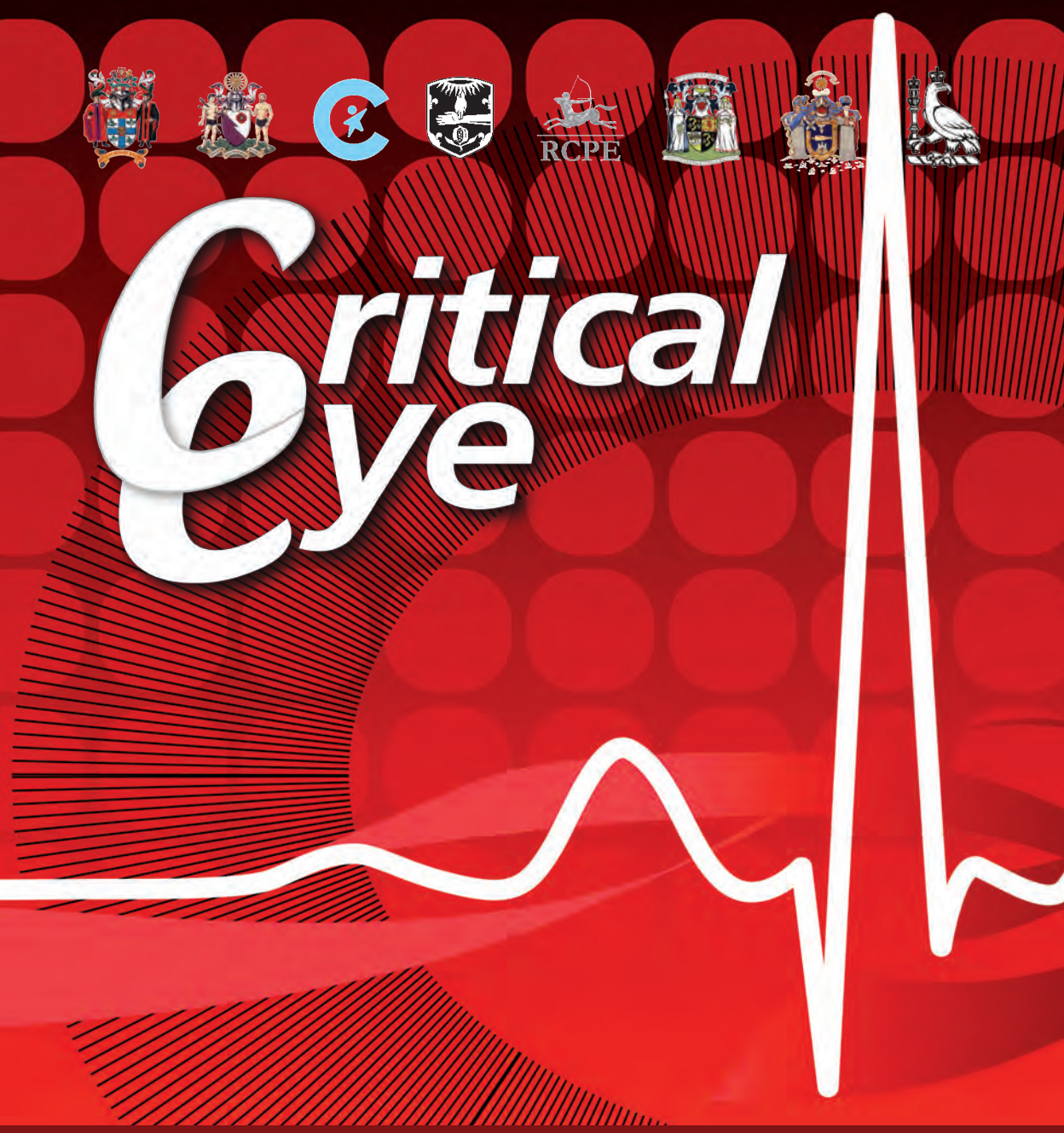


Critical Eye

Issue 6 Summer 2014

The Faculty of
Intensive Care Medicine

Inside:

Welcome

Dr John Butler
Clinical Editor

Welcome to the sixth edition of *Critical Eye*. As the new Clinical Editor my first duty is to pay tribute to my predecessor, Dr Graham Nimmo, for all the hard work and commitment he has put into the development of *Critical Eye* over the last two years. Under his guidance the newsletter has developed into a crucial way of championing the achievements of the specialty and I hope to continue his excellent work.

This newsletter contains detailed updates on all the latest developments concerning Intensive Care Medicine in the UK. There are, however, a couple of specific developments that are worth mentioning. Firstly the Faculty recently welcomed the Royal College of Paediatrics and Child Health (RCPCH) as its eighth trustee college. In April the Faculty received unanimous support from the Council of the Academy of Medical Royal Colleges for its application to become a member. This is a fantastic achievement and reflects the considerable efforts of everyone involved in the process.

This edition includes updates from a number of critical care nursing organisations highlighting recent political and clinical developments. Other articles of note include a report from the National Audit Programme Manager from ICNARC, and an update from the Professional Standards Committee outlining details of a joint initiative between the Faculty and the ICS to obtain NICE guideline accreditation. Of interest to both trainers and trainees will be the article discussing the launch of the new ePortfolio, the report from the chairman of the Court of Examiners outlining significant successes in the FFICM examinations, and an informative article from the Lead RA for Scotland detailing aspects of recruitment and training north of the border.

The Faculty would welcome any ideas and suggestions for future articles. Please send your correspondence and feedback to ficm@rcoa.ac.uk.

Contents

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

Update from the Dean

Dr Anna Batchelor
Dean

Its always nice to write about happy events and I was really pleased to welcome some of our first FFICM diplomates in Westminster Central Hall on the 2 May. For the first time we shared 'Dips Day' with the Royal College of Anaesthetists and the Faculty of Pain Medicine. I had to shake hands and smile for the camera with 12 new holders of FFICM, a moment of pride for all of us. These new holders of the FFICM are very special indeed because they have just passed an exam they did not need to take. They did it to show their dedication to our specialty and to critically ill patients. I must confess I did not envy J P van Besouw the RCoA President who had over 300 new holders of FRCA to welcome; smile fatigue bravely averted. This large and beautiful venue has plenty of space for family to share the sense of pride and achievement with the diplomates, take lots of photographs and enjoy the day. The cream scones were good too!

The second new event to report is that the Royal College of Paediatrics and Child Health have formally become our eighth Trustee College. This was one of the recommendations made in *Collaborating for Quality*. Another outcome from this project was the creation of a leadership forum to bring representatives of nursing, AHP, doctors both clinical and academic together. There are already benefits accruing from this collaboration.

And the third big event (things do seem to come in threes) is as many of you will have seen on the website, that the Faculty is now a member of the Academy of Medical Colleges, this is quite a big step for a small organisation. Each College or Faculty has an equal vote so pays an equal amount to be a member. We didn't quite have to tip out all the pockets in our wardrobes and search down the back of the sofa to raise the subscription, but we did need to think twice whether it was of value to our specialty. The conclusion of the Faculty Board was a resounding yes. To carry weight with politicians, medicine needs to speak with one voice and ICM is now able to play our part in deciding what that voice says. The Faculty has contributed to our first AoMRC document, *Guidance on Taking Responsibility: Accountable Clinicians and Informed Patients,* which can be downloaded from the Academy website. When patients are admitted to critical care accountability moves to an intensivist, referring clinicians are encouraged to maintain a continuing interest in the patient whilst in critical care (as most already do) and of course resume responsibility when the patient is discharged from critical care.

The Shape of Training Review has been accepted by all four home nations and all are keen to see it implemented. The Academy will be playing a significant role in the implementation of what could be one of the biggest changes in medical training since Modernising Medical Careers. Reorganisations of training will soon be as frequent as those of the NHS. MMC, by streamlining recruitment and training in specialties, has resulted in a gap in acute services. We, as a Faculty, need to consider how ICM is going to play its part in the acute hospital services and how training in ICM should work. We have a view on how we would like this to work within the Faculty Board and Training and Assessment Committee.

Since *Comprehensive Critical Care* was published in 2000 we have established outreach teams, there has been a very significant growth in critical care beds mostly at Level 2 or high dependency beds and intensivists have embedded themselves in the pathway of care for the acutely ill patient. We see this continuing and expanding. An expansion of the Acute Care Common Stem seems a sensible first step along with more collaborative work with the other acute specialties. Early recognition and treatment of critical illness is something I think we are good at. How will post-operative patients fit in? Too many are cancelled because of lack of an HDU bed, should we develop post-operative care units? If so who should run them?

But how do you think ICM should fit in to acute services? Is ICM training okay as it is or do you think we should be changing it? Please tell us what you think by emailing the Faculty office, your messages do get passed on (ficm@rcoa.ac.uk).

If we are going to expand our sphere of activity we shall need more intensivists. This year we filled 108 of our 112 specialty training posts and whilst this is very good, growing from 70+ to 80+ to 100+ over our three years of recruitment to the specialty, we are still not up to the levels required to fill advertised consultant posts with ICM trained candidates without increasing our sphere of activity. Most of the slack has now been taken out of the system, trust grade posts have been converted to training posts and now we will be looking for new posts and new money. All at a time when the pressure is on to increase the number of trainees in community-based specialties such as general practice and psychiatry. We continue to press our case with Health Education England and the home nations' equivalents.

Following on from the *Core Standards for Intensive Care Units* which were published at the end of last year, the Joint Professional Standards Committees have been working on producing GPICS (*Guidelines for the Provision of Intensive Care Services*). The Core Standards are embedded in GPICS, and they also include descriptions of aspects of the service along with recommendations. Over time we hope to firstly develop the evidence base, if possible, for these recommendations and then progressively see the recommendations move to standards. This is an exciting piece of work and thanks go to Simon Baudouin and Gary Masterson who are leading this for the Faculty and Society respectively.

So to the continuing and important saga of raising chickens, those of you following this with interest (!) may remember that over the last two years out of 17 eggs hatched, we have had 16 boys and one girl. So not to be defeated more eggs into the incubator this spring and five hatched: one girl and four boys. What are we doing wrong? The joys of *coq au vin* and tandoori chicken aside I really would like some more hens, mine are getting older. The boys are very handsome but they fight so we cannot keep them. Statisticians out there, how likely is it to get 20 out of 22 boys? Suggestions gratefully received and in the meantime there are more eggs in the incubator. I'll keep you posted!

Faculty Calendar 2014

September			
	09	MEETING:	FICM/ICS Joint Standards Committee
	29	MEETING:	FICM Recruitment Sub-Committee
	30	MEETING:	FICM Training & Assessment Committee
	30	MEETING:	FICM RA meeting
October			
	23	MEETING:	FICM Board Meeting
November			
	10	MEETING:	FICM Recruitment Sub-Committee
	11	MEETING:	FICM Training & Assessment Committee
December			
	05	MEETING:	FICM/ICS Joint Standards Committee

FICM ePortfolio: What do I need to know?

Dr Louie Plenderleith
ePortfolio Lead

The Intensive Care Medicine ePortfolio is now live via www.nhseportfolios.org (with some areas still under development). This means that most Fellows and trainees will now have some engagement with the ePortfolio. This article attempts to answer some questions about getting involved.

