CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 21 | WINTER 2022

Life After Critical Illness: service planning, logistics and delivery

The Faculty of Intensive Care Medicine

In this issue

The Faculty of Intensive Care Medicine

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6 May 2022
RCoA, London**

ACCP Conference

10 June 2022
Newcastle-upon-Tyne**

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22 September 2022
RCoA, London**

** Location may be subject to change

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WELCOME

Dr John Butler
Clinical Editor

Welcome to this winter edition of *Critical Eye*. I hope you all had at least some time to rest and relax during the festive season. As we enter the year 2022, many of us will be understandably apprehensive about the potential additional impact of the emerging Omicron variant of COVID-19 on our ICU workload and, in particular, on our ICU workforce.

We are yet to fully see the effect that this variant will have, but the next few weeks may present a selection of difficult challenges for Intensive Care departments. Amazingly, in the face of these concerns, our speciality continues to provide high quality life-saving care to patients 24 hours a day, 7 days a week in units up and down the country thanks to the commitment of our NHS professionals.

The strength and resilience demonstrated by the staff working within our units has been truly remarkable and inspirational. Hopefully 2022 will provide a period of much-needed relief from the relentless pressures of COVID-19 and allow us to reflect on our experience of the pandemic and of the NHS response to it.

This is the time of year when we reflect on our achievements in 2021 both as a speciality and as a Faculty. It is difficult to look past the dominance of COVID-19 on Intensive Care Medicine in the last year, however, there are many notable developments that are worth highlighting here. Thanks to the significant efforts of the Training, Assessment & Quality Committee the GMC have approved the triple CCT programmes for ICM and the medical specialities. This is a significant success for our specialty and secures the ability for future doctors to train in Intensive Care Medicine alongside a defined group of physician specialities. The medical specialities supported by this programme are Acute Internal medicine, Renal medicine and Respiratory medicine. Further advice for prospective trainees is included in this edition.

The final publication for the Faculty's Critical Futures initiative is also now available on the Faculty's website. *Life After Critical Illness* (LACI) provides guidance on how to develop and deliver post-ICM services for the benefit of our patients and will have a positive impact on recovery from critical illness. I would also urge you to visit www.ficm.ac.uk/criticalfutures to see the full breadth of publications and guidance this initiative has produced over the years, including care at the end of life, enhanced care, and commissioning.

I hope you enjoy reading this edition and I wish a happy New Year to you all.

We welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

Message From The Dean

Dr Alison Pittard
Dean

Welcome to the first edition of *Critical Eye* for 2022. I do hope that you managed to get some time away from work over the festive season. We have seen our workforce decimated due to COVID and many of us are still waiting to see if the Omicron variant has an impact on ICU admissions. I continue to be amazed, and immensely proud, of your resilience over the last two years and offer you my sincere thanks.

FFICM OSCE exam

I cannot write this update without mentioning the FFICM OSCE exam from October 2021. We heard from trainers, and trainee representatives, the impact the result was having at our engagement events. The devastation was palpable and we committed to doing whatever we could to help ameliorate it.

This has involved multiple discussions with HEE, the GMC, external assessment experts and an in depth exploration of the exams process. We had hoped to find an error but this was not the case. The GMC would also not support a change to our standard setting process, so the result stands.

I know how hard this must be for everyone involved and I am truly sorry that we were unable to resolve this before Christmas. We are liaising with HEE, and also strengthening our own internal resources, to ensure you are better supported.

As an eternal optimist I find a new year is a time to reflect on the positives. Despite the pandemic the FICM has achieved so much to benefit our specialty.

GMC approved triple CCT programmes

The GMC has now approved triple CCT programmes for ICM and the medical specialties. Although the detail is yet to be finalised

> **"The decision making around capacity transfers is nuanced and we hope our joint statement supports clinicians who may find themselves in these situations a nd to try and ensure that they do not become the norm. Capacity transfers are not a long-term solution to a lack of resources.**

it means we can continue to offer ICM training to physicians. A huge thanks to Chris Thorpe and Natalie Bell for the enormous amount of work they and others have put into this.

Board Elections

In October I was delighted to inform Liz Thomas and Monika Beatty that they had been successful in our Board elections. It was also a pleasure to have Julia Wendon re-elected for a second term but I was very sad to have to say goodbye to Gary Mills. Jonathan Goodall also completed his second term of office. A big thank you to both of them for all the work they have done for ICM during their time on the Board.

Our next election will be in July so look out for more information in April. We also say goodbye to Guy Parsons as Lead Trainee Representative and welcome Matt Rowe, from Bristol, as the new Deputy Trainee Rep. Guy, and Catriona Felderhof in her deputy role, have been instrumental in our communications regarding the exam and have ensured that we hear the trainee voice. Thank you Guy and I look forward to Cat taking over for her term as Lead Rep.

Life After Critical Illness

The final publication from our Critical Futures initiative, *Life After Critical Illness*, is now available on our website. It builds on clinical practice, the evidence base and existing national guidance to give clear and detailed guidance to clinicians in the hospital and community settings, to hospitals, to regional health care providers and to commissioners, on how to develop, deliver and fund these services.

This work was clinicallly led by Carl Waldmann, Joel Meyer and Andy Slack, but also huge shout out to Ms Anna Ripley, Mrs Dawn Tillbrook-Evans, Mrs Nicola Wood, Mr Daniel Waeland and Mr James Goodwin for their administrative support and guidance throughout this project, and throughout the entire Critical Future initiative.

Critical Care transfers statement

FICM and ICS published a statement on critical care transfers in November which was followed by an NHSE framework in December. The most important aspect of these is the identification of patients, already in ICU, who may need to be transferred to another hospital for the same level of care to allow the admission of someone requiring P1 or P2 treatment. This is called a capacity transfer, as opposed to a mutual aid transfer in an acute setting such as a pandemic or mass casualty situation.

The decision making around capacity transfers is nuanced and we hope our joint statement supports clinicians who may find themselves in these situations and to try and ensure that they do not become the norm. Capacity transfers are not a long-term solution to a lack of resource.

The year ahead

I hope that 2022 brings us some relief from COVID-19. It would be nice to be able to have some face to face meetings before I finish my tenure as Dean in October.

We also hope to return to in person exams in April but at the time of writing that decision has not yet been made, and relies on variables beyond our control such as access to Churchill House. Until then I wish you all the best for the New Year and thank you for your continued support.

Your New FICM Board Mem

Dr Liz Thomas
Chair, WICM
Sub-Committee

I graduated from Manchester Medical School in 2003 and completed my training in Anaesthesia and Intensive Care Medicine in the North West. I was appointed as a consultant at Stockport NHS Foundation Trust in 2003, and I was Clinical Director of my unit for four years (2017-2021).

Having been Clinical Director during the pandemic means I have strategically planned and increased ICU capacity by 300%, adapted to the needs of the pandemic, ensured the welfare of all critical care staff, submitted data to national stocktakes and presented at peer reviews.

My role as Chair of Women in ICM allows me to promote ICM as a career for all and work on a national committee for the benefit of both ICM doctors and the specialty as a whole. I am also the Co-Lead for FICM Thrive mentoring scheme which launched in May 2021.

I passionately believe in compassionate leadership, clear communication and workforce wellbeing, as positive actions in these areas increases patient safety.

Roles

Joint medical lead for the Greater Manchester Critical Care Network. Chair of Women in ICM, a sub-committee of FICM. I am co-lead for the FICM Thrive mentoring project and a Final FRCA Examiner for RCoA.

Dr Matt Rowe
FICM Deputy
Trainee Rep

I'd like to say an enormous thank you to all those who chose to vote for me in the recent Trainee Representative elections. I'm well aware that the past 18 months or so have been particularly challenging for us as trainees and am proud to say we have all risen to such challenges in a way that's often far exceeded expectations.

I'm now really looking forward to getting started working with the FICM Board to ensure our needs are represented as we move towards living with these additional challenges. I grew up in Devon and had an unorthodox route into medicine with three rounds of applications, 12 rejections and one last minute offer to the postgraduate programme at the University of Birmingham, graduating in 2013. Prior to this I did a degree in Medical Sciences. My employment history ranges from managing a less than high quality leisure centre and making sandwiches for Ginsters

bers

to phlebotomy and aeromedical retrieval. Following foundation training in the Midlands, I moved to Bristol.

I'm dual training in ICM with Anaesthesia and have completed Stage 1 training. I was an academic rep during my undergraduate training and am currently the regional ICM trainee rep for the Severn Deanery.

Having had an odd route into medicine, time out of training and many, many interviews at both undergrad and postgrad level, I feel I have encountered my fair share of some of the challenges we face as trainees. This has fostered a firm desire to ensure that all our views are heard and that training is kept pragmatic, rewarding and tailored to our needs.

Interests

My interests outside medicine include drumming, mountain biking, snowboarding and basically anything that might land me a visit to my local major trauma centre. Please don't hesitate to contact me with any issue, big or small and I'll do my absolute best to help.

Dr Monika Beatty
Lead Regional Advisor for Scotland

Since I took up my consultant post, improving the quality of ICM training and education has been a key priority of mine, progressing from Faculty Tutor, to Lead ICM RA for Scotland. I'm also a FFICM examiner and member of the SOE examiners' group.

As Lead RA for Scotland, I have been in the privileged position of working with the SICS, the Scottish Critical Care Delivery Group, FICM and other stakeholders to increase the profile of ICM as a specialty in Scotland, secure dedicated funding for the ICM training programme and achieve a significant increase in ICM trainee numbers, within the Scottish Deanery. I'm keen to develop this work further, on a more UK-wide basis, in my new role.

Roles

I have also represented the specialty in co-opted and ex officio roles, on the FICMTAQ and FICMCRW committees, SICS Council and RCoA Scottish Board. I am an appointed member of the FICM Legal and Ethical Policy Unit and hold an MA in Health Care Ethics in Law. I'm particularly interested in treatment escalation decision making, end of life care and capacity law, as it applies to all four UK nations. One of my ongoing priorities, is to educate and train critical care health care workers in this field, stimulate ethical analysis and debate and ensure a patient-centred approach, to decision making.

I'm delighted and extremely honoured, to have been elected to the FICM Board. I am very grateful for the opportunity to support the development of our specialty and will do my very best, to represent the views of the electorate.

Burnout Post-COVID

Anonymous
ICU consultant

The plastic box in my hall is open. Half of my work things are wiped clean and sitting sullenly in it. The others are in a puddle next to me on the rug. They and I are contaminated from a day, a weekend, a year and a half of working as a critical care consultant in a pandemic. I am at home now and I haven't been able to stop crying. My decontamination routine has been superseded by this avalanche. Anti-bacterial wipes replaced by tissues. My husband, two metres away, can't hug me. Coronavirus sits between us. He leans on the wall and absorbs my misery. Sadness, anger, grief, despair, exhaustion. None was ever washed away in the hundreds of showers. It has seeped into my soul. The box is open, I am broken. Both seem too insubstantial now to ever have hoped they'd hold this.

Burnout happens gradually and all at once

Adrenaline and cortisol are first your friend. They fuel the exams, the night shifts, the interviews, the exercise on days off. Sweating out the body's plea for endorphins; the antidote to your quotidian life or death responsibility. What goes up must come down. Thank you, drama. You come in sharp alarms and slick teams. In blood staunched, hearts restarted and nursed back to steady beats with optimism and infusions. Pride lifts us. Lifts in the beating back of death and his septic scythe. In the very best of colleagues.

You made my work, my life seem hyper-real, substantial, worthwhile. Thanks, but no thanks drama. Make it stop.

Graveyard humour

I pine for the graveyard humour, camaraderie and detachment of before. Dissolving in the hall, I long for the dead inside days we joked about as the pandemic surged. Now I see the faces of patient's relatives screaming at me. Swearing. Contorted in anger. Maskless, filterless. Did their hands ever clap for us? Did I want them to? In the dark, sobbing towards my car I imagine they'll strike me. They see lies in test results, malice in caring hands. I am out of body, accused of murder. Suspicion and conspiracy dripping from their mouths, grief forced into balled fists. They don't want their mother to be a COVID statistic.

Neither do I. My God, neither do I.

It's all we exist for now. To fight this. What we would give to take this away, to go back to critical care as advertised. I would take this cup from them, from the last family who screamed at me, from the hundreds before. The faces and names grip my chest. The screams over phone lines as death announces itself. My voice immerses families in suffocating loss over, and over again.

Can I keep them safe

I see the family resemblance. Will COVID turn their bodies against them too? Can I keep them safe? Say 'vaccines' and you flame the fire. Adrenaline my old friend flushes me. Burns this memory home for future unwelcome visits. Makes shouting a weapon, a school playground a relentless siren, my workplace a battleground. If we only have so many heartbeats for critical care, mine are running out.

I am held up. First by the colleague who goes back into this arena while I sip coffee, breath catching. "No offense' they say to him. I am not offended. I am broken. I make one last effort to suppress it all; get through the shift. I cry again. I cannot admit your patient. I have nothing I can offer him. Offer him a good death, his family at his side. A privilege denied to so many. The wave of the surgeon's frustration washes my last wall down. It cannot be raised again. I am lost.

