# CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 25 | WINTER 2024

## Fire Safety in the Intensive Care Unit

The Faculty of Intensive Care Medicine

In this issue

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# WELCOME

**Dr John Butler**
Clinical Editor

Welcome to this winter edition of *Critical Eye*. Activity at the Faculty of Intensive Care Medicine continues at a rate of knots with the odd interruption to catch up on the latest revelations from the COVID enquiry.

Work is currently underway on GPICS V3 which is intended to be an evolution from the previous editions. In the article by Dale Gardiner, we learn that GPICS V3 will incorporate less standards and recommendations than in previous editions but that the new standards will be regarded as a "minimum standard expected" for the safe provision of critical care. Fellows and members will be given the opportunity to comment during the consultation process in 2024 and your input will be vital to the success of this endeavour.

During the summer months the NHS Long Term Workforce Plan was finally published. The report highlights that workforce recruitment and retention remains a huge pressure throughout the NHS as it undoubtedly is for many intensive care departments. What is also clear from our experience and highlighted in a number of the articles within this edition, is that medical training is changing rapidly. There is increasing use of flexible training opportunities with an estimated 25-30% of trainees now Less Than Full Time or taking Out of Programme time. Evidence also suggests increasing numbers of trainees are now pursuing the CESR (recently rebranded the Portfolio Pathway by the GMC) route to specialist registration. As Dr Williams points out in his article the demographic of the speciality's future workforce is changing as we move towards more of a multi-speciality consultant workforce. In the last round of recruitment over 62% of applicants for ICM training were from non-anaesthetic core training routes. Further details are included in the relevant sections.

There are lots of excellent articles in this edition including updates from the Trainee Research in Intensive Care (TRIC) Network, from the Educational Subcommittee outlining its free open access online educational material, from the Reverse Mentoring Project group and from Dr Quinn on sharing ideas on how to bridge the empathy gap. I hope you enjoy reading it.

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

# Message From The Dean

**Dr Daniele Bryden**
Dean

These are fevered times. Conflict appears endemic in the news cycle, on social media and amongst our professional groupings. Those in their early years of practice aren't feeling very valued at present. Add in to the mix some of the behaviours observed and a fear of what the future may bring and it all appears to add up to a pretty toxic mix.

Who in their right mind would work in healthcare at present? What is the point of being a doctor and especially one working in ICM? Tough questions. To address them we need to acknowledge emotions like frustration and anger that can lie at the heart of some reactions and often lead to polarised opinions.

## Systems

I'm not pretending the short term picture is rosy. Over the course of my consultant career, medical knowledge has improved and the standing of intensivists and those working in ICM as 'expert' in their respective fields has increased: this will continue as long as we understand that as a relatively new specialty, we will have to continue to showcase what we offer to healthcare as the pandemic disappears in the rearview mirror. Alongside the growth in ICM however have been huge changes in our workloads and the expectations placed upon us. I don't subscribe to the view that clinical care in general has gone to hell in a handcart but rather that it's a time of huge potential for those of us willing to adapt and seize opportunities. As a result, we have to embed ourselves within the systems to make change happen in a way that we'd like to see. We have to be the change we'd like, but it takes time to achieve this, and in the interim patience can sometimes wear thin.

Some things cannot wait, and as the Faculty, it is our role to speak truth. There is no doubt working conditions have been eroded over my career. Attempts to correct the mistakes embedded in previous training systems haven't been able to adapt to new challenges and have created their own issues. Shift working was meant to correct the dangerous fatigue of long on calls but has resulted in more commuting and shifts worked at great intensity for all our team members as demand has grown. And don't get me started on the 20 minute wait for an NHS

> **Let's define and describe ourselves by what we offer as intensivists, celebrating our diverse professional backgrounds.**

computer to boot up, access to a hot meal at night or the fight for a spot in the car park...

As Dean, a significant part of my role is to advocate for ICM and those of us working within the specialty as we try to improve outcomes for our patients. Our strategic aims give us a clarity of purpose, our Officers, Board and committees are accessible and accountable to you in that work, and the new college will give us greater independence to represent you within the structures we form and the decisions that are made. No other organisation can do what we now do in relation to ICM.

## Communication

Our decisions are taken with care and thought although we know that sometimes we haven't always communicated as well with some of you as you might have liked. We have to acknowledge where that occurs and do what we can to make amends. The StR Subcommittee came about directly from a recognition that there was a need for a greater doctor in training voice in our existing structures and processes. In this edition of *Critical Eye*, you can read about many such areas of activity.

During my training, there was a perception that ICM was not a suitable job for a woman. Setting up WICM within the Faculty was my contribution to addressing one obvious imbalance of representation in ICM. But there is more work we need to do, and part of our thinking in developing the new College of ICM, is recognising how we improve what we offer for you.

## Inclusivity

I am extremely proud of the generation of doctors behind me and those in ICM training now, who have moved things on to a widening awareness of and action to improve inclusivity.