Who will use ePortfolio?

- Trainees
- Supervisors
- Assessors (anyone who completes a WPBA)
- Administrators

Trainees

Trainee access to the ePortfolio will be limited to ICM CCT Trainees on the new programme registered with the Faculty. All such trainees are encouraged to use the ePortfolio. Currently use is optional but it will be mandatory for:

- Trainees who start ICM CCT training on or after August 2014
- Current trainees when they move to their next Stage of training

Some trainees have extensive paper-based portfolios and have almost completed Stage 1. We do not expect such trainees to move everything to ePortfolio. However as any forms from the ePortfolio can be printed such trainees are encouraged to use the ePortfolio for at least new WPBAs and Educational Agreements from now on.

Will dual CCTs trainees need two portfolios?

Trainees undertaking ICM in conjunction with a partner specialty will be obliged to maintain two separate portfolios, one for each specialty. This is because two separate ePortfolio systems are not designed to interact directly with each other. This is true even for two portfolios which are designed and built on the NES framework; it is equally the case for the anaesthetic ePortfolio which was designed and bespoke built for the RCoA by an external provider.

The Faculty recognises that this is not an ideal situation, and steps have been taken to make the transfer of information between two systems as easy as possible. Trainees may output (in PDF format) an assessment from their partner specialty portfolio and upload it to the ICM portfolio; this can then be 'tagged' within the system both to identify which kind of assessment it is (e.g. DOPS, CEX, Professional Activity, etc) and also to which ICM curriculum competencies it applies.

Can Joint CCT trainees use the ePortfolio?

As the ePortfolio supports only the 2011 curriculum it is unfortunately not suitable for Joint CCT trainees.

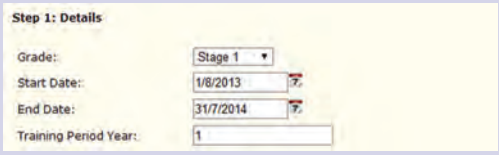
Supervisors

The term 'Supervisors' relates to trainers who are responsible for overall supervision of trainees during a placement or a period of time and are responsible for completing either Educational Supervisor's Reports or Educational Agreements. Trainers who oversee trainees on a day-to-day basis or who only complete WPBAs are *not* 'Supervisors' for this purpose – they are 'Assessors' (see below).

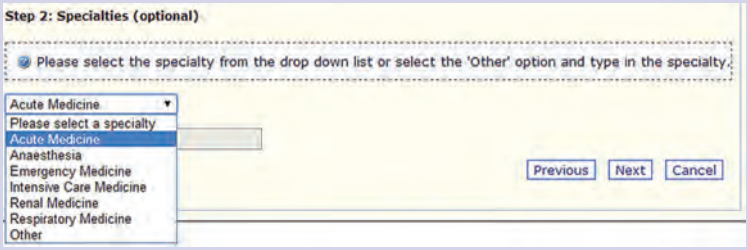
Roles that fall under the category of 'Supervisor' include Educational Supervisors, Faculty Tutors, Regional Advisors and Training Programme Directors. Some users may well hold more than one 'role' within the system. When searching for trainees, the results will depend on the role of the user: an Educational Supervisor will be able to see all the trainees they are supervising; a Faculty Tutor all the trainees in their hospital, and a Regional Advisor all the trainees within their region.

As Supervisors are required to sign off documents, all Supervisors need to be able to access and use the ePortfolio from now. Faculty Administrators have added all Regional Advisors and Faculty Tutors to the system; Deanery Administrators are adding local Educational Supervisors and allocating these roles, as inevitably there is more local knowledge and awareness of who holds these positions in the units.

Managing Posts on ePortfolio

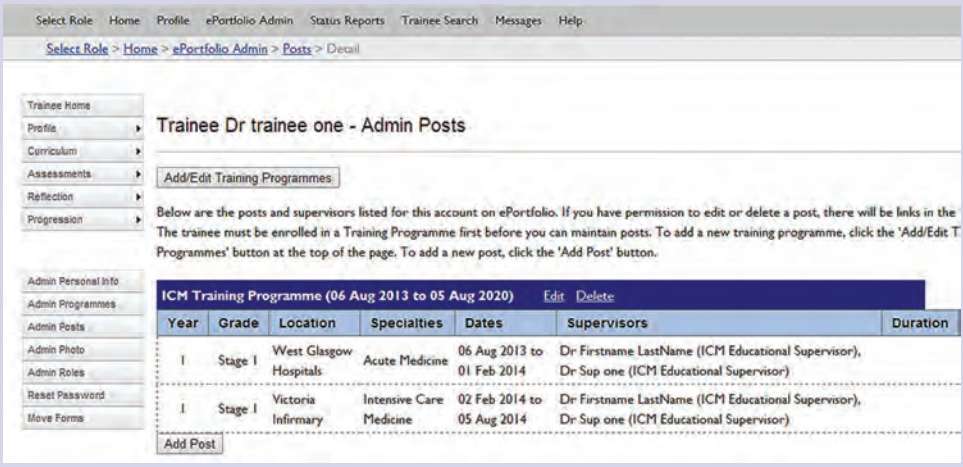


Left: *Drop down screen for adding the information reflected above. 'Training Period Year' relates to the trainee's year within their current training Stage (identified by 'Grade'). It is important to note that when entering the dates of posts, these dates cannot overlap.*



Left: *Drop down screen for selecting the relevant specialty for each post. Only one specialty can be entered for each post - please note that this is a generic NES screen and 'Specialty' is* ***not*** *optional.*

Step 3 is for an Educational Supervisor to be allocated to the post. These can be searched by name or location but a Supervisor must be added for each post - there can be more than one. Adding a Supervisor here allows the Supervisor to sign forms related to the post. It is suggested that both the Supervisor directly responsible for that post and the Supervisor who has overall responsibility for that trainee are added.



Above: *Completed list of posts; those posts already entered can be edited. Only administrators or the trainee can add or edit posts; it is expected that maintaining posts will be the the individual trainee's responsibility.*

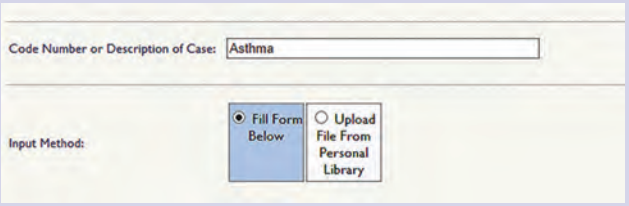
Assessors

These are trainers who complete WPBAs but do not have responsibility for overall supervision. Assessors can complete WPBAs via the NES 'ticketing' system and can view those WPBAs which they have completed, but they cannot initiate WPBAs without a ticket or see assessments which they themselves have not been the ticketed Assessor for. Assessors are set up on the system as part of the process of completing their first ticket. Trainers who have used the Foundation ePortfolio should be familiar with this process.

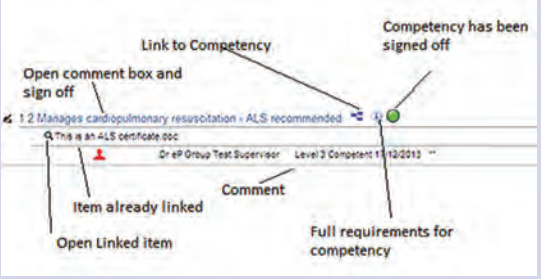
Administrators

Deanery Administrators are responsible for ensuring Supervisors and Deanery Administrators are on the system. Faculty Administraters will be responsible for Regional Advisors and Faculty Tutors and will add trainees to the system once they have registered with the Faulty. Please note that if trainees are not registered with the Faculty then they will not be added to the system. Please encourage any unregistered trainees in your region to register as soon as possible.

Managing the Curriculum and Linking Competencies



Left: *Trainees have the option of initiating an assessment as an electronic form within the ePortfolio itself, or of using a separate assessment from another portfolio which has been uploaded to their personal library. This upload can be 'tagged' as a DOPS, CEX, etc and linked to curriculum competencies.*



Above: *Summary list of assessments completed within a particular training Stage or post. Assessments are identified by type, date and descriptor title.*

Left: *Example of how individual Stage curricula appear to the trainee within the portfolio; possible links are highlighted. The 'green light' for this competency indicates that the trainee has supplied sufficient evidence (at least one satisfactory assessment) and been signed off for this competency at this Stage of training.*

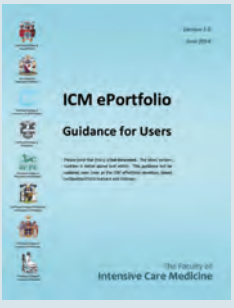
What information is needed to set up a user?

The minimum requirements to be set up on the ePortfolio is name and email address. If you already have a NES username and allocated email address (for example from training in or assessing for Foundation, Emergency Medicine or another physician specialty), you should use these when accessing the ICM ePortfolio. The ICM ePortfolio role will be added to the existing NHS ePortfolio roles. The user then has only one username and password for all NES ePortfolios and can switch between them without logging out of the system (via the 'Choose Role' tab).

The ePortfolios remain separate and forms cannot be moved directly between them, but can be output as a PDF from one and then uploaded to the other. Please note that as the Anaesthesia ePortfolio is not a NES ePortfolio it will always have a separate login.

Training

The structure of the ICM ePortfolio is very similar to other ePortfolios so we expect that most users will understand the principles. However, some training will be required. There have already been three training days in Glasgow, London and Dewsbury and more will be held in future, with further training cascaded out by attendees. A NES training site for ICM is being set up and the details will be circulated.



A full ICM ePortfolio guidance document is now available on the FICM website. This document is 'live' and will be updated regularly as feedback is received and best practice developed.

Please go to www.ficm.ac.uk/training-icm/icm-eportfolio.

The Interface between EM and ICM

Dr John Butler
Board Member

Emergency Medicine (EM) and Intensive Care Medicine (ICM) have obvious clinical links with up to a quarter of admissions to intensive care departments originating directly from emergency departments in the UK. In order to achieve the best possible outcomes for these patients it is essential to have close collaboration between the two individual specialties. Critically ill patients need critical care on arrival to the emergency department and the knowledge, skills and attitudes needed to provide effective treatment to this cohort of patients in the resuscitation room is common to both specialities. The two specialties have much in common in addition to the clinical connections. Both are rapidly evolving and share a common goal of establishing the clinical structures necessary to effectively manage patients with life-threatening illnesses.

The development of the speciality of EM has seen a shift in emphasis from the minor to the major and from orthopaedics to Acute Medicine and Intensive Care Medicine. In the UK, the specialty has moved closer towards the Australian/North American model of Emergency Medicine, by extending the scope of practice to encompass skills and interventions that traditionally were within the remit of general physicians, anaesthetists and intensive care physicians. Interventions, such as the application of non-invasive ventilation, invasive line placement and advanced airway management, are commonly applied by UK emergency physicians in the resuscitation room. The utilisation of many of these clinical skills is now considered to be an essential part of the clinical practice of a modern day emergency physician. Emergency Medicine, as a specialty, has always enjoyed tremendous support from intensive care physicians and many of these developments could not have taken place without the support of ICM both locally and nationally.