The helpers need help

The sticking plaster of service is ripped off and I am at home. No morning alarm to herald the emergencies of the day. The tears not dammed by exile. Searching for help. I call numbers I have distributed in the name of staff wellbeing. Call backs are promised, some are denied from the start. 'We are overwhelmed'. The helpers need help.

Do more with less has come to this.

Funding not given is survival stolen from us. Joy is long lost. I pour my confusion and exhaustion onto understanding colleagues and friends. The tears and sleepless dreams surge on.

The intensive care unit is some hellish underwater landscape, diving through the worst days of others' lives. PPE both prison and protection. Half-remembered but relived. In a sea of sorrow, others lose their life to some darkness I fear I recognise. I am helpless to help them too. Kind messages like tiny flares ping on my phone.

We are here, sitting beside you. Flowers come, cards are read again and again.

They are a balm on worthlessness.

The final call

I make the final call. It should have been my first. The very best of colleagues. I try to book the quickest appointment. I scrabble for anyone free. NHS practitioners notice my cancelled appointment. The concerned email becomes a face on screen. I am forever indebted. There is no clapping now. The world is bored of our struggle but not them. There is a plan, medication, expertise. Mostly there is time and humanity.

I am changed

But there is no satisfaction, nor an ending. I am changed. I suspect we all are. "Come back when you are ready. The most important thing is getting better". Better than what I wonder? Why did I fall when you kept standing? Was I never good enough? Guilt and shame plague me. I watch my colleagues struggle through my idle fingers. I can't look away.

I try to understand myself meeting painful scars and small victories. I share qualities of many doctors but have issues all my own. My standards are impossibly high but shifting them unravels me. Does it matter anyway? When the water gets high enough, we all drown.

Hope

I write an article hoping it helps someone feel understood. I hear of a life with more good days than bad and hope I live it again.

https://www.practitionerhealth.nhs.uk

LACI: Life After Critical Illness

Dr Joel Meyer
Dr Andrew Slack
Dr Carl Waldmann
LACI Working Group

The overall objective of the *Life After Critical Illness* Working Party was to provide the 'nuts and bolts' of post-ICU recovery service planning, logistics and delivery.

The *Life After Critical Illness* guide (www.ficm.ac.uk/criticalfutures/life-after-critical-illness) is the first document to amalgamate all the post-ICU clinical experience along the patient's journey from ICU into the community across the four UK nations alongside national guidance and standards for ICU care.

1989

In 1989, The King's Fund declared, "There is more to life than measuring death". Survival after critical illness is often associated with reduced quality of life, delayed return to work, and physical, psychological, and cognitive impairments.

Affected patients and families require co-ordinated services to support their rehabilitation after critical illness. However, post-ICU recovery services across all four nations are lacking, compared to rehabilitation services after cardiac, neurosurgery, neurology and trauma.

May 2019

In May 2019, 50 'champions' from across the UK who were experienced in the delivery of post-ICU services convened at a one-day conference at the RCoA, and reported widespread non-adherence to gold-standard post-ICU care specified by NICE and GPICS. The meeting identified scarcity of definitions, toolkits, infrastructure, and funding as the major barriers to initiating, embedding and expanding effective post-ICU recovery services.

From this inaugural event, the *Life After Critical Illness* Working Party (LACI) of the FICM was born in order to respond to Recommendation 12 of FICM's Critical Futures project.

UK-wide survey

The LACI document was published alongside the UK-wide survey of recovery services after critical illness by Bronwyn Connelly et al, which had been commissioned in 2020 by the LACIWP (BMJ Open 2021;11:e052214. doi:10.1136/bmjopen-2021-052214).

This survey was sent to all ICUs within the UK to provide an update on the current landscape of the provision for recovery, rehabilitation, and follow-up services for adult critical care patients.

COVID-19

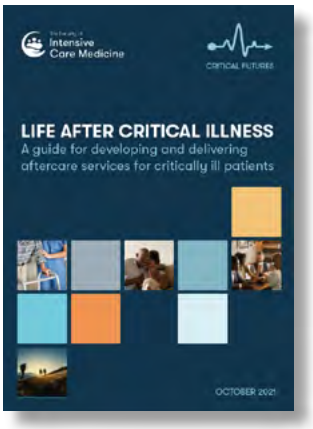
Following the pandemic, the government provided millions of pounds in funding for the development of specialist clinics for treatment of 'long post-COVID-19'. As the vaccination programme begins to see a positive effect on COVID-19 hospitalisations and admissions to ICU, then the need for these community post-COVID-19 clinics will diminish, and this may provide an opportunity to transfer the resource from COVID-19 to post-ICU.

In summary, it is hoped that in the near future all patients that have been critically ill in the four nations of the UK will have access to a standardised but individualised programme to aid their recovery back to a good quality of life.

LACI

Survivorship following critical illness is often characterised by reduced quality of life, delayed return to work and physical, psychological and cognitive impairments. A comprehensive online survey commissioned by FICM that was sent to all ICUs within the UK shows that post-ICU recovery services across all four nations are lacking.

LACI Survey Findings



1 **Survey response rate of 72%**

176/242 UK hospitals reporting data on provision of post-ICU recovery, rehabilitation, and follow-up services

Inpatient phase

2 **72% of hospitals have inpatient post-ICU recovery and follow-up services,** commonly delivered by nurses (90.6%), physiotherapists (55.1%), and/or

3 Only 32% have a speech and language therapist, 31% a dietitian, 21% a pharmacist and 21% an occupational therapist

Outpatient phase

4 **74% of hospitals have outpatient post-ICU services,** predominantly as outpatient clinics (up from 27% when surveyed in 2013)

5 Only 11% have an occupational therapist, 9% a dietitian, 8% a pharmacist and 7% a speech and language therapist

Funding

6 **71% of sites are funded at risk** from internal or miscellaneous funds with no financial security

Service changes

7 **45% of centres anticipate changes to their post-ICU recovery outpatient services** associated with COVID-19, including change from in-person to virtual format

8 **21% of centres report plans to expand their existing post-ICU recovery service** and 19% are preparing to launch a new post-ICU recovery service

Training, Assessment and Quality (FICMTAQ)

Dr Chris Thorpe
FICMTAQ Chair

As I write this update, the lead examiners are deep into investigating the reasons for the low pass rate in the recent OSCE examination. We have just heard from trainees and trainers. By the time this is published, conclusions on the way forward will already be known, so I will limit this section to simply saying that the distress suffered by some trainees and trainers was harrowing to hear.

The triple CCT has finally been approved by the GMC. There were a lot of hoops to jump through, that's for sure — we have been working with the General Medical Council, Health Education England, the Conference of Postgraduate Medical Deans (COPMeD), Medical and Dental Recruitment and Selection (MDRS), the four Statutory Education Bodies, multiple Specialty Postgraduate Lead Deans and Specialty Advisory Committee Chairs and our respective Training Committees, and it was a great relief to get it over the line. This vital step safeguards the future of doctors being able to train in Intensive Care Medicine and a defined group of physician specialties.

As Internal Medicine Training (IMT) will be fully incorporated into the associated Group 1 medical specialty from August 2022, trainees that successfully complete a triple CCT training programme will gain a CCT in Intensive Care Medicine, Internal Medicine and their chosen medical specialty. The medical specialties that are currently supported by this programme are Acute Internal Medicine, Renal Medicine and Respiratory Medicine.

One of the great plus points of the process was working closely with the JRCPTB. There is no doubt that the coordinated and mutually supportive approach helped enormously in convincing stakeholders that this had to happen.

Useful steps for prospective trainees

1. Some doctors may already be training in one of the specialties and planning to apply for the other in the 2022 recruitment round. Others may be applying for their first specialty.
2. Trainees can apply for either the Medical Specialty (for example Respiratory and Internal Medicine) or Intensive Care Medicine first.
3. Trainees can then apply for the other specialty in the following recruitment round.
4. During the transition period, some trainees in ICM may not have the required experience to apply for HST in medicine, as this now requires completion of IMY3 capabilities. With further lobbying, we have obtained approval for the window of application to the second specialty to be extended to two years to allow completion of IMY3 capabilities. These could potentially be completed while within the ICM training scheme but would need to be carefully planned with respective trainers in ICM and medicine.

Useful References

- ICM Curriculum webpages
- FICM Recruitment webpages
- ICM National Recruitment Office (HEE)
- JRCPTB specialties webpages
- Physician Higher Specialty Training Recruitment
- Specialty Person Specifications

Ms Natalie Bell
FICM Board & Training Projects Manager

FICM Lifelong Learning Platform

The FICM Lifelong Learning Platform (LLP) is now live, coinciding with the launch of the new ICM curriculum. You should have received an email with your login details or been given access to the FICM side of the platform if you're an existing user. If you haven't, please get in touch with us as soon as possible.

To access the LLP you need to login via the RCoA's domain page, https://lifelong.rcoa.ac.uk/login. Once you have logged in you will see the FICM branding to know that you are on the right site for ICM training.

Key Points

1. User Guide: The user guide can be found in the LLP section of ficm.ac.uk. Please read this to help you navigate the new system and to answer any immediate questions you might have. The User Guides for Supervisors are currently in development and will be published in due course.

2. 2021 Anaes/ACCS Supervised Learning Events (SLEs) are now live in the FICM Learner tab: We have just deployed the new Anaes/ACCS 2021 curriculum assessments onto the SLE page for FICM Learners. This means you can now complete the Anaesthetic assessments for your placements in Anaesthesia and link them to your ICM Curriculum without having to download them from the RCoA website and then reupload to your FICM LLP.

3. Placements for Dual Learners (e.g. RCoA and FICM): You can now create and replicate placements with different Educational Supervisors (ie one Anaes ES and one ICM ES) across your RCoA and FICM Learner tabs in the platform. We emailed all our doctors on the Dual Anaes and ICM programme using the LLP to notify them about how to do this. If you are still unsure, then please contact us. This should ensure that your respective Educational Supervisors can now access and monitor your progress against the ICM and Anaesthetics curricula.

4. Creating SLEs and linking to both ICM and Anaesthetics curricula for Dual Learners: We have just deployed functionality that will now allow Dual Learners (on the 2021 Anaes and ACCS curricula ONLY) to create an Anaesthetic or ICM SLE and link it to both curricula.

We did attempt to also include Dual Learners on the 2010 Anaesthetic and ACCS curricula in this, but it proved too complicated to implement the fix for both sets of curricula. It would have caused numerous complications and we did not have the budget to overcome these difficulties. These users will still have to download completed SLEs from the respective sides of the platform and upload and link them to their curricula as Personal Activities.

See below for detailed instructions.

5. ESSRs: The ESSR is created by the StR and is sent to their ES and Faculty Tutor to review and approve. This document is important as this is the form your ARCP Panel will review.

ARCP panels can only view evidence pulled through in completed ESSRs. You might find it helpful to create some test ESSRs in the LLP to see how your portfolio looks when you have added some evidence to give you a feel for what an ARCP panel would be reviewing and identify any potential gaps. You can then delete any of these test ones if they're not needed. If you are on a dual Anaes and ICM programme all of your completed ESSRs from your progress against the Anaes

and ICM curricula are available for your ARCP panel to view. It is therefore imperative that you give them accurate titles (e.g. Anaes ESSR/ICM ESSR) so that your ARCP panel knows which ESSR they should be reviewing.

There is a glitch in the system where your current ES is not listed in the ESSR. However, rest assured that the system will send the ESSR to the ES you have added to your current placement, even though the form does not currently list anyone in the ES field. You can check this when you have sent it by accessing the form from your 'Recent Activity' box in your FICM dashboard. If you click on the ESSR you have just created and sent, to open it, it should then list the name of your ES in that field.

You need to choose your Faculty Tutor before the system will let you send the form to your ES to review and approve. If you are not sure who your Faculty Tutor is, please contact us. Ideally your ES and FT should be different people, if they are the same person (as is necessary in some hospitals) then you can enter your ES's name in the Faculty Tutor search field in the ESSR or alternatively you could send it to a Faculty Tutor in another hospital. All Faculty Tutors have been entered onto the LLP and will come up in the search results for the form even if they are outside of the current hospital you are working in.

6. Difficulties in finding ICM Assessors (for SLEs), and ICM Educational and Clinical Supervisors: If you are unable to find a consultant on the system, it is likely they have not been given an LLP account yet or if they already have an existing LLP account, they might not have been given the necessary ICM roles for them to be able to appear in the ICM Assessor/ Supervisor search results. As we are just onboarding onto this platform it is going to take time for us to create accounts for all the consultants that need them and ensure everyone already on the system has the right ICM roles added to their accounts, so please do bear with us during this time.

It is not automatic for all the anaesthetic consultants to be visible on the FICM side of the LLP, the FICM secretariat must go into their account and give them the respective ICM roles for this to happen. The Faculty asked the ICM Faculty Tutors to send us the details for all of the registered ESs and CSs in their hospitals so we could be prepared for the launch, but we did not receive a 100% return rate.

