee. The remit of the new committee will include professional practice standards and guidance, revalidation, patient safety and quality improvement. All future clinical practice guideline development will be through individually commissioned task and finish groups, involving key partners, including the ICS and our partner Colleges. The End of Life Care and Enhanced Care Working Parties, which now report into FICMPAS, are examples of two current work streams that have been commissioned on this basis.

A wide range of topics were discussed at the first meeting that will be the focus of the Committee in coming months. These included airway care, paediatric transition, interaction with the emergency department and patient feedback for revalidation.

Feedback from the draft of GPICS V2 suggested a need for more detailed guidance on the provision of airway care in critical care units. This builds on related guidance such as the recent Difficult Airway Society publication regarding intubation in the critically ill. The Committee agreed that this would be an appropriate work stream and plans to establish a subgroup involving key stakeholders.

The transition of adolescents from paediatric to adult ICM can present a number of practical and ethical challenges to adult clinicians. These patients usually have long-term conditions, with previous (and possibly frequent or prolonged) paediatric ICU admissions. This is an area that the Committee felt required the development of a guidance document, pulling together current best practice. To start the process, a survey of current practice and issues is planned for early 2019.

The recent survey on revalidation and patient feedback has identified a wide range of practice, and highlighted some of the difficulties in obtaining feedback relevant to the care of critically ill patients. The Faculty will be updating their guidance relating to this matter, emphasising that this is not mandated and that there

are other, valid approaches where it is impractical to obtain direct patient feedback.

I represented the Faculty at a meeting organised by the Academy of the Royal Colleges with the Healthcare Safety Investigation Branch (HSIB) regarding approaches to ensuring that significant, unexpected findings on radiology reports are acted upon. This continues to be an issue nationally with serious patient safety incidents continuing to be reported; the HSIB will be issuing guidance in due course for additional safety nets. I recall an incident in our own unit some years ago where a small lung nodule on a chest X-ray performed for a central line check was not noted by the clinician, but highlighted in the radiology report issued after the patient was discharged from hospital as requiring further investigation. As a result, this did not occur and the patient sadly re-presented two years later with in-operable lung cancer. This reminds us of our responsibility as referrers for radiological investigations is to ensure reports are reviewed and acted on, even when patient care has been transferred to another clinician. Units should have a process in place to ensure that radiology reports are reviewed and important information handed over.

Finally, I must thank all the committee members for their hard work and Dawn for her excellent administration. If you have any comments about the topics outlined above or there are issues that you feel the committee should address please feel free to contact me on contact@ficm.ac.uk.

GPICS V2

The work towards completing the first, full revision to the Guidelines for the Provision of Intensive Care Services (GPICS) is approaching completion. The first edition of GPICS, which was published in 2015, was a landmark publication for the Faculty and has had a major impact on the delivery of our specialty and improvements in patient care. Throughout the development of the second edition of GPICS, we have undertaken extensive consultation as to the desired changes. As a result, GPICS V2 will focus on service delivery, quality and safety; there will be less emphasis on it being a source of specific clinical practice guidelines, which we found were mostly published elsewhere in greater detail.

There was a fantastic response to the public consultation, which took place in November. This generated over 600 individual lines of comment with a lot of very useful and constructive feedback. Together with my co-editor, Stephen Webb, we have been working through each of the comments and, as a result, we are making a number of amendments in consultation with the chapter authors. The final version of the document will be ready for sign off by the endorsing organisations towards the end of January 2019 with publication still on track for the first quarter of 2019.

One of the potential challenges with producing a guidelines document can be the lack of a hard evidence base for some of the standards and recommendations; as a result, they are often based on professional opinion, established practice and/or best practice meaning they can be open to challenge. In the GPICS V2, we have tried to keep the existing standards from the first edition, unless there are strong arguments to change or new evidence to justify modification. We have also considered the role of a document such as GPICS, which is to improve the standards of care that critically ill patients receive and to reduce geographical variation.

GPICS is written to assist and support units in developing their services in order that patient care is of the highest quality. Many units found the standards in GPICS V1 very helpful when putting together business cases to develop local services. For every unit, there will be some aspects of GPICS V2 that are not currently met; I hope that units will use these gaps as a driver and focus of where to develop and enhance their local service for the benefit of patient care.

LEGAL AND ETHICAL POLICY UNIT

Dr Chris Danbury
Chair: Legal and Ethical Policy Unit

> "IF, AT THE END OF THE MEDICAL PROCESS, IT IS APPARENT THAT THE WAY FORWARD IS FINELY BALANCED, OR THERE IS A DIFFERENCE OF MEDICAL OPINION, OR A LACK OF AGREEMENT TO A PROPOSED COURSE OF ACTION FROM THOSE WITH AN INTERST IN THE PATIENT'S WELFARE, A COURT APPLICATION CAN AND SHOULD BE MADE.
>
> **Lady Black,** Justice of the Supreme Court

As reported in the last issue of Critical Eye, LEPU intervened, on behalf of FICM and the ICS, in the case of Re Y. We have been told that the submissions we made were helpful to the Court in their final verdict. The Supreme Court decided that it was not necessary to consult the Courts if family and clinicians agree about withdrawal of clinically assisted nutrition and hydration (CANH).

Lady Black noted in her speech that, "... the Official Solicitor's focus is on only one sub-set of patients ... and it emerges with some force from the written submissions of ... the ICS and the FICM ... It is not easy to explain, therefore, why [CANH] should be treated differently from other forms of life-sustaining treatment, and yet that is the consequence of the legal position for which the Official Solicitor contends." People would do well to remember Lady Black's closing remarks, "If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application can and should be made." This is an important case. Although the Mental Capacity Act does not apply in Scotland or Northern Ireland, decisions about patients who lack capacity should be made by consensus between treating clinicians and those who are close to the patient. We should not ignore the family. If there is dispute that cannot be resolved any other way (mediation anyone?) then we are obliged to seek a decision from the Court.

The Government has started the process of replacing DoLS with what are currently called Liberty Protection Safeguards (LPS). At the time of writing, this was being debated in Parliament, so we wait to see what comes out. I sincerely hope that it will have little impact on the day to day running of intensive care. Rest assured that LEPU will be monitoring discussions closely.

Finally, we aim to release the first of a potential series of one-page information sheets soon. These will focus on legal considerations that need quick, practical and secure decisions in the clinical environment. We look forward to your views and suggestions for future pieces.

GUEST ARTICLES

1 Critical Care Rehabilitation Services at Royal Stoke University Hospitals

2 50 Years of Intensive Care in Sri Lanka

3 Mortality After Major Injury in the New Major Trauma Networks

4 Emergency Planning: The New ReSPECT Process

CRITICAL CARE REHABILITATION SERVICES AT ROYAL STOKE UNIVERSITY HOSPITALS

Ms L Powell
Rehabilitation Coordinator
Department of Critical Care, Royal Stoke University Hospitals

Ms J Steele
Rehabilitation Coordinator
Department of Critical Care, Royal Stoke University Hospitals

Dr Ram Matsa
Clinical Lead for Critical Care Rehabilitation
Department of Critical Care, Royal Stoke University Hospitals

Background and Introduction

Critical care survivors develop physical, psychological and cognitive dysfunction and evidence suggests that morbidity could be significantly reduced through a structured multidisciplinary approach to care. Recommendations from NICE and GPICS act as drivers to promote high impact early rehabilitation for best patient outcomes. However, resource restrictions, cultural and financial implications remain challenges to developing and delivering such services. This article is to demonstrate how we, as a team at Royal Stoke University Hospital (RSUH), developed and implemented integrated patient-centred, multi-modal, multidisciplinary rehabilitation despite such challenges and how we are performing after a year.

RSUH is a tertiary referral and Major Trauma Centre. The 36-bedded critical care unit (CCU) has an annual admission rate of over 1500-patients. The unit receives heterogenous mix of medical, surgical and complex trauma patients including spinal injuries. It is essential to maintain the throughput, but, at the same time to offer high quality service to the patients. The Critical Care Rehabilitation (CCR) service offers a multi-disciplinary package of care to enhance early mobilisation through multi-modal interventions including sedation, analgesia and delirium management, occupational therapy etc. with an aim to decrease the length of stay and to improve the functional quality of the critically ill patients at discharge.

Service Development

Highly motivated and rehabilitation focussed members were identified and a strategic group was formed. The team included medical, nursing and physiotherapy staff. Strategic and stakeholder meetings were held including number of comprehensive scoping exercises to agree on a definitive rehabilitation pathway and the necessary workforce that would be 'fit for purpose' in order to meet the needs of our patients. A three-month pilot was conducted which demonstrated a clear reduction in mechanical ventilation days. This raw data acted as an important driver in demonstrating the potential benefits of this service operationally and for patient outcomes. On the back of the supporting evidence and national guidance the business case was approved resulting in the creation of a fully funded, multidisciplinary CCR workforce and pathway.

The Rehabilitation Team

Through significant investment the predominantly physiotherapy led service has now evolved into a full complement of multidisciplinary rehabilitation team. The CCR workforce is elaborated in *Table 1*.

The Royal Stoke University Hopsitals Critical Care Rehabilitation Team

Roles and responsibilities of team members

Rehabilitation Coordinator (RC)

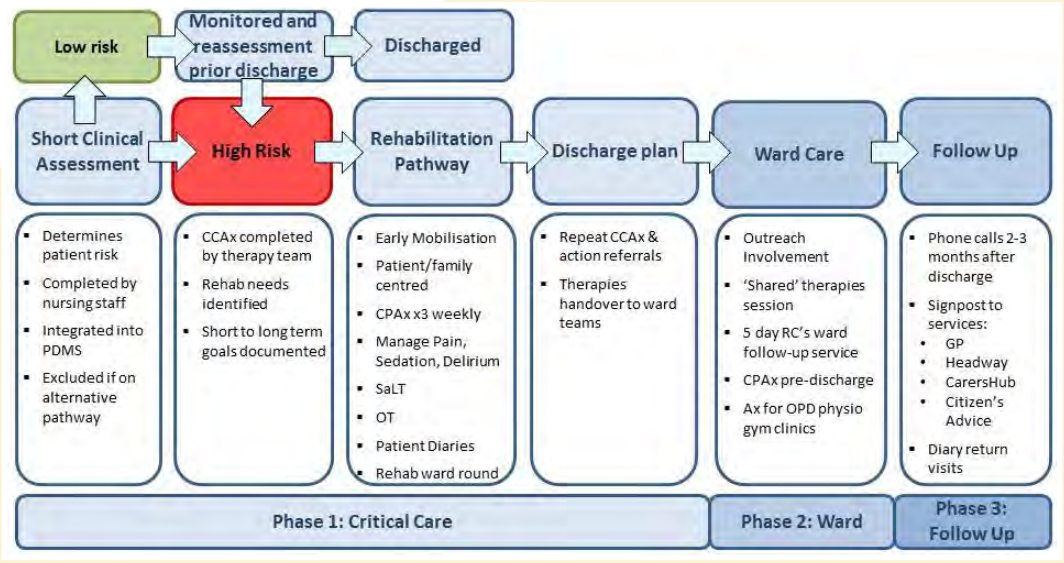
In addition to ensuring service delivery and compliance with national guidance, the RC is pivotal in leading and coordinating the rehabilitation of high-risk patients in the CCU setting through to discharge home. The RC chairs the weekly ward round which focusses on barriers to rehabilitation and reviewing patients' individualised goals. They bring together specialist teams to review complex cases to maximise patient rehabilitation potential, whilst promoting patient and family involvement. The RC participates in the development of clinical guidelines for best practice and disseminates this through education both locally and regionally.

Physiotherapist (PT)

Physiotherapists play a vital role in early-mobilisation to promote patient independence and a return to their pre-admission functional status. Physiotherapists perform the comprehensive clinical assessment and are involved in the setting of short, medium and long-term goals in collaboration with the patient and family where possible. They provide advanced skills in optimising patient respiratory function and lead the weaning process for spinal cord injured patients. PTs regularly monitor functional progress using the Chelsea Critical Care Physical Assessment tool [CPAx] and adapt therapy accordingly.

Table 1: Multidisciplinary Rehabilitation Team Workforce

	Whole Time Equivalent (WTE)	
Role	**Pre-Service (2016)**	**Post Service 2017**
Additional Rehabilitation Consultant time	0	0.2
Rehabilitation Coordinator	0	1.0
Qualified Physiotherapist	8.0	12.0
Therapy Technician (dual role)	1.0	7
Occupational Therapist	0.2	1.3
Dietician	1.15	2.9
Speech and Language Therapist	0	1.0
Clinical Psychologist	0	05.
Clinical Psychology Assistant	0	0.5
Administrative Support	0	0.2



Royal Stoke University Hospital Critical Care Rehabilitation Pathway

Dietetics

The CCU Dietitian undertakes nutritional assessments to determine patients' nutritional risk and requirements, providing recommendations to optimise recovery and nutritional adequacy. They also provide education support to all staff and participate in audit to ensure provision of best practice.