Recent modifications to the training of junior doctors have enhanced the interactions at the interface between Emergency Medicine and intensive care. Specialty postgraduate training in both Emergency Medicine and Intensive Care Medicine frequently begins with a 2 year ACCS (Acute Care Common Stem) rotation. Trainees rotate through 6 month blocks of training in the four acute specialities (Emergency Medicine, Acute Medicine, ICM and Anaesthesia) with all the trainees working to a common curriculum regardless of their base speciality.

This unified approach has enabled trainees from all the acute specialties to develop the generic skills, attitudes, and knowledge to effectively manage critically ill patients throughout the hospital. It has also given them an understanding of current clinical practice in the individual specialties and consequently an appreciation of the importance of the interface between the emergency department and intensive care. In addition, there are a small number of Emergency Medicine trainees who wish to pursue dual training with Intensive Care Medicine with a view to joining the small but expanding number of consultants in the UK who are currently working across both departments.

Emergency Medicine and intensive care physicians have collaborated successfully on a number of high profile research studies involving critically ill patients. This includes studies such as 3CPO, which investigated the use of non-invasive ventilation in patients presenting with cardiogenic pulmonary oedema, and Promise, a randomised controlled trial of early goal directed therapy in patients presenting with severe sepsis and septic shock which is nearing completion. These studies are examples of high quality research collaboration and joint innovation.

Interventions and decision making at the Emergency Medicine and Intensive Care Medicine interface can have a significant impact on the outcome of critically ill patients in the resuscitation room. It is therefore essential that both specialities continue to build bridges to strengthen the interface between them in order to deliver timely and optimal care to our patients.

Training and Assessment

Dr Alison Pittard
FICMTAC Chair

This is my first article as Chair of the Training and Assessment Committee. Simon Baudouin is a hard act to follow but I hope to continue to strive for excellence as he has. Since the last publication the Committee has devoted most of its time to updating the curriculum in time to submit to the GMC's Curriculum Advisory Group (CAG) in mid June. Following consultation with stakeholders and posting on the Faculty website, the following is a summary of the major changes:

- Update the design to reflect that the Royal College of Paediatrics and Child Health (RCPCH) is now the eighth trustee college of the FICM.
- Update to reflect the new edition of GMC's *Good Medical Practice*.
- Update to reflect the new core competencies produced by the Academy of Medical Royal Colleges on drugs and alcohol.
- Terminology update to reflect new LETBs instead of deaneries in England.
- **Run-through Emergency Medicine training:** competencies achieved during this training are acceptable for entry into ICM CCT – this needs to be made clear to trainers and trainees, as per the GMC letter of January 2014.
- **Pre-Hospital Emergency Medicine:** PHEM is now a sub-specialty of ICM and open to competitive entry for ICM trainees.
  This update details the requirements for entry to the PHEM programme and directs trainees to the appropriate resources.
- **ICM ePortfolio:** update to reflect that this now exists for use by trainees and trainers.
- **Assessment System:** numerous updates to assessment guidance to reflect feedback from trainers and trainees since v1.0 was published.
  These include:
  - » More explicit explanation of the assessment ethos of the ICM CCT.
  - » Revised guidance on the amount of WPBAs required to measure progression.
  - » *Part II* updated with new outcome paperwork to better assist trainees in recording their progress.
  - » *Part II* updated with revised ARCP Decision Aids and training Stage checklists to make the requirements clearer.
  - » *Part II* Training Progression Grid updated for CAT entry levels to come into line with revision of Annex F of *The CCT in Anaesthetics*, updated following a joint working group between RCoA and FICM.
- **Special Skills Year:** a new *Part V* of the curriculum produced to clarify the competencies and learning objectives for the Special Skills module within Stage 2 ICM. Several possible modules have been produced and will operate based on local capacity and deliverability. Regions are not obliged to run every possible module. It is expected that dual CCTs trainees will spend their SSY training in their partner specialty.
  It is important to note that the SSY was already built into the 2011 curriculum approval – this additional section has been added to provide greater clarity.
- **Equality and Diversity:** updated to reflect the new Equality Act of 2010, which replaces many previously disparate pieces of legislation, to emphasise the need to consider the impact of actions upon the social groups with protected characteristics, and to provide links to further learning resources for trainers and trainees.

We now have nine modules that can be undertaken during the Special Skills Year of the curriculum. This is obviously a completely new section (*Part V*) being submitted to the GMC. Each module has its own competencies mapped to the curriculum and assessment methods which can be used. There is also a generic completion form for the year which can be used to inform the ARCP process. New modules will continue to

be developed such as home ventilation, but will need to be approved by FICMTAC and the GMC. This will occur on an annual basis and therefore anyone wishing to create their own will need to plan ahead. Trainees on a single CCT programme will be able to choose their module from a selection offered by their LETB. If a trainee wishes to undertake a module offered by another LETB they will need to apply for OOPT. Those following a dual CCTs programme will spend the special study year in their partner specialty.

As alluded to above and discussed elsewhere in this issue, the ICM ePortfolio is now online. A big thanks goes to Dr Louie Plenderleith, who has expertly led on this project. Trainees commencing the programme in August will be expected to use it but it is recommended that all trainees start to record their evidence electronically. There have been a number of successful training days around the country and it appears to have been well received. Please inform the Faculty if any problems are encountered.

A very successful examination was held earlier this year. As the exam goes from strength to strength the examining body will need to expand to keep up with demand. We are also in the process of establishing an FICM exam prep course. There are already a couple of extremely successful courses in the South and therefore we intend to focus these in the North of the country. The exact format of these is yet to be decided but the Faculty will ensure that the courses are organised by clinicians who have experience in this area.

At the time of writing the results of the National Training Survey for 2014 were not available. Engagement in this is vital to ensure that our training programme is of the highest quality. The survey contains 14 specialty specific questions:

1. Is there a consultant immediately available on your ICU during daytime hours?
2. Does your ICU have consultants on call whose only daytime commitments are to other units?
3. Have you received sufficient supervision 'out of hours' in your department?
4. Does a consultant attend the morning shift handover?
5. Does a consultant attend the evening shift handover?
6. Are you required to cover non critical care areas (e.g. theatre) when you are covering the ICU?
7. Do your complementary training posts in medicine meet your training needs?
8. Do your complementary training posts in anaesthesia meet your training needs?
9. How frequently are you working on the critical care unit 'overnight'?
10. Please indicate how much you agree or disagree with the following statement: I am confident I have received sufficient training or exposure to paediatric ICM to meet the curriculum outcomes.
11. Please indicate how much you agree or disagree with the following statement: I am confident I have received sufficient training or exposure to cardiac ICM to meet the curriculum outcomes.
12. Please indicate how much you agree or disagree with the following statement: I am confident I have received sufficient training or exposure to neurological ICM to meet the curriculum outcomes.
13. Please indicate how much you agree or disagree with the following statement: The case mix in my general ICM attachments is appropriate to allow me to meet the curriculum outcomes for this level of training.
14. Please indicate how much you agree or disagree with the following statement: The case volume in my general ICM attachments is appropriate to allow me to meet the curriculum outcomes for this level of training.

Survey results will appear on the GMC website and will feed into the FICM Quality Nexus, led by Jonathan Goodall. Other evidence that will be used to assess quality includes data obtained from the workforce census, Regional Advisor reports, QA visits, ePortfolio, examination results and our specialty specific survey. This will provide a holistic view of training at both local and national level.

I would like to thank the committee for accepting me as Simon's successor and for all the time and effort that goes in to the work that we do.

ICM National Recruitment 2014

Dr Tom Gallacher
ICM National Recruitment Lead

For National Recruitment to Intensive Care Medicine in 2014 the total number of posts available for recruitment in England, Wales and Northern Ireland increased to 112 compared with 72 in 2012 and 88 in 2013. I would like to thank Regional Advisors and Training Programme Directors for their efforts in securing the increased training post numbers which in the current economic climate is challenging.

The increase in the numbers of available training posts for Intensive Care Medicine is encouraging. However, the Faculty's current workforce data suggest we are still not meeting the expected future demand for ICM CCT holders. The Centre for Workforce Intelligence (CfWI) has recently completed a review of ICM requirements and is expected to report later in the year.

2014 Interviews and Online Recruitment Portal

The venue this year was The Hawthorns, West Bromwich Albion's football ground, and to maximise the number of applicants to whom we could offer an interview we increased the number of interview days from two to three. This meant with 80 interview slots available per day we had the capacity to invite 240 shortlisted candidates for interview. The logistics of such a process are immensely complicated and I would like to thank our colleagues at Health Education West Midlands for their excellent support. I would also like to thank everyone who gave up their time to come to Birmingham to interview and I hope to see you all again in 2015.

This year, for the first time, we had a dedicated ICM Recruitment Portal with all the necessary application resources accessed from a single website. We hope this was an improvement on previous years and made the application process as straightforward as possible for applicants.

Regional Information for Applicants

We recognised that information regarding Intensive Care Medicine regional training programmes and the training opportunities offered by specific Trusts in their roles as local education providers was not readily available. To address this Regional Advisors were asked to submit an overview of their regional training programme and Faculty Tutors to submit a detailed description of their own Trust's training opportunities. This information can now be accessed from the Faculty's website at www.ficm.ac.uk/national-recruitment-icm/regional-information.

The available information includes contact details, unit structure, consultants' special interests, research opportunities and shift patterns amongst others. It is hoped that trainees considering applying to Intensive Care Medicine will now have an informed choice as to which regions they may wish to apply. Information is now available for most Trusts who provide Intensive Care Medicine training, however, where this is absent please contact the Regional Advisor or Faculty Tutor directly for information.

For the 2014 Recruitment Round, all specialties were asked to provide feedback from the interview process to all trainees as opposed to only those who requested it. A national template for this feedback, common to all specialties, was used and this included the candidates overall score, their ranking and the minimum score required to be deemed appointable.

Background	Posts Offered	Total Posts Available
CAT or ACCS (Anaesthetics)	81 (75%)	**112** Fill rate: **96.4%**
CMT or ACCS (Acute Medicine)	24 (22.2%)	
ACCS (Emergency Medicine)	3 (2.8%)	
Total	**108**	

Upper Limit for ICM Recruitment

The following information is very important and I would be very grateful if Fellows could make any trainees intending to apply to an ICM dual CCTs programme aware of it. We have now agreed with our partner colleges to introduce an upper limit of seniority to be appointed to a dual training programme – this will be the end of ST5. In order that no-one is excluded from applying as a result of the introduction of this requirement we have deferred its implementation until the 2016 recruitment round.

Since this will be implemented for 2016 it is vital that any trainee who will have commenced ST6 by August 2016 understands that their final opportunity to apply for a dual CCTs programme will be the 2015 recruitment round. To emphasise and for clarity, a trainee may not be appointed to a second training programme after the 2015 recruitment round with a view to undertaking a dual ICM programme if they have progressed into ST6 by the time of commencement of their second CCT training programme i.e. August 2016.

Inviting Fellows to submit interview questions

Having now completed three rounds of recruitment, as part of our quality assurance, we will undertake some statistical analysis of our questions and make any necessary changes if required. We will also require an expansion of the current question bank and it is our intention to invite Fellows to submit questions which they feel may be appropriate and if suitable Danny Bryden's group who are responsible for the content of the interview material will then assess and edit these before adding to our question bank.