Please contact your Faculty Tutors to help send through all of the details of the doctors in your hospital that will need access to the LLP (ie names, GMC numbers, which hospital they work at and level of access required (ie are the doctors an ES, CS etc.)), so they can then be sent ICM SLEs to review and approve and be added as ICM ESs/CSs.

However, please note you should still be able to send SLEs to consultants not on the LLP to review and approve via the 'Guest Assessor' function, but this functionality only works for those not already on the system.

If the doctor already has an existing LLP account and you attempt to send them an assessment via the 'Guest Assessor' route, you will receive a notification that their email already exists on the system, preventing you from completing this action. If that happens, you will need to contact the Faculty to add the necessary ICM role(s) to the doctor's existing LLP account.

7. Supervisor/Assessor accounts: The FICM LLP works slightly differently to the ICM NES ePortfolio. In the LLP, all actions are StR led, meaning they initiate all forms and assessments (including stage certificates) and send them to their trainers when they need reviewing and or approval. Trainers should not initiate any forms for their StRs in the FICM LLP. Trainers only need to act on anything that has been sent to them to review and approve by StRs, which will all be displayed in their LLP accounts under their 'Assessing' tabs. All the ICM and Anaesthetic assessments they are sent to approve from doctors in training and any ARCPs they have been invited to attend should all appear in the 'For your review' and 'Next ARCP' boxes in their 'Assessing' tab. When FICM Learners have added consultants to their ICM placements as Educational or Clinical Supervisors they will be able to see a list of the ICM doctors they are supervisor for in their LLP accounts under their 'Supervising ICM' tabs.

Unlike in NES, the LLP only notifies trainers to act via a direct email for certain functions, **it is imperative that supervisors and assessors regularly check their 'Assessing' tabs for notifications.** They should check the 'For Your Review' and 'Next ARCP' boxes in their 'Assessing' tabs to ensure they have reviewed and approved all forms sent to them and to note when they have

been invited to attend ARCPs.

8. Moving over: Any doctors in training that will CCT by 31 August 2022 should contact us if they want to move to the LLP, as we have assumed you will be remaining on the NES platform unless we are informed otherwise.

Further development

Now that it has been established, work on the LLP does not stop. The platform will be continuously reviewed and monitored for issues by the LLP Project Team. We will also be creating a roadmap for future improvements we would like to implement, subject to receiving further funding.

Should you have any queries or do not believe something is working for you in the LLP, please do not hesitate to contact us via llp@ficm.ac.uk.

How to link a SLE to both the 2021 ICM and Anaes/ACCS curricula

You can also find this guidance online at https://bit.ly/Linkup-SLE-Curricula.

1. Open any of the SLE forms (either ICM or Anaes) in your FICM Learner tab (apart from the ICM LOC form as this is only relevant for the ICM Curriculum) (**Image 1.**)

2. On the chosen SLE form page add the date of the assessment first, then go to the 'Add Learning Outcomes' field (**Image 2**). Now when you go to Choose an Assessor to send the form to, the assessor list is displayed according to which curriculum it is linked to.

   If it is purely an ICM SLE then only ICM Assessors will be displayed, if it is a purely an Anaes SLE then only Anaes Assessors will be displayed and if it is a dual SLE both ICM and Anaes Assessors will be displayed for you to choose the right person to send the assessment to. Therefore, you have to link it to the curricula first, so it knows which group of assessors to display.

3. When you have clicked on the 'Add Learning Outcomes' link, you will then see the following screen that enables you to choose capabilities to link the assessment to from the Anaesthetic/ACCS curricula and outcomes to link it to from the ICM curriculum. (**Image 3**).

Image 1

Image 2

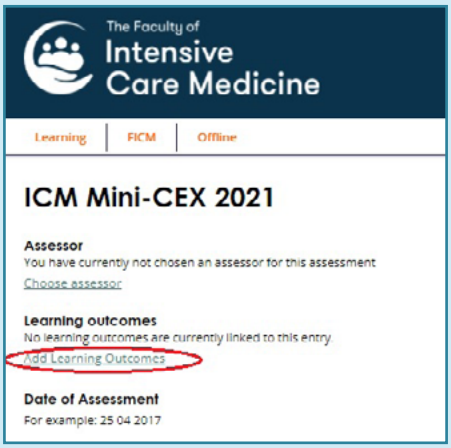


Image 3

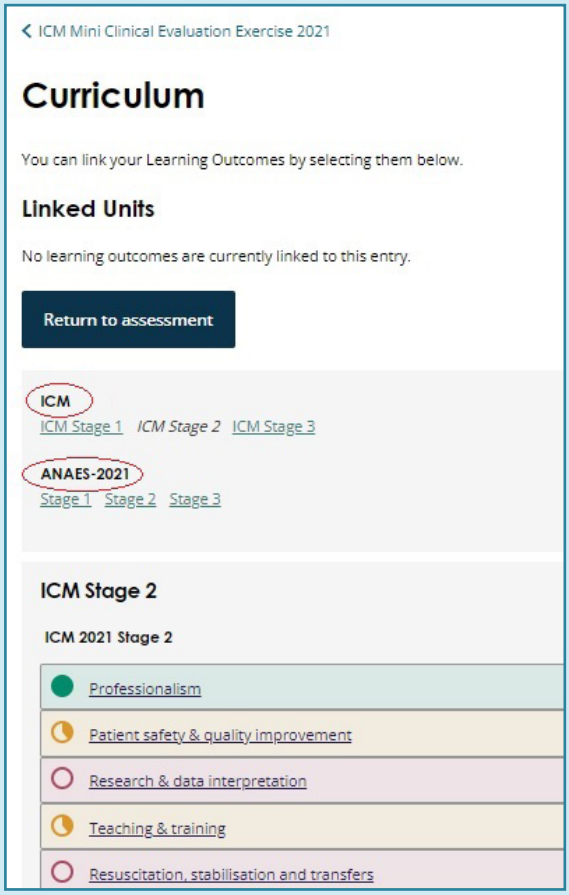
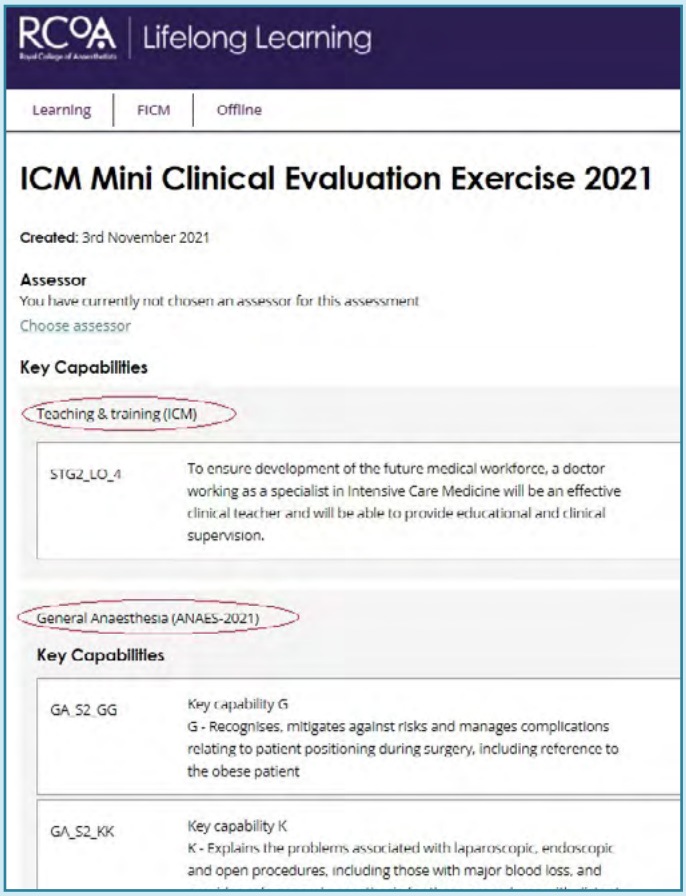


Image 4



1. Toggle through both curricula and link your assessment to all the appropriate capabilities and outcomes. Once you have added one capability/outcome, to add more you should click on the 'Return to Curriculum' button.

2. Once the SLE becomes a 'Dual SLE' (ie you have linked it to both the Anaes and ICM curricula) the default branding for the form will be RCoA, even if you have created an ICM SLE.

3. Once you have finished selecting the appropriate capabilities and outcomes to link the assessment to, you should then click the 'Return to assessment' button and you should then see the following screen displaying all the capabilities and outcomes connected to this assessment.

   It will show you which ones you have linked to the Anaesthetic/ACCS Curricula and which ones to the ICM Curriculum. Look at the wording in the brackets next to the capability/outcome. (**Image 4**).

4. For reference, it will state clearly in red on the form that the assessment has been linked to both Anaesthetic/ ACCS and ICM curricula.

5. You should then go back to the 'Choose Assessor' field and select the right person to send the assessment for approval. On receipt of a 'Dual SLE' the Assessor should carefully review all the capabilities and outcomes the form has been linked to. If they believe anything has been linked inappropriately, they can amend the form before sending it back to you.

6. After you have chosen your assessor, complete the rest of the fields in the form as usual and add any supporting documents if necessary.

7. Then you can send to your

Image 5 As an SLE in the Anaes 2021 Curriculum under the General Anaesthesia Outcome

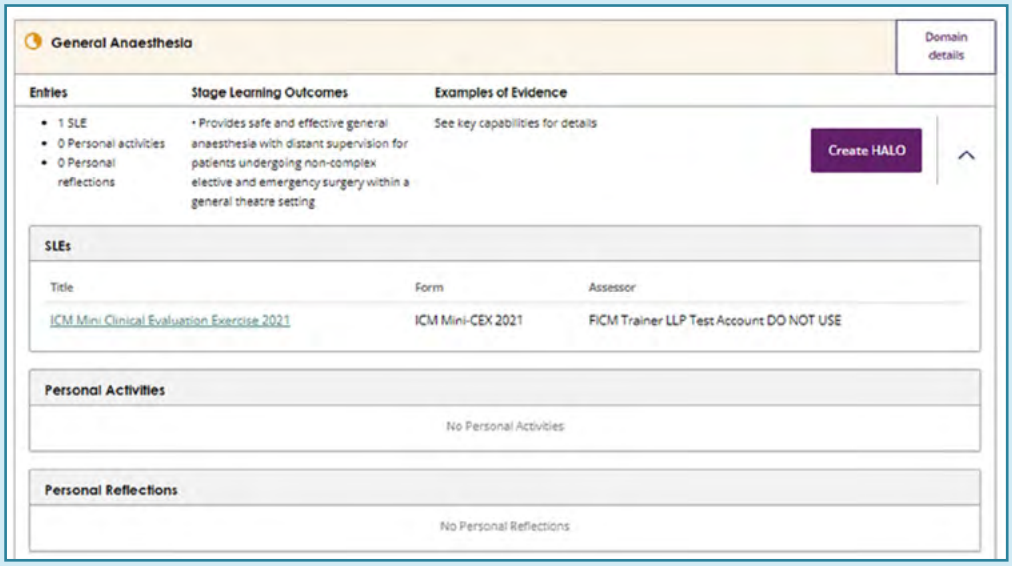
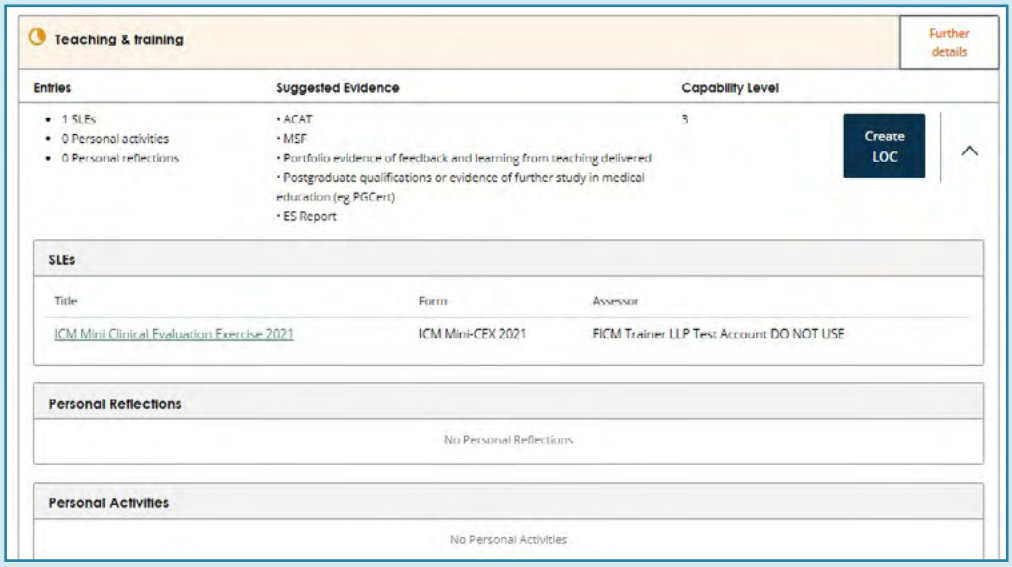


Image 6 As an SLE in the ICM Curriculum under the Teaching and Training HiLLO



chosen assessor for approval, either via the normal route or via the 'Quick Approval' route if your assessor is in the room with you.