Inclusivity for ICM doesn't just include recognising the skills contributed to patient care by our MDTs but also, the variety of clinical training backgrounds that contribute. Doctors who train and practice exclusively in ICM have much to offer, as do those with other specialty training backgrounds. Let's define and describe ourselves by what we offer as intensivists, celebrating our diverse professional backgrounds, and not by what someone is or is not.

Doctors are clearly vitally important and make a huge difference to the practice and development of ICM and we do this best when we work with others: together is the way we get the best outcome for our patients. Those entering ICM medical training are doing so in the expectation of being a consultant one day, but often don't have a great idea of what that means when in post. Healthcare professionals become expert as they acquire experience over time and across a wide range of clinical situations. Ultimately, we're training people to manage uncertainty and in the case of consultant intensivists, hold the risk of ICM decision making on behalf of the team. If consultant intensivists don't do that, care becomes worse as decision making is increasingly inappropriate with knock on effects for the patient, family and escalating healthcare costs. This in turn impacts on our environment and sustainability.

It's a huge responsibility, and we should expect to have that and the time it takes to acquire that expertise recognised.

## Sustainable

As you read this, the Facuily will be entering its 14th year. We have come a long way from that founding Board and along the way have started work to form the college. It does not mean we are ignorant of or lacking focus on the issues that matter today. We are making changes in a considered way and with the full intention that they will be sustainable into our next iteration. We cannot solve present challenges unless we work together, understand our differences and recognise we have a common goal to move in the same direction: toward a better ICM service for our patients and those who work and train in it.

# Fire in the Intensive Care Unit

**Dr Sarah Marsh**
ESC Chair

**Dr David Harding**
ST6 Anaesthesia

Intensive Care Units are hives of activity. They require a vast number of electrical machines to facilitate life sustaining treatment, utilise litres and litres of oxygen per day and use huge quantities of consumables in doing so. The design of intensive care units differs markedly from single rooms with fire resistant doors to open units with bed spaces separated by curtains. Many ICUs are "elderly" (*adjective*: old or ageing) and do not possess modern sprinkler systems or the ability to shut off the oxygen supply to separate areas of the ICU if needed. Whilst there are standards to adhere to when constructing a new ICU, these cannot always be applied to existing units or those undergoing a refurbishment such as relocating to a ground floor location, having multiple exits or creating zones in which to care for patients.

From a staffing perspective, following the pandemic, the intensive care workforce has seen the loss of many experienced staff members, and faces difficulties in recruiting new ones. The flux created by the ebb and flow of the workforce requires continual training and education to ensure the team are up to date with mandatory information including policies and procedures.

As the infrastructure is difficult to influence and the level of local knowledge and practices within the current workforce is inevitably likely to be less than before the pandemic, it is vital that we acknowledge areas of potential weakness in our buildings, policies and staff members including how to manage the risk of a fire.

## Fuel

With the presence of a fuel (a solid, liquid or a gas that can ignite), an ignition source (any device that is capable of creating a spark of a flame) and oxygen in abundance in ICUs it is easy to understand how a fire could happen within our floor plan. This has sadly occured in the UK as well as around the world in recent years. At least three major fires have occurred in UK ICUs over the past 15 years, all of which have required a full scale emergency evacuation of patients, staff and relatives. Other major fires have occurred in Russia, Romania, Turkey, India, Iraq Russia, Romania, Turkey, India, Iraq and Ukraine. Anecdotally, there are also reports of smaller fires that go unrecorded including electrical pump fires, deliberate combustion of waste material and of course from those pesky toasters.

Whilst fire safety training is mandatory in many trusts, it is unlikely to address the complexity around the processes and procedures required to evacuate an ICU.

A joint working party led by Dr Fiona Kelly, involving the Intensive Care Society and the Association of Anaesthetists published *Fire Safety and Evacuation Guidelines for ICUs and Operating Theatres* in 2021[1]. This document addressed the inherent risk of fire in these areas, and produced recommendations with regard to the design of ICUs, the safety equipment required, emergency evacuation policies, oxygen safety and staff welfare amongst others. Fire safety was also a new addition to *Guidelines for the Provision of Intensive Care Services* version 2 in 2022 featuring it's own chapter[2]. The chapter outlines standards and recommendations for ICUs to address. A key part of both publications includes the need to review major incident planning and the role of critical networks as both the infrastructure of a unit as well as it's staff could be incapacitated (with staff potentially becoming patients as well).

## Standards

Following a refurbishment of the ICU at Harrogate District Foundation Trust, a review of fire safety was undertaken and a multifaceted project launched to address the national recommendations. Initially, a survey was distributed to nursing, medical and allied health professionals involved in the care of patients on the ICU to ascertain their knowledge of fire safety and evacuation procedures on ICU. The results were concerning but not unexpected. Less than a quarter of staff knew of the fire and evacuation plan or where the fire alarm call points were located. Only 7% of staff knew the locations of the fire extinguishers on the ICU.

Following this survey, meetings were held between staff members from the ICU, the fire department and the estates team from the trust and included on site 'walk throughs' and troubleshooting of potential obstacles to a rapid and safe evacuation. From this, and using the national guidance, a bespoke fire safety evacuation plan was produced and summary action cards of the plans were printed and displayed next to fire call points giving stepwise instructions to staff in the event of an evacuation as per chapter 6.1 (Fire and Evacuation) in the GPICS v2.