Trainee Intentions

Information gathered from our interview debriefing showed that 58% of candidates came with a partner specialty NTN and 42% came directly from core training. The overall pattern of future training intentions shows a pattern consistent with 2013 where 64% intend to undertake a dual programme with anaesthesia, 25% with medicine, 3% with Emergency Medicine and 8% intend to pursue an ICM single CCT.

HEE West Midlands staff were on hand throughout the day to ensure that candidates had brought the correct materials to their interview.

One of the stations used in the interview process. Candidates faced five interview stations in total; three manned stations (with two assessors per station) and two OSCE stations.

FFICM Examination

Prof Nigel Webster
Chair of FFICM Examiners

Background

The third sitting of the Fellowship of the Faculty of Intensive Care Medicine Final examination took place in January and April 2014. The bank of questions has now been considerably extended and evaluated in line with the methodology required by the GMC. The examiners are confident that this examination represents a testing but fair marker of training in Intensive Care Medicine comparable with anything that is available elsewhere in the world.

From a total of 46 examiners from the Faculty's Court of Examiners, 32 attended the OSCE/SOE examinations held on 14 and 15 April 2014 and carried out examining, auditing and question writing duties over the two days of the examination.

The FFICM MCQ

The MCQ was held in January and 78 candidates sat the exam, of whom 71 passed (91.02%). The MCQ pass mark was 72.44% which was reached by Angoff referencing, which was carried out by a dedicated MCQ Angoff group. The Angoff score was further adjusted by the use of Standard Error of Measurement to allow for the borderline candidates – reliability was 0.76 through KR20.

The FFICM OSCE/SOE

In order to assist with the standard setting of the SOE exam, Angoff and Ebel methods were carried out by the SOE Core Group two weeks before the exam using the questions set. The linear regression and Hofstee calculations were plotted against data post-exam. All statistical analysis was made available and was discussed by the Court of Examiners and the final pass mark of 26 was again reached through a combination of statistical analysis and expert judgement after consideration of what would be expected of borderline candidates. This pass mark matched the score obtained from the Hofstee calculation. It is also noticeable that all candidates who failed received a low overall global score with the majority receiving scores below the minimally competent.

Therefore 56/74 (75.6%) passed the SOE component. Of the 56 who passed 23 candidates achieved maximum marks of 32, which is an indication of the high calibre of candidate attending this exam.

All OSCE questions were Angoff standard set by the OSCE working party in advance and cumulative pass marks of 158/240, 154/240, 156/240 and 153/240 were reached for the four questions sets used across both days of the exam. The Court of Examiners looked at various methods of supportive statistical analysis of the exam data post-examination but none of the findings were conclusive. It was therefore agreed that the pass marks reached by the working party were set in good faith using the approved Angoff procedures and therefore should stand. Out of 71 candidates 54 (76%) passed the OSCE component, once again a reflection of the high calibre of the candidate cohort. Overall, in April 2014 there were 48/76 candidates (63.2%) who passed all parts of the FFICM examination.

General comments

The range of topics covered on both exam days was considerable. The following list is not comprehensive but does give a flavour of the coverage:

- Stress ulceration
- Intracranial pressure
- Never events on ICU
- Traumatic aortic injury
- Guillian Barre syndrome
- Delirium
- Serotonin syndrome
- Staffing the ICU
- Organ donation
- Endocrine physiology

As in previous sittings the high pass rate confirms that the questions were generally handled well.

It was again apparent that the weakest OSCE examination stations were those involving ECG and X-ray interpretation. We will continue including such stations in future examinations in an attempt to improve standards in these areas. It is again worth stressing that the candidates need to convince the examiner that they are aware of the logical approach to reading an ECG or X-ray investigation. Candidates should assume that the examiners will require a thorough and systematic interpretation of the ECG and X-ray unless told otherwise. Candidates often simply jump to what they consider to be obvious abnormalities and miss things as a result. One particular OSCE station was also generally answered poorly – the issues around refeeding syndrome.

I would like to thank the Examinations Department of the Royal College of Anaesthetists without whose considerable help and expertise we would not have been able to conduct the examination so smoothly. At this sitting of the examination we had a total of ten visitors who observed the examination (including David Hepworth from the College's Patient Liaison Group) and all were impressed with the examination especially the well-oiled conduct of the SOEs and OSCEs and the face validity of the communication stations in particular.

I would also like to thank Andrew Cohen (Vice Chair), the chairs of the various parts of the exam – Mike Clapham (Audit), Gary Mills ably assisted by Giles Morgan at short notice (SOE), Jeremy Cordingly (OSCE) and Jeremy Bewley (MCQ) – as well as all of the Court of Examiners – for all their hard work in setting this examination. Due to various reasons that have since been resolved, at this sitting we had fewer examiners available than usual and we had the very capable assistance of several Regional Advisors in ICM who acted as floor managers during the examination. I would like to acknowledge their help because without them the examination could not have gone ahead in the same format.

Examination Calendar August 2014 - July 2015

	FICM MCQ Examination		FICM OSCE/SOE Examination	
Applications and fees not accepted before		Mon 20 Oct 2014	Thurs 10 July 2014	Thurs 8 Jan 2015
Closing date for Exam applications		Thurs 4 Dec 2014	Thurs 4 Sept 2014	Thurs 19 Feb 2015
Examination Date		**Tues 13 Jan 2015**	**Tues/Weds 7-8 Oct 2014**	**Tues/Weds 24-25 March 2015**
Examination Fees		**£465**	*Both* **£560** *OSCE* **£310** *SOE* **£280**	*Both* **£560** *OSCE* **£310** *SOE* **£280**

Examination Calendar July 2015 - July 2016

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

Trainee Update

Dr Mike McAlindon
FICM Trainee Representative

Once again welcome to our new FICM Trainee Members! Our numbers are now in excess of 350 and continue to grow. Congratulations to all those with recent success in the ICM CCT recruitment process. This year has seen an expansion in the number of training posts available (112) in keeping with projections for an increasing demand in ICM Consultants. Congratulations also to those successful in the recent Final FFICM examination.

You will have received the first edition of *Trainee Eye* in March. This bi-annual e-newsletter will interspace the summer and winter editions of *Critical Eye* and will allow us to keep you up to date with important news and events. Make sure it doesn't end up in your spam folder! The FICM is very open to suggestions and contributions for future content.

We are also continuing to update the trainee section of the website with relevant information and links. You may have noticed the 'Unit Briefs' of ICUs in your Deanery (sorry; Local Education and Training Board for those in England!) which may help to guide your requests for training rotations. There will soon be a selection of biographies from trainees from all the combinations of ICM training pathways so you can see how the other half live! These will also be of use to current single CCT trainees or more junior colleagues who may be considering their options for training in ICM.

FFICM examination resources are growing and please look out for the FICM's own preparation course in the near future. Of note, Trainee Members can now take advantage of a half price subscription to *Intensive Care Monitor* and a link to their new website can be found in the trainee section of the FICM website. This is a useful resource for the busy ICM trainee and provides a helpful summary of relevant ICM literature with critical appraisal of evidence. Very handy for answering those tricky 'evidence-base' questions on the ward round.

Feedback on the CCT programme continues via the GMC survey. Regional Advisors, Training Programme Directors and Faculty Tutors are all listening to your views to help improve training. Trainees have also been involved in the development of the new *Core Standards for Intensive Care Units* and *Guidelines for the Provision of Intensive Care Services* documents to ensure high quality training and working conditions for ICM trainees.

The ePortfolio is coming soon to a Faculty Tutor near you. General release for single/dual ICM CCT trainees will be underway by the time you read this. Joint ICM CCT trainees will continue on a paper-based system.

It is my pleasure to introduce Dr David Garry as Trainee Representative Elect. He will fulfil this role until he assumes the full representative role at the end of October when my term comes to an end. The candidate with the next highest number of votes (a very close run thing) was Dr Ian Kerslake who will then replace David as Trainee Representative Elect. We have chosen to overlap the two year office to better serve the needs of the Faculty and its trainees in its ever expanding role. The new team will continue to be advocates for you at the highest level and will be available for help, advice and support.

This will be my final contribution to *Critical Eye* as Trainee Representative and may I take this opportunity to thank you all and the Faculty for your support during my tenure. I have found the role hugely informative and enjoyable. I hope that you have found my updates and email correspondence useful and I would encourage you to make use of your new representatives in the future. Until then please continue to get in touch with me at mikemcalindon@doctors.org.uk as required. Many thanks.

FICM Trainee Representatives Election 2014

The FICM ran an election in April 2014 to elect two new Trainee Representatives. The Board extends its congratulations to the successful candidates and its thanks to the other candidates who stood. The strong field is evidence of the high quality of ICM trainees and their enthusiasm for the specialty.

Candidate	Votes
GARRY, David Andrew	31
KERSLAKE, Ian	30
FUDGE, Timothy	25
MEYER, Joel	25
CAIRNS, Thomas	22
GUIDIBANDE, Sandeep Raghavendra	12

Dr David Garry

FICM Trainee Representative Elect

For the first time since the Faculty was formed in 2010 intensive care trainees have two voices on the Faculty Board. I feel extremely privileged to join Mike who has been flying solo as the FICM Trainee Representative. It is a busy role and he has clearly done a fantastic job. One thing that becomes quickly apparent when attending a Faculty Board Meeting is the sheer amount of work that goes on behind the scenes to drive and maintain the high standards of the Faculty. It is therefore with great pleasure that I assume the role of Trainee Representative Elect to give Mike a helping hand. It is a very exciting time to be an ICM Trainee. The current training structure allows people from a variety of different specialties and with a range of special interests and skills to obtain specialist registration in ICM; looking forward, the future of the profession is looking ever brighter!

David Garry is a Specialty Registrar (ST6) in anaesthesia and intensive care in Oxford, now part of Health Education Thames Valley. He graduated from Cambridge in 2003 and moved to Oxford after completing his House Officer year. He has a particular interest in echocardiography in the critically ill, and is currently completing a fellowship that will result in British Society of Echocardiography accreditation in transthoracic echocardiography. He also has a strong interest in teaching and training. He is a regular member on FICE courses and currently leads weekly bedside FICE teaching for the Oxford Deanery ICM trainees. He has been an ALS Instructor for the last seven years and also teaches on a regional simulation based transfer training course. He was previously the ICM Trainee Representative and ICS Trainee Linkman for the Oxford Deanery (2012-2013), and hopes to build on this role as the FICM Trainee Representative Elect. He spends most of his spare time trying to keep pace with his two children – his five year old already gives him a good run for his money on his bicycle, and his two year old is not far behind.

Regional Advisor Update

Dr Chris Thorpe
Lead RA in ICM

Is it really a good thing to treat the two imposters of triumph and disaster just the same? Rudyard Kipling was of course talking about individual strength but we seem to lurch between the two extremes at all levels of the NHS at the moment. On a personal level I fail miserably at this test – give me triumph any time – but there is an element of truth in the poem. You have to be able to ride out the downturns and keep moving forward. There is however a potential problem in trying to maintain your equanimity and that is inertia: the growing feeling that perhaps you can't make a difference and that contribution is pointless can lead to disengaging with the ever-changing NHS. There are opportunities to influence change however and the important thing is to pick the area in which you want to expend your energies, and understand where to apply pressure.