8. As this is a 'Dual SLE' it will appear in both of your dashboards (RCoA and FICM) in your 'Recent Activity' boxes.

Once your supervisor has approved the form you can then see that it appears as evidence towards attainment of the respective outcomes in both curricula (e.g. **Images 5 and 6**).

9. You can also see this functionality demonstrated in our most recent webinar for StRs held on 30 September 2021, available at https://www.ficm.ac.uk/trainingexamslifelonglearning/llp-guidance-material.

Trainee Update

Dr Cat Felderhof
FICM Lead Trainee Representative

Our brains are not designed to cope with uncertainty. When we don't know what lies ahead, we run through all the various scenarios, often fixating on the worst possible outcome. Fear of the unknown can trigger a physiological state of stress and activate our sympathetic response which in the long term can have negative health impacts.

Revealingly, in 2016 a team at University College London demonstrated that participants in their study were even more stressed by an unknown outcome than by a predictably bad one.

Unease and unpredictability

Being a doctor in training involves living with significant levels of uncertainty over a period of (sometimes many) years. I have lost track of the number of consultant colleagues who have told me "Post-CCT just knowing what you're doing consistently every week is so much better". During training, our minds are filled with questions "what rotations will I being doing, when will the rota come out, will I get paid correctly when I move, will I pass my exams, can I progress to the next stage, what does the new curriculum mean for me, and will I get the consultant job I want?" A continual, exhausting, anxiety-inducing unease and unpredictability, linked with continually feeling like a temporary member of staff, being the new person and wanting to make a good impression creates the perfect storm for a large-scale wellbeing crisis.

Wellbeing and the basics

It would be impossible to eliminate all uncertainty from life however we can seek to minimise it. For me, wellbeing is about providing certainty around some of the basics — knowing that you can travel to work/park reliably, that your rota will be sent out with adequate notice, that you can get hot food and somewhere to rest during a night shift, that you will be paid correctly, knowing that if you work hard and make the most of opportunities that you will progress through training, that if you study 'x y and z' that you are in with a good chance of passing your exams first time.

The exam results brought a huge amount of disappointment to many in October and the resultant, necessary investigation prolonged the uncertainty for those involved, for that I am very sorry. In addition to the ongoing exam review we are looking towards improving exam educational resources going forward and I am pleased to be part of the working group at FICM tackling this. The engagement event with the regional reps from across the UK following the exam results has highlighted the need for continuing improved engagement with StRs and we are working on ways in which this can be done; I hope to be able to release more information on this soon.

Forward together

2022 brings some absolute certainties for us as reps — Guy Parsons has completed his tenure, he will be sorely missed; I have really enjoyed working with him and we thank him for all his hard work. He moves on to take up the role of Vice Chair for The Academy of Medical Royal Colleges Trainee Doctors Group.

I'm pleased to say that Matt Rowe has commenced his position as Deputy Rep, and we are already making plans for projects we can take forward together this year. We seek to build a solid foundation on which StRs can stand confidently rather than shifting sands and we would encourage all others to seek how they can do the same for their pre-CCT colleagues.

Regional Advisor Update

Dr Matt Williams
Lead ICM Regional Advisor

2021 was another incredibly busy year for the Faculty and its representatives, with its work and projects being complicated by the impact of COVID. I hope that, as you get to read this, you have managed some rest and time with those important to you over the festive period, and that this restores some level of resilience for the months ahead.

Alongside their clinical day-to-day activities, it has been clear just how much key educators in ICM (RAs, TPDs and Faculty Tutors) have been striving to support and deliver education and training as best they can. Thanks must go to them for all that they do; FICM's responsibilities are reliant on their engagement.

The impact of having to adapt

So much has been affected, including the FFICM exam which is being considered carefully and will be covered outside of this publication. An example is regional training days being (by necessity) adjusted to virtual platforms, providing continuing access to education, but at the detriment of losing the pastoral benefits of personal contact with peers and educators. We should not underestimate the significance of the impact on training or wellbeing that this is likely to be having (for both StRs and trainers); my hope for the New Year is that we are all ever more mindful of asking after each other, making attempts to understand each other's issues, and of being kind to each other in all interactions.

New curriculum

Our new curriculum commenced in August 2021, supported by the move to the Lifelong Learning Platform e-portfolio. Acknowledging some inevitable initial teething problems, this seems to have gone reasonably smoothly. Thanks must go to the huge amount of work from Natalie Bell and Rohini Makwana in the FICM secretariat in responding to enquiries from StRs and trainers.

Whilst change at this time might not be ideal (not that anyone likes change), reducing the assessment burden, encouraging more ownership and professionalism towards one's own training, and moving to 'entrustment' decisions on capability progression has been sought and encouraged by those in training and trainers. The timing of implementation has been set by the GMC. A hidden benefit from COVID (important to think positively!) is the derogations that we have in place; they encourage a shift in mindset towards judging overall progression of an individual StR, which is the essence of the new curriculum.

> **"It is hard to see the light, but dare we be hopeful that the recent data might be starting to suggest the influence of vaccinations and changing variants on the severity of illness.**

NES e-portfolio deadline

I'd like to highlight two specific things whilst mentioning the curriculum. Firstly, the deadline for StRs to download data from the old NES ePortfolio platform has been extended until **31 January 2022**., recognising wider recent pressures.

However, it is important that StRs and their supervisors actively engage with documenting their meetings, and their progression with training on the new curriculum since August 2021. So please do ensure any data to be uploaded to the LLP from the NES ePortfolio is accessed ASAP.

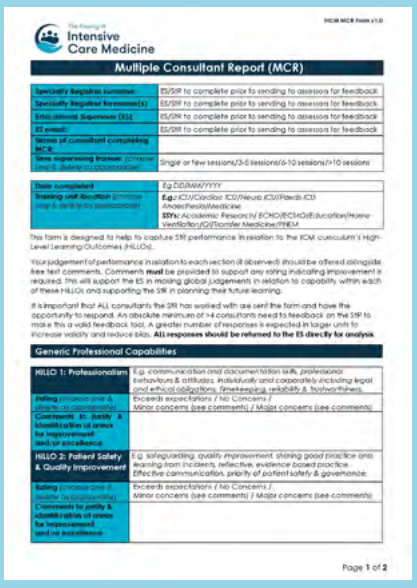
Multi-Consultant report

Secondly, there is a pilot Multi-Consultant Report (see image) available to help inform StR progression. It can be used in every module of training. Such faculty-wide assessments are in use in other specialties; its use should help support Educational Supervisors' judgements on HiLLO progression, and the feedback they can give to their StRs.

ICM Recruitment 2022

The recruitment round for starting specialist training in August 2022 is currently in progress. A large number of consultants will be needed to run the (virtual) selection centre in March, so **all volunteers are welcome!**

Hopefully, we will see the same interest in applying to join our specialty as in 2021. It is important that TPDs and RAs play their part locally in negotiations to encourage Statutory Education Bodies to increase the number of ICM training posts. This local work complements the work that FICM and other stakeholders can play in making the case with those controlling workforce planning.



Intensive Care Medicine

Multiple Consultant Report (MCR)

Specialty Registrar Surname:	ES/SR to complete prior to sending to assessors for feedback
Specialty Registrar Forename(s):	ES/SR to complete prior to sending to assessors for feedback
Educational Supervisor (ES):	ES/SR to complete prior to sending to assessors for feedback
ES email:	ES/SR to complete prior to sending to assessors for feedback
Names of consultant completing MCR:	
Time supervising trainee: (choose one)	Single or few sessions/3-5 sessions/6-10 sessions/>10 sessions

Date completed:	*Eg DD/MM/YYYY*
Training unit location (choose one)	**Eg** ICU/Cardiac ICU/Neuro ICU/Paeds ICU Anaesthesia/Medicine **SSYs:** Academic Research/ ECHO/ECMO/Education/Home Ventilation/GI/Transfer Medicine/TIME

This form is designed to help to capture StR performance in relation to the ICM curriculum's High-Level Learning Outcomes (HLLOs).

Your judgement of performance in relation to each section (if observed) should be offered alongside free text comments. Comments **must** be provided to support any rating indicating improvement is required. This will support the ES in making global judgements in relation to capability within each of these HLLOs and supporting the StR in planning their future learning.

It is important that ALL consultants the StR has worked with are sent the form and have the opportunity to respond. An absolute minimum of >4 consultants need to feedback on the StR to make this a valid feedback tool. A greater number of responses is expected in larger units to increase validity and reduce bias. **All responses should be returned to the ES directly for analysis.**

Generic Professional Capabilities	
HILLO 1: Professionalism	E.g. communication and document taken (safe, professional behaviours & attributes, individually and corporately including legal and ethical obligations, Timekeeping, reliability & trustworthiness)
Rating (choose one & delete as appropriate)	Exceeds expectations / No Concerns / Minor concerns (see comments) / Major concerns (see comments)
Comments to justify & identification of areas for improvement and/or excellence	
HILLO 2: Patient Safety & Quality Improvement	E.g. safeguarding, quality improvement, sharing good practice and learning from incidents, reflective, evidence based practice. Effective communication, priority of patient safety & governance.
Rating (choose one & delete as appropriate)	Exceeds expectations / No Concerns / Minor concerns (see comments) / Major concerns (see comments)
Comments to justify & identification of areas for improvement and/or excellence	

Page 1 of 2

TLAM

I am really looking forward to our next annual Training Leadership Annual Meeting (TLAM), taking place on **28 February 2022.** Thanks to Andrew Sharman (Deputy Lead RA) and Rohini Makwana for organising what is always an important event of the year, at which more than just the curriculum is on the agenda.

TLAM 2022 will take place on Microsoft Teams and we can look forward to lots of great sessions, on the day, including:

- ICM Workforce now and then in 10 years
- Recruitment — Then, Now and the Future
- How to attract and retain ICU Consultants to Smaller Units
- How to inspire Medical Students to ICM
- FFICM then and curing COVID
- Simulation and its role in ICM training.

Hope

I am writing this in a brief, very necessary step away from the 'coalface'. It is hard to see the light, but dare we be hopeful that the recent data might be starting to suggest the influence of vaccinations and changing variants on the severity of illness. Here's hoping… I hope that we can all keep ourselves safe and well through the next few months.

The CESR Process

Dr Sarah Clarke
CESR Curriculum Lead

A doctor must be on the Specialist Register of the UK General Medical Council (GMC) if they are to be employed as a substantive consultant in the UK. Entry to the Specialist Register is via a Certificate of Completion of Training (CCT), applied for after final ARCP and Outcome 6. An alternative route of entry is via a Certificate of Eligibility for Specialist Registration (CESR).

With the GMC approval and roll-out of the 2021 curriculum for ICM, came the simultaneous publication and approval of new guidance for CESR applicants.

It must be emphasised that the curriculum has not changed in content, and still aligns with the CoBaTrICE framework. However, it has fundamentally shifted its focus from a competency-based to an outcomes-based curriculum (after the GMC's *Shape of Training* and *Excellence by Design* reports).

This is paralleled in the CESR approach, and any new CESR applicant must now align their application to the new High Level Learning Outcomes (HiLLOs) as described in the 2021 ICM curriculum. It is for this reason that the ICM SSG refers and links to the new ICM curriculum throughout the document. There are many similarities between the two; resources, layout of the HiLLOs, supporting tables, advice, language and terminology. The successful approval of a CESR application includes the importance of completing an ICM examination, which is referred to as a 'Test of Knowledge' in the ICM SSG. Examples are the FFICM, DICM, EDIC and FCICM.

It is important to emphasise the rigorous standards and transparency that is applied when the Faculty is reviewing ICM CESR applications. This is necessary to ensure robust standards are met to provide confidence in the process for the regulator, the profession and the patient.

Top Tips for applicants

- Read the ICM Specialty Specific Guidance in detail. Heed the guidance, suggestions and 'checklists'.
- Identify a local CESR Lead in your Trust or regional mentor, who is familiar with the new 2021 ICM curriculum and CESR process and can advise and support you.
- You must fulfil the specialty module requirements; Neuro, Cardiac and Paediatric ICM, and those of the complementary specialties; Medicine & Anaesthesia. An application will be rejected if the evidence towards these modules/ specialties are lacking.
- The CESR process is quite lengthy so organisation and planned submission of evidence will strengthen your application.
- A piece of evidence need only be submitted once and attached to the most relevant HiLLO. It can then be justifiably mapped against other HiLLOs.
- Only submit evidence that is directly relevant to your HiLLOs. Submitting high volumes will not push your application to be granted for a CESR in ICM.
- The CESR application is GMC led and entry onto the Specialist Register is awarded by the GMC.

Visit www.ficm.ac.uk/equivalence-cesr for more.

Careers, Recruitment & Workforce (FICMCRW)

Dr Jack Parry-Jones
FICMCRW Chair

The ups and downs of this pandemic just keep on going. It's like a long stay critical care patient's course. That roller coaster of illness and recovery, illness and recovery, illness and recovery until with luck the patient enters their true recovery phase before discharge home. We all know how much this takes out of the family.