A further standard in GPICS v2 chapter 6.1 (Fire and Evacuation) states that staff must undergo regular training in fire prevention and fire procedures including in situ training. This includes location and use of fire call points, location and use of fire extinguishers (if trained), and the location of the medical gas pipelines shut off valves.

## Training

We therefore created a fire evacuation safety video that moved methodically through the ICU outlining important locations such as the Area Valve Service Units to shut off piped medical gases, fire alarm call points and fire extinguishers as listed in the guidelines. This was then uploaded to computers within the ICU for staff to watch (with plans to upload to mandatory training portal for annual completion).



Multidisciplinary simulation scenarios were written using the examples of the fires that had occurred within UK ICUs. They were delivered in situ and made as immersive as possible with low lit red/orange lighting and plastic visors (with the film kept on) to obtund vision and dexterity. The evacuations were done in real time and used different exits to holding areas identified in our fire evacuation policy.

The survey scores following review of the video and completion of the simulations reached 100% in almost every question, with anecdotal feedback including:

*"Very helpful. Not a common scenario, but one we need to be prepared for."*

*"Big eye opener."*

*"I definitely think that everybody should do this course."*

In conclusion, the evacuation of an ICU due to a fire presents unique challenges that most will never have faced or considered. Loss of power, poor visibility and colleagues becoming incapacitated are all aspects of emergency training that are not routinely prepared for. We would encourage departments to review their fire evacuation policies and procedures, and trial an in-situ simulation which will educate staff on the correct procedures but also inform any required updates and tweaks to the plans including exit routes and equipment required. The scenarios we used will be shared in the simulation section of FICMLearning for anyone to use and adapt. Case studies include:

## ICU Fire, Bath, 2011

A CD oxygen cylinder ignited on a patient's bed, setting fire to the bed linen, mattress, curtains and ceiling tiles. The ICU filled with acrid smoke, reducing visibility to less than one metre and made breathing extremely difficult. The patient was dragged from the bed and onto the floor by staff whilst the fire was extinguished using several fire extinguishers. Ten patients on the ICU were evacuated within seven minutes, with the eleventh 10 minutes later. Following the evacuation, two staff members were admitted to hospital with smoke inhalation, five of the ICU patients were transferred out to other units and seven remained on site in the

## ICU Fire, Royal Marsden, 2008

A fire in the roof of the Royal Marsden spread rapidly and destroyed the intensive care unit. This necessitated a complete evacuation of the building, with six patients from ICU and three from theatre being transferred to the nearby Royal Brompton Hospital.

## ICU Fire, Royal Stoke, 2017

A fire was deliberately started in the corridor between theatres and ICU, resulting in smoke spreading into the ICU. Consequently all 24 ICU patients were evacuated to neighbouring PACU and alternative theatre suites on site.

## References

1. Kelly FE, Bailey CR, Aldridge P et al. Fire safety and emergency evacuation guidelines for intensive care units and operating theatres: for use in the event of fire, flood, power cut, oxygen supply failure, noxious gas , structural collapse or other critical incidents. Anaesthesia 2021; 76 (10): 1377-1391.
2. Guidelines for the Provision of Intensive Care Services. https://www.ficm.ac.uk/standards/guidelines-for-the-provision-of-intensive-care-services.


# Bridging the Empathy Gap

**Dr Aoife Quinn**
Consultant in Neuro and Trauma Critical Care and Anaesthesia

The transition to consultant is always a significant stepping stone, but for those of us who took up our consultant mantle recently, the challenges have perhaps been of a different nature to previous generations. We are emerging from the impact and shadows of COVID-19 into an NHS landscape burdened by unhappiness and discontent. I have found that the WICMEL (Women in ICM Emerging Leaders) programme offered me the opportunity to gain skills to help navigate this time. One of the topics explored both with my mentor and peers was the topic of empathy and I would like to share the fruits of some of these deliberations.

We are all familiar with the one dimensional view of empathy; the ability to understand and share the feelings of another. It's helpful to nudge that definition a little and think of things more in the frame of the platinum rule[1] whereby we treat others as they would choose to be treated, not how you would want to be treated.

Forbes have identified empathy as a core leadership skill[2]. Empathetic leaders have the tools to create a productive and psychologically safe work environment. There are a range of online tools to check how empathetic a person is at base line[3] and happily a variety of means to become more empathetic should our natural inclination be a trifle lacking.

Condensing the issue of empathy to making sure that everyone feels happy at work feels insipid. The very substance of what we do means that part of our normal work load will place us in emotional situations which resonate with our personal lives and that can feel like someone is banging on a bruise. A leader with great empathetic skills will be able to utilise this in a flexible manner. A periarrest situation calls for clear leadership and decisive instructions communicated and executed rapidly, but also the ability to generate a space where the team can voice their opinions regarding cause or next steps, and then the ability to ensure everyone is comfortable with perhaps drawing things to a close, communicating with families and having the resources for a hot debrief. Then the leader is going to have to move on and start making progress with the rest of their day.