One of the more obvious ways to try and influence the system is to attend likely looking meetings. Meetings can be a mixed bag – Chairman Mao used regular meetings as a way of controlling the masses. He had no intention of altering his plans but the meetings served to occupy the people and perhaps give the illusion of an element of control in their lives. Of course we do not live in a totalitarian society of this type, but I can't help thinking of Mao's strategy when I see the sheer volume of meetings that pop up in my inbox. We therefore need to concentrate hard on what we can realistically achieve. For many of us, we can make a difference locally but struggle to have any influence on the wider NHS.

The FICM has direct contact with many of the groups that are enmeshed within the NHS hierarchy, such as the Department of Health and the GMC. Directly influencing these behemoths is very difficult as an individual but as a group we can have a coordinated approach that stands a good chance of influencing policy.

The FICM Board needs ammunition however – the delivery of training and service on the shop floor varies considerable between hospitals, regions and countries and the Faculty Board cannot effectively represent the whole of the UK without information from the various parts. The need for up to date and relevant information explains the variety of forms and surveys that come through. Examples would include the workforce survey – to argue our case for increasing the number of Intensivists needed we need the baseline information – and the FICM trainee survey which drills down to the teaching within individual attachments.

Another method of communication is via the 'education pipeline', where information flows from trainees and consultants to Tutors, and from here to the RA. The RA fills in a report every year based on Tutors' comments and their own perceptions, and outlines the successes and weaknesses within their region. Important and common issues are identified and these are then discussed further at the RA meeting in autumn, where a priority list is generated. This is then presented to the FICMTAC where an element of realism in injected and a plan of attack discussed. From there the points are presented to the FICM Board. The following actions depend on the points raised – for example two of the points last year were concern about the competency sign-offs and the variation of SPA time within job descriptions. Competency sign-off concerns were addressed 'in house' and then presented to the GMC. The SPA time was discussed at Faculty Board level. This thorny issue is not easily solved, as there is a variation between Trusts about how they value consultant's time and this boils down, as usual, to cold hard cash. The Faculty viewpoint is that 1.5 sessions is the minimum required to revalidate, and that extra time is needed for additional roles, including teaching and training. Job planning should act as the cornerstone to identify the amount of extra time needed, however in this time of financial constraint enforcing this is an ongoing battle in some Trusts.

The FICM is set up with a system that can distill our concerns into action points to take to those in higher office. So do make sure that your Faculty Tutor or RA knows about the strengths and weaknesses in your department, and in this way feed the system with the fuel it needs!

Spotlight on Bonnie Scotland

Dr Liz Wilson
Lead RA for Scotland

At a time when "ye'll take the high road and I'll take the low road" could echo sentiments (from some parties!) that Scotland's path is diverging from other parts of the UK, it is important to note in terms of ICM training such differences are small, yet worthy of clarification. All regions within the UK are currently facing the same challenge; delivering the complexities of dual ICM CCT programmes without any additional funding. The curriculum, assessment process and training programme are all identical in Scotland. What is currently unique is the recruitment process.

UK national recruitment advocates a policy of 'plurality of access' which gives applicants an equal opportunity to be appointed to an ICM training programme, regardless of core or partner specialty. Recruitment is stepped, with appointment to each specialty programme in sequential years. This process does not take into account workforce planning and assumes increased critical care demand will result in the appointment of more fulltime intensivists and those dually accredited in specialties, other than traditionally, anaesthetics. The Scottish Government took the opposite stance and mandated that recruitment reflect the current workforce. Scotland has diverse geographical requirements, with large ICUs in the major cities and smaller units elsewhere, which are reliant on anaesthetics cross-cover. Consequently for the last two recruitment rounds, the majority of ICM training posts have been reserved for those wishing to dual train with anaesthetics.

Dismissing plurality of access meant that Scotland could not take part in UK recruitment. Details of the Scottish recruitment process can be found on the Scottish Medical Training (SMT) website, www.scotmt.scot.nhs.uk. For those intending to dual train with anaesthetics, there is the benefit of being appointed to both training programmes in the one recruitment round. Two applications are required: one for ICM training through the SMT website *and* one for anaesthetics through national recruitment. Appointment to dual ICM training programes for trainees in other partner specialties occurs through SMT, but applicants must already have a NTN. The Scottish recruitment process for 2015 may change, with partial or full integration into UK national ICM recruitment. Further details will be available towards the end of the year.

Thus far we have been unable to offer a single CCT in ICM. We are hopeful this will change soon, particularly as this is the preferred option for academic training and Scotland has a strong record of producing high calibre academic trainees. Recently in South East Scotland alone, three ICM trainees have completed MDs, the region has produced the Gold Medal winner at three out of the last five State of the Art meetings and a further three trainees are in Wellcome Trust supported clinical academic training posts with three years guaranteed funding towards a PhD.

Scotland's intensive care community is active and thriving with most of the verve centred around the Scottish Intensive Care Society (SICS), www.scottishintensivecare.org.uk. This organisation incorporates several highly respected groups including the renowned audit group, the Scottish Intensive Care Society Audit Group (SICSAG), which maintains the national database. This holds detailed information on patients in all the general ICUs and combined ICU/High Dependency Units (HDU) throughout Scotland and acts as a focus for quality improvement, service planning and research. The Scottish Critical Care Trials Group, Evidence Based Medicine and Education and Training groups cover other interest areas. Each January the SICS Annual Scientific Meeting attracts speakers and delegates from all over the world. Wes Ely will be the next keynote speaker and with the conference being held in the Old Course Hotel in St. Andrews, the venue hasn't done attendance any harm either!

Scotland is a beautiful place to train, live and work and has a long history of excellence in the field of medicine. We hope that any concerns harboured about joining us in Scotland, will be dispelled after 18 September.

Commissioning of Intensive Care

Dr Bob Winter
National Clinical Director for Critical Care and Emergency Preparedness

Dr Jane Eddleston
Chair of NHS England's Adult Critical Care Clinical Reference Group

Since the latest NHS reorganisation the commissioning landscape has altered significantly. The two bodies responsible for commissioning are NHS England and the Clinical Commissioning Groups (CCGs). CCGs are effectively consortia of GPs within a geographical patch. They can 'buy in' commissioning support from either the Commissioning Support Units or the independent sector. NHS England (formerly the NHS Commissioning Board) is responsible for commissioning specialist services and also directly commissioning general practice. The CCGs are responsible for commissioning everything else based on their 'intimate knowledge' of their population and their clinical priorities. CCGs cannot commission Primary Care as that would mean commissioning from themselves.

Where this gets interesting for intensive care is that both organisations commission the service. NHS England commission intensive care where it forms part of another specialised service such as Major Trauma, and Vascular Surgery; CCGs commission the rest. The Manual of Specialist services detail which service is Specialist and which is not[1]. Each specialist service has a Clinical Reference Group (CRG). There are 75 CRGs. These CRGs are grouped into five Domains of care[2].

Adult Critical Care resides in the Trauma Programme of Care. Clinical members for the CRG are drawn from the 12 senate areas in England and are voluntary appointments for three years. Up to four patient and carer members and up to four professional/ training organisations also send representatives. For Adult Intensive Care the four organisations are, the Faculty of Intensive Care Medicine (FICM), the Intensive Care Society (ICS), the British Association of Critical Care Nurses (BACCN) and the Critical Care National Network Nurse Leads Forum (CC3N). The accountable commissioner holds the managerial accountability for the work of the CRG, thereby linking the commissioning of our services to the clinical community, our professional bodies and our patient and carer organisations. This should ensure appropriate adoption of clinical standards within the commissioning of our service, and permit widespread early adoption of initiatives for the speciality to enhance quality, improve outcomes for patients and work collaboratively with other CRGs which have a direct relationship with Intensive Care. This should facilitate joint working to address cross-boundary/speciality issues.

CRGs have no budget, so all expenses are paid by the members employing organisations, except for the patient/carer representatives whose expenses are paid by NHS England.

To date the main work of our CRG has been to produce a service specification (D16), for the intensive care element of clinical services commissioned by NHS England's Specialist Commissioning teams. This service specification sits as an appendix to all other service specifications which NHS England commission and detail the clinical standards for Intensive Care Medicine (ICM), the components of a National Dashboard, the initiatives proposed for Commissioning Quality (CQUIN) and Productivity (QIPP) and the co-location relationships for services which work alongside ICM. To date the service specification has been discussed informally with professional bodies and their membership and will shortly be subjected to a formal 12 week public consultation. At this point the specification will be available on NHS England's website. This process is standard for any specification. In preparation for formal adoption discussions should be ongoing between NHS England's Local Area Teams (LAT) and individual Trusts on their current compliance with the draft specification. Where there are deviations from

the specification Trusts will need to seek a derogation from individual standard(s) and provide a clear action plan demonstrating how the standard(s) will ultimately be met. Such derogations need to be time limited. Critical Care Operational Delivery Networks (ODNs) will play an active role in this process and will ultimately also be involved in conducting peer reviews of individual Trusts' intensive care services to provide commissioners with the assurances of the quality of care provided on individual sites.

Formal adoption of the D16 specification is anticipated for October 2014. The term ICM incorporates both intensive care and high dependency care and the specification will apply to all ICM sites irrespective of whether the service is a single specialty, for example Cardiothoracic Surgery or Neurosurgery, or a general service incorporating a broad case mix of patients.

Currently approximately 10% of all discharges back to a ward are delayed by greater than 24 hours. This creates significant operational challenges for ICM consultants and frequently leads to delays in unplanned admission or the cancellation of high risk elective surgery for other patients. Neither scenario is acceptable. The CRG has therefore chosen delayed discharges of greater than 24 hours as the QIPP for our speciality in the hope that organisations will finally address the operational difficulties which many sites have in the discharge of their patients back to a ward after recovery from critical illness.

As most units will be providing intensive care for a mixture of patients whose treatment will be commissioned by either NHS England as part of a specialised stay or their CCG, a common service specification is required. NHS England does not have the power to mandate to CCGs but clearly there is no logic to having patients in adjacent beds whose care is commissioned to different service specifications.

The CCGs do not have a single point of contact but there does exist a Commissioning Assembly which acts as a forum. The service specification was therefore sent to the Rapid Response Group of the Commissioning Assembly for comment. They were supportive, making D16 the first service specification intended to be used across both specialised and general commissioning. The advantage of the service specification is that it applies to all intensive care commissioned by the NHS. Independent sector providers who wish to compete for NHS work will, in the future, be held to the same service specification as NHS Hospitals. This could include membership of their local ODN.

The payment structure for critical care remains the Critical Care Minimum Dataset[3] (CCMDS) derived Healthcare Resource Groups (HRGs). The CCMDS has been mandated for use in Adult Critical Care since 2006. This dataset categorises patient related activity within Adult Critical Care into one of seven HRGs[4]. The HRGs reflect the total number of organs supported throughout an individual patient's clinical episode within Critical Care. Trusts then quantify their actual costs per HRG through the annual reference cost submission. Payment for the ICM stay is in accordance with the highest HRG multiplied by the total length of stay in bed days for individual patient episodes in either intensive care or high dependency care. This payment is in addition to the dominant HRG for the overall hospital stay. Patients can have more than one episode in critical care.