Another wave

As I write this, we are well into a pandemic wave. I hope as you read it, things are getting better again. For us all working directly in intensive care, although each patient's "death may diminish us," there can be a strong emotional reward from delivering care and, in the main we receive gratitude and some praise. This pandemic however has hit all of us and I would like to give particular thanks and pay tribute to those not in the immediate "frontline". Our Faculty's own staff have been incredible; despite their workplace relocating to home, often with young family members seeking attention, they have continued to deliver outstandingly well.

Critical care's workforce also includes non-clinical staff, who across the spectrum sadly don't often get enough recognition and not enough thanks. We could not do what we do without you, so a big thank you and a shared hope that we all, together, soon enter our own rehabilitation phase.

Alongside the usual work that Careers, Recruitment and Workforce does we are currently particularly interested in diversity in the critical care workforce and better understanding and rectifying any differential attainment. Trying to ensure that opportunities are not based on what protected characteristics an individual has, but on meritocracy; ability, hard work and desire. We have already looked at differential attainment in applications for specialist training (National Training Numbers) and hope that data will be published soon.

The FICM workforce census

This year the census will only go to lead clinicians and Clinical Directors. The census asks questions of clinical leads and CDs around their own protected characteristics and career progression. We are also looking at progression to Faculty Board. The composition of the Faculty Board in terms of gender already reflects wider society; a testimony to the trailblazing Women in Intensive Care Medicine. The Board however does not currently reflect the diversity in backgrounds of you, our members, or wider society. We need to do more to encourage, nurture and seek representation from a broader membership base. We encourage anyone interested in standing for positions on Faculty working groups or on the Faculty Board, to make contact with us as individuals on the Board, or through the Faculty.

IMGS

We are also looking to provide better support to international medical graduates working in critical care both as locally employed doctors, as well as those looking to go down the route of a Certificate of Eligibility for Specialist Registration (CESR). We are very fortunate to have Shashi Chandrashekaraiah on CRW working on this. This requires joint work with deaneries and regional educational advisors to improve matters for this vital section of those working in critical care.

ICM National Recruitment 2022

Dr Tim Meekings
Recruitment Lead

As 2021 draws to an end and we look forward to 2022, planning is well underway for the 2022 national ICM recruitment round. The clinical workload imposed by the COVID pandemic meant that in 2020, ICM recruitment had to entirely depend upon a submitted portfolio self-assessment score.

In 2021, another wave of the pandemic meant that ICM recruitment still had to be based around a submitted self-assessment score, this time with a verification system in place by Consultant Intensivists with some assessor training.

Relying only upon a portfolio score to recruit to ICM training is obviously less than ideal — however a portfolio is scored, it is very difficult to assess critically important attributes like communication skills, clinical decision-making, teamwork and leadership. As these are all vital skills for a Consultant Intensivist, the intention for the 2022 ICM recruitment round is to return to some form of interview to enable these attributes to be assessed, in the hope that this time we will have Consultant Intensivists available to interview.

The portfolio self-assessment score remains part of the ICM recruitment process, but we plan to augment this with an interview.

Interview format

Ongoing concerns about the prevalence of COVID in the population have led to a decision that the interview process for 2022 will be conducted online. At time of writing (November 2021), the platform to deliver this is in the final testing phase by ICMNRO, to establish what can be delivered.

The proposed interview format will either be a single 30 minute station with a pair of interviewers, or two 15 minute stations with a pair of interviewers in each. Obviously, the preference will be to have a two station interview, as this doubles the number of interviewers that each applicant will be seen and assessed by, but we will have to see what the software is able to deliver. Whichever format is chosen, the content of the interview will be the same.

There will be a clinical scenario and a task prioritisation exercise. These will be followed by questions assessing the applicant's commitment to the specialty of ICM and more generic questions relating to professionalism and the duties of a doctor. A combination of the verified portfolio score with the score for the online interview will give a total score, which will enable all applicants to be placed in rank order. Then, as in previous years, a matching process will allocate training posts to applicants according to their ranking and preferred unit of application.

February to March 2022

If all goes to plan, the verification of portfolio scores will be completed before the end of February and the online interviews will take place in March. This will then allow offers to be released by the end of April. The last couple of years have shown, more than ever before, the importance of our specialty and the need to continue to expand and enhance our workforce — we look forwards to meeting the applicants!

Women in Intensive Care Medicine (WICM)

Dr Liz Thomas
WICM Chair

Women in Intensive Care medicine (WICM) meets quarterly to discuss the promotion of ICM as a career for all. We strive to take down barriers to ICM as a career. The committee has 12 members – ten consultants and two trainees and I am proud to hold the role of chair.

At the time of writing we are seeking to appoint two new members to WICM — they will be in post by the time this is published. I wish to thank Drs Cattlin and Flavin for their terms on the WICM committee and for their hard work.

In May 2021 we launched our Thrive mentoring scheme – more on this from me over the page. Thrive is hosted by WICM but is for consultants of any gender during their first years of their consultant job.

Annual meeting

Our Striking the Balance meeting ran on 30 November with an excellent and full programme. We had over 100 registrations and over 60 people attend live. The meeting was via the web but we are hoping to run the 2022 meeting face-to-face. We are always open to new ideas — if you would like to suggest a topic or be considered to speak at our next meeting feel free to get in touch via email at wicm@ficm.ac.uk.

WICM Emerging Leaders

The second cohort of fellows started their programme in July. The WICMEL fellows undertake an OU course and have a mentor who is on the FICM Board. They also gain experience of chairing meetings. The first cohort really found the programme helpful and they fed back that their leadership skills have been developed. We are planning for the future and may be extending the scope of WICMEL. We will let you know of any updates.

Medical schools project

In order to continue to promote ICM as a career for all and to start the promotion earlier in people's careers we are working on a project to provide critical care resources to medical schools.

This project is still in the early days but we have a focus group with medical students planned and have surveyed every medical school in the UK. We are aiming to make resources (probably video) to give to medical schools help to increase the exposure medical students see of critical care.

Women in WICM wider group (WWG)

We are delighted that we have almost 100 women registered to be in our wider group. We have had some excellent social media content from WWG members and we are aiming to pull on the collective expertise for all of our projects. It is not too late to join the wider group – if you are interested please email us to get involved!

Get involved

We are also always happy to have volunteers to write blog posts or other social media events (e.g. tweet my week on Twitter) – anything that helps promote ICM as a career for all. We also welcome AHPs/ACCPs into the WWG. If you don't already follow us on twitter you can find us at @WomenICM.

FICM Thrive

Thrive, the mentoring scheme for consultants in the first five years of their job, launched in May 2021. Thrive is hosted by the Women in ICM sub-committee (WICM) but the career mentoring and personal progression is a programme for all ICU doctors.

Our key objectives

- To empower and support ICM doctors in their careers
- To provide a strong network to enable suitable matching of mentees with mentors
- To provide resources and support to ensure that the mentoring relationship and interactions are fulfilling and product tangible outcomes for both mentees and mentors.

Having launched in May 2021 the first pairings are underway, and reports from people involved in the scheme is that the meetings are worthwhile and the programme is going well. We have, probably unsurprisingly, had more requests to be mentored than to mentor — so we are particularly looking for new mentors.

Initial launch

We have initially launched the scheme inviting consultants in the first 5 years of their post to be mentored. We are hoping once the scheme is established to roll this out to any ICU doctor and then to any FICM member or affiliate.

Can I be a mentor?

We are looking for established ICM consultants to volunteer as mentors. You do not have to have had any prior experience in this area and all our mentors who have signed up so far are finding the process straight forward, fulfilling and rewarding. To be a mentor we ask that you complete a short (approx. one hour) e-learning module and be a consultant with more experience than the person you are mentoring.

Therefore, you can also be a mentor if you are a consultant in your first 5 years of your consultant job. Also, mentoring does not take a huge amount of time — during the partnership, which lasts generally twelve months, there should be four meetings which last approximately an hour. The scheme is described in full on our web page — visit www.ficm.ac.uk/careersworkforce/ficm-thrive or search 'Thrive' on the FICM website. The forms to register as a mentee or mentor are available on the FICM website, or you can drop us an email on contact@ficm.ac.uk.

Benefits of mentoring

Mentoring has many benefits for the mentee, the mentor and the workplace as a whole. The GMC are keen to promote mentoring and recommend that all doctors consider having a mentor. We wish to highlight that mentoring is for all doctors, and it is certainly not just for any doctors in difficulty.

Mentors often find taking the time to mentor someone else enhances their career, encourages self-reflection and learning, increases wellbeing and prefects communication skills. I have really enjoyed mentoring others and would strongly recommend everyone becomes a mentor.

Smaller & Specialist Units Advisory Group

Dr Chris Thorpe
SSUAG Chair

It's amazing how life has changed working for the Faculty, and other bodies, in recent times. I was regularly going up and down to London on the train – a three and a quarter hour journey each way – for meetings.

I now do all my meetings over remote links, which does save a lot of time. Ironically, I probably now attend twice as many meetings as they are easier to access. The quality is not quite as good as face to face though. This step change in communication has also affected clinical management and practice. Networks have really come into their own during the pandemic. Necessity is the mother of invention, and the need to manage patients and beds across a region became an essential part of every day intensive care management. We have therefore seen a surge in methods of communication.

Fostering a sense of community

Morning video link catch ups between our region and also across the whole of Wales have helped foster a sense of community and organisation. WhatsApp groups amongst Intensivists across the region help in organising patient flow and capacity issues. We also have useful groups within the department.

How do you communicate?

We would like to assess how useful you have found the different methods of communication. The SSUAG will therefore be sending out a survey to smaller units to find out how communications have changed, and how effective you have found the different aspects. It doesn't take long, and we then plan to send it out to corresponding tertiary centres. The information will help shape development going forward.

In other news, there are still not enough Intensivists and other staff in the system, and ongoing recruitment problems in smaller hospitals continue.

International innovations

While the GPICS guidance for smaller units provides some flexibility, we look with interest at what is going on in other parts of the world, in particular the development of telemedicine from e-ICUs. Recent developments in Georgia, USA have included the ability of e-ICU staff to work from home which has dramatically increased the availability of staff to cover night shifts at short notice.

They also partially shifted their work to Australia, with staff going over for 6-8 week attachments on the West coast (12 hours time difference). This allows them to cover night calls while having a daytime working pattern, and to spend their spare time on the beach. I'm not jealous at all.

Critical Care Pharmacists

Ms Lorraine Moore
FICMPSC Member

The FICM Pharmacy Sub-Committee (FICMPSC) have been working to progress a critical care pharmacist advanced practice curriculum, working with the United Kingdom Clinical Pharmacy Association (UKCPA) and the Royal Pharmaceutical Society (RPS). The curriculum and assessment methods are nearing completion and we continue to work on how credentialling will be implemented nationally. Exciting times ahead!

Pharmacist training and career development varies significantly to that of our medical colleagues and it is generally less structured. Whilst critical care pharmacists make up only a small minority of UK clinical pharmacists, we continue to be on the vanguard of advanced practice developments. This is one of the first workstreams of the FICMPSC, and was the joint redevelopment of the current specialist curriculum into a new national framework; bridging the existing RPS foundation and consultant frameworks whilst sitting alongside the core generic RPS advanced practice framework. The whole creates a defined pharmacist career pathway.

Five domains

The new specialist framework complements the core pharmacist framework. It compromises five domains: Person centred care and collaboration, professional practice, leadership and management, education, and research. Within each of these domains are a number of specific capabilities which are further broken down into measurable outcomes with methods of assessment. We have ensured that relevant content and terminology used in the FICM ICM and ACCP curricula were incorporated.

Each development stage was approved by a larger task and finish group comprising UK wide multiprofessional members with educational or critical care experience including our past Dean of FICM, Dr Anna Batchelor. Further support was provided by an inclusion and diversity panel.

New assessments

A change from previous syllabuses will be the addition of a clinical knowledge and skills assessment to demonstrate competence. Evidence for all the domains will be gathered into an e-portfolio using a variety of tools such as the acute care assessment tool (ACAT), case-based discussions (CBDs), clinical evaluation exercises (mini-CEX) and multi-source feedback (MSFs), which will more closely align with postgraduate education in other professions. Portfolio submissions will be reviewed by an expert panel before being given the title 'Advanced Specialist Pharmacist'.

Mentoring and support

Following this, the FICMPSC are now turning our attention to developing sustainable methods of assessment, continued credentialing and support for our members as a commitment to lifelong learning and career development. We also hope to include a mentorship programme similar to FICM Thrive.

Get involved

The FICMPSC is always looking to expand its membership. Please highlight the FICMPSC work to your critical care pharmacist colleagues and signpost them to the benefits of FICM pharmacist membership, as we work to strengthen our community. If you have any ideas or suggestions, please contact a member of the FICMPSC and get involved.