## Complex teams

Our days of course, are about more than lurching from one crisis to the next. We work with large and complex teams to provide nuanced patient care and as part of this train the next generation of doctors. It feels like there is a sense of disconnect between the expectations of others both peers, the wider multidisciplinary team and those we train. Where differences and ways of behaviour seem increasingly alien and difficult to accept. I have found that others try my empathy much than before, and probably I try their empathy in return. We have an empathy gap if you will.

If you, like me, accept that there is an empathy gap, can we tease out what creates it, and use empathy to help bridge it. We work in an environment where interruptions are common, and can impact performance[4] and many of which are unavoidable. Many hospitals have holes, some gaping, in the nursing rota. Crucially, many experienced nurses have been lost from the system and our newer nursing colleagues are under strain to get up to speed. Questions and clarifications from newer nurses are a natural and essential consequence of this, how could it not be, but without empathy this can lead to an increasingly stressed environment and a lack of civility a consequence. There is no doubt that civility saves lives[5]

The population who make up junior doctors has evolved from previous generations with increased gender balance, more graduate entry medics, only ever worked European Working Time Directive compliant rotas and increasing proportions are choosing less than full time employment. These doctors have had a torrid time recently between exams in an online format, making up training time lost during the pandemic, and balancing the decision to strike.

Families are rightly viewed as extensions of the patient. Updating families is a fundamental part of our job. The return of families being able to visit on the unit post COVID-19 is welcome. Face to face communication is vastly easier and more effective than the various remote communication measures necessary during the pandemic. But unhurried appropriately paced communication takes time. Our time is a valuable resource which could also be directed towards clinical decision making in a time critical manner. Those quick little updates which crop up on rounds can cause an internal tension as we know it will now take longer to reach the patient in the last bed space. Additionally those little updates are never quick, nor easy as they are frequently alluding to life changing injuries, or sowing the seeds for future discussions about direction of care.

## Bridging the gap

So how can we use empathy to bridge these gaps. There are easy wins. Recognising the consequences of feeling hunger, angry, tired or late and employing strategies to diffuse the trigger, even if it's just acknowledging it exists. But we can think bigger and try to generate systems which make empathy the default. We can focus on team building, shared purpose and vision of clinical care, recognising the value and privilege of training

> **Team building doesn't have to be about a grand corporate away day, but could be about placing emphasis on sharing a coffee break where we can have informal natters with the team and learn what would make a difference.**

the next generation, and being comfortable setting boundaries that promote self-care.

Team building doesn't have to be about a grand corporate away day, but could be about placing emphasis on sharing a coffee break where we can have informal natters with the team and learn what would make a difference. Similarly, reassuring colleagues that concerns have been heard and are valid, or that you will be back to talk to the family but after time critical tasks have been attended too. Every ward round can be an opportunity to put the ball in the trainees' court in terms of what they need to achieve to grow develop and gather evidence of training. There is no shortage of clichés or memes in this arena but one can't pour from an empty cup seems most apt.

Keeping some fuel in the tank is important because it is possible to be too empathetic. The drain can lead to exhaustion, cognitive overload, and being too tired to connect with our friends and family outside work. Its inviting to think that might start to stray into burnout territory but there is ample evidence to suggest empathetic tendencies are possibly protective[6]. As we become more seasoned consultants so much of the poise, experience and self belief seems like it's a natural state. The value of a mentor for people reaching a new career stage cannot be overstated.

Descriptions of the workplace make it seem like we are working in glass buildings, between basements excluding men from the more traditional female roles, walls preventing marginalised people move sphere, ceilings limiting potential but also pertinently the concept of the glass cliff. Research indicates that for companies going through a time of crisis  a female leader can be seen as an inviting choice to help  demonstrate the companies interest in focusing on team connects, regrouping and refocusing on corporate social responsibilities. Due to gender balances at work, oftentimes this newly appointed female leader doesn't have a strong network to help navigate an incredibly challenging potentially unsalvageable situation leading to the inevitable fall over the cliff edge[7].

## Connection

The NHS is a massive machine, made possible by innumerate people doing their best to keep individual cogs turning. Connection between these people both with each other and the users of the machine are vital. But we don't want a harsh cold grinding machine. We want a vibrant, fresh, thriving, self-replenishing ecosystem where being empathetic is the norm. We need to critically and honestly appraise both ourselves and the processes we work in to relentlessly strive towards generating a work space that allows us to develop our skills to treat the individuals in our workforce how they would chose to be treated and bridge the empathy gap.