Clinical Psychologist

The Clinical Psychologist provides assessment, formulation and intervention for the psychological or emotional difficulties some patients experience as a result of their admission. This may include: difficulties associated with anxiety about their treatment or what has happened to bring them into hospital; feeling low in mood and struggling to engage with the treatment or rehabilitation that is recommended; or the effect their illness, injury or treatment has had on their cognition. The Clinical Psychologist also liaises with staff to provide recommendations and education.

Speech and Language Therapy (SLT)

The Speech and Language Therapist assesses and supports swallowing and communication in ventilator-dependent, tracheostomised and post-extubation patients. They carry out specialised instrumental methods for assessment for swallowing difficulties such as fibreoptic endoscopic evaluation of swallowing (FEES) and video fluoroscopy (VFS). They provide specific communication aids and training to carers and other professionals in order to optimise a person's function. They play a major role in contributing to the MDT assessment of weaning.

Occupational Therapist (OT)

The OT aims to increase function in everyday activities to allow patients to become as independent as possible. The assessment and treatment is uniquely tailored to the needs of the patient to reduce the consequences of a CCU admission. They help the patients through coordinated tasks, neuromuscular re-education, and the establishment of visual and cognitive rehabilitation including patient centred goal setting.

The Grand Scheme of provision of CCR services

Screening

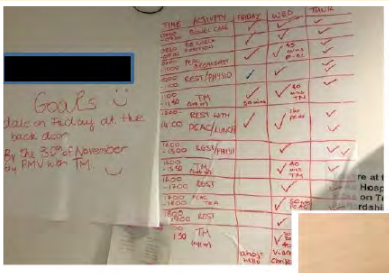
All patients admitted to the CCU are risk assessed by the nursing team for long term morbidity. High-risk patients enter the CCR pathway with a comprehensive clinical assessment which identifies the patient's specific needs and results in patient centred goal setting and necessary referrals. Patients requiring specialist rehabilitation services are identified and referred early to ensure their needs are met.

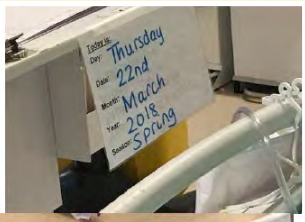
Goal Setting

Individualised goals (both functional and cognitive) are created in collaboration with the patient, family and members of the MDT. This process uses a holistic approach in order to maximise patient engagement and meaningful progression. The goals are documented electronically through the Patient Data Management System (PDMS) which can be viewed by the wider MDT to enhance information sharing. Goals are also displayed at the patient's bedside to clarify, motivate and communicate the patient's progression and future objectives.

Board rounds

Daily MDT board rounds are undertaken to agree a preliminary plan of care to enable patient progression. The collaborative board round also helps to improve communication between the clinical and rehabilitation teams. This approach supports the assessment of patients for early liberation from mechanical ventilation and early mobilisation, and allows discussion of any issues that may limit progress. Appropriateness for awakening trials is criteria led, those patients not eligible have their sedation titrated to achieve the prescribed Richmond Agitation and Sedation Score (RASS) utilising the departmental pain, agitation, delirium and sleep protocols (PADS).





Bedside Orientation Charts & Patient Engaged Goal Achievement Charts

Physical, functional and cognitive rehabilitation

All patients admitted have a dedicated physiotherapy assessment and mobilisation is achieved in the earliest possible time. Each patient receives 45-minutes of therapy daily, and interventions vary from passive range of movements to full mobilisation, based on their clinical condition. Patient's functional progress is monitored three times a week using the CPAx tool and a variety of different adjuncts, including a motormed machine and a tilt-table, are used to promote mobility.

Occupational therapy referrals are made according to agreed criteria. In addition to functional interventions, the OT is pivotal to the assessment of patient's cognitive needs, supporting patients with acquired brain injuries, delirium and sleep deprivation. Recognised tools such as Hospital Anxiety and Depression Scale (HADS) [, Wessex Head Injury Matrix (WHIM), and the Post Traumatic Amnesia (PTA) assessment tool are used and result in referrals to specialist services, including Clinical Psychology, where appropriate.

Delirium and sleep management

Delirium is widely documented as having significant, negative long-term implications for critically ill patients. It is also to barrier to effective rehabilitation. The PADS guideline provides a structured approach to assessment and management of delirium based upon best practice. Delirium screening is completed eight hourly and a management bundle is implemented promoting non-pharmacological measures unless essential for patient safety.

Sleep deprivation can precipitate delirium so assessment of patients sleep quality and quantity is fundamental in any delirium prevention strategy. Sleep is assessed using sleep charts and direct observation. First line non-pharmacological management involves methods like eye masks, ear plugs, minimal night-time intervention and re-establishing day night routine. Pharmacological options are only explored in extreme cases of sleep deprivation.

Patient and family involvement and CCU Diaries

Relatives and visitors are given information about our unit and common critical care experiences more widely through the ICU steps booklet and the criticalcarerecovery.com webpage. Families are encouraged to participate in discussions about patient progress and goals, as well as in the completion of '*All About Me*' documents used by the CCR team to understand patients better. Critical care patient diaries are also started for all Level 3 patients. All members of the MDT are encouraged to write in the diaries, as well as patient's family and visitors, with the aim of creating a brief written representation of the patients journey to support their psychological recovery. The RCs are responsible for the governance, storing and returning of the diaries according to the agreed protocol.

Weekly multidisciplinary rehabilitation ward rounds

A weekly multidisciplinary ward round is held with the aim of assessing high risk patients' progress utilising a clear and structured proforma. The reasons for non-achievement of the patient's goals are discussed and solutions are explored, which may include referrals to specialised rehabilitation services, regional complex weaning unit, or the arrangement of a complex case review (see *Case Study 1*). Recommendations from the ward round are communicated, through PDMS, to the wider clinical team.

Rehabilitation following CCU discharge

Following their CCU stay, high risk patients are provided with a structured therapy handover of goals and achievements to date to ensure progression. This will also include a shared therapy session where applicable, enabling ongoing patient engagement and building trust in their new therapy team. The RC continues to support the patient whilst on the ward, through ward visits, to ensure effective transition of care and identification of any further rehabilitation needs.

So far ...

Our new rehab service is still in its infancy however, the results seem promising:

- The Modified Manchester Mobility Score at critical care discharge has improved by 22.5% since the service was introduced, and 53% since December 2010.
- Since the creation of the service, 89% of patients are screened eight-hourly for delirium, compared to less than 50% previously.
- There has been a 27% improvement in the number of patients achieving 80% of their estimated nutritional requirements (up from 25% to 52%).

Conclusion

Whilst challenging, we have developed a new integrated multidisciplinary rehabilitation service, focussed on improving patients' functionality, reducing the physical and psychological impact of critical illness, reducing overall length of stay and ensuring compliance with NICE [NICE, 2009] and GPICS [Faculty of Intensive Care Medicine, 2015] rehabilitation recommendations. There is evidence that the functional ability at discharge is significantly improved compared to pre-service levels.

Acknowledgements

We would like to thank our Physiotherapists: Ms L. Swinscoe, Ms S Sussex, Ms D Rowley and Ms H McCreary; Dieticians: Ms C Dempsey, Ms S Cook and Mr C Emm; Occupational Therapists: Ms C. Latham, Ms E Holmes, Ms K Frear; Speech and Language Therapist Ms V. Eley and Clinical Psychologists Mrs S. Khan, Ms G Mercer and Assistant Clinical Psychologist Ms C. Cooper for their valuable contribution towards this article.

"WHILST CHALLENGING, WE HAVE DEVELOPED A NEW INTEGRATED, MULTIDISCIPLINARY REHABILITATION SERVICE, FOCUSSED ON IMPROVING PATIENTS' FUNCTIONALITY, REDUCING THE PHYSICAL AND PSYCHOLOGICAL IMPACT OF CRITICAL ILLNESS AND REDUCING OVERALL LENGTH OF STAY.

CASE STUDY 1

A 70-year old gentleman was admitted with severe pneumonia and type 2 respiratory failure. requiring intubation and ventilation. Underlying chronic lung disease, obesity and poor premorbid state, along with profound septic shock lead to severe complications which included ARDS and multi-organ failure. This led to a prolonged duration of mechanical ventilation requiring tracheotomy.

Although he improved from other organ system failure, profound delirium and complex functional issues resulted in difficulty in liberating him from mechanical ventilation. The agitation was profound and was uncontrolled despite on antipsychotics.

The rehabilitation team provided a multidisciplinary approach and interventions included:

- day light therapy
- mobilisation
- cognitive assessment and interventions
- relaxation therapy
- clinical psychology review, behaviour charts and management plan

Advice from the Rehabilitation Coordinator regarding the risk of silent aspiration, given recurrent ventilator associated pneumonia, lead to cessation of all oral intake and eventual improvement (there was no established SLT service). Recurrent issues with establishing ventilation independence resulted in a complex case review, which included the patient and family. The patient was transferred to our hospital's respiratory weaning ward and he was, eventually, decannulated

CASE STUDY 2

A 76-year old female was admitted following an out of hospital cardiac arrest, secondary to in-ferolateral STEMI, and complicated by aspiration pneumonia. Post PCI and stent to RCA, the patient was transferred to the critical care unit for usual post cardiac arrest care. A subsequent awakening trial commenced 24 hours post admission however, a tracheotomy was required, due to poor neurology, in order to liberate from mechanical ventilation.

Appropriate referrals to physiotherapy, dietetics and occupational therapy were overseen by the Rehabilitation Coordinator. Cognitive deficits were identified early which included issues with initiation and attention. Initially, these were thought to be related to delirium and poor sleep cycle. Non-pharmacological measures were implemented to manage delirium and altered sleep cycle, without success, which necessitated the introduction of antipsychotic medication.

In anticipation of the patient having an acquired hypoxic brain injury, a specialist rehabilitation service referral was made, and input was gained, resulting in an initial plan of continuing to optimise the management of delirium and sleep deprivation.

During this time the patient was successfully weaned from mechanical ventilation, however issues with on-going agitation and poor sleep limited her rehabilitation. On discharge to the cardiology ward, the Rehabilitation Coordinator regularly monitored the patient to assess the response to interventions made, including full medicines reconsolidation. The patient's agitation resolved with improved sleep cycle and functional progress was made, although she required significant assistance with her ADLs due to serious problems with memory, orientation, initiation and sequencing. The patient was transferred to a specialist rehabilitation ward for a comprehensive, multidisciplinary neurological rehabilitation programme, where she made significant progress and was discharged home with the input of the community rehabilitation team and the support of her family.

For further information please contact Dr Ram Matsa: Ramprasad.Matsa@uhnm.nhs.uk

50 YEARS OF INTENSIVE CARE IN SRI LANKA

Dr Jayantha Jayasuriya
Past President, College of Anaesthesiologists & Intensivists of Sri Lanka

2018 was the 50th anniversary of the opening of the first Intensive Care Unit in Sri Lanka. The imminent commencement of cardio-pulmonary bypass surgery was the catalyst for its establishment. In 1965 Dr ATWP Jayawardene was appointed the Chief Anaesthetist of the Cardiothoracic Unit in Colombo and was entrusted to plan, design, implement and manage the proposed unit. The Surgical Intensive Care Unit (SICU) of the Colombo General Hospital was declared open on 16th June 1968.

A building intended for the recovery area at the central quadrangle of the operation theatre complex was identified to house the Intensive Care Unit. Jayawardene has described in detail the work that went into setting up the unit. The available floor space was a constraint. In return for additional space, two beds had to be reserved for medical patients. This resulted in the unit being open for admission to coronary care, medical and general surgical patients in addition to cardiac surgical patients. This arrangement continued until such time as other intensive/coronary care facilities became available at General Hospital, Colombo. The unit also admitted paediatric surgical patients, as well as neonates, who needed to be ventilated until intensive care facilities were established at the Lady Ridgeway Hospital for Children.

The unit had six beds and two incubators, three Bennet Pressure cycled ventilators, American Optical monitors with facility to monitor cardiovascular parameters and core/skin temperature (both at the bedside as well as at a master monitor at the nursing station), Defibrillator/cardioverter unit, and a weighing machine with a platform which could be slipped under the patient and their weight accurately measured. The Radiometer blood gas analysis machine which worked on the Astrup principle and the Morgan Pulmonary Function Machine to assess the lung function were the first such machines in the country.

There were four medical officers working on a shift basis providing 24 hour care for the patients. A senior staff nurse, Miss Mudannayake, was chosen to be the nurse in charge of the unit. She was sent to the UK for a short training programme. There were 24 nurses allowing 1:1 nursing care. The anaesthetists in the cardiothoracic unit provided anaesthetic cover to the SICU. There was a dedicated physiotherapist who also looked after the equipment and an ECG technician.