The first Critical Care HRG reference cost submission occurred in 2008/2009. At that time the total expenditure for Adult Critical Care in England, Wales and Northern Ireland was approximately £1 billion and covered approximately 3400 Adult Critical Care beds. The current model is based on individual HRG tariffs (local pricing) and does require Trusts to have robust processes in place to capture expenditure and assign costs based on the type of organ support provided. Such a model carries a financial risk to Trusts, and clinician involvement in deriving reference costs for such a high cost relative low volume clinical service is essential. Some costs are excluded from reference cost submission and these are detailed in DH Reference Cost Submission Guidance[5]. Critical care is a specialty with a significant use of high cost products.

References

1. Specialised Services. http://www.england.nhs.uk/ourwork/commissioning/spec-services/spec-comm-resources/
2. National Programmes of Care and Clinical Reference Groups. http://www.england.nhs.uk.
3. Critical Care Minimum Dataset. www.isb.nhs.uk/documents/isb-0153/amd-81-2010/0153812010spec.pdf
4. NHS Information Centre. www.isb.nhs.uk. HRG4 LP12-13; Chapter Summary Adult Critical Care 12/13
5. PbR exclusions guidance. www.monitor.gov.uk/nt (see document 7b)

UK Critical Care Nursing Alliance

Andrea Berry
Chair UK Critical Care Nursing Alliance

In March 2013 an independent review of critical care organisations resulted in the publication of *Collaborating for Quality*[1]. The review was commissioned to explore the working relationship between professionals and the effect these relationships had on the care of critically ill patients and their families. The review body recognised there were a number of professional nursing organisations representing critical care that could benefit from closer working and collaboration.

As a result of the review the UK Critical Care Nursing Alliance (UKCCNA) was established in July 2013. The alliance brings together the British Association of Critical Care Nurses (BACCN), the Critical Care National Network Nurse Lead Forum (CC3N), nurse representation from the Intensive Care Society Nurses and Allied Health Professionals Committee (NAHP), the National Outreach Forum (NOrF) and the Royal College of Nursing Critical Care & In-Flight Forum, Military Critical Care Nurses plus other co-opted stakeholders, in order to facilitate joint working.

The UKCCNA provides a more formal structure to facilitate partnership working amongst the professional critical care nursing organisations throughout the United Kingdom. The initial focus of the alliance has been to develop a shared understanding of issues impacting on critical care nursing and to consider future needs of the service at a national and local level.

The aim of the alliance is to provide a shared strategy to assist in the development of a nursing workforce who are equipped to provide high quality care. There is also a role to actively inform and contribute to the broader multi-professional quality agenda for critical care services across the UK. This multi-professional working is being achieved through representation and membership sitting on national strategic forums including the Critical Care Leadership Forum and the Clinical Reference Group for Adult Critical Care.

To achieve its aims the alliance has identified four key workstreams: Training & Education; Workforce; Standard setting and Research. A considerable amount of work has already been achieved in an attempt to provide a standardised approach to critical care nurse education. This has been realised by producing national standards describing the content of post registration critical care nurse education programmes of study[2] and producing a national competency framework for critical care nurses[3]. These outputs were created through collaborative working across the alliance members. In September 2013 the UKCCNA were approached to share this work with Health Education England as an example of good practice.

The UKCCNA has also produce best practice critical care nurse staffing standards which have been incorporated in to the intensive care *Core Standards*[4] document and informed the Adult Critical Care Service Specification[5]. This work has posed questions relating to the future critical care nursing workforce and the UKCCNA acknowledge a need to explore the possibility of undertaking research to assist with identifying workforce activity and acuity tools. Producing a solution to safe and reactive nurse staffing should assist in providing a more robust and responsive approach to workforce decision making in the future.

The UKCCNA meets quarterly and in its first 12 months has established the foundations for fruitful collaborative working across the critical care nursing organisations. As a fledgling group we look forward to the future with enthusiasm and excitement.

References

1. CfQ. *Collaborating for Quality*, 2013
2. CC3N. *National Education Standards for Critical Care Nurses*, 2012
3. CC3N. *National Competency Framework for Critical Care Nurses*, 2013
4. FICM/ICS. *Core Standards for Intensive Care Units*, 2013
5. NHS England. D16 Adult Critical Care Service Specification – pre-consultation draft, 2014

Critical Care National Network Nurse Leads

The Critical Care National Network Nurse Lead Forum (CC3N) has been a functioning forum for Critical Care Network Nurse Leads to meet and communicate collectively since 2003.

Some of the broad functions of the group are to:

- Provide a strategic vision and generate consensus opinion relating to critical care nursing issues and the future delivery of critical care linked to national strategies.
- To offer clinical expertise by formulating recommendations/consensus decisions statements that impact upon critical care nursing issues.
- To provide nursing leadership whereby organisations, professional bodies and/or others can consult and/or gain a clinical opinion regarding critical care services in England.
- To influence, contribute to and review strategies and policies that impact upon nursing issues as appropriate and provide a timely response.

Over the past few years CC3N has instigated and facilitated collaborative working groups to produce: *CC3N National Standards for Critical Care Nurse Education* (2012); *CC3N National Competency Framework for Adult Critical Care Nurse Education* (2013) and *CC3N Quality Assurance Standards to Underpin Student Placements in Critical Care Units During Post Registration Critical Care Educational Programmes* (2014). CC3N has also had the opportunity to contribute to other national documents such as *BACCN Standards for Nurse Staffing in Critical Care* (2010) and has used its infrastructure to gather comments or inform on other national documents out for consultation or implementation such as NICE CG 83.

CC3N is represented, through some of its members, on many of these professional organisations and is actively involved as a participative member on national forums such as the CRG, Critical Care Leadership Forum and is a key stakeholder in the newly formed UK Critical Care Nursing Alliance (UKCCNA).

Angela Himsworth, CC3N Chair

The National Outreach Forum (NOrF)

NOrF was founded in 2004 by a group of enthusiastic professionals involved with the first Critical Care Outreach Teams. Since then it has evolved into a highly successful multi-professional interest group that seeks to promote excellence in the care of acutely unwell patients.

NOrF provides a multi professional forum for Critical Care Outreach Service providers and users across the country who strive to optimise the quality and safety of the acutely unwell patient's treatment, care and experience. NOrF supports the Dept of Health objectives for critical and acute care, and to ensure there is a strategic approach to delivery of Critical Care Outreach Services nationally, which reflects that of the National Strategy and those of the Critical Care Networks and professional colleges.

NOrF defines Comprehensive Critical Care Outreach (3CO) as "a multidisciplinary organisational approach to ensure safe, equitable and quality care for all acutely unwell, critically ill and recovering patients irrespective of location or pathway". Critical Care Outreach Teams have become increasingly important in the prevention, detection and response to acute patient deterioration, and integral to organisational patient safety strategies.

Critical Care Outreach Teams can be viewed as one of the great successes that followed the publication of *Comprehensive Critical Care* (DOH, 2000). The recognition that practitioners from critical care had transferable skills that were relevant to the care of the general ward patient has been key to supporting acutely and critically ill patients outside of critical care units. The extension of the multidisciplinary working practices of the best critical care units into the wider ward areas has brought nothing but benefit to patients and staff alike.

NOrF continues to strive for equity of access to 24/7 Critical Care Outreach Services for all and in 2012 published a set of 'Operational Standards and Competencies for Critical Care Outreach Services' to assist with this aim: www.norf.org.uk/NOrF_operational_standards_competencies_CCOS.

Sarah Quinton, National Outreach Forum Chair

British Association of Critical Care Nurses

The British Association of Critical Care Nurses (BACCN) is a leading non-profit organisation dedicated to the promotion of nursing in critical care. BACCN aims to:

1. Provide a National voice to shape the strategy for critical care nursing.
2. Promote safe, quality, evidence based nursing care to the critically ill patient.
3. Provide wide ranging benefits and opportunities to BACCN members.

BACCN was established in 1985 and has grown and developed through its regional and national structure, which ensures it maintains a focus on communication and collaboration for all activities related to critical care nursing. It currently has a membership of circa 2500 throughout 13 regions including Northern Ireland, Wales, Scotland and the Military region. BACCN continues to work on building links with other critical care colleagues across Europe and the rest of the world. BACCN is a member of the UK Critical Care Nursing Alliance (UKCCNA), the Critical Care Leadership Forum, the European Federation of Critical Care Nursing Associations (EfCCNA) and the World Federation of Critical Care Nurses (WFCCN).

BACCN are the owner of the semimonthly journal *Nursing in Critical Care*, which in 2011 after 16 successful years was awarded an Impact Factor and has since retained a high ranking in the nursing category. BACCN provides CPD points for study events and short courses to provide nurses with tangible evidence of their CPD activities when re-registering with the NMC and undergoing individual performance reviews. The BACCN is committed to developing and delivering an annual world class conference. The conference is member, research and clinically driven. It provides a conference that is innovative, evidence based and aimed at delivering safe and effective services.

These activities and developments set the BACCN apart as one of the most progressive critical care nursing organisations in the world.

Annette Richardson, BACCN National Board Chair

RCN Critical Care and In-Flight Nursing Forum

The RCN has 35 forums in areas of nursing specialism, which work purely within the professional side of the organisation. The RCN Critical Care and in-Flight Nursing Forum is a group which is free to RCN members and has 7866 members in total (as of March 2014). The large majority of members work in critical care with a small number working in patient transportation.

The forum is led by a committee of seven with expertise drawn from the areas covered by the forum; adult critical care, paediatric critical care, international fixed wing air ambulance, assistance companies and commercial flight escorts. Committee members are appointed following a rigorous application and interview process and serve for a maximum of eight years. The committee is in turn supported by a professional advisor.

The purpose of the forum is to provide expert advice, representation on professional issues, conferences, workshops and publications. Collaboration with professional colleagues is a key component of our activity and we have engaged with a number of organisations in ensuring a nursing perspective is incorporated into their work. Recent examples include our work with the RCP on the development of the National Early Warning Score and with NCEPOD on the Tracheostomy Care Study. We have also represented the college on a number of committees, commissioning groups, NICE working groups and the Care Quality Commission.

A recent example of our publications is 'Nursing on the Move' (http://www.rcn.org.uk/__data/assets/pdf_file/0008/518075/004364.pdf). This was in response to the increasing number of patients moved between hospitals both within the UK and from abroad. The document outlines the role of nurses working in this environment and the skills set required as they develop through their career.

The Critical Care and in-Flight Forum is the largest organisation representing nurses in critical care and acts with the support of RCN resources.

David Quayle, RCN CC&IFNF Chair

Accessing National Critical Care Data

Ms Lucy Lloyd-Scott
National Audit Programme Manager, ICNARC

ICNARC believes that access to high quality data on adult critical care admissions is crucial to understanding how care can be delivered more effectively. Only when we understand how critical care is currently being delivered and the impact of this on patients, can we identify how it can be improved and act upon it.

The Case Mix Programme (CMP), set up and run by ICNARC, is now in its twentieth year and holds data on over 1.5 million admissions to adult critical care units (general and specialist) in England, Wales and Northern Ireland. Participating CMP units benefit from analyses using these data (as provided in their comparative Data Analyses Reports for local quality improvement and through the publically available Annual Quality Report on key potential quality indicators).