First FICM ACCP Accreditation:

An important development for UK ACCP training

Dr Gregor McNeill
ACCP Sub-Committee member

It has been an aim to develop an HEI accreditation process for ACCP training for some time. The first HEI accreditation visit in late 2021 was the culmination of a long period of preparation by many within the FICM as well as members of the FICM ACCP Sub-Committee.

ACCP training has developed rapidly over the past decade and the recent pandemic has again reinforced their crucial role as part of our critical care workforce. Within the context of this rapid development, it has been a key aim of the FICM ACCP Sub-Committee to encourage a high standard educational experience that is mapped to the FICM ACCP Curriculum. This helps ensure that ACCPs coming forward to become ACCP FICM Members have achieved an equivalent standard of training, where-ever that training has been undertaken across the UK.

What is Accreditation?

HEI Accreditation is a well-established process in Health Care training. When developing the HEI ACCP accreditation process, FICM looked to mirror what has been undertaken to accredit training programmes in other settings.

Accreditation is a process by which a national body, such as FICM, defines standards and verifies the standards of local provision. The main aims of FICM ACCP Accreditation are to:

- Establish and monitor national standards for the design and delivery of ACCP programmes
- Ensure that programmes of study are designed to meet the specifications of the Curriculum Framework for the Advanced Critical Care Practitioner and delivered within a conducive learning environment
- Enhance the quality of ACCP programmes
- Ensure proposed ACCP programmes meet the standards of professional competence as per FICM's Curriculum Framework for the Advanced Critical Care Practitioner
- Ensure proposed ACCP programmes meet the standards for higher education as described by the Quality Assurance Agency for Higher Education's (QAA) Academic Infrastructure (namely, the Framework for Higher Education Qualifications (FHEQ), the accreditation of prior learning, Benchmark Statements, the Code of Practice, Programme Specifications and progress files: www.qaa.ac.uk/academicinfrastructure/default.asp.
- Ensure that ACCP programmes are supported by appropriate staffing and resources and operate within an appropriate academic and professional culture including the

assurance and development of quality

- Share good practice across providers of ACCP programmes as a mechanism of quality enhancement.

Development

By early 2021, the ACCP Sub-committee had developed the process sufficiently to request HEIs to undertake the inaugural accreditation. Due to the ongoing Pandemic the processes were adapted from an "in-person" accreditation visit to a virtual visit. Following an application process the University of Plymouth were chosen to undertake this first ACCP Accreditation evaluation.

Plymouth

Prior to our HEI virtual visit, Plymouth provided us with detailed information about all aspects of their ACCP Programmes, Postgraduate Diploma and MSc. The FICM Accreditation team comprised ACCPs and Consultants who sit on the ACCP Subcommittee.

Over the course of a very intensive one day visit, we considered all aspects of the programme. We were provided with a broad overview of the course by the Dean and Head of School. This was followed by more detailed discussions with the Programme Lead and Advanced Practice team. Meetings with academic support staff gave an insight into the educational resources available to trainee ACCPs and a demonstration of the Plymouth Digital Learning Environment (DLE) gave us an understanding of the systems that are at the heart of the blended/distance learning model used to deliver the Plymouth ACCP programmes.

Local delivery and learner experience

The second half of our visit focused on discussions with trainee ACCPs themselves as well as qualified ACCPs and ICM Consultants who delivered local aspects of the Plymouth course. This allowed us to gain an in-depth understanding of the local delivery of the ACCP programme as well as the experience of the learner. We heard about many aspects of course delivery as well as use of the Plymouth ePortfolio system. Peer support is a crucial part of ACCP training and it was very useful to hear about this from current and recent trainee ACCPs. It was interesting to hear how the Plymouth course had been adapted to the pandemic.

This part of the visit also helped us to understand the breadth of centres that use the Plymouth course. We were very grateful to ACCP and Consultant colleagues from several UK centres including Coventry, Bath and Hull who took time out from busy clinical schedules to give us further insights.

Accreditation report

Following completion of our visit and additional evidence submission, we worked with FICM colleagues to produce an accreditation report that has since been shared with the Plymouth team. We were delighted to confirm the Plymouth course as the first ACCP Programme to be accredited by FICM.

Finalising the process

Overall, as an Accreditation team we were very pleased with the overall process of our first accreditation. We aimed to examine all aspects of the educational content of a course but also have absolute focus on the clinical application of learning and the delivery of effective clinical ACCP training as outlined in the FICM ACCP Curriculum. We will continue to work as Sub-committee members to refine the process and look forward to further visits in the coming year.

#DiscoverACCP

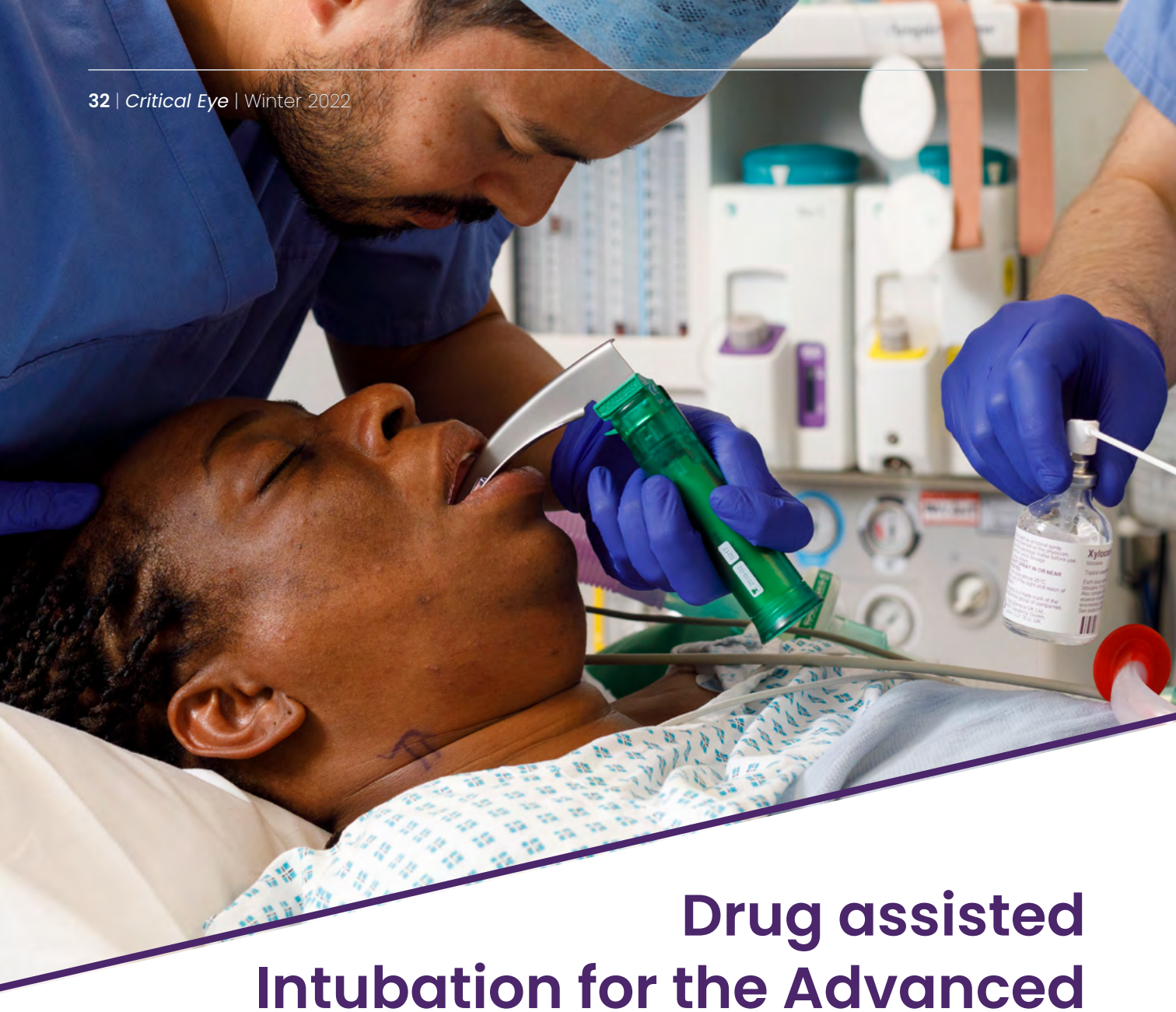
These tweets are designed to highlight the careers and experience of ACCPs. If you would like to take part, please get in touch with the Faculty.

SAVE THE DATE! FICM ACCP Conference

10 June 2022

- Royal Victoria Infirmary
- Newcastle upon Tyne
- 5 CPD points expected

The annual FICM ACCP Conference is due to take place in June 2022. We intend for this meeting to be face to face. More details including prices, booking and programmed topics will be made available on the Events section of our website in due course. Please visit www.ficm.ac.uk/events.



Drug assisted Intubation for the Advanced Critical Care Practitioner

Madison Larden
ACCP

Bill Allen
ACCP

Scott Hawkins
ACCP

The role of the Advanced Critical Care Practitioner (ACCP) is to provide patient-focused care, supporting their needs through their critical care journey, and initiating life-saving treatments. The extent and scope of practice vary between units at the requirements of the service.

Although airway management is an integral part of the FICM curriculum, this does not currently extend to Drug Assisted Intubation (DAI). DAI by Non-Medical Professionals (NMPs) is a contentious issue despite it being a common skill adopted across similar professions within neonatal critical care and well-established in other countries including the USA, Canada, and Australia.

The ACCPs within the Cardiothoracic Intensive Care Unit (CICU), work on the Cardiac Anaesthetic Fellows rota, as defined within the job description. They are required to perform inter and intra-hospital transfers independently and provide drug assisted endotracheal intubations in an emergency.

Training

Incorporated in ACCP training, two three-month theatre blocks were allocated with exposure to cardiac/thoracic theatres to develop basic and advanced airway skills. This included endotracheal tubes and double lumen tubes under direct consultant anaesthetist supervision.

In addition, general theatre time was allocated to provide development of airway skills involving supraglottic airway devices. After a period of training in theatres, skills were developed under consultant supervision within the ICU and the cardiac catheter suite.

Further opportunities encompassing training included attending a recognised regional advanced airway management course. Theoretical component of drug-assisted advanced airway management based on FICM ACCP competencies and the Royal College of Anaesthetists' guidelines (CCT in Anaesthetics, Basic level training, Annex B).

Governance

As stated above, DAI is a contentious issue and subsequently a robust governance structure needs to be in place, this includes sign off at Trust level, providing evidence of the training and competency. It is also essential that an escalation and support system is in place, ensuring that assistance can be gained within minutes if required.

Achieving competency

Becoming competent demands that an individual has the broad ability to practise to a required standard in a predetermined range of clinical fields and across a range of situations.

All airway procedures, including elective and emergency cases, were noted and overseen by the consultant supervisor. Entries within the logbooks include grade of airway, equipment used, attempts made to pass the tube, level of supervision and a note of problems that occurred. ACCPs were placed on the on-call Fellows rota once consultants felt that basic and advanced skills had been assessed as sufficient and safe.

Maintaining competency

The rota is an eight-week rolling rota, two weeks are allocated to cardiothoracic theatres to provide consistent exposure to the skills of drug-assisted advanced airway management in an elective capacity to facilitate the process when needed in an emergency. The theatre time also provides a supportive environment and an opportunity to self-assess skills and any areas that may require further development with direct anaesthetic consultant supervision.

Moving forward, The Faculty of Intensive Care Medicine will be releasing the Advanced Airway Optional Skills Framework which provides further support and direction of the practice of Advanced Airway Management for ACCPs.

As defined within the *National Education and Competence Framework for Advanced Critical Care Practitioners* (2008), ACCPs are required to practise responsibly and autonomously as part of a team to provide a patient-centred, sustainable service. The ACCP role crosses professional boundaries and they are required to perform clinical skills within their scope of practice whilst acknowledging limitations within their practice.

Professional Affairs and Safety (FICMPAS)

Dr Pete MacNaughton
FICMPAS Chair

The collaboration with the national patient safety team has continued to be very productive with the latest *Safety Bulletin* recently being released. I would like to thank Prof Gary Mills for his hard work in analysing the data and summarising the lessons and would refer you to his article in this edition of *Critical Eye* with a review of the key themes.

REMINDER!
GPICS v2 Audit Tool data submissions due by **28 February 2022!**
Submit to **info@ics.ac.uk**

No Trace = Wrong Place

The Faculty is a key stakeholder in the RCoA's campaign to highlight the risks of unrecognised oesophageal intubation, as outlined in Tim Cook's article in this edition of *Critical Eye*. I would encourage everyone to watch the excellent video on *Capnography in Cardiac Arrest: No Trace = Wrong Place*. Simulation flashcards have been developed to support theatre team training and will be adapted for use by the ICU team.

Concerns over the use of patient transfers between units to facilitate elective surgery recovery has been a topic of intense discussion. This resulted in the joint position statement on Capacity Transfer of Adult Critical Care from the Faculty and ICS.