Jayawardene reported the profile of patients managed in the unit from its inception to his retirement in 1994 – a period of 26 years. There were a total of 7594 admissions (approx. 300 patients/year) and 85% of the admissions were post cardiac surgery. 6.3% of the admissions were for medical causes. 3.88% were admitted after non-cardiac surgery and 3.17% after acute myocardial infarction. After 1971 these patients were admitted to the Recovery Unit and the Coronary Care Unit. There were also many publications detailing the results of different aspects of management.

Between 1972 and 1974 four patients with tetanus were paralysed and ventilated in the thoracic unit using an East Radcliffe ventilator at the General Hospital, Jaffna (in the north of Sri Lanka). From July 1975 to June 1976, thirty patients were ventilated for periods ranging from two hours to 47 days. Except for nine patients admitted following anaesthesia, the other admissions were due to medical causes.

A second intensive care unit was opened at General Hospital, Colombo in 1976. Dr Kenneth Perera, Senior Consultant Anaesthetist was instrumental in setting it up. About the same time, a three bed neurology intensive care unit was set up at one end of the Neurology ward by Dr JB Peiris, Consultant Neurologist. It had two Blease ventilators and two cardiac monitors.

The first ICU outside Colombo (and the third in the country) was a five bedded unit opened in 1980 at the Teaching Hospital, Peradeniya. A basic ICU was opened in 1982 in General Hospital, Kandy. The same year, at General Hospital, Colombo the Medical ICU (MICU) was opened. This unit differed from the others in that the Consultant Physician responsible for the patient at admission to hospital, continued to manage the patient whilst in the unit. In 1983 the ICU at Sri Jayawardenepura General Hospital was opened.

"BY 1995, THERE WERE 12 ICUs IN THE COUNTRY, WITH AN EXPONENTIAL GROWTH IN ICUs SINCE THEN; TODAY THERE ARE 100 ICUs ON THE ISLAND. 35.7% OF THE UNITS ARE MULTI-DISCIPLINARY.

1984 January saw the opening of a six bedded multi-disciplinary ICU at General Hospital, Jaffna. Dr R Ganeshamoorthy the Consultant Anaesthetist shared its administrative functions with a Consultant Physician. There was a substantial output of literature including a financial analysis from this unit.

Although there were no formal intensive care units, patients were ventilated in the wards in some Base Hospitals. Gunawardene and Arulananthan reported their experience of ventilating 13 patients during May – December 1986 in the medical ward at Base Hospital, Chilaw. These patients were suffering from acute respiratory failure following snake bite, insecticide poisoning and CNS infection.

In January 1992, a specialised obstetric ICU with three beds was opened at Castle Street Hospital for Women in Colombo. Dr Lakshman Fernando, an Obstetrician and Dr Nalini Rodrigo, Consultant Anaesthetist were instrumental in getting this unit opened and the latter was in charge. Specialised ICUs were opened for neonates, paediatrics, neurosurgery, neurotrauma and for medical subspecialties.

By 1995, there were 12 ICUs in the country, with an exponential growth in ICUs since then; today there are 100 ICUs on the island. 35.7% of the units are multi-disciplinary. The units are widespread in the country but, there is inequality in distribution as 43 of the units are concentrated in the Western Province. 73% of the units are headed by a Consultant Anaesthetist.

With the expansion of critical care units, changes took place in the training of intensivists. Initially all anaesthetists, during their postgraduate training, for the MD degree, undertook six months training in intensive care. Subsequently, it was possible for those who wanted to play a major role in intensive care to undergo further training and obtain the Board Certification in Anaesthesiology with special interest in intensive care. The training programme has further evolved so it is now possible to obtain post MD Board Certification in Critical Care. This programme is open to trainees with either the MD Anaesthesiology or the MD General Medicine who undergo a further three years of training. In parallel, there is also a training programme for junior medical officers leading to a Diploma in Critical Care. All these training programmes come under the purview of the Board of Study in Anaesthesiology of the Post Graduate Institute of Medicine.

Pioneering work in relation to organophosphorous insecticide poisoning and the use of magnesium sulphate for the control of spasms in patients with tetanus and eclampsia took place in the local units. This work has received international recognition.

The Sri Lanka Society of Critical Care and Emergency Medicine was formed in 2002. The membership is multi-disciplinary and multi-professional. The College of Anaesthesiologists of Sri Lanka inaugurated the Faculty of Critical Care Medicine in 2010. As mentioned by Dr Neil Soni, who was the Chief Guest at the inauguration of the Faculty, this predates the Faculty of Intensive Care Medicine in the UK by a few months. It is only fitting that, in 2014, the name of our College was changed to the College of Anaesthesiologists and Intensivists of Sri Lanka to more correctly reflect the importance of critical care.

MORTALITY AFTER MAJOR INJURY IN THE NEW REGIONAL TRAUMA NETWORKS

Professor Fiona Leckey
Clinical Professor in Emergency Medicine

Traumatic injury continues to be the commonest cause of death and disability in UK citizens under 40, and, with increased access to early CT brain scans in the Emergency Department, life-threatening injuries are increasingly diagnosed in older people after falls in the home. In-hospital mortality is an outcome* that patients, politicians, commissioners and health care professionals see as an important benchmark of the quality of care of 'the trauma system'.

There has been a good deal of interest in the recent Lancet E Clinical Medicine publication, *'Changing the system – Major Trauma Patients and Their Outcomes in the NHS (England) 2008-17';* the period of study covered the introduction of Regional Trauma Networks (RTN) from 2010 in London and the national roll-out from 2012-14 in the rest of NHS England. 27 Major Trauma Centres were commissioned by NHS England but, the other elements of the new networks (120 Trauma Units (TUs), Trauma Rehabilitation, Ambulance Service Trauma Triage) were non uniform and commissioned regionally.

> "MORTALITY DURING EACH YEAR WAS COMPARED TO THE BASELINE FINANCIAL YEAR OF 2008/9 ... THE RISK ADJUSTED ODDS OF SURVIVING TO REACH HOSPITAL ALIVE ... IMPROVED BY 19% (95% CI3-36%) IN THE 2016/17 FINANCIAL YEAR.

Trauma triage intends to safely convey most major injury patients to MTCs; with TUs catering, mainly, for less severe injuries or patients in extremis who cannot be safely conveyed longer distances. The other important system changes were care elements incentivised solely within the Major Trauma Centres through a £1500 best practice tariff (BPT- level one) paid if patients with an Injury Severity Score (ISS) of > 8 had data submitted to the national clinical audit (www.tarn.ac.uk) within a month of death or discharge, and had a rehabilitation prescription if appropriate. Patients receiving blood transfusion should also have received Tranexamic Acid within three hours of injury. A further BPT of a similar amount could be awarded to an MTC if the patient was ISS >15, saw a Consultant on arrival at the Emergency Department and received a CT head scan within 30 minutes of arrival if the Glasgow Coma Scale was 13 or less.

The study utilised data from the Trauma Audit and Research Network (TARN) over the 10 year period however, half of all trauma receiving hospitals were not TARN members prior to RTN roll-out. The primary analysis was therefore conducted in 110,863 patients presenting to 35 large hospitals (including 15 of the 27 major trauma centres) that had consistently submitted data to TARN from 2008.

Mortality during each year was compared to the baseline financial year of 2008/9, crude mortality remained at 8% throughout the study period however, the median age of patients with ISS >8 increased from

45 to 59 years with median ISS annual remaining 14-16 between 2008-2017. The risk adjusted odds of surviving to reach hospital alive (adjusting for year on year variation in age, gender, injury severity and co-morbidity through logistic regression) improved by 19% (95% CI3-36%) in the 2016/17 financial year when compared to 2008/9.

has proven to be less than an exact science and there is still a lack of clarity concerning which single (and combination) of injuries require MTC care and which need to bypass a closer TU. So when asking whether or not Regional Trauma Networks and Major Trauma Centres have improved survival to hospital discharge the best data available can only answer 'probably'.

> "A SECOND INTERRUPTED TIME SERIES LOOKED AT 'QUARTERLY EXCESS SURVIVAL RATE' = OBSERVED - EXPECTED SURVIVAL RATE ... AND IDENTIFIED EIGHT EXCESS SURVIVORS PER 1000 TRAUMA PATIENTS PRESENTING IN EACH QUARTER AFTER RTN INTRODUCTION.

The improving trend was significant and began in 2013/4, the first full year of RTN implementation. Similar results were obtained when 'all submitting hospitals' were assessed. A second interrupted time series looked at 'quarterly excess survival rate' = observed – expected survival rate (the expected survival rate calculated from the aforementioned logistic regression model of trauma patient characteristics) and identified eight excess survivors per 1000 trauma patients presenting in each quarter after RTN introduction.

The authors acknowledged the significant limitations of this evaluation being essentially an uncontrolled before/after study. The data quality submitted to TARN by Welsh hospitals was too patchy to provide a contemporaneous control. The casemix changed (silver trauma), as did reporting; there was a 200% increase in major trauma centre patient volume reported to TARN in consistent submitters. However, much of this can be attributed to better clinical diagnosis of traumatic brain injury in older people as reporting to HES also increased over the study period. Some processes improved (use of tranexamic acid, shorter times to imaging, better rates of Consultant review in the Emergency Department) but times to hospital from the scene and times to surgery lengthened.

Overall exposure to MTC care improved by less than expected; 10% (72-82%) in the primary cohort and 4% in 'all submitting hospitals' (45-49%). Trauma triage

*Disability and quality of life are also important but difficult to measure reliably outside of research studies – younger patients tend not to respond to service questionnaires outwith of clinical reviews.

**(Within the networks some hospitals opted out of TU status and now will not normally receive trauma patients conveyed by ambulance).

EMERGENCY PLANNING: THE NEW ReSPECT PROCESS

Dr Peter-Marc Fortune
President, Paediatric Intensive Care Society (PICS)

The new admission of a critically unwell patient, with an incomplete history, is a familiar scenario. Treatment is guided by standard protocols that may not reflect the realistic medical options for the patient and may not be congruent with their wishes. DNAR/DNACPR documents are familiar, but blunt tools, that have been available for some time. There has also been increasing use of advance care plans (ACP), particularly in paediatrics. There is no nationally agreed format for either of these and both present significant risks when used in an emergency because of their overly narrow or overly wide focus.

Following the Tracey case and House of Commons Health Committee report on End of Life Care, it was clear that a new approach was required. The Resuscitation Council (RC (UK)) and Royal College of Nursing (RCN) convened a working group drawn from disciplines across healthcare and incorporating patient representatives. The group agreed to describe a process suitable for use across all clinical environments, applicable to all ages, that generated a focused document to capture key summary information to guide (and not to dictate) the decision-making process at the time of a medical emergency. It would make no presumption regarding the requirement to, or not to follow certain paths. Importantly it was agreed that the process should support a culture change where discussions must address a person-centred review of the patient's care that would include, but should not be restricted to, decisions regarding cardiopulmonary resuscitation.

Within two years, the process was mapped out and a summary document designed. The materials were published, a public consultation was undertaken, and a limited usability pilot was conducted in four centres. The feedback from these exercises was overwhelmingly supportive and provided valuable information that enabled the materials to be improved. Further refinements included reflecting capacity legislative differences across the UK and the discussion and consent process for young people.

In 2017, the RC (UK) committed to supporting the ongoing management of the ReSPECT project. The supporting materials were published in March 2017. There was an immediate interest in adopting the process by a number of trusts, CCGs and STPs. On 1 October 2018 16 Trusts, 10 CCGs and five Ambulance Trusts were actively using the process with six further sites planning to adopt before Christmas.
A further 31 sites were in the process of planning their adoption. The Child and Young Person's Advance Care Plan Collaborative (CYPACP) have also embraced the ReSPECT process and have embedded the ReSPECT form in their documentation. In parallel to the clinical adoption, an NIHR evaluation project is in progress across a number of the early adopter sites and will be reporting in 2020.

During the process of adoption there has been considerable interest in realising ReSPECT in a digital format. The Scottish Government and the Public Records Standards Body (PRSB) have supported the development of open data standard archetypes (using the OpenEHR platform). At the current time, Fast Healthcare Interoperability Resources (FHIR) are also under development, and the realisation of a full digital deployment is under discussion in one of England's Local Health and Care Record Exemplar (LHCRE) areas.

In addition, multiple prospective users have requested SNOMED-CT coding for ReSPECT. An application for code(s) was delayed whilst safely concerns, raised by the use of other resuscitation codes leading to unintended consequences, were explored. These have been addressed and a request for a code to provide an indication that a ReSPECT form is available, but with no further coding of content, is currently in submission.

Further information, including contact details for the clinical support team can be found at: www.respectprocess.org.uk.