## References


1. Biffi M. https://www.integrative9.com/media/articles/26/the-golden-rule-versus-the-platinum-rule#:~:text=For%20this%20reason%2C%20many%20have,be%20treated%20the%20same%20way.
2. Brower T. https://www.forbes.com/sites/tracybrower/2021/09/19/empathy-is-the-most-important-leadership-skill-according-to-research/?sh=53c63f443dc5.
3. https://greatergood.berkeley.edu/quizzes/take_%E2%80%8Bquiz/empathy
4. Westbrook J et al. Task errors by emergency physicians are associated with interruptions, multitasking, fatigue and working memory capacity: a prospective, direct observation study. BMJ Qual Saf 2018;27:655–663
5. https://www.civilitysaveslives.com
6. Wilkinson H et al. Examining the relationship between burnout and empathy in healthcare professionals: A systematic review. Burn Res. 2017 Sep; 6: 18–29.
7. Vongas J et al. The Evolution of Empathy and Women's Precarious Leadership Front Psychol. 2015; 6: 1751.


*The TRIC Network Team at SOA23 with our expert panel Prof Summers, Prof Gordon and Dr Connolly.*

# Trainee Research in Intensive Care (TRIC) Network

**Dr Luke Flower**
TRIC Co-Chair

The TRIC Network is dedicated to facilitating and delivering research, audit and quality improvement amongst Intensive Care Medicine trainees throughout the United Kingdom. The past year has been one of the Network's most successful to date and the future of trainee-led research is looking brighter than ever. Founded in 2019, the Network has been involved in the running and promotion of numerous regional and national projects, including its first two studies, PIM-COVID and IID-ACCT.


We are soon to launch our third study, NEAT-ECHO, that will be run in collaboration with the Faculty of Intensive Care Medicine, the Intensive Care Society (ICS) and the British Society of Echocardiography (BSE). We hope the success of the work described in this article will inspire you to get involved with the TRIC Network and help us continue to drive our specialty forward.

## A Year in Review

During 2023, the Network hosted a Trainee Research session at the ICS State of the Art Conference, concluded its first national research project, PIM-COVID, and launched our second national project ID-ACCT. We formed links with leading voices in ICM training and research, in the FICM and the National Institute for Health and Care Research (NIHR).

### State of the Art 2023

We were invited to host the Intensive Care Society State of the Art Conference's inaugural Trainee Research session. The session opened with an inspirational talk from the NIHR Critical Care Specialty Group Chair and the University of Cambridge's VPD Heart and Lung Research Institute Director, Professor Charlotte Summers on how to succeed in a career in academic ICM and overcome the many trials and tribulations you may face.

This was followed by the final stage of our national trainee project competition. Three short-listed candidates presented excellent project proposals to a packed audience and an expert panel of judges, Professor Charlotte Summers, Dr Bronwen Connolly and Professor Anthony Gordon. The overall winner was Dr Tom McClelland with his proposal on the Identification of Difficult Airways in Critical Care Units (ID-ACCT). We are very pleased to share that we will be returning to the State of the Art Conference in Liverpool in 2024. Not only will we have a Trainee Research session, we will be running another national trainee project competition. Keep an eye out for more details about this in the coming months!

### ID-ACCT

The winner of our national project competition was Dr Tom McCelland's ID-ACCT project, which is a service evaluation looking at our practice around identifying difficult airways in ICU. The project originates from the outcomes of NAP4, which showed that airway-related complications were over 50 times more common in critical care than in anaesthesia and were more likely to lead to serious harm. Although multiple recommendations were made by NAP4, when a follow-up survey was conducted two years later, the assessment, planning and handover of patients with either potentially difficult or known difficult airways remained suboptimal. Ten years on, ID-ACCT aims to assess whether further improvements have been made in our assessment of patient airways, anticipation of airway difficulties and communication of airway management plans within ICUs in the UK. The data collection period closed in December. Analysis of the data has begun, and we very much look forward to sharing the results with you in the near future.

### PIM-COVID

The PIM-COVID study investigated the psychological outcomes of ICU survivors treated for COVID-19 infection. It was an ambitious first project for the Network on a limited budget, managed by Dr Alicia Waite and Mrs Karen Williams. Study team members, including trainees participating in research for the first time, successfully recruited over 1,600 patients at 52 sites in England, Northern Ireland, Scotland and Wales. We are very grateful for the Intensive Care Society's New Investigator Award, which provided the majority of the study's funding, and to the Mersey School of Anaesthesia charity for their contribution towards costs. In addition to the main study, which assessed patient experiences using surveys at three, six and/or 12 months after ICU discharge, interviews were also conducted with a subset of patients to better understand their experiences

after leaving ICU. In addition, a national survey of the ICU follow-up services made available to patients treated for COVID-19 infection has also been conducted. The results of these sub-studies are being analysed and we look forward to sharing the findings.

## The future

### NEAT-ECHO

We are very excited to announce that we will be launching our next project, the National EvaluATion of the Use of Critical Care ECHOcardiography (NEAT-ECHO), in March of this year. This will be the first coordinated evaluation of the provision of critical care echocardiography across the British Isles, in Great Britain and Ireland.

The project is being run in conjunction with the Faculty of Intensive Care Medicine, the Intensive Care Society and the British Society of Echocardiography. Echocardiography is an invaluable diagnostic tool in the management of critically ill patients presenting with shock, facilitating rapid identification of the underlying aetiology and assessing response to treatments, at the bedside. Current national guidelines from both the ICS and NHS England recommend that echocardiography should be available at all times to assess shocked patients. Anecdotally, however, we know that this standard is not currently met in the British Isles.