> "The process for access to data or analysis from the CMP Database has been formalised and its transparency enhanced"

CMP data are of vital importance to both clinical and research activity across critical care and are regularly used to: inform changes in practice; understand specific patient groups; support grant applications for new research studies; link with other databases to reduce data collection burden in primary research studies; and to support business cases for service transformation.

Data Access Advisory Group (DAAG)

ICNARC has always encouraged participating CMP units and other stakeholders to request access to data or analyses from the CMP Database. Since December 2013, this process has been formalised and its transparency enhanced. An independent Data Access Advisory Group (DAAG) with an independent chair and clinical representatives from the Critical Care Leadership Forum (CCLF) now review all requests submitted to ICNARC on a bi-monthly basis. They are the ultimate arbiters on whether or not requests can be approved and they apply strict criteria to aid their decision making. To be approved, requests must aim to improve the quality of care and outcomes or support research, education or training. Terms of Reference for the DAAG are publically available through our website. As members retire from the DAAG (once their term has ended) new members will be sought from the CCLF.

Providing even the simplest data extracts or analyses take time and resources so, in line with other national clinical audits, requests may be subject to a reasonable charge to cover ICNARC's costs. As a registered charity, these are charged on a 'cost recovery' basis and rates are clearly laid out in our data access and analyses policy.

We understand the need for accurate data or analyses, at short notice, to support policy changes, research and other outputs but all requests have to be factored into our existing workload. We do endeavour to meet requester timescales providing deadlines do not fall ahead of the next available DAAG meeting and to give our statisticians time to provide the data/analyses.

CMP units can request analyses on their own data for local quality improvement purposes. These are provided by ICNARC (as our workload allows) as part of our continuing service to units, without the need for DAAG approval. CMP units will also shortly be receiving their own, validated data back to enable them to analyse and use these data locally.

Details of our data access and analyses policy (and associated costs), our request form and a full list of requests to the DAAG to date, are available from our website: https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports/Access-Our-Data.

Workforce Advisory Group

Prof Timothy Evans
Workforce Lead

Planning is required to ensure that the NHS has an appropriately located, skilled workforce present in the right numbers at times and places patients need to access them.

The creation of Health Education England (HEE) was designed to ensure that the service can access staff to meet this demand in the future, whilst avoiding excess or over supply. Secondly, there is a perceived need to connect workforce planning with the wider strategic aims of the NHS[1]. The Centre for Workforce Intelligence (CfWI) is the national authority on workforce planning and development providing advice and information to the NHS and social care system. In February 2012 the CfWI published the report *Shape of the Medical Workforce: starting the debate on the future consultant workforce*, which urges employers, the medical profession and policy makers in the healthcare system to start a debate on the future medical workforce which is long overdue.

Accordingly, CfWI's planning team established connections with Royal Colleges and Faculties to determine future speciality training numbers, including integrated links to non-medical clinical workforce planning[2]. Within this context, the Shape of Training Review of 2013, following an investigation headed by Professor David Greenway, set out to establish a framework for delivering relevant changes in education to ensure we train effective doctors who are fit to practice in the UK and thereby provide high quality care and meet the needs of the patients and public they serve[3].

Within this context, the FICM Workforce Advisory Group (FICMWAG) aims to develop a strategy for the medical workforce in ICM for the whole of the UK. Specifically, we should be able to advise national authorities of the number of trained clinicians needed to accommodate the requirements of different models of ICM service delivery as these evolve in accordance with changing patient needs. We hope thereby to inform recruitment and training strategies for the speciality, in the context of the whole of the intensive care team. The Group meets four times per year, and is comprised of the Chair (who is a member of the Faculty Board), and two consultant and two trainee members appointed by the Faculty Committee membership process. There is also a member to represent each of Scotland and Wales. The Group's current programme of work is summarised below.

FICMWAG programme of work

- To develop and run a workforce census annually to inform the Faculty concerning numbers and location of (initially) consultants; their demographic, working practices and environments; and their career ambitions.
- To engage with other Royal Colleges and Faculties, professional societies and relevant organisations both medical and in the wider professional context with regard to NHS workforce strategy.
- To engage with external agencies as determined by the Faculty, specifically the Centre for Workforce Intelligence, to assist in national planning.
- To provide and publish an annual report on its work and provide updates in *Critical Eye* where appropriate.
- To assist where appropriate in producing literature and information promoting ICM as a specialty, in particular in attracting future ICM practitioners.

The Group's deliberations by necessity accommodate extensive discussions concerning future models of care. Some of these are dictated in content by published reports such as that of the Future Hospital Commission of the RCP[4] and others will inevitably be influenced by ongoing research relating to the evolution of healthcare delivery such as that covering 7-day care[5]. Moreover, such discussions will involve extending the Group's reach

into discussions not only with national bodies, but also those providing acute care to patients 'upstream' of the intensive care unit and its associated outreach services. Specifically these would be those practicing in the specialties of Emergency and Acute Medicine.

To that end the Faculty has been engaging with the College of Emergency Medicine and the Royal College of Physicians in determining what models of care, and in particular which overlapping competencies between our speciality and those listed above, are likely to require emphasis in future training programmes. Secondly, the Committee has been actively engaged in co-operating with CfWI in a 'deep dive' analysis of future workforce requirements in ICM (and anaesthesia). The Group has found this challenging. In particular, developing strategic imperatives based upon hypothetical scenarios (see below) that will pertain for the next 20 years has proved to be both controversial and difficult.

Hypothetical scenarios used in workforce modelling by CfWI

- *Laissez-faire, cash rich:* Less political involvement in how the NHS outcomes framework is delivered coupled with more cash for the NHS.
- *Cash poor fragmentation:* Less political involvement in how the NHS outcomes framework is delivered, coupled with less funding for the NHS.
- *Cash rich centralisation*: More political involvement in how the NHS outcomes framework is delivered, coupled with more funding for the NHS.
- *Cash poor centralisation:* More political involvement in how the NHS outcomes framework is delivered, coupled with less funding for the NHS.

Data emerging from other sources such as ICNARC is likely to fuel this discussion. Some 20 members of the Faculty have contributed to the data input that will determine the models employed by CfWI so far, making projections based upon the scenarios above. The results of this will be used to develop a mathematical model which it is hoped will provide some answers to the vexed question as to precisely how many clinicians we need to train.

FICM Workforce Census

Thirdly, the Faculty has started running an annual workforce census. This builds upon the work of Alasdair Short who made a 'rough and ready' analysis of the trained workforce immediately after the Faculty was established in 2010.

Working with the Royal College of Physicians Workforce Unit, which has an established tract record of consultant workforce surveys amongst physicians, the WAG has developed a survey which we hope is straightforward to answer, is non-time consuming and will become part of the annual commitment of our Fellows and Members. You will be assisting us in increasing the accuracy of our assessments as to how workforce requirements will evolve, and also empower us in our dealings with the wider health service and central government.

Finally, the Group spends a good deal of time not only evaluating systems in place in other jurisdictions (including Scotland and Wales) but also perusing publications that emerge from HEE[6].

If the Faculty can produce accurate data concerning its constituencies it will be in an immensely strong position in advising central government upon future planning and the structure of our speciality. I encourage you to support the work of the Group, particularly with regard to future rounds of the workforce census.

References

1. NHS Health Education England. *Workforce Plan for England. Proposed education and training commissions for 2014/15*, 2013
2. www.NHSemployers.org/planningoyurworkforce/medicalworkforce/
3. www.shapeoftraining.co.uk
4. Future Hospital Commission. *Future Hospital: Caring for Medical Patients*. Royal College of Physicians of London, 2013.
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6. NHS Health Education England. *Investing in people for health and healthcare. Workforce plan for England* (proposed education and training commissions for 2014-15).

Professional Standards

Dr Simon Baudouin
FICMPSC Chair

This article will focus on three areas of recent activity for the Professional Standards Committee:

- The creation of *Core Standards for Intensive Care Units.*
- The development of *Guidelines for the Provision of Intensive Care Services* (GPICS).
- The development of evidence-based critical care guidelines.

Core Standards

Critical care is a genuine multidisciplinary and collaborative environment and this is exemplified by the recent work that led to the creation of the *Core Standards for Intensive Care Units* (CSICU) document. The new CSICU document involved close collaboration between the Faculty and the Intensive Care Society (ICS) with significant input from several stakeholder organisations including the Royal College of Nursing, the Royal College of Speech and Language therapy, the British Association of Critical Care Nurses, the Critical Care National Network Nurse Lead Forum, the Chartered Society of Physiotherapists, the British Dietetic Association and the Critical Care Group of the UK Clinical Pharmacy Association. Cynical observers might have predicted that such a large and diverse group would fail to produce any consensus whatsoever. However, the expert representatives from these organisations, under the leadership of the FICM and ICS, successfully produced the first edition of the United Kingdom *Core Standards for Intensive Care Units*. Particular thanks should go to Chris Danbury and Tim Gould for expertly managing the process and editing the final version. The document defines a series of standards covering four main domains which include staffing, operational areas, equipment and data collection. Where possible these statements are evidence-based but in a number of areas the standards represent expert consensus.

The document has been very well received by the critical care community. Inevitably some of the statements are controversial. Occasional concerns have been voiced over some of the statements in the staffing section. In particular there has been some feedback that smaller critical care units may struggle with some of the standards. This feedback has not been ignored but the future of small and geographically isolated units reflects a much broader question of hospital reconfiguration and distribution of acute services.

GPICS

The *Guidelines for the Provision of Intensive Care Services* (GPICS) document which is currently entering an editorial stage is a further example of the productive collaboration between the Faculty and ICS. GPICS is intended to provide a broad range of critical care stakeholders with succinct, background information and evidence on critical care services and key interventions. The document has been deliberately modelled on the Royal College of Anaesthetists *Guidelines for Provision of Anaesthetic Services* (GPAS) document as well as on other documents produced by similar organisations.

The final version will contain 14 themed chapters with a total of approximately 60 sections, each of which has a standard structure. A brief one or two paragraph introduction is followed by a series of recommendations. These should be thought of as the attributes of very high quality units and services. A number of these are likely to be aspirational but over the course of time some of these are likely to be incorporated in future editions of the CSICU document. The next section lists the relevant standards from the CSICU. A more detailed background section follows containing references and some sections will make brief reference to research in progress that will inform practice in the near future.

NICE accreditation

Many of the standards and recommendations contained in these documents have resource implications for the National Health Service. Purchasers of critical care services are more likely to be persuaded that the standards should be implemented if they are backed up by high-quality evidence. The role of evidence-based medicine in promoting health policy in the United Kingdom is

exemplified by the National Institute for Health and Care Excellence (NICE). NICE produce an increasing number of evidence-based guidelines and guidance which to some extent sets an agenda for the National Health Service. However NICE guidelines are by no means comprehensive and there are relatively few that are specific to critical care.

It is acknowledged that some guidelines that have been previously produced are of poor standard. NICE have launched an initiative to improve the quality of clinical guidelines. They have developed a formal process whereby organisations that wish to produce clinical practice guidelines and guidance may apply to NICE for accreditation. If successful the organisation can then place a NICE 'kitemark' on their guidelines which acts as a quality marker. Purchasers of healthcare are more likely to be influenced in their decisions by organisations that produce guidelines to this standard.