CAREERS, RECRUITMENT AND WORKFORCE

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee (FICMCRW)

Committee business takes a full day, unsurprising considering the outputs from a group who work very hard. Recruitment for 2019 is moving ahead, same place (West Bromwich Albion Football Ground), slightly different times (12-15 March). To facilitate interviewer travel, we're running the interviews over four days with slightly shortened days on Wednesday and Friday. Most people interview for a maximum of two days and this should, hopefully, give earlier finishes and more reasonable travel times home. New interviewer training is set for Friday 15 February. If you haven't done ICM interviews before we strongly recommend you attend this training (it's free and carries 5 CPD points).

The completion of the careers materials, ready for autumn recruitment information events, means the CRW is shortly moving on to a new careers project. We retain the same ethos of providing free, open access content that can be modified or delivered unchanged, depending on local preference and that meets an identified need. I've used some of the materials for Foundation career discussions.

The Annual Meeting, 'Mind the Gap' demonstrated a need for more personal and professional development resources for the workforce. Highlighting a problem is only half the story, and potentially renders us all feeling powerless unless we can identify the changes that are needed. CRW works towards development of solutions. We work hard in ICM, and although it's immensely rewarding, it can also be very stressful. I've had times of great personal and professional difficulty in my life, some of which I've coped better with than others. Often it's been a package of changes that have affected my ability to respond to some of the onslaughts. We've started developing resources people can use as an introduction to their own exploration of personal solutions. The first is resilience, in a joint initiative with the Management Advisory Service. On the CRW webpages are free materials for improving personal and team resilience, alongside information on resilience for leaders. There is also paid for content available that people can access should they choose to do so. In the background, we continue to meet with and lobby central NHS bodies and key individuals to push the case for ICM and wider workforce and resource solutions.

Photograph courtesy of ICCU, City Hospital Sunderland NHSFT

FICM WORKFORCE CENSUS

Dr Jack Parry Jones
Workforce Lead

Mental health, wellbeing in the workplace and suicide are all highly topical. The key however lies not in words but the implementation of changes that will make a difference.

When I look back to the death of my mother, by suicide, it is clear much has changed over the intervening 40 years. I can write this now without the same feelings of guilt and shame that were attached, at that time, to the cause of her death. Societal attitudes have changed, the stigma attached to mental illness is reducing. For many years I wouldn't, or couldn't, say how she died. People preferred to assume that she had died of cancer aged 39 years. Cancer was a sad and acceptable cause of death, suicide was bad and not acceptable; especially so for a mother of three young children. Christian morality and society did not extend forgiveness or understanding at that time. The guilt I felt was also deeply personal; did I, an 11 year old boy remember to kiss my mother goodbye when I left for school the morning she died. Did she kill herself because her children were growing up and no longer needed her in the same way? I say this because whilst societal attitudes have changed to mental illness and suicide, those deep feelings of personal guilt that those left behind often feel has not. The beautifully moving article and words by Kate Harding[1], whose husband was an intensivist and anaesthetist who took his own life, are testimony to this.

All of us working in critical care have seen many cases of attempted suicide, some of which resulted in death despite all the team's best efforts. These cases are very upsetting, often with the most tragic being the impulsive deaths of young people who hadn't felt able to reach out for help in their darkest moment. The mental devastation of the parents and siblings stays with you when you witness this. These deaths often aren't the end result of years of treatment for depression but an impulsive act that seemingly comes out of the blue. We, society, need to put real help within as easy reach as we possibly can if we are going to reduce the incidence of these deaths. The same too applies to the departments that we work in. We need to have professional help within as easy reach as possible, and we need to watch out for our colleague's mental wellbeing. Especially when something goes wrong. To have the care we deliver questioned is very upsetting, and the more you care the more upsetting it is. The huge, and often lengthy mental strain of being referred to the General Medical Council (GMC), or having to deal with a personal complaint should be met by our departments, and by our employers with a response that includes the offer of real meaningful help, not platitudes. The GMC do have a support service offered through the British Medical Association[2], but in your departments do you know what structures you have in place to support colleagues, or yourself if it was needed? What does your employer have in place to help?

> "WE NEED TO HAVE PROFESSIONAL HELP WITHIN AS EASY REACH AS POSSIBLE, AND WE NEED TO WATCH OUT FOR OUR COLLEAGUE'S MENTAL HEALTH.

As attitudes to mental health and suicide change, I do however watch with some trepidation the blame shift from the mentally ill individual to their employer, and also to the nature of the work that we have chosen to undertake. Doctors have high rates of suicide therefore, it must be the long hours and mentally draining nature of our work. Whilst this plays a contributory role in

some deaths, I think we need to be very careful where and how we apportion blame. Yes, our employers undoubtedly have a duty of care to their employees, but we too have a duty of care to ourselves. To pre-emptively look after our own mental and physical health as best we can. To eat and drink in moderation, to exercise regularly and to make the time and the space in our lives to sleep. To be mindful as we age of our changing needs and to seek help when we need it. Laura McClelland puts the case around fatigue and the mutual responsibilities of the employer and the employee extremely well in her podcast. The results of the Faculty 2018 'Wellbeing' census do not indicate that we as a group are unduly unwell, or made ill as a consequence of being intensivists. The mental rewards of working in an interesting and challenging job, as part of a team that delivers meaningful care that is valued by our patients and their families, may well balance out the hard demanding anti-social work that we do.

My mother had been treated for severe depression and bipolar illness for nearly 10 years before she died. She didn't die for lack of effort by her family, for not enough love, for failures by her mental health team. Severe mental illness is sometimes no more treatable, despite all the effort made by families, colleagues and healthcare teams, than some forms of cancer. Despite this, those of us left behind after a suicide, still blame ourselves for the death, where if it had been a cancer death we might not, or to a lesser degree. It took me many years to truly understand and believe that mental illness can be refractory to all treatment, and love. We belittle the severity of the disease, and the nature and depth of our love if we think it is always curable. Where we have tried and the outcome is still death, then guilt and blame are surely misplaced. Death, and I include death by suicide, is not always someone's fault. Deaths related to where and how we work is not necessarily a fault of the organisation, provided that the structures and processes are in place to try and deal with work related mental illness. As well as understanding and forgiving those that take their own lives, we should be more forgiving of ourselves and each other.

1.https://blogs.bmj.com/bmj/2017/12/14/kate-harding-i-have-lost-my-husband-could-not-be-more-accurate-it-feels-like-a-carelessness/
2.General Medical Council Support for Doctors. BMA Doctors support service.

2018 CENSUS DATA

Below is a summary of some of the 2018 Census Data; a full report is expected early in 2019.

Percentage of daytime clinical committment (DCC) in ICM

DCCs in ICM (%)	Number of responses
0-25%	110
25-50%	288
50-75%	339
75-100%	136
Declined to answer	3

Do you intend to practice ICM for the rest of your career?

Yes	79%
No	20%
Declined to answer	1%

Do you plan to alter your ICM commitment in the next two years?

Increase	8%
Decrease	16%
Neither	75%
Declined to answer	1%

Do you have any ACCPs on your unit?

Yes	28%
No	72%

Number of ACCPs on each unit

No of ACCPs	Units with this number
1	5
2	3
3	9
4	3
7	2
8	2

WORKFORCE ENGAGEMENT: PENINSULA

Dr Richard Gibbs
Consultant in Intensive Care Medicine, Taunton

A typically wet and blustery autumn day in Taunton saw an excellent multidisciplinary turnout from all of the units in the region for the Peninsula Workforce Engagement. The regional workforce engagements are now well established and this is the sixth such day that the Faculty has supported. These events aim to identify current and future critical care workforce and demand issues, and propose potential solutions. Following each meeting, the Faculty produces a report to aid local negotiations with deaneries, trusts and commissioners to develop the ICM workforce. Past reports illustrate both national and region specific problems and can be accessed at https://www.ficm.ac.uk/local-engagements/reports.

The Southwest faces several unique demographic and logistical challenges that impact on workforce planning. These include a large geographic area with low population density, but with the caveats of high net immigration from other parts of the country and the largest proportion of over 65s in the nation. There is a wide spectrum of units from a tertiary referral centre and specialist critical care units to smaller, remote units. Despite this, with an active critical care network and the fact that significant numbers of consultants trained in the region, communication between units is good and morale on the day was positive.

Following an introduction by Danny Bryden and Jack Parry Jones from the FICM Careers, Recruitment and Workforce Committee, the day started with some historical context and predictions on future clinical and workforce demands. The general trends in the region seem aligned with projected ICNARC increases in critical care bed days, with the majority of these bed days being populated by Level 2 patients. Discussion groups then got down to the crux of sorting out where the main workforce issues lie and how to address them. From wide-ranging discussions, several threads emerged as areas of focus: retention and career progression of the non-medical workforce, out of hours resident cover and the need to attract and train more consultants in ICM.

It was apparent that the Peninsula ACCP programme, based in Plymouth, has had an impact on workforce in the region. As significant number of trusts are now training ACCPs or have them embedded in their units, however there is concern about future retention of these valuable staff and their options for career progression. Similarly, the question of how to retain skilled nursing staff was also discussed. With many nurses being used to staff wards when occupancy dips, working antisocial hours and with limited opportunities to progress to a higher band in intensive care, a good number of nursing staff eventually tend to seek career progression outside critical care. The constant turnover leads to problems with skill mix and an increased training burden on unit educators.

Out of hours airway cover seemed to be a universal area of concern in the District General Hospitals. Difficulties recruiting non-consultant career grades and a finite numbers of trainees with advanced airway skills mean that cover for increasingly busy services is stretched. Significant numbers of ICM consultants are due to retire in the near future and many others are cutting back on activity for a number of reasons highlighted in the FICM census. The number of local advanced trainees has, fortunately, been increasing in the last few years (funded by trusts) so there is optimism that consultant recruitment from within the Peninsula will expand.

I would like to thank Danny, Jack, Daniel, Lucy, Natalie and Susan from the Faculty for organising and supporting what was a stimulating and productive day. I look forward to receiving the Faculty report in due course.

A CRITICAL FOUNDATION

Dr Daniele Bryden

Chair: Careers, Recruitment and Workforce Committee

" I think that early exposure is very helpful to work out whether you are suited to [ICM] or not … the educational side of it is so good and I think that the relationships you have with your consultants are pretty unique, so that must be attractive."
Stage 2 ICM Dual trainee

'Science, Skills and Safety' was a joint FICM, FPM and RCoA initiative to highlight to medical schools the ways in which the specialties could provide core elements of the undergraduate curriculum. Part of the intention was to increase undergraduate exposure to specialties that are traditionally perceived as firmly postgraduate, and hopefully nurture a longer-term interest amongst medical students.

The next obvious step for ICM, is to look at Foundation training provision; the CRW committee are on the case. Not having an ICM core programme, it is vital that we showcase the specialty before significant career decisions are made. The changes to Core Medical Training will help by increasing exposure and understanding of ICM amongst a group of doctors who have had, at best, inconsistent exposure to ICM across the UK. However, a disconnect has been developing between completion of Foundation programmes and entry into core training of any description.

The 2017 UK Foundation Programme Career Destinations Report indicates that only 69.6% of doctors completing Foundation training in 2017 remained in the UK and only 42.6% chose to go directly into specialty training. Although there are multiple reasons for this early attrition rate, one clear theme is that many trainees prefer to wait at least a year before applying for training, using the time to improve their CV and settle on choice of specialty and location: 90% of trainees are back in UK training four years after completing their Foundation training. This growth in unofficial 'F3' posts is an additional opportunity to showcase ICM so that when they do come back into training, doctors consider core programmes that allow them to apply for ICM training subsequently. Career decisions in Foundation are not fixed (over 35% of trainees change their minds over the course of the Foundation programme) and we want to ensure that ICM exposure at this crucial time is maximised across all four nations.

In early 2019, we will be releasing 'A Critical Foundation' that will highlight ways in which Foundation doctors can work in critical care areas to meet their Foundation competencies and also provide a degree of service to units. The intention is to show the variety of ways a Foundation doctor can be exposed to ICM and the benefits of having Foundation doctors in the team. There are a mixture of firsthand accounts from clinical leaders and educators, Foundation doctors and the ACCPs they work alongside. One of the key messages in the document is that Foundation doctors are not automatically a burden on our service, and like ACCPs, they can make valuable contributions to patient care. In addition, they benefit enormously from exposure to ICM and are the future of our specialty.

The focus group interviews of existing ICM trainees confirmed that many of our current trainees decided on ICM at early stages of their careers, after they had exposure to the specialty. They're now encouraging and mentoring more junior trainees, acting as excellent role models. The building blocks are all there to nurture additional interest in ICM training, and it's hoped that 'A Critical Foundation' will provide some practical advice and ideas to encourage Directors of Medical Education, Foundation Schools and Clinical Directors to expose more Foundation doctors to training in ICM.