NEAT-ECHO will have in two components; a one-off survey assessing the current provision of echocardiography training in ICUs, and a snapshot audit that will ascertain the availability of echocardiography for patients presenting with shock. We are looking for local leads for NEAT-ECHO. All study team members will be recognised as collaborators in publications and local leads will receive certificates acknowledging their role as a national trainee project lead. For more information about the study you can contact us through our website, www.tricnetwork.co.uk, or by emailing the project lead, Dr Luke Flower, at luke.flower@doctors.org.uk. If you are interested in taking part, please get in touch.

### Other projects

We are involved in supporting several other projects run throughout the country, including the NIHR-funded EXTEND trial and AIRWAYS-3. Both are involved in the NIHR Associate PI Scheme and present an excellent opportunity to gain supervised experience in clinical research. If you are interested in getting involved, let us know and we can give you advice on who to speak to at your site.

The best way to hear about opportunities to participate in research is to join our mailing list, which you can find on our website. In addition to information about TRIC Network studies, we will share opportunities, throughout the year, about studies that are participating in the Associate PI scheme and are keen to have trainees involved.

## How to get involved

Whether you are passionate about trainee-led research or you just want to meet your ARCP requirements, the TRIC Network has something to offer you. To find out more about the work we are doing and how you can get involved, contact us through our website, on X (@TRICNetwork) or come and chat to us at SOA24.

We would like to thank everyone involved with the TRIC Network for making 2023 such a successful year and look forward to working with you in 2024!

# FICM Reverse Mentoring Project

**Dr Matt Rowe**
Lead Trainee Representative

## Background and purpose

It is well established that doctors from an ethnic minority or International Medical Graduate (IMG) background face significant and disproportionate challenges throughout their training and subsequent careers[1]. Furthermore, this group of doctors experience worse outcomes during recruitment at all stages of their employment, perform worse in examinations and experience slower progression through training[2]. An unexplained variation in performance between groups who share a protected characteristic and those who do not share the same characteristic, for example ethnicity or gender, is known as 'differential attainment'. Differential attainment refers to an average group performance and not that of an individual.

Clearly many doctors from such backgrounds excel whilst many doctors from a White British background do not. Nonetheless, the importance of addressing the inequalities in training, recruitment and retention experienced by this group of colleagues is undeniable. Furthermore, those with the responsibility for the delivery of training and health care provision in the United Kingdom (UK) have a statutory obligation to do so[3]. The Faculty of Intensive Care Medicine acknowledges that differential attainment is an issue that affects many of its doctors in training. A lack of lived experience of the determinants of differential attainment amongst educational leaders may be a contributory factor in this regard. Following a successful pilot of a 'Reverse Mentoring' programme in the Yorkshire and Humber Deanery, the Faculty has embarked on its own Reverse Mentor Programme aimed at improving the lived experiences of trainee level doctors, whom identify as from an ethnic minority background, in intensive care. By improving the understanding of these issues amongst educational leaders in ICM, we hope to address some of the factors contributing to differential attainment and reduce some of the barriers towards the provision of equitable training and opportunities for further professional development.

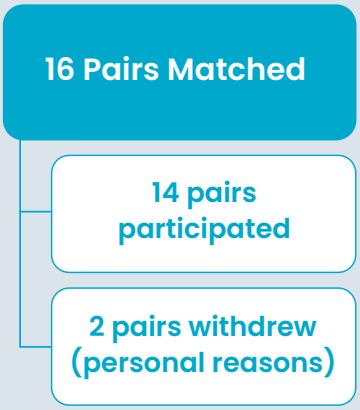
## Reverse Mentoring

Reverse Mentoring seeks to invert the classical mentor-mentee relationship in which typically a more junior colleague is mentored by a senior. In reverse mentoring, the more junior team member supports the development of their more senior colleague on a specific area of expertise. In this case trainee level doctors from an ethnic minority or IMG background were recruited to mentor consultant intensivists, each with a specific responsibility for the delivery of ICM training in the UK.

## Recruitment and pairing

Mentees were initially recruited from a pool of consultant volunteers identified from within the FICM Board and its co-opted members. The mentors were then recruited via the FICM secretariat who sent an email to all ICM trainees requesting that trainees who identified from an ethnic minority or IMG background register their interest in participating in the project. Sixteen trainee (mentor) and consultant (mentee) pairs were then

matched at random using a random number generator. Each consultant and trainee taking part were then asked to declare any conflicts of interests, for example knowing their pairing personally or working in the same region, via the project facilitator. These pairs were then re-matched to another participant anonymously prior to the project starting. At the end of this process 14 Mentor-Mentee pairs were identified with two pairs withdrawing from the project for a variety of personal reasons.