The Faculty and the ICS have therefore decided to support a joint initiative to obtain NICE guideline accreditation. The process is not for the fainthearted. The NICE accreditation process manual describes a very rigorous assessment for a candidate organisation. The organisation(s) need to demonstrate that their guidelines follow an internationally recognised method of production summarised in the AGREE instrument and must submit two examples of completed guidelines along with a manual describing the guideline production process. Other evidence that is required includes full documentation of the meetings, consultations, stakeholder and lay involvement and explicit documentation of decision-making processes informing guideline recommendations.

Whilst this may sound daunting much of the methodology has now become standard. Both NICE and the Scottish Intercollegiate Guidelines Network (SIGN) produce very comprehensive guidelines manuals. Many UK specialist societies have already obtained NICE accreditation and the FICM/ICS Joint Standards Committees (JSC) have already received significant advice and support from the British Thoracic Society who have achieved a NICE 'kitemark'. Very significant administrative support is needed for this process and the Faculty and ICS have agreed to jointly support 50% of a new administrative post which will be housed within the Faculties secretariat.

Two guidelines have been initiated. The first will focus on effective interventions in ARDS and the second will provide recommendations on the management of delirium in the critical care unit. Updates on progress with the guidelines will occur at National meetings where it is envisaged that summaries of recommendations will be presented to allow for interactive stakeholder feedback. More formal stakeholder feedback will also be obtained. Completed guidelines will be available electronically and are likely to be published in *JICS*. This is very much early days for this project so do bear with us.

In time it is envisaged that the CSICU and sections in GPICS will be supported by evidence-based clinical guidelines produced by the JSC. However this is a longer term aim and it is likely that it will take two to three years to achieve NICE accreditation. In the shorter term the joint guidelines group will seek to identify existing high-quality guidelines, that are relevant to the critically ill, to support our standards.

Faculty Annual Meeting 2014

Dr Anna Batchelor
Dean

The FICM held its Annual Meeting on Friday 7 March. The meeting mixes a view of the wider world of health policy, high quality science and an opportunity to honour those who have served our specialty.

Our first speaker Mr Yair Erez eloquently laid out the problems facing healthcare and the potential costs, but also came with some interesting solutions. Among them why do we have so many health centres for GPs when there are a lot of supermarkets and McDonalds where they could be co-located enabling patients to kill two birds with one stone? I do have a slightly surreal view of patients being issued with statins after a Big Mac and large soda but if that's how we cut down demand maybe we should look at it! But more seriously if Tesco can operate almost 24/7 and EDs are overwhelmed with patients who don't really need to be there maybe there are opportunities here! Developing this idea further based on recent dietary advice, if supermarkets not only had GPs and nurses but also removed excess sugar from the products they sell and encouraged healthy eating habits this could lead to the biggest improvement in health since 1948.

Next up was Mr Adrian Masters who has been at the centre of health politics for several years, including being Director of the Health Team in the Prime Minister's Delivery Unit under the last government. He is now at Monitor. Whilst emphasising the same problem of how we continue to afford healthcare he brought an understanding of policy and political drivers along with insights into how Monitor hopes to improve outcomes.

These two talks led to a very lively Q&A session. A question about regulation revealed some interesting thoughts. The hospital in Israel where Yair had worked used to be top flight with active research output, but had gone bankrupt. No one knew there was a problem until it happened because Israel has no regulatory system like Monitor. Audience members highlighted areas where Monitor had flagged up high staff costs resulting in loss of staff but then costs really went up when agency use shot through the roof. There are no easy answers but high quality, effective leadership of organisations seemed to be in there somewhere. And a view from Adrian … overwhelming financial pressures will mean that political expediency (i.e. getting re-elected) will give way to action on reconfiguration in the next parliament.

The next session started with Ms Candace Imison, Deputy Director of Policy at the Kings Fund, continuing the theme of what the future might hold but counseled against expecting the hope that condensing services into large acute hospitals was necessarily the answer. Having worked in a variety of senior management and board level roles in the NHS a mixed economy with some specialist hospitals and many closer to home services got her vote.

Prof Sir MIke Richards, Chief Inspector of Hospitals at the CQC, giving the Annual Faculty Lecture

Left to Right: Fellow by Election Prof Sir John Temple, speaker Prof Sir Mike Richards, Vice-Dean Carl Waldmann, Dean Anna Batchelor, Fellow by Election Prof Jon Cohen, Immediate Past Dean Prof Julian Bion and Immediate Past Vice-Dean Prof Tim Evans

Professor Mary Dixon-Woods, who is among many other things Deputy Editor in Chief of the *BMJ*'s Quality and Safety section, eloquently led us through the problems of measuring patient safety and the pitfalls of figures taken from very small studies being multiplied up to cover a country, then repeatedly cited until they become almost an accepted truth despite very weak foundations. She introduced concepts of blindsight (reliance on knowledge which may conceal rather than reveal risk), fugitive intelligence (difficult to define or grasp), problem sensing (being honest and open about problems) and comfort behaviour (ticking boxes and so appearing to take problems seriously but in reality just going through the motions). And the disturbing thought given our CQUIN targets that when data are used with regulation or control purposes, they may cease to be effective as a measure of the phenomenon of interest.

Mike Grocott, Mark Glover and Mervyn Singer gave us new views on critical illness based on climbing Everest, diving the depths and hibernation in the animal kingdom respectively.

Fellowships by Election were awarded to Prof Ron Bradley, the originator of the pulmonary artery catheter (Swan added the balloon) and one of the UKs earliest intensivists; Prof Jon Cohen, microbiologist and among many other things a member of the working group behind *Collaborating for Quality*; and Prof Sir John Temple, past President of the Royal College of Surgeons of Edinburgh, who lead *Collaborating for Quality*. Wearing a gown with gold braid and a fixed grin for the photos is one of the nicer, if more difficult, parts of the role of Dean. Unfortunately Prof Bradley was unable to attend.

The Annual Faculty Lecture was delivered by Prof Sir Mike Richards, Chief Inspector of Hospitals at the CQC. Critical Care is one of the core services that the CQC are looking at in their new, revised inspection regime. We were led through the development and implementation of the new processes and the new system of ratings, which is on a four point scale so forcing visitors to make a decision as to whether a service was Outstanding, Good, Requires Improvement or Poor rather than plumping for the middle. So far intensive care seems to mostly be rated (and very few hospitals have been rated so far) Good with a sprinkling of Requires Improvement for effectiveness, appearing largely to relate to access and patient through-put. Pretty good you might think; however as Mike pointed out if all ICUs are rated good then it will seem as if we are sorted and without problems and attention will focus elsewhere such as emergency departments and outpatients both of which had far more poor ratings. He particularly mentioned ICNARC and how good it was that we all produced our data swiftly and proudly. He emphasised that CQC want to work with professional organisations and will use GPICS standards from FICM/ICS to benchmark services.

And if you thought the day couldn't get any better we finished up with drinks and delicious canapés in the college café. A great end to a brilliant day.

Consultations - FICM responses

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

NICE Quality Standard - Head Injury
June 2013

This quality standard covers the assessment and early management of head injury in children and adults. It also covers rehabilitation for adults (aged 16 and over) after traumatic brain injury.

Statement 1: Quality measure should also include time to report for the CT scan. Delays in reporting contribute to delays in access to definitive care including appropriate discharge from hospital.

Statement 3: Although the published evidence is only available for warfarin we would prefer to see the text changed to "Children and adults with a head injury who are receiving anticoagulants have a CT scan within 8 hours of the injury".

Statement 4: We would like to see the statement strengthened to read "have access to specialist treatment through ongoing liaison with or transfer to their regional neuroscience unit". There remain examples where critically ill patients are transferred outside their region due to lack of bed availability despite national recommendations (Society of British Neurosurgeons) that emergency treatment is carried out at the regional neuroscience centre and then transfer undertaken as necessary.

Statement 5: Many patients with moderate and severe head injury have prolonged admissions in intensive care and acute ward beds due to delays in timely access to assessment. As such we would also support measurement of time to assessment..

Statement 6: We would recommend removal of the word 'community'. Although we strongly support the requirement for rehabilitation, this should be from specialist through to community based rehabilitation, dependent solely on patient need. Many patients with moderate and severe head injury have prolonged admissions in intensive care and acute ward beds due to delays in timely access to appropriate rehabilitation.

AOMRC: Taking Responsibilty - Accountable Clinicians and Informed Patients
February 2014

- The Faculty of ICM strongly agrees with the general premise that every patient should have an accountable clinician.
- Admission to an intensive care or high dependency unit is an example of where a change in circumstance necessitates a transfer of this accountability for the duration of the time in the higher care unit. However it is appropriate for the referring clinician to maintain contact with the patients progress and to undertake to reassume responsibility for the patient on their discharge from the unit.
- Intensivists work in teams, commonly in blocks of days on the unit sharing responsibility for patients during their time in critical care. After discharge back to the ward the intensivists remain accountable for the time in critical care, continue to provide professional support to the patient and the ward team and if appropriate be involved in post discharge rehabilitation in line with NICE 83.

NICE - Sepsis: the recognition, diagnosis and management of Severe Sepsis
April 2014

- There are major issues with over-diagnosis and concerns over excess/inappropriate use of antibiotics. Sepsis does not necessarily have to involve two or more organ systems in terms of obvious dysfunction.
- Young children are not particularly susceptible (unless they have other risk factors), except with certain types of infection e.g. influenza or meningococcus. The elderly are a much greater at-risk population.
- The current definition of 'sepsis' can include someone with a bad cold. Such patients do not need hospital admission. More emphasis needs to be placed on the early recognition of new onset organ dysfunction, and to consider whether infection is the underlying cause.

Membership Update 2014

FFICM 2014

Alexander Abraham
Nicholas William Airey
Nabeel Amiruddin
Elaine Baby Anderson
Shabana Anwar
Timothy Astles
Matthew Stephen Atkinson
Benjamin Cheadle Attwood
Wendy Rebecca Aubrey
Lucy Bates
Katy Louisa-Mary Beard
Sian Bhardwaj
Thomas Bongers
James Francis Buckley
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Andrew Forbes Campbell
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Caroline Walker
Benjamin Ivan Walton
Michael Peter Ward Jones
Orlando Warner
Stephen Wilson
David Robert Windsor
Gillian Mary Helen Wray
Eoin Young

AFICM 2014

Richard Bateman
Nicholas Barrett

MFICM 2014

Charudatt Vaity
Graziella Isgro
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Dr. Conn Russell, UK
Dr. John Simpson, UK
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Prof. Jan Wernernan, France
Dr. Bob Winter, UK

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Churchill House, London

OCTOBER

15 **Chest Ultrasound**
Churchill House, London

20 **Tracheostomy**
Churchill House, London

27 **Haemotology and Oncology**
Churchill House, London

NOVEMBER

11 **Trainee Career Day**
Churchill House, London

19 **Core Topics: Examining the Evidence**
Churchill House, London

26 **BSE Exam**
Churchill House, London

DECEMBER

7 **FICE Course**
Crown Plaza,
London Docklands

8-10 **The State of the Art Meeting**
ICC East ExCeL, London

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