COACHING FOR SUCCESS

Dr Suzy O'Neill
WICM Sub-Committee

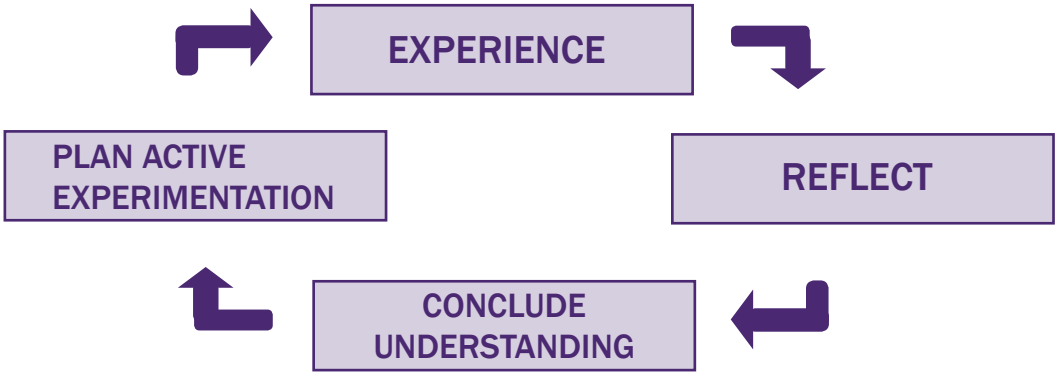
Coaching is an increasingly popular tool for supporting personal and professional development. The Chartered Institute of Personnel and Development (CIPD) define coaching as 'developing a person's skills and knowledge so that their job performance improves; it targets high performance and improvement at work, although it may also have an impact on an individual's private life.'

As a junior doctor you receive mentorship, supervision and development plans that are supported and guided by the people who are supervising you. Once you have been a Consultant for several years you are probably in the position where **you are** the person **giving** the supervision, mentorship, guidance and motivating your junior medical colleagues, as well as dealing with your own clinical workload.

Coaching has something to offer everyone at any time in their professional career. It is a safe, confidential, non-judgemental environment to promote learning and development for an individual. It is a personal time for reflection which can empower the coachee to effect change and improve the quality of their professional and personal life. One of the key elements is positive reinforcement of successes which may be something that is missing from a busy professional life.

When coaching begins, a confidential contract is drawn up between the coach and coachee, detailing aims and expectations for both parties. Coaching sessions occur every 4-6 weeks usually, over a four-month period. The coachee fills in an agenda prior to the meeting to use as a focus for the session. They decide the content of the session, which allows flexibility and means that issues that have arisen between sessions can be addressed, as well as longer term items.

There are many different models that can be used in coaching. One model is the Adult Learning Cycle by David Kolb, which is useful for three reasons. It is very simple and memorable; it encourages reflection; and it is very pragmatic, transferring learning back in to the work place to improve patient care and team working. Using Kolb's Adults Learning Cycle (see below), the coach can help the coachee to work through the stages of the learning cycle with their particular issue, and have a plan of action for how they are going to transfer their learning back into their workplace. The following are just some examples of what can be achieved in coaching.



Specific Skill Acquisition

Learning to say 'no': for example to how to say no to requests for giving presentations. The coach may ask the coachee to consider a simple SWOT analysis of their situation and to answer the following questions:

- Why are you giving these presentations?
- Do you want to do this?
- Do you have to do this?

By considering their answers the coachee can identify strategies to say 'no' and to delegate a task to others. They can collect data over several months about their success in using this approach, which can be discussed in future coaching sessions.

Increased Self-Awareness

Many people will have completed Myers Briggs (MBTI) and know their own profile. Coaching may explore how different personality types interact and how to manage conflict and negotiation for example, accepting differences rather than seeing these as difficulties.

Celebrating Success

Coaching is an opportunity to identify individual and team successes by bringing these to the attention of the coachee.

Other areas that may be focused on include career development, or coaching following a critical incident or issues raised at appraisal. Coaching for teams may facilitate understanding of how different people respond in a situation and how the team can work effectively together towards a common goal.

We all lead busy lives. We deal with difficult situations every day. There is often too little time for reflection. We need to develop our skills to maximum benefit in the various arenas in which we are expected to perform. Coaching is one method of increasing the effectiveness of clinicians in their working environment, reducing work related stress and improving the quality of working lives.

The NHS Leadership Academy also has a register of approved coaches and some coaching resources:
www.leadershipacademy.nhs.uk/resources/coaching-register/
www.nelacademy.nhs.uk/coaching-and-mentoring

ADVANCED CRITICAL CARE PRACTITIONERS

Ms Carole Boulanger

Co-Chair: ACCP Sub-Committee

Dr Simon Gardner

Co-Chair: ACCP Sub-Committee

The Department of Health, following the recent stakeholder and public consultation, has announced that Physicians Assistants (PAs) and Physicians Assistants in Anaesthesia (PA(A)s), would proceed to independent specialty regulation via the Medical Associate Professional (MAP) route. Unfortunately, ACCPs and Surgical Care Practitioners (SCPs) were not included in this project going forward. For the time being at least. This decision is disappointing. As discussed with the National Association of ACCPs and the Faculty's ACCP Sub-Committee, we firmly believe that only, via independent specialty recognition and regulation, can the role of the ACCP develop truly robust governance, training and professional development structures.

The decision does not address the primary issue of ACCPs needing to work within a defined, recognised and officially regulated scope of professional practice. We are also left with no ability to recruit from the ranks of the other allied healthcare professionals (ODPs, perfusionists, etc) to ACCP training as they cannot currently be licensed to prescribe.

The FICM has worked extensively with HEE over the last 18 months to clarify how ACCPs could be incorporated within the MAP regulation and we aim to continue this work with a view to ACCPs becoming incorporated as MAPs in the near future. We now have the opportunity to see the reality of regulation in practice for PAs and PA(A)s.

It has been extremely gratifying to witness, alongside the growing number of ACCPs nationally, the rapid development of regional/network based ACCP training and educational forums such as ACCP Northern Region (ACCPNR), London ACCP Regional Network, Midland Advanced Critical Care Practitioners Group, and the North West England Advanced Critical Care Practitioners (NWACCP). These forums, as well as providing an invaluable, inexpensive and accessible educational and CPD resource, also provide an invaluable opportunity for ACCPs to meet, to network and to further develop educational and support structures.

Members of the FICM ACCP Sub-Committee have had the opportunity to attend several of these events around the UK. The FICM fully support their proliferation and we advise that at a local level, ICU Leads/Clinical Directors should do everything possible to facilitate ACCP attendance at such events. In the absence of nationally identified funding streams for ACCP CPD, these events can help provide a highly cost-effective interim solution.

ACCP CONFERENCE

The 2019 Annual ACCP Conference is being held at the RCoA Building in London on **Friday 7th June.** The London ACCP Network will be assisting us this year and, as always, there will be a combination of lectures and workshops, which we have tried to base on feedback from last year's event.

Topics suggested included nutrition, evidence appraisals, renal failure, endocrine emergencies, variations to the role and transitioning from training to qualified. The programme and online booking will be available in early 2019. We look forward to seeing many of you there!

UPDATES

1 ACCEA Awards Process

2 Smaller and Specialist Units Advisory Group

3 Membership Update

ACCEA AWARDS PROCESS

Professor Gary Mills

Chair: FICM Nominations Committee

Dr Carl Waldmann

Deputy Chair: FICM Nominations Committee

The FICM are pleased to annouced that we have been given the ability to nominate members for Clinical Excellence Awards for England and Wales in the form of a ranked list and citations. This mirrors other organisations such as Royal Colleges.

The Advisory Committee on Clinical Excellence Awards (ACCEA) application system usually opens in February and closes in April; as part of the process, consultants need to have follow the guidance and complete the online documentation. Importantly, applicants need to have gained support from professional bodies, and also from their own Trust/Health Board, who will assess the completed application in the same domains as the ACCEA. Each Trust/Health Board will have its own deadline to achieve this. Applicants might want to start writing an application now, ready to submit to your College, the Faculty and the ICS. Be careful with character limits; the official website has automatic set limits, but the downloadable practice forms often do not.

How are applications made?

Consultants must apply by completing Form A, including a personal statement (which, if successful, will be published) and information on five domains. The applicant can also choose to use an additional form to expand on one of the following three domains: 'leadership and managing a high quality service', 'research and innovation' or 'teaching and training'. For Gold Awards, two areas can be expanded upon and for Platinum Awards, three supplementary forms can be used. Make sure that any statements made show your role and the important contribution you made. Applicants will also have to provide details regarding their qualifications, employment information and job plans. The exact titles and emphasis of each domain change from year to year.

The form will be submitted by the applicant to their employer, who will rate each of the domains and comment. Once the employer has completed their section (called part 2), the applicant cannot make further changes, unless they resubmit their entire application. Finally, the applicant needs to submit the completed forms to the ACCEA before the deadline. The FICM citation and ranking will run in parallel with this.

Who considers the applications for the awards?

Applications are considered by sub-committees; there are 13 regional sub-committees in England and additional sub-committees covering Wales, DHSC/ Arm's-Length Bodies and Platinum applications. These sub-committees consider all applications from their area, as well as citations and ranked lists from nominating bodies, and produce a shortlist that passes to the main committee. This committee comprises 50% professional members, 25% lay members and 25% employer members.

Organisations like FICM submit a ranked list, which can then be considered by the relevant ACCEA sub-committee. To gain support from the FICM you need to send a completed application form to contact@ficm.ac.uk. If this year's forms have not yet been produced by the ACCEA, use the previous year's forms for this purpose.

You will also need to nominate someone (not from your own hospital) to write a citation on your behalf, using the online document (usually called Form B). Your submission will then be ranked by a panel of existing award holders. Because of the limited number of applicants we are allowed to support, sadly some very good applicants will not gain support. However, you may still be successful even if you do not make the FICM ranked list.

Who can apply?

To have a realistic chance of success, consultants will need to have been in post for longer than the one year minimum. Applicants must have engaged in the appraisals process and employers will be asked to confirm this. Part-time consultants can apply and, if successful, will be paid pro-rata. Once an award is made, it is important to show what new progress has been made in the intervening period before a higher award is applied for.

Locum Consultants cannot apply, although once they are in a substantive post this experience may count. Consultants without a clinical role (such as full-time management) cannot apply. Consultants will need to inform the ACCEA if they have any adverse outcomes from investigations by the GMC or their employers, or disciplinary procedures, or successful court actions that relate to professional conduct. The ACCEA will determine how this affects applications or existing awards.

> "MOST ACCEA AWARDS REQUIRE RENEWAL EVERY FIVE YEARS. APPLICATIONS ARE MADE IN THE FOURTH YEAR OF THE CURRENIT AWARD BECAUSE THE RENEWAL APPLICATION MUST BE MADE BEFORE THE AWARD EXPIRES.

Retiring Consultants

If a consultant applies for an award, but retires before the results are announced, they will be considered to have withdrawn from that application. If Consultants return to work after retiring, they will not be paid at a rate that includes their award, because this will have been incorporated into their pension.

If a Consultant plans to retire within six months after the closing date for a round in which they would be expected to renew their award, (the date may vary depending on each year's timetable) they must notify the ACCEA Secretariat before the closing date and seek confirmation that the existing award will be valid until the date of retirement.

Renewal of Awards

Most ACCEA awards require renewal every five years. Applications are made in the fourth year of the current award because the renewal application must be made before the award expires. It is therefore vital to check the ACCEA website and the date of your award to ensure you renew in time. In some situations, awards are renewed for less than five years.

Renewals are competitive and are made against the standard for that award in that region. A renewing consultant must be at least as good as the lowest new award made at that level in that region. If a Gold or Silver Award renewal is not competitive, it will be compared to the level below i.e. a silver application for renewal will be compared to the bronze applications and so could be renewed at bronze level. Where an award is not renewed it will cease on 31st of March in the year after the application was submitted.

Until this round, those not being granted a renewal faced the prospect of falling to zero points on the local scale or dropping down to a lower, national award if they were above bronze on the scale. There has been an adjustment this year, as those current bronze award holders not applying to renew will fall to eight or seven local points; unless their score is very low in which case they might be reduced to less or even zero.

What are we doing?

We are setting up a committee, that consists of current award holders to select those candidates who are most likely to succeed in competition against the other specialties. So decide if the ACCEA process, which is very competitive, can help you. Weigh up the risks of failing to renew depending on the regulations at the time and above all read the latest ACCEA guidance in detail. We want to try to help potential applicants.

SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

'There needs to be an acceptance that smaller hospitals cannot simply be mini-versions of large tertiary institutions, with the same expectations of service provision and staffing requirements. Smaller hospitals cannot do it all on their own. They need a fairer allocation of junior doctors, a big commitment from larger hospitals to support smaller ones and a more reasonable system for paying for hospital services. Most of all, they need permission to test alternative approaches and regulation that better reflects the differences between larger and smaller hospitals, rather than people assuming that the practice developed in our largest hospitals can or should be applied across all of them.'