## Inductions and Support

All mentors and mentees were required to attend an induction for their respective groups. These were held online with the mentor inductions occurring first in order that insights from this meeting could be shared with the mentee group. Mentor-mentee pairings were only revealed after these inductions had taken place and as such, no communication between pairs occurred prior to this. This was done in-order-to ensure both parties knew what to expect from the project and to maximise the psychological safety of the participants. At the halfway point of the project each group also attended respective Mentor and Mentee Midpoint Meetings. This offered the opportunity for mentors and mentees to share what worked well for them, to reflect on the mentor-mentee relationship and discuss strategies for dealing with any challenges or conflicts that had arisen.

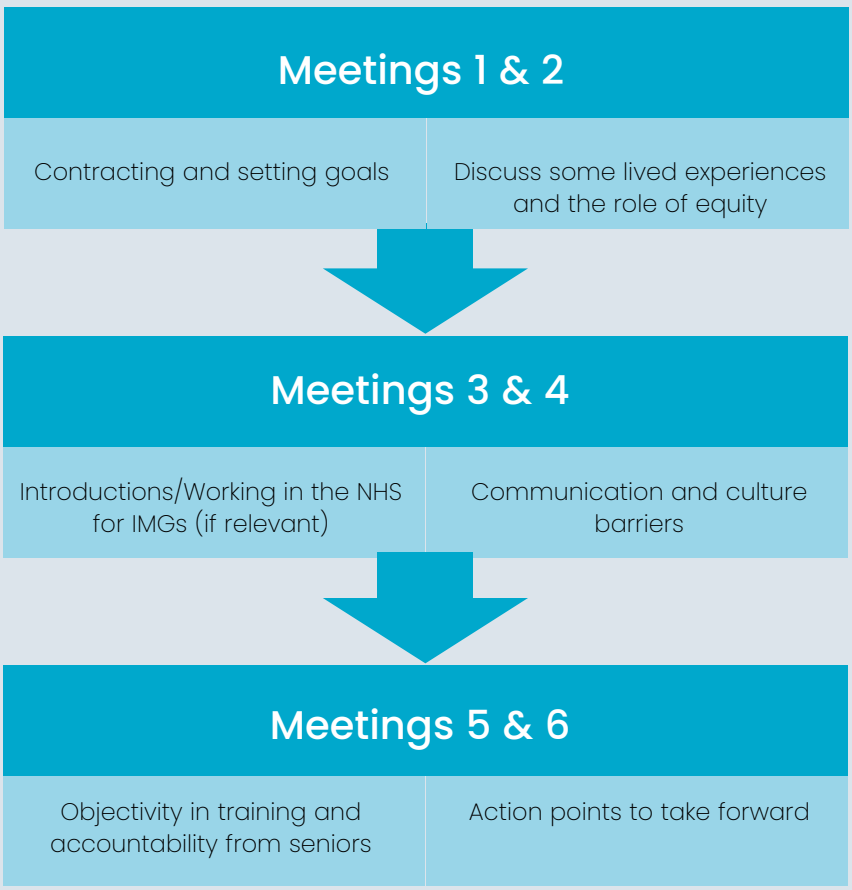
## Structure of the project

The project's basic structure followed a course in which each Mentor-Mentee pair conducted approximately 4-6 meetings over the course of approximately 6 months. Each meeting was expected to last approximately one hour but timings weren't restricted to allow a more natural, conversational tone. Participants were provided with a handbook detailing some principles around effective mentoring and a basic framework on which to structure their meetings. These were then permeated by the mentor and mentee midpoint meetings at which point a review of each participants experience was conducted. Finally, there will be a wrap-up meeting in December/January at the project's conclusion in which action and learning points generated from each pairs experiences will be collated.

## Outputs and Future Plans

When the project concludes in December/January, it will generate a number of learning/action points that will be brought forward from the project with the intention of enacting positive change for ethnic minority and

*Example of a draft agenda between a mentor and mentee*



IMG doctors in training. These findings and any pertinent recommendations will be published and disseminated throughout the ICM community in the UK.

Following the conclusion of the first iteration of the project we hope to run it again, expanding the project further to include regional educational leads. This would involve inviting training programme directors (TPD), regional advisors (RA), Faculty Tutors (FT) and Heads of school (HoS) to participate. In this way, we hope to share and expand upon the learning and action points generated by the project so-as-to deliver meaningful improvements to the lived experiences of this group of doctors.

## Acknowledgements

The Faculty would like to thank each of the doctors taking part in the project and acknowledge the significant contributions made by each of the doctors in training who volunteered as mentors. They have all dedicated a significant portion of their own free time in order to share their own experiences on what is often a very emotive and personal subject. The Faculty would also like to acknowledge and thank Dr. Alice Pullinger, Leadership Fellow in Diversiry, Equity and Inclusion at NHSE Yorkshire And Humber for her help and support in setting up the project.