GPICS audit toolkit

The GPICS audit tool is now available which allows units to benchmark themselves against the current standards. We would encourage all units to complete the audit to inform and support the development of their local service. We also hope that units will share their summary data so that we can build a national picture of compliance with GPICS v2 that will be used to inform the writing of the next edition. Further details are on the website with a deadline of **28 February 2022** for data submission.

Brain stem testing proformas updated

Following the reversal of a diagnosis of brain stem death in a patient who had undergone bilateral decompressive craniotomy, an additional red flag was added and the Faculty approved brain stem testing proformas updated. Further guidance has been developed to support clinicians when diagnosing brain stem death in the presence of a red flag which is available on the website.

We have received a number of communications regarding the challenges in obtaining relevant individual clinician related patient feedback for the purposes of revalidation that have become even more difficult as a result of the pandemic. The Board recognise these challenges and support the use of other methods of patient feedback and have produced guidance to support members in discussions with their local Responsible Officer.

Safety Incidents in Critical Care: Themes from the Safety Bulletin

Prof Gary Mills
FICM Safety Lead

The last two years have been a time of increasing patient workload, decreasing numbers of available staff and increasingly complex and distracting organisational issues, all of which are a recipe for safety incidents. FICM have tried to increase safety and critical care incident awareness, with updates during COVID, SBAR and Regulation 28 reports and over the last year, quarterly *Safety Incidents in Critical Care* Bulletins.

These are available in the Safety section of the FICM website. As the *Bulletin* develops, the aim is to expand the readership beyond medical staff, to include and involve critical care Allied Health Professionals with the intention of the *Bulletin* being circulated widely. Editions to date have summarised well over a thousand incidents, with the aim of converting extensive but inaccessible spreadsheets of data, kindly provided by NHSE/I, into digestible reports in a readable and informative style. Future aims are to extend the data sources to the whole UK.

Reliant on reporting

Despite the huge number of incidents reported, they are not a perfect quantitative representation of incidents on critical care, because they rely on reporting in difficult circumstances. The data is anonymised, so relies heavily on the original wording and completeness of each report. We have tried to include suggestions to reduce the frequency with which similar events occur. Unfortunately, events do recur and I will therefore try to summarise some of the more common types of incidents in the *Bulletin* that have led to morbidity or death. Notably, low staffing ratios are often mentioned in the reports.

Common themes

Disconnection

Most of the time staff notice disconnections before adverse events occur, but in every report; CPAP/NIV circuits, tracheostomies or endotracheal tubes become disconnected. When unobserved the consequences can be fatal. This is particularly so in side rooms, which have many other advantages, but bring hazards particularly for the level 2 patient who shares their nurse with a neighbour or level 3 patients, where staff need to leave to help others. Ideally a disconnection alarm would sound both inside and outside the room before the patient desaturates. Rooms need better design to allow patients to be seen from outside and alarms heard outside. Solutions might in the future include a device linked to the patient, which carries the alarms wherever the carer might be.

Obstruction

Tubes or filters block. The importance of the mantra of "the patient, the machine and everything in between" has been strongly illustrated by blocked HME filters or blocked ET tubes.

Dislodging

Dislodging tracheostomy tube or an endotracheal tube during turning is common. Dedicating someone to protect the ETT or trache is vital.

The leaking endotracheal tube or tracheostomy cuff

leading to a replacement ET tube is a hazardous scenario, with occasional failure in railroading a new tube into position. Full preparations and an understanding of the likely difficulties of the upper airway with immediate access to staff and difficult airway equipment are

essential. The dangers of this can sometimes be underestimated.

Forgetting to turn on a ventilator

when a patient has been moved from or to the transport ventilator has been described. The distraction at these times means that this is not noticed, and other monitors/alarms may not be in place. Switching a ventilator temporarily to 'standby' to avoid aerosols during COVID and then forgetting to switch it back does occur. Checklists are vital in these situations with two people being aware that the ventilator is being stopped and started.

Failing to fully connect oxygen supplies

or cylinders or turn a cylinder on and then check it is functioning have also been described.

Nasogastric tubes

Placement of an NG tube via the trachea into the lungs has been reported in every *Bulletin*. Most are recognised early. Despite this, Xray confirmation or pH tests are missed and feeding into the lungs occurs. Less well appreciated are pneumothoraces that can be caused when the NG tube enters the smaller airways. Chest Xrays after this has happened may reveal a pneumothorax that might otherwise go unrecognised.

Arterial Lines

Hand ischaemia resulted in patients who were reported as having had ulnar arterial lines. Hand ischaemia also occurred in patients who had had brachial artery lines. Ischaemia appeared more common when another artery in the same arm had already been used. Seldinger wires were lost in patients on insertion and the tips of lines lost into the artery when dressings were cut free.

Central Venous Catheters (CVC)

Misplacements are not always immediately detected because the guide wire placement is not confirmed by ultrasound and then once inserted the CVC waveform is not checked, resulting in infusions passing intra-arterially. After insertion unsutured lines or even occasionally sutured lines, are not protected during turns and are pulled out with sudden loss of cardiovascular supporting drugs resulting in hypotension and sometimes cardiac arrest. Loss of three-way taps, or three-way taps being left open are also commonly reported with deaths resulting from air embolism.

Medication Errors

Misunderstandings often lie between prescribing and administration, especially with infusions that have been started in another area, where concentrations used may be different. Unfortunately, new syringes with new concentrations may be loaded into the pump without a suitable change in rate. Electronic drug administration systems should be intuitive and logical to use, with appropriate dosage checks when prescribing. Current systems often are complex and not cross compatible with systems in another area.

Capnography

Must be functioning and have completed its start-up checks before a procedure begins.

Lack of beds or staff and slowness to transfer

The impact of not being able to rapidly admit to ICU and treat has strongly featured, especially where patients have been in need of continuous renal replacement therapy. Provision to allow this is very important.

Delayed investigation results

Low blood sugar levels on blood gas measurements are sometimes overlooked for lengthy periods. Some abnormal results are reported with unusual symbols, rather than values, which can cause confusion. Late addenda to reports do occur and are not always seen, so having reliable methods of flagging additional reports is vital.

Pressure ulcers

These are very commonly reported. Sometimes patients are reported as being so unstable that any movement causes deterioration, which means early attention to reduce the development of pressures sores is even more important. Patient positioning, avoiding lines being trapped under patients' nerves or pressure points or excessive pressure on eyes or faces, are essential. Tension exerted by NG tubes or urinary catheters can cause injury. Prone positioning requires even more attention to detail.

Conclusion

These are some of the more frequently reported problems, but safety incidents should always be considered in the context that allowed them to occur. We need to be better prepared, trained, organised and equipped across specialties and locations, in an environment designed and staffed to maximise our ability to care for patients. We hope the *Safety Bulletin* heightens awareness and encourages the provision of safer care.

Safety Alert

Confusing a plain breathing cicruit filter for a heat and moisture exchanging filter (HMEF)

The RCoA and FICM have received a coroner's Regulation 28 report to prevent future deaths. We are sharing the lessons from this tragic case to ensure they are incorporated into our practice.

Situation

A patient being ventilated for COVID pneumonitis in a surge ICU sustained a cardiac arrest on day 7. At the time an anaesthetic machine was being used to provide ventilatory support due to lack of conventional ICU ventilators. The cardiac arrest was thought to have been precipitated by the tracheal tube becoming blocked by thick secretions. The patient was successfully resuscitated following replacement of the tracheal tube but subsequently developed acute renal failure. The patient sustained a further deterioration in ventilation six days later when a partially blocked tracheal tube was identified at bronchoscopy and replaced.

At this stage the patient was being ventilated with a conventional ICU ventilator. Following the second episode, it was realised that there was no humidification in the ventilator circuit as what was thought to be a HMEF was in fact a plain bacterial/viral filter. The plain filter included a sampling port (used for capnography) which led the staff to incorrectly consider that it was a HMEF. Sadly, the patient subsequently died from multiple organ failure secondary to COVID pneumonitis and the cardiac arrest was considered a contributory factor.

Further Investigation

Further investigation identified up to 10 more patients who were not receiving humidification due to the incorrect use of a plain filter in place of a HMEF. The coroner was concerned that there was confusion between HMEF and filters by many staff over a number of days that could occur and that action was needed to reduce the risk of harm to future patients.

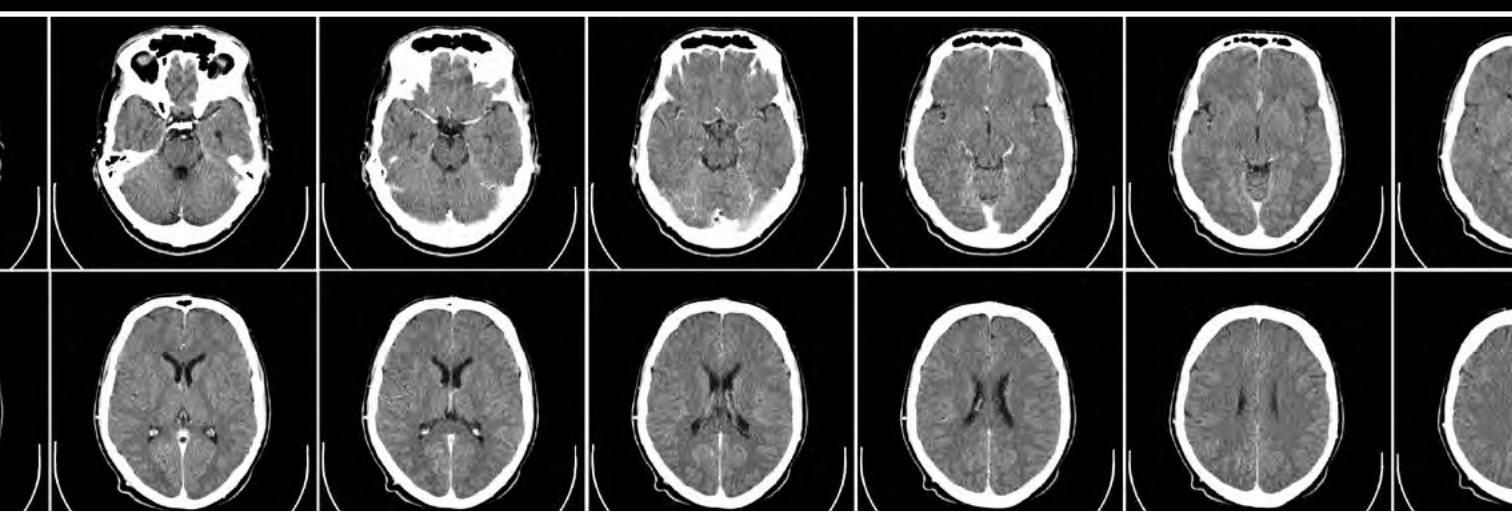
Lessons

- HMEF and plain filter may be confused as they can look similar and the labelling may not be clear. Standardisation of labelling including colour coding could reduce the risk of a plain filter being mistaken for an HMEF. This has been referred to the MHRA for consideration. The presence of a sampling port on a plain filter may increase the risk of it being mistaken for a HMEF.
- The use of an anaesthetic machine as an ICU ventilator by staff unfamiliar with the equipment is likely to have contributed to the errors. Plain filters with sampling ports are designed only for use in anaesthetic machines when undertaking short cases and they should not be available in an ICU.
- All members of the MDT involved with managing ventilated patients must be aware of the difference between the plain filters and HMEFs in use on their unit and their correct placement in the ventilator circuit. If an HMEF is being used it must be at the patient end and there should be no other filter in the circuit. If an active humidifier is being used (heated water bath) then a plain filter should be placed in the expiratory limb of the circuit close to the ventilator.
- Regular checks of the ventilator circuit must be undertaken. This should be undertaken at least once per shift. A check list may assist the correct procedure. The check should ensure that an appropriate form of humidification (wet circuit with an active humidifier or use of an HMEF at the patient end but never both). The risks of combining a wet circuit and HMEF have been previously highlighted in a national safety alert (MRHA Patient Safety Alert NHS/PSA/W/2015/012. Risk of using different airway humidification devices simultaneously).

Additional FICMPAS Guidance for Decompressive Craniectomy and Diagnosing Death using Neurological Criteria (DNC)

Dr Dale Gardiner
Endorsed by FICMPAS

Some clinicians have asked for additional guidance in this specific circumstance. We suggest that until further evidence becomes available to guide practice, the diagnosis of DNC in patients who have undergone a therapeutic decompressive craniectomy can be supported by the demonstration of absence of intracranial blood flow, for example, by CT angiogram.



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Data from the potential donor audit (PDA) shows that death is confirmed using neurological criteria in approximately 1,700 persons per annum in the United Kingdom. The PDA also suggests that each year, on average DNC is only confirmed in 5–10 patients who have undergone a therapeutic decompressive craniectomy (0.3-0.6% of all DNC determinations). Few intensivists will have significant experience of confirming DNC in the presence of therapeutic decompressive craniectomy. This limited experience in confirming DNC in the presence of therapeutic decompressive craniectomy is not surprising given that the procedure has only re-emerged as a therapeutic option in recent years. Also, it is likely that these cases will be seen almost exclusively in neuro-intensive care units.