The Nuffield Trust has put together perhaps the most detailed look yet at delivering acute medical services to smaller hospitals in the UK. Published in October 2018, 'Rethinking acute medical care in smaller hospitals' explores a number of the difficulties in developing and sustaining safe acute care in smaller hospitals. The paper is based on conclusions from UK and international evidence, as well as from a series of workshops involving a wide range of clinicians and managers. The conclusion above summarises some key messages, but the paper is a great read for those in smaller units and, perhaps even more importantly, those in bigger units! Many of the themes resonate with the work done by the SSUAG, such as the benefits of care closer to home, the need for context in applying standards and the lack of evidence for improved outcomes or finances for centralised care for most general medical conditions. The potential solutions are explored in some detail but again, the message that strong networks, built on mutual trust is of high importance and there is also detail on potential changes to physical layouts.

Many of these themes from 'rethinking acute medical care' are developed along similar lines within the GPICS V2 chapter, including definitions. Definitions for smaller, remote and rural vary, but the best detail has come from work by Monitor for NHS England, where 'smaller' was defined as an operating revenue of < £300m/annum, with very small at < £200m/annum. According to this definition, there were 75 smaller acute providers in England in 2014; this may have altered a little in the last four years.

However, with inflation and alteration in funding, classification according to finance is not a particularly useful definition. Therefore some of the characteristics of the two groups at this time are potentially more useful as they are not so vulnerable to change.

	<£200m	£200-£300m	>£300m
No of providers	30	45	67
Average no of beds	396	548	953
Average no FTE consultants	113	164	346
Average inpatient catchment population	195,000	275,000	470,000

The most practical definition for us is population base, and the GPICS V2 chapter therefore roughly reflects the 'very small' level of around 200,000. The Monitor paper goes on to define distances as:
Remote = >30km from next Emergency Department
Intermediate = 20-30km from next Emergency Department
Urban = < 20km from next Emergency Department

The Nuffield Trust paper points out that every hospital has different challenges; so individual assessment has to acknowledge this when planning for a safe service that serves the local population. A blanket rule can help with obtaining resources but may not be applicable for all. Hopefully this discussion can be part of improved network relationships.

MEMBERSHIP UPDATE

Mr Daniel Waeland
Head of the FICM

The Faculty has been in the process of gradually opening up all potential routes of membership since the launch of Foundation Fellowship in January 2011. In late 2017, the Board agreed a series of new membership routes, which were ratified by the RCoA, as our lead governance parent College, in May 2018. The Faculty hopes that now, like all Royal Colleges and Faculties, there will be a route on offer for all healthcare professionals working in critical care. We look forward to welcoming anyone who wants to join the Faculty into our growing family. Find out more about the routes below. Do please cascade this to your colleagues who might be interested and through your networks.

Core, Foundation and Medical Student Register
This route is open to all doctors in undergraduate and foundation training and all doctors in training on core programmes that lead to ICM. We look forward to hosting such endeavours as prizes and other resources as this membership grows.

ACCP Member
The current route of 'Associate Membership', a route of portfolio entry for trained ACCPs, has now been renamed 'ACCP Membership' and all current and future holders will be able to term themselves ACCP Members of the Faculty.

Associate Member
A new route of Associate Membership has then been created for any doctor who is not eligible for another form of Fellowship or Membership of the Faculty. This could be doctors on temporary or locum contracts or doctors on SAS contracts not eligible for full Membership.

Affiliate
The Affiliate route is open for all nurses, Allied Health Professionals and practitioners working in critical care that would like to stay up to date on the work of the Faculty and wider critical care matters.

Changes to Fellowship by Assessment and Associate Fellowship
When the Faculty was established, a route of Foundation Fellowship was opened for a period of 12 months to admit all those currently practicing as consultants in ICM. Following the end of Foundation Fellowship, the Faculty Board agreed there would need to be an additional transitional period of entry into Fellowship, which included the creation of Fellowship by Assessment (which continued aspects of Foundation Fellowship) alongside Fellowship by Examination.

Now the Faculty and the training specialty are more firmly established, there has been reasonable concern expressed by those pursuing the training and examination route, that Fellowship should now be achieved solely via this route (excluding the few rare occasions of honorary routes of Fellowship). The Board unanimously approved a change to reflect this and to bring us in line with other postgraduate specialties.

The Board agreed that we should give fair and due notice of this change. This change was first communicated in December's Dean's Digest and will come into effect on **Monday 16 December 2019**, therefore giving almost one full year of notice. On that date, Fellowship by Assessment will close and full Fellowship (FFICM) will only be achievable via Fellowship by Examination, Fellowship ad eundem and the honorary routes.

Associate Fellowship (AFICM), currently only open to consultants in ICM who originally trained overseas, will open a second route for ICM consultants who would previously have applied via Fellowship by Assessment.

Questions?
For more information, visit the FICM website at: **www.ficm.ac.uk/membership.** Should you have any queries, please do not hesitate to contact the Faculty at contact@ficm.ac.uk.

TRAINING AND ASSESSMENT

Dr Tom Gallacher
Chair: Training, Assessment & Quality Committee (FICMTAQ)

I am very pleased to announce that Paediatric Intensive Care Medicine has now been formally recognised as a subspecialty of ICM with the Royal College of Paediatrics and Child Health being the responsible College and lead for the curriculum content. Whilst it will be possible to undertake PICM as a dual trainee with anaesthesia, this will require an extension to a trainee's training time and will only be possible with the prior agreement of the Postgraduate Dean.

Thank you to everyone who completed our trainee survey! The results are now available and have been distributed to the Regional Advisors. They will consider the findings with a view to implementing any changes that may enhance trainees' training experiences. I would like to encourage all trainees to participate in this year's survey when it is circulated in May. The information you provide is extremely valuable and we cannot reliably acquire this from other sources. We are required by the GMC to produce much of the information you provide as evidence to support our new curriculum submission.

ICM is now a mandatory module of the Royal College of Physicians Internal Medicine (IM) curriculum that will replace the current Core Medical Training curriculum in August 2019. The IM trainees will spend a minimum of 10 weeks undertaking ICM training in a maximum of two blocks, and these placements will include dedicated out of hours commitment integrating the IM trainees into our multi-disciplinary teams. In conjunction with the Royal College of Physicians, we are working with a few regions to help them implement this change, where they have been experiencing some local difficulties.

I would ask that you make our new colleagues feel very welcome, though I am aware that many of you will have had physician trainees as part of your teams for many years. The Faculty feel that this initiative will be good for patients since it will better prepare our physician colleagues to manage acutely unwell patients presenting to hospital, it will benefit them for the same reason and it will be good for the specialty going forward since it will increase the pool of doctors in training who are able to experience what ICM can offer as a career. The hope is that, in time, this will translate to increased numbers of doctors training and qualifying in ICM, filling an increasing gap in our medical workforce.

QUALITY

Dr Chris Thorpe
Quality Lead

The results of the 2018 trainee survey are in and analysed. Thank you very much to all the trainees who completed the online survey. It gives us the best picture about how trainees feel their training is delivered and highlights both the positive and the negative. We have been collecting data for a while now, so can see any continuing problems; this is helpful as a one off difficulty may be just that, a one off. Let's take as an example the cardiothoracic attachment in Stage 2.

The question was: how would you rate your training in this placement? (2018 in bold)

	Replies	**%**	2017 %	2016 %
Excellent	**25**	**34**	29	18
Appropriate	**40**	**55**	62	65
Inappropriate	**8**	**11**	9	18

It is helpful to see that training has improved over the three years as a whole. Behind this overview is the very detailed information on the specific posts, including comments, that help the RAs and TPDs address problems, and feel like a job is well done with positive feedback. The positive feedback is a necessity; the trainers are putting in a real shift to support the trainees and this is often done well beyond their allocated time for training. To have praise from their trainees is an extremely motivating force!

This year, we wondered if the cardiothoracic training varied depending on the type of attachment. Some are within anaesthesia only, some combined anaesthesia and ICM and some just ICM.

	Anaesthesia	**Anaesthesia/ ICM**	**ICM**
Excellent	0	15	10
Appropriate	3	17	20
Inappropriate	1	1	6

> "THANK YOU VERY MUCH TO ALL THE TRAINEES WHO COMPLETED THE ONLINE SURVEY. IT GIVES US THE BEST PICTURE ABOUT HOW TRAINEES FEEL THEIR TRAINING IS BEING DELIVERED.

They are small numbers, so it's difficult to be certain, but the numbers and linked comments favour a combined attachment. Specific comments however, included points that could be addressed by individual units such as lack of formal teaching and an inappropriate on-call structure. Similar analyses have been performed for paediatrics and neurosciences; further details on these will be available in the Quality Report for 2018.

Another aspect of the Quality work that is bearing fruit is development of remote quality assurance of ARCPs. Very few of us have time to spare nowadays, and it is a big commitment for external reviewers to attend all the ARCPs taking place up and down the country. The digital age is upon us however, and although most of it seems to mean I take four times as long to do anything (insert dinosaur emoji here), which means that we can remotely assess completed ARCP reports and ensure that the process is standardised across the country. This is great for the GMC, as one of their interests is to make sure a trainee coming out of Wales, for example, is of equivalent standard to one coming out of Aberdeen. The process is surprisingly easy, and encouragingly, we have seen some absolutely brilliant efforts by dedicated tutors and trainees across the country. We can see the amount of work put in and it just serves to emphasise that cutting down on the paperwork is an absolute priority.

CURRICULUM RE-WRITE

Dr Tom Gallacher

Chair: FICM Training, Assessment and Quality Committee

Work continues on the re-write of our curriculum to meet the new GMC standards, *Excellence by design: standards for postgraduate curricula'.* One of the overarching themes of the new curriculum standards is to reduce the burden of assessment associated with demonstrating achievement of the curricular requirements. A provision which, I'm sure, will be welcomed by trainees and trainers alike. This does increase the burden of responsibility now placed on named Clinical (nCS) and Educational Supervisors (nES) and their assessment the of available evidence.

Stage One: Strategic Support

The GMC has set up the Curriculum Oversight Group (COG) that comprises members of the Medical Education UK Reference Group (UKMERG). UKMERG has representation from organisations responsible for UK medical workforce planning and education including include NHS Employers, NHS Scotland, Wales Deanery, the Northern Ireland Medical and Dental Training Agency and the Departments of Health. UKMERG are responsible for ensuring the new curriculum meets the requirements for the whole of the UK, including strategic workforce needs. They do this by approving the curriculum's purpose statement, which is the first stage of the approvals process.

Stage Two: Curriculum Approval

When the purpose statement has been approved and we have completed our stakeholder consultations we can then submit the final curriculum for GMC approval as stage two of the process. This submission is to the Curriculum Advisory Group (CAG), a GMC body with representation from medical educationalists, including consultant, lay and trainee representatives, and psychometricians. CAG's role is to recommend to the GMC whether our curriculum meets the new standards. If there is any impact on resources, such as the requirement for extra funding, then this will be assessed simultaneously by a sub-committee of the Curriculum Oversight Group (COG), comprising postgraduate deans representing each country of the UK, as well as Dr Michael Bannon our Lead Dean for Intensive Care Medicine. The latter will confirm whether the curriculum is feasible and deliverable with the GMC's Assistant Registrar, making the final decision.

> "THE NEW CURRICULUM SHOULD INCLUDE GENERIC AND SHARED CONTENT, ALLOW FLEXIBILITY AND TRANSFERABILITY, AND SHOULD SUPPORT RECOGNITION OF ACHIEVED CAPABILITIES BETWEEN AND ACROSS SPECIALTIES.

The Purpose Statement

The curriculum has to be based on patient and population needs, as well as strategic service needs, and be formally endorsed by the four countries of the UK; the purpose statement must clearly address these requirements. It must set out specialty-specific capabilities, including scope of practice and the levels of performance expected of those completing training. The new curriculum should include generic and shared content, allow flexibility and transferability, and should support recognition of achieved capabilities between and across specialties. Notable exclusions or limitations to the training or scope of practice

associated with the new curriculum should also be highlighted in the purpose statement. The curriculum needs to meet the following requirements:

- Explain the need for the curriculum based on an analysis of patient, population, professional, workforce and service needs.
- Give the purpose and objective of the curriculum, including how it links to each stage of critical progression.
- Describe the scope of practice of those completing the curriculum including notable exclusions.
- Specify the high-level outcomes so it is clear what capabilities must be demonstrated, and to what level, to complete training.
- Demonstrate the curriculum has four-country endorsement of the purpose statement.
- Demonstrate how the key interdependencies between the curriculum and other training programmes, professions or areas of practice have been identified and addressed.
- Explain how the curriculum supports flexibility and transferability of learning outcomes and levels of performance across related specialties and disciplines.

Curriculum and Outcomes

The curriculum describes what trainees 'will be able to do' either at the point of entry onto the Specialist Register or at key progression points. The trainee must achieve a series of High-Level Learning Outcomes (HiLLOs), which are broad and descriptive of what the trainee must be 'able to do'.

They are a synthesis of the syllabus elements that are considered the most important things a doctor in training will have learned at the point of entry onto the Specialist Register or at key progression points. Each of these HiLLOs have a set of descriptors that are illustrations of the learning opportunities and/or experiences likely to provide evidence of attainment of each learning outcome. These descriptors will be examples of the types of evidence that can be used to demonstrate attainment of each learning outcome but they will neither be exhaustive or exclusive. The HiLLOs will describe the process as well as product e.g. 'will be able to complete a Quality Improvement Project' vs 'will be able to plan, implement, synthesise findings and evaluate Quality Improvement Projects aimed at developing professional and clinical practice in the Specialty/workplace'. For each stage of training, a trainee will be required to demonstrate a different level of attainment in keeping with a 'spiral learning' model. These levels of attainment are already defined in our current curriculum.

Generic Professional Capabilities (GPCs)

Doctors in a UK CCT training programme must demonstrate an appropriate and mature professional identity applicable to their level of seniority. Satisfactory achievement of these generic outcomes (applicable to all doctors and all specialties) will demonstrate that doctors have the necessary GPCs needed to provide safe, effective and high-quality medical care in the UK.

The GMC's Generic Professional Capabilities framework gives a detailed description of the interdependent essential capabilities that underpin professional medical practice in the UK and are therefore a fundamental and integral part of all postgraduate training programmes. At the heart of the GPC framework are the principles and professional responsibilities of doctors, as set out in Good Medical Practice and other GMC professional guidance, along with the statutory and legal requirements placed upon doctors. These professional responsibilities have been converted into educational outcomes with associated descriptors, to facilitate incorporation into curricula. The Generic Professional Capabilities domains are listed in the table below and each has its associated detailed descriptors.

- **Domain 1:** Professional values and behaviours
- **Domain 2:** Professional skills
- **Domain 3:** Professional knowledge
- **Domain 4:** Capabilities in health promotion and illness prevention
- **Domain 5:** Capabilities in leadership and teamworking
- **Domain 6:** Capabilities in patient safety and quality improvement
- **Domain 7:** Capabilities in safeguarding vulnerable groups
- **Domain 8:** Capabilities in education and training
- **Domain 9:** Capabilities in research and scholarship

These capabilities will be incorporated into our curriculum just as Good Medical Practice currently is in our existing curriculum. Trainees will need to show they have achieved these capabilities in order to demonstrate overall achievement of the HiLLOs. Whilst not every GPC domain will be relevant to a particular HiLLO, some GPC domains will be expected to be demonstrated in more than one HiLLO.

ICM Curriculum High Level Outcomes

The new curriculum will have 14 HiLLOs that have been agreed by the Curriculum Working Group (CWG) made up of members from the FICM Training, Assessment and Quality Committee. There will be four non-specialty specific and ten specialty specific HiLLOs. The non-specialty specific HiLLOs will cover non-clinical areas of practice such as being a clinical teacher, ethical and legal considerations and NHS structures, whilst the specialty specific HiLLOs will describe what a doctor must be able to do in order to practice independently as a specialist in Intensive Care Medicine; this will include the requirements of our partner specialties of Internal Medicine, Anaesthesia and Emergency Medicine.

Assessment Strategy

To be able to reduce the burden of assessment for the new curriculum, a new assessment framework will be required. Educational supervisors' judgements will be pivotal to the successful functioning of the new assessment system and therefore it is anticipated that education and support will be needed for nESs in advance of the introduction of the new curriculum. The CWG anticipates that this will be a very challenging requirement and will consult widely as the proposed assessment system evolves.

> "IT IS IMPORTANT TO DEMONSTRATE THAT THE CURRICULUM IS FIT FOR PURPOSE IN TERMS OF PRODUCING QUALITY DOCTORS.

Consultation

It is important we can demonstrate that the curriculum is fit for purpose in terms of producing quality doctors who can deliver excellent care for our patients, whilst also ensuring the curriculum is deliverable and satisfies the workforce requirements of the UK's NHS. We will consult with a wide range of stakeholders including (but not limited to) trainees, trainers, Fellows and Members, patients, partner Colleges, employers and representatives of groups with protected characteristics.

Timescale

We have submitted our Purpose Statement to the COG and await their decision. We have agreed the HiLLOs and their descriptors, and have indicated which GPCs will need to be demonstrated in order for the trainee to show they have attained the necessary outcome. We plan to submit the full curriculum to the GMC towards the end of 2019 and, if accepted, we would aim to introduce it in August 2020. These timelines are indicative since much will depend on the GMC's decision on whether to approve the new curriculum. We anticipate that this will be an iterative process from the experience of Colleges who have successfully negotiated the new process and had their new curricula approved.

> "TO BE ABLE TO REDUCE THE BURDEN OF ASSESSMENT FOR THE NEW CURRICULUM, A NEW ASSESSMENT FRAMEWORK WILL BE REQUIRED. EDUCATIONAL SUPERVISORS' JUDGEMENT WILL BE PIVOTAL TO THE SUCCESSFUL FUNCTIONING OF THE NEW ASSESSMENT SYSTEM.

FICM FOCUS GROUP PROJECT

Dr Daniele Bryden

Chair: FICM Careers, Recruitment and Workforce Committee

'It's amazing what you hear when you listen.'

Have you ever heard 'The Listening Project' on BBC Radio 4? The idea of the programme is to record two people having a chat and then play back part of their discussions for the audience; there's always something to consider from listening in on the conversations. The Faculty has run its own 'Listening Project' over the summer. A group of senior FICM educators and trainees have been having recorded conversations, so we could gauge some thoughts about the future of ICM training and any planned curriculum revisions. The GMC had asked us to consider some radical ideas for ICM training and we wanted to know what current ICM trainees felt about those options.

I got the job of listening in to all of the conversations (six hours in total) between trainees in Scotland, the North East, North West, Yorkshire and Humber and Thames Valley. It's been great; conversations have made me laugh, challenged some of my assumptions and at times left me feeling quite humbled at the hoops some trainees jump through in their lives. I have no doubt ICM will be flourishing when these people are leading the specialty.

So what have I learnt?

Well, bearing in mind we have a clear CCT in ICM now, trainees do not want to go back to any system that resembles the old Joint CCT. No one wants ICM to be a post-CCT credential, partly because they see it as having a negative impact on recruitment to the specialty but also because people doing ICM are committed to the current training which they see as generally achieving its aims and their career goals. Although the vast majority are dual training, the creation of the Single CCT programme is viewed as a positive development for the future of ICM and how it is perceived as a medical specialty.

People are pleased to see intensivists arrive on the ward as we're helpful; as clinicians we have respect and intellectual gravitas which is what attracts people to come to work with us (I've never considered myself a 'beard stroker' before - one of the more unusual descriptions!).

However, we've also been delivered some harsh messages. Stage 2 ICM was described as overly and unnecessarily burdensome and trainees clearly want us to do something about the admin workload in that stage. Moreover, some of the rules around the FFICM exam and how training is structured between the different entry points have exposed some inequities in the amount of time trainees have to sit and pass the exam. They want us to look at some of those rules and consider that, on occasion, depending on personal and training circumstances, we're holding some trainees back for reasons that are not always clearly outlined or reasonable to them.

We've already started a process of consultation with partner specialties to make the case for future HEE computer software tendering to allow for more flexibility in recruitment. We've tried to make the best of stepped recruitment, but irrespective of specialty, trainees have said that if they know they want to do two CCT programmes they want to be able to interview for and be appointed to both at the same time so they can just get on with training.

The report recommendations will be considered by both our TAQ and CRW Committees and the information has already been used in one of our presentations to the GMC's Curriculum Oversight Group. My thanks to Mark Carpenter, Liza Keating, Carol Murdoch and Sarah Clarke for facilitating the conversations, and to all the trainees out there who contributed - you know who you are. We are listening to what you told us.

e-PORTFOLIO

Ms Natalie Bell

FICM Education and Training Manager

Due to several Royal Colleges deciding to leave the NES (NHS Education for Scotland) ePortfolio platform we have had to investigate alternative ePortfolio providers to ensure we have a sustainable option for the future. We currently operate on a shared funding stream (ie if any upgrades or changes are needed for the system then all of the partner colleges share the cost). The Royal College of Physicians is our last remaining stakeholder that has not yet decided on its future ePortfolio provider and we need to be prepared for when they make their final decision.

We began an engagement process with various providers and began first to work with the RCoA's ePortfolio provider that developed and built a bespoke ePortfolio system for the College. With considerable help from the College we have progressed discussions and our upcoming workshop with them will help tease out financial as well as functional issues.

We have also progressed talks with other suppliers who are experienced ePortfolio providers that already have a couple of Royal College customers on their books. The benefit of this provider is they have considerable expertise in building and exporting ePortfolios from previous NES customers and have assimilated many lessons learned from the data migration they have performed for others and we could use this knowledge to make it as smooth a transition as possible.

All the systems we have looked at offer more customisation, meaning we will be able to make changes to the system ourselves, without charge or the need to seek permission via a joint committee as with the current ePortfolio. This will prove invaluable when we have to implement our new curriculum in 2020

> "WE ARE GOING TO CONTINUE TO WORK ON TRYING TO MAKE IT EASIER FOR ALL OUR TRAINEES AND TRAINERS TO RECORD PROGRESS ON OUR VARIOUS TRAINING PPROGRAMMES.

The next steps will be to hold a workshop with each provider to determine their ability to achieve our requirements for the new system and the current (and upcoming) curriculum. We will be working with our ePortfolio subcommittee (with trainee and trainer representation) and via stakeholder consultation with you. We are going to continue to work on trying to make it easier for all our trainees and trainers to record progress on our various training programmes.

If you have any particular issues with the current system or have any helpful suggestions that you would like us to consider during this process then please do not hesitate to contact us: contact@ficm.ac.uk.

We will publish further updates on this project on the website and in future editions of Critical Eye, so watch this space!

CESR: THE PITFALLS

Dr Louie Plenderleith

Chair: FICM Equivalence Assessors

The number of applications and enquiries to the FICM and Regional Advisors about obtaining a Certificate of Eligibility for Specialist Training (CESR) via equivalence have been rising. While 80% of applications are ultimately successful, only 30% are successful on first application.

Applications are made via the GMC who review the information, verify evidence and feedback issues to the applicant, who may then provide further evidence. The applications are usually 800 to 1000 pages and following GMC review, are passed electronically to the FICM for assessment by the Equivalence Committee. Two assessors review the documentation against the current ICM curriculum; they then make a recommendation to the GMC, quoting the evidence for supporting or rejecting coverage of each section of the curriculum. If rejected, the recommendation must also state what further evidence or training is needed for successful reapplication.

The GMC requires applicants to have competencies equivalent to those of a UK trainee who has just completed training; it is not enough for them to be functioning well in an ICM post. For example, an applicant may be functioning as a locum consultant in a general adult ICU but, if they have no training in paediatric ICM, they will not have achieved equivalency. This is directly comparable to a trainee who would not achieve their CCT if they were missing an area of training. The assessors must compare the evidence for the applicant's training and experience with that required for the **full, current** ICM curriculum. They look at duration and breadth of training/experience as well as the **current** level of competencies. The applicant must provide evidence to demonstrate all of this. When the new curriculum is introduced in 2020, applications received after that point will be assessed against the new curriculum. Possible, future applicants should be made aware of this.

Applications fail because the applicant has not covered the full curriculum. The assessors are not looking for identical training, but coverage must be similar and they will consider relevant experience in addition to formal training. Applications often have more than one failing; the most common failings are:

- Insufficient Anaesthesia training: there is flexibility on how this is achieved, but applications with less than one year of Anaesthesia training, and no other experience, will fail.
- Lack of Specialist ICM: this particularly applies to Paediatric ICM but also Cardiac and Neuro ICM.
- Lack of evidence for Quality Improvement/Audit and Teaching and Training.

How can an applicant reduce the chances of failure?

- Read the ICM curriculum. Look especially at Parts I, II and III.
- Read the GMC General and Specialty Specific Guidance documents. These contain guidance on what type of evidence is acceptable in general and for ICM specifically.
- Make sure you **show** you have covered all areas both in duration and competency level.
- Make it easy for the assessors to identify relevant evidence.

For experience gained in the UK, the standard UK training documentation can be used. For other training, applicants need to supply information and assessments that show the range and competency level they have achieved. Ensure competencies are current. If any evidence is more than five years old, there must be evidence of maintenance of skills. This can be an issue for specialist ICM.