Following a case in the United Kingdom in early 2021 where a patient who had undergone bilateral therapeutic decompressive craniectomies and diagnosed DNC using clinical criteria but went on to start breathing and regain consciousness, an expert group reviewed the case in detail. The group recommended that decompressive craniectomy should be added to the list of Red Flag patient groups on the FICM and ICS endorsed Forms for the Diagnosis of Death using Neurological Criteria. This recommendation was accepted by both organisations and added to the updated version of the forms.

Red Flag groups are those that have been identified in the literature or from clinical experience as cases where irreversibility of the apnoea and coma is more difficult to establish.

Red Flags

The list of Red Flags which appear on the nationally endorsed testing forms[1] are:

1. Testing < 6 hours of the loss of the last brain-stem reflex
2. Testing < 24 hours of the loss of the last brain-stem reflex, where aetiology primarily anoxic damage
3. Hypothermia, 24 hour observation period following re-warming to normothermia recommended
4. Patients with any neuromuscular disorders
5. Steroids given in space occupying lesions such as abscesses
6. Prolonged fentanyl infusions
7. Aetiology primarily located to the brain-stem or posterior fossa
8. Therapeutic decompressive craniectomy

Approaches

There are four approaches to consider in the presence of **any** red flag situation before confirming death using neurological criteria:

1. Delay testing and give more time if this will resolve the red flag concern
2. Consider the use of drug antagonists or measure plasma levels of sedatives, if this will resolve the red flag concern
3. Carry out an ancillary investigation, which should be considered additional to the fullest clinical testing and examination carried out to the best of the two doctors' capabilities in the given circumstances
4. Conclude it is not safe to make the diagnosis of death using neurological criteria, which may lead to a decision to withdraw life sustaining treatment.

Therapeutic decompressive craniectomy

In the context of a patient who appears to meet the criteria for DNC following a therapeutic decompressive craniectomy we suggest that clinical tests can be supported by the use of an ancillary investigation. Most ancillary tests either confirm the absence of cerebral blood flow or of neurophysiological activity. The investigation undertaken depends on local availability of the test and access to expertise to interpret the result. It is also dependent on the sensitivity and specificity of the test in confirming the diagnosis.

Types of ancillary investigations which have been used to confirm absence of cerebral blood flow include CT angiography, persisting measurement of Intra Cranial Pressure greater than Mean Arterial Pressure (ICP > MAP), 4 vessel angiography, transcranial doppler, MR angiography and positron emission tomography.

In the UK the ancillary test that is most widely available in hospitals (not just neuro centres) is likely to be CT angiography. It is recognised that some intracranial vessel opacification is present in approximately 15% of patients who are confirmed DNC[2]. However, in cases where CT angiography (or any other ancillary investigation) is used to exclude confounders, such as is the case in therapeutic decompressive craniectomy, absence of intracranial flow is necessary to confirm DNC.

A FICM working group is currently collaborating with the British Society of Neuroradiologists to create a standardised protocol for CT angiography when used as an ancillary investigation for DNC.

Undetected oesophageal intubation and critical care: A decade on from NAP4

Prof Tim Cook
RCoA Advisor on Airway

In August 2020 Glenda Logsdail, a former NHS radiographer, died of undetected oesophageal intubation. The Royal College of Anaesthetists is working to highlight this issue as a potential cause of avoidable deaths.

Glenda Logsdail's undetected oesophageal intubation did not take place in critical care, and nor did the two high profile cases that four years ago led to the 'No Trace = Wrong Place' campaign. However, the issue is highly relevant to critical care.

4th National Audit Project

A decade ago when the 4th National Audit Project of the Royal College of Anaesthetists and Difficult Airway Society (NAP4) was published, critical care was identified as the area most in need of improvement. Events were more frequent and more of the events led to death than either in the emergency department or during anaesthesia.

Use of waveform capnography was at best sporadic and structured airway assessment, planning, equipment provision and education were in need of improvement.
To the great credit of the critical care community the response was dramatic with much of the 'safety gap' closed within a couple of years and now airway management in critical care is transformed. But there is no room for complacency.

No Trace = Wrong Place

The principle behind the 'no trace = wrong place' campaign is to emphasise that if after intended tracheal intubation there is a flat capnograph trace, it should first be assumed that the tube has been placed in the oesophagus and immediate action should be taken to exclude and correct this. While there are other causes of a flat trace at intubation, it is oesophageal intubation that is readily fixed and predictably fatal if missed.

In many cases action may be simply to remove the tube and reintubate but in higher risk settings re-laryngoscopy (in preference with a videolaryngoscope) or immediate bronchoscopic examination via the tube may be indicated. As the 'no trace = wrong place' video emphasises, cardiac arrest is NOT sufficient explanation for a flat trace and during cardiac arrest an attenuated capnograph trace is present if intubation is successful.

Relevant to critical care

Why is this so relevant to those of us who work in critical care medicine?

Summary: oesophageal intubation

is **avoidable**

is **always fatal unless rapidly detected**

has been a **never event** and may soon be again

correct interpretation of waveform capnography is the primary tool for detecting it. NO TRACE = WRONG PLACE

training and empowerment of whole airway team is essential to safety

factors reducing risk include videolaryngoscopy, training, good monitoring practices and a safety culture

Firstly, in NAP4 amongst nine cases of undetected oesophageal intubation reported, four were from intensive care — more than in any other location — and all these patients died or suffered permanent harm. Our intubations are amongst the highest risk.

Most patients are already hypoxaemic and cardiovascular collapse at intubation is common, with cardiac arrest occurring in 2% of intubations. Secondly, physiological, and logistical difficulty is almost ubiquitous in critical care airway management, decreasing success rates and increasing complications. The rate of oesophageal intubations in the recent INTUBE study was 5.6%.

Waveform capnography

Universal use of waveform capnography and a universal ability to interpret the basics of a capnograph trace are modern pre-requisites of safe airway management in critical care. Of note in human factors language, capnography is 'error trapping' rather than 'error preventing'.

Error prevention is achieved by preventing oesophageal intubation in the first place. Increased training in and use of videolaryngoscopy, use of an intubation checklist, team training, a flattened hierarchy and crisis management practice with simulation may all improve both error prevention and trapping.

What's next?

Over the next few months, the Royal College of Anaesthetists in conjunction with a number of other stakeholders will be developing resources for multidisciplinary team training to prevent and detect unrecognised oesophageal intubation. I encourage all those working in critical care to head to the College webpage for up-to-date information on the campaign: Prevention of future deaths.

Author's information

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Liberty Protection Safeguards

Mr Alex Ruck Keene
LEPU Member

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The Liberty Protection Safeguards are scheduled to come into force in due course in England & Wales to replace the Deprivation of Liberty Safeguards. When the regime comes into force, it will place new responsibilities upon NHS Trusts to authorise deprivations of liberty within hospitals for those aged 16 and over.

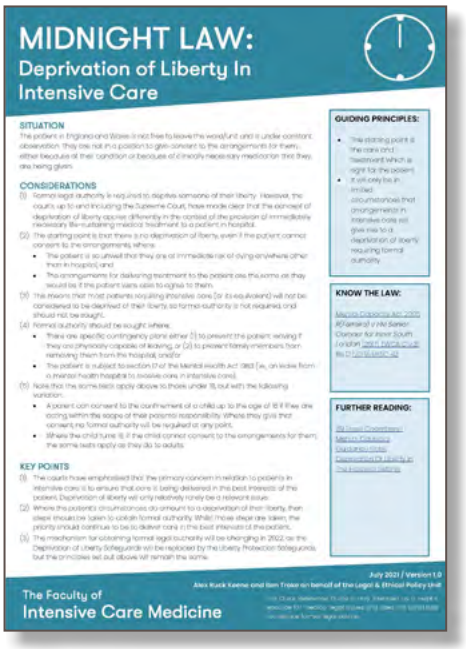
Government position

At the time of writing, the Government's position is that the LPS will come into force in April 2022. However, it is clear that this is impossible because key preparatory steps have yet to be taken, including the publication for consultation of a draft Code of Practice, and also regulations to set out who can carry relevant tasks.

The DHSC's LPS website (www.gov.uk/government/collections/mental-capacity-amendment-act-2019-liberty-protection-safeguards-lps) contains updates; a detailed, targeted, article will appear in Critical Eye in due course identifying the key aspects of the LPS relevant to the critical care community.

Midnight Law

In the meantime, it is necessary to keep making use of the tools that are available to authorise deprivation of liberty — i.e. the Deprivation of Liberty Safeguards and (for those under 18) applications to court. The Midnight Law document prepared by the Legal and Ethical Policy Unit provides a concise guide to identifying who, within the critical care setting, is to be considered to be deprived of their liberty. Visit www.ficm.ac.uk/midnightlaws. for more.



Further useful resources

www.hilldickinson.com/sectors/health/liberty-protection-safeguards

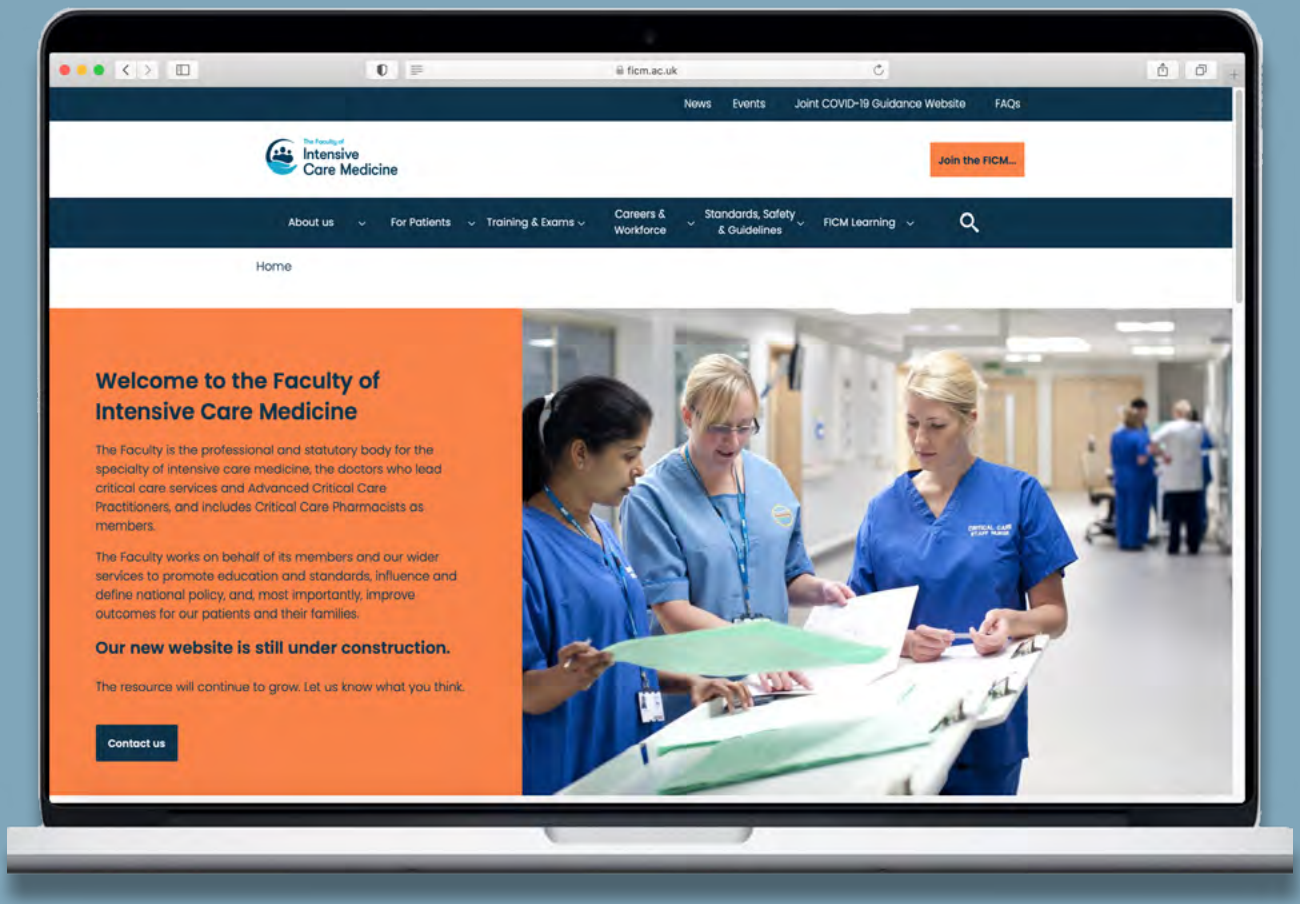
www.mentalcapacitylawandpolicy.org.uk/resources-2/liberty-protection-safeguards-resources/

NEW FICM WEBSITE

The brand new www.ficm.ac.uk is now live!

After much work behind the scenes, we are delighted to launch the new and improved FICM website. We think the site is brighter, fresher, and easier to use than before, with better navigation and new content sections.

The site is still under construction and more content is still to come, but for now please enjoy the new site and let us know what you think.



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