For more information, visit: www.ficm.ac.uk/training-examinations/equivalence.

TRAINEE UPDATE

Dr Richard Gould

Lead Trainee Representative

Dr Andrew Ratcliffe

Deputy Trainee Representative

Although we're writing this in early autumn warmth, we know that by the time it's read that we'll undoubtedly be in the depths of another busy (and probably cold) winter.

During our busiest part of the year, sometimes we all feel that our training seems to become an afterthought. It's worth reminding our trainers (and ourselves) that time spent completing assessments and competencies, whilst surrounded by the multitude of interesting and complex patients in front of us, will only reap greater rewards come the usual summertime ARCP rush!

Refining and modifying the curriculum is the remit of the TAQ committee. During the last year, the focus has been on the substantial re-write of our curriculum to fulfil the GMC changes. This project continues to make exciting progress. At the time of writing, a draft of all the new High Level Learning Outcomes is complete. As you read this, these will have been shared with our partner colleges to ensure that the dual programmes are as seamless as possible. A wider consultation will follow, in which trainee feedback will be essential to refining the curriculum and ultimately getting GMC approval.

In 2019 the GMC will introduce the concept of 'credentialing' for all specialist training programmes. The idea is to package a subspecialty component into a short training pathway that would most likely be taken following attainment of a CCT. One of our Special Skills Years is a possible example within ICM, but the details still need to be worked out. The GMC currently have an online feedback form (open until 25 January 2019) and are keen for your views: www.gmc-uk.org/education/standards-guidance-and-curricula/projects/credentialing. I would encourage you all to read the information on the website and consider submitting your opinions.

Establishing and maintaining our ICU workforce and building a sustainable career structure falls to the CRW committee. Following on from his well-received presentation at the FICM Annual Meeting, Dr Derek Mowbray has provided the Faculty with a wealth of information on resilience and dealing with difficult events. Training in ICM exposes us to a multitude of interesting and challenging cases. Understanding how to cope with these situations, not just from a medical perspective, but also from a personal and reflective viewpoint, enables us to build life-long, sustainable careers and minimise the risk of burnout. We would encourage you to use this fantastic new resource available via the FICM website.

Similarly, this time of year sees many Deaneries begin the process of recruitment with locally run careers events. CRW has put great effort into establishing the Careers Hub on the website. A package of presentations, workbooks and delegate information is available for you to download, adapt and use to run a tailor made careers evening with approved FICM slides and guidance. The evenings are a great way to network and engage with future colleagues in addition to promoting our specialty. Take a look online, everything you need to set up an event is available on the website; it's a great opportunity to get involved at a local level, and will look great on the CV!

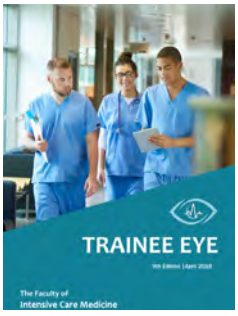
It is always great to receive communication from trainees throughout the year. No matter how small the problem seems to be, we are only too happy to help resolve any situation.

Issues arising over the last year have included providing clarity on the curriculum, attempting to untangle complex dual programmes and supporting those who want to work LTFT.

Equally, it is great to have opportunities to promote the work that trainees across the country complete. You may have already found the logbook summary document on the Faculty's website that was kindly submitted by Dr Tan (www.ficm.ac.uk/assessment-forms-stage-certificates/logbook-resources). The Trainee Eye newsletter has also been redesigned in the last year and now offers further opportunities for trainees to submit articles for publication. If you have any piece of work that you feel would be of benefit to the wider trainee audience then please get in touch at contact@ficm.ac.uk.

January is the time where the Trainee Representatives at the Faculty change. Richard is stepping down after his two years of service, and Andrew has become the Lead Trainee Representative. We are delighted that Richard Benson was successfully elected from a strong field of candidates as the new Trainee Representative Elect and we will both continue to strive to represent yourselves to the best of our abilities.

TRAINEE EYE



The next issue of **Trainee Eye** will be published in March 2019. If you would like to contribute, please get in touch at:

contact@ficm.ac.uk

NEW DEPUTY TRAINEE REPRESENTATIVE

Dr Richard Benson

I am a dual ICM and Anaesthesia trainee based in the North West of England.

I graduated from Edinburgh University and following the completion of my Core Anaesthetics I took time out of training working in Anaesthetics, Intensive Care and air retrieval in South Island, New Zealand. I am currently a stage 2 trainee at Lancashire Teaching Hospitals Trust. I have an interest in Neuro-Intensive care and use of simulation in training.

I am passionate about trainee welfare and have had experience of working with my local STC as a trainee representative to bring about positive change.

Outside medicine I enjoy time with my wife and two children and I am a keen competitor in long distance triathlon having recently completed my first ironman distance event.

I am very much looking forward to working with the board to further improve both the training experience and opportunities for trainees nationally.

WEST MIDLANDS

Dr Mamta Patel

Regional Advisor

To outsiders, the West Midlands evokes an image of the decaying Victorian industrial landscape which inspired the 'Twin Towers' of J.R.R. Tolkien fame. Tolkien grew up in Birmingham and many locations in his books are said to be inspired by there. However, the reality is far from Mordor!

With a population of nearly six million, the West Midlands covers a vast and varied geographical area. It ranges from Shropshire and Herefordshire to Staffordshire, Warwickshire and Worcestershire as well as the well-known cities of Birmingham, Coventry and Stoke. With convenient transport links to other parts of the country, including London, the West Midlands is literally in the heart of the country.

The region encompasses three major teaching and several district general hospitals, offering a varied and enriched ICM training, lifestyle and culturally diverse experience.

Training Variety

The region prides itself in providing high quality training; last year's GMC survey showed several hospitals in the Midlands in very respectable positions nationally with respect to overall satisfaction scores. Whilst the majority of the trainees are Dual CCT trainees with anaesthesia, we appreciate that each trainee's goals are different. In this respect, we are fortunate to have strong ties with ICM linked specialties and can individualise training to a greater degree.

We now have a collaborative, established ICM academic training programme with NIHR funded posts, supported by Professors Bion, Gao and Perkins. Several ICM trainees are pursuing an academic career in ACF and ACL posts whilst continuing to participate in clinical management.

The region has several Trusts where the Advanced Critical Care Practitioner (ACCP) programme is embedded and ACCPs are employed to support services whilst offering additional mutual training and educational opportunities.

ICM Training Programme

Care of the critically ill patient requires the cooperation and integration of care across of multiple specialties. The West Midlands benefits from a breadth of ICM programmes that provide exposure to complex critical care and foster the acquisition of skills compatible with helping trainees develop into leadership roles.

Over the last few years, with the help of enthusiastic educators, we have expanded our regional educational programme, beyond the established monthly teaching for FFICM, to ensure that the skills essential to delivering excellent critical care are provided. We now have a regular local FFICM exam preparation course established by Nehal Patel at UHNM which attracts trainees locally as well as nationally. In addition, we have themed regional teaching days, led by Catherine Snaith. Several trusts regularly run BASIC courses for the junior ICM trainees which are enthusiastically received. These courses enable the senior ICM trainees to cultivate their skills as teachers and course organisers. Additionally, as part of complimentary specialty training, Airway Management and Adult Transport courses are provided at UHCW.

Special Skills Years undertaken to date include echocardiography, quality improvement, research and Pre-Hospital Emergency Medicine (PHEM). We have several accredited mentors offering training in FICE. Additionally, Ashley Miller (West Midlands lead for ICM echocardiography training) has set up a multifaceted,

echocardiography/ultrasound fellowship training programme adaptable for ICM specialist skills training in echocardiography.

After considerable negotiation, we have increased placements in the district general hospitals, offering advanced training and flexible management opportunities to ensure that Stage 3 trainees procure the experience to prepare for life as an ICM consultant.

Consultant Numbers

In National ICM recruitment, competition for West Midlands ICM posts is substantial and we are fortunate to have an occupancy rate of 100%. Despite this, we remain significantly short of the numbers required for the region in terms of ICM consultants. This was the conclusion of the West Midlands Regional Workforce Engagement meeting organised by the Faculty and the Midlands Critical Care Network endorsed this. Increasing our trainee posts is one way of addressing this. Within the School of Anaesthesia, we are negotiating with HEE to increase ICM post numbers.

The Future

The challenges facing the West Midlands mirror those across the country:

- Lifting trainee morale in the wake of the bitterly contested new Junior Doctors' Contract
- Recovering from the recent setbacks in provision of new hospital infrastructure caused by the collapse of Carillion and
- Expanding trainee numbers to equip the region with a sustainable consultant workforce to elevate patient care and meet GPICS standards.

Overcoming these are key to promoting the ICM programme and retaining our trainees through to the consultants we need. Come and experience the excellent training first hand in the not so stereotypical West Midlands!

DEFENCE MEDICAL SERVICES

Dr Stuart Dickson
Regional Advisor

Deaneries across England and the devolved nations currently deliver ICM training to 21 doctors of the Defence Medical Services (DMS). ICM trainees and trainers in NHS hospitals across the UK will train and work with this small, but important, group of intensivists. In this article I will explore how the DMS works in partnership with the NHS to deliver military intensive care training.

Doctors of the Defence Medical Services are employed by one of the three armed services; the Royal Navy, Army or Royal Air Force. Following Foundation training, junior doctors typically complete a period of service as a General Duties Medical Officer with their respective parent services, on completion of which they begin postgraduate medical training.

The Defence Postgraduate Medical Deanery (DPMD) based in Lichfield, Staffordshire is responsible for postgraduate medical training in the Defence Medical Services. The structure of the DPMD is based upon the NHS Deanery model and retains strong links with the West Midlands Deanery and the University of Birmingham. In keeping with most postgraduate medical training programmes, ICM training for military doctors is delivered in NHS hospitals across the UK with trainees being fully integrated in host Deanery training programmes, alongside civilian peers, but with oversight by the DPMD.

Workforce planning for secondary healthcare specialties is undertaken by each of the armed services, with guidance from single service Consultant Advisors led by a triservice Defence Consultant Advisor (DCA).

The Defence Consultant Advisor in ICM assumes the role of Regional Advisor with support from the Deputy Regional Advisor.

ICM training in the Defence Medical Services is open to specialty trainees in Anaesthesia, Acute Medicine, Respiratory Medicine and Renal Medicine. Trainees in Emergency Medicine may be permitted to undertake a dual programme with ICM at the discretion of their parent service. In contrast to civilian colleagues, military doctors must hold a training number in their partner specialty prior to applying for ICM training. A Single CCT training programme in ICM is not currently supported by the DMS. Following a preliminary selection process administered by the DPMD, approved candidates are interviewed alongside civilian applicants at the annual National ICM Recruitment interviews. Whilst the interviews are not competitive for military doctors they must benchmark with a sufficiently high score to be appointable to the ICM training programme. If, successful the trainee will undertake ICM training in the same civilian Deanery as their partner specialty with their training programme being tailored by the local ICM Training Programme Director alongside civilian ICM trainees.

Military ICM trainees are supervised throughout their training by civilian Educational Supervisors and Faculty Tutors. The ARCP for military trainees is administered by their host Deanery, with the DPMD represented by either the DCA in ICM or the military Deputy RA. This is an invaluable opportunity for both military trainees and ICM trainers from host Deaneries to discuss and resolve any issues of concern. Military trainees, like all doctors in training, can run into difficulties and may need increased support and mentorship at times throughout their training programme. Educational Supervisors, TPDs and RAs in host Deaneries are strongly encouraged to liaise directly with the military Deputy RA or DCA to discuss and resolve issues arising at any time throughout the training programme.

Whilst the administration of ICM training for military trainees across the UK is devolved to host civilian Deaneries, their parent service and the DPMD retain authority, as the employer, over decisions related to application for various forms of statutory leave, periods of time 'out-of-programme' and any other factors that may result in the extension to the duration of training.

On completion of ICM training, the military intensivist must be capable not only of undertaking the duties of an ICM consultant in the modern health service, but must also have developed the military skills required to deliver intensive care in challenging and often austere deployed operational settings. Periods of military specific training are undertaken throughout the training programme in order to ensure the military intensivist is prepared for the challenges of their future consultant career.

The special relationship which exists between the DMS and our civilian colleagues in the NHS gives rise to a unique training experience that ensures the UK armed forces benefit from the knowledge and skills of a highly trained and capable workforce of intensive care clinicians.

FFICM EXAM CALENDAR 2019

	FICM OSCE/SOE Examination	FICM MCQ Examination
Applications & fees not accepted before	Monday 7th January	Monday 15th April
Closing date for Exam applications	Thursday 28th February	Thursday 13th June
Examination Date	**Tuesday 26th March & Wednesday 27th March**	**Tuesday 9th July**
Examination Fees	Both: £585, OSCE: £335, SOE: £300	TBC

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