*Reverse Mentor Group*: Dr Hagar Aly; Dr Soumyanil Saha; Dr Angela Lim, Dr Jonathan La-crette, Dr Shah Rahman, Dr Tijesunimi Afolabi, Dr Hannah Wilkincrowe, Dr Sekina Bakare, Dr Kyron Chambers, Dr Ben Hylton, Dr Dong Lin, Dr Ayshea Redford, Dr Enyioma Anomelechi

## References

1. K. Woolf (2020) Differential Attainment in Medical Education and Training. BMJ 2020;368:m339
2. General Medical Council. The state of medical education and practice in the UK.General Medical Council, 2015.
3. General Medical Council Promoting excellence—equality and diversity considerations. GMC, 2016.
4. Woolf K, Viney R, Rich A, et al Organisational perspectives on addressing differential attainment in postgraduate medical education: a qualitative study in the UK BMJ Open 2018;8:e021314. doi: 10.1136/bmjopen-2017-021314
5. Woolf K, Rich A, Viney R, Needleman S, Griffin A. Perceived causes of differential attainment in UK postgraduate medical training: a national qualitative study. BMJ Open2016;6:e013429. doi:10.1136/bmjopen-2016-013429 pmid:27888178

# Severn Women in Intensive Care Medicine (SWICM)

**Dr Jeanie Worthington**
ST7 Dual ICM and Anaesthetic Trainee

**Dr Inthu Kangesan**
ECMO Fellow

As I reach the end of my training in anaesthesia and Intensive Care Medicine, one of the more gratifying developments I have seen, is the clear shift in a culture once regarded as an 'Old Boys Club', to one where diversity is increasingly regarded as fundamental to delivering good care to our patients and creating a rich and stimulating workplace.

In 2019, the European Society of Intensive Care Medicine (ESICM), one of the largest professional ICM societies globally, recognised that medicine lagged behind other fields in implementing specific and structured programs to improve diversity.[1] At this time women represented only 31.8% of all members, and only 15% of the ESICM Executive Committee. Furthermore, studies have indicated that a majority of women in ICM describe experiences of being personally or professionally impacted by gender disparities at work.[2]

This problem is now being recognised at a national and international level, and the ESICM has made improving gender equality, and diversity more broadly a key strategic priority. However, this change remains very much in its early stages.

## Demand

The Faculty of Intensive Care Medicine (FICM) has estimated that the demand for critical care beds in the United Kingdom will likely double from 2015 to 2033.[3] Recruitment and retention of new consultants in ICM is crucial to meeting this increase in workload, and yet in 2022 the FICM recognised that "there are currently insufficient doctors completing their ICM Certificate for Completion of Training (CCT) as either single, dual or triple training in Intensive Care Medicine, to fulfil present demand across the UK".[4] It is increasingly clear: we can no longer afford to fail to attract and retain trainees from diverse backgrounds.

The reasons for the recruitment shortfall are thorny and complex, and there are no easy solutions to redress this. But what can we do as practicing ICM doctors trying to keep our heads above water as we navigate specialty applications, exams, training requirements, home responsibilities (and so on, and so on.....)? It is easy to feel as if the problem is too big and too complex for us to contribute as individuals. We would argue that a complex problem needs solutions at every level, and that local, grassroots action can have real impact on the trainees around you, and in your region.

## Isolation

As COVID started to release its stranglehold on intensive care units in our region, we as a group of trainees felt more exhausted than

ever. My female colleagues described feeling isolated, particularly as frequent rotations made it difficult to form lasting relationships with other trainees before moving on again, and lockdowns had decimated the regionwide social events we used to hold. This was felt by trainees regardless of gender; however this sense of isolation can be amplified when you are already in the clear minority within your peer group. And sometimes it can be a little exhausting always being the only female ICM trainee, and trying to fit in in a male dominated department you would like to view you as a future consultant colleague.

## Community

We knew from personal experience that what gets you through the tough moments in training (which are inevitable!) is the community you form around you, that understand you and the challenges you face, and are ready to share their hard-earned collective wisdom.

So, from the ashes of COVID, SWICM (Severn Women in Intensive Care) was born. Our aims were simple at first. To create a group that would welcome female ICM trainees (or aspiring ICM trainees) at any stage of their career, to allow them to meet and get to know each other. To talk, laugh, commiserate and celebrate. To create an atmosphere of peer support that allows our junior colleagues to benefit from those who have gone before and met the same roadblocks and frustrations. And finally, to create some visibility for women in ICM so that those female trainees who are considering a career in the field have somewhere to look to, to show that it can be done.

Because *if you can see it, then you can be it.*

None of this is rocket science, but we believe it is simple actions like these that can make the difference in attracting female trainees to a specialty and helping to prevent attrition through a long and sometimes difficult training process.

We have only been up and running for around 18 months, however in that time we have become a close group, comprising female colleagues that I had never previously had the opportunity of meeting or working with, due to the realities of rotations and less than full time (LTFT) working. Not only this, but we have started to realise what we can achieve together.

## Support

Within a short space of time we were invited to speak to prospective ICM trainees at a careers evening, and we have had meetings with departmental leads within our region to explore how they may make themselves more attractive to female trainees considering where to apply for consultant jobs.

We also have a good relationship with our Regional Advisor, and Trainee Programme Director, who have both been extremely supportive and are receptive to us raising any training related issues that may have affected our members particularly. In addition, we have supported several of our members in completing formal peer mentorship training, with the hope that in the future, any female entering ICM training in our region will be able to pick a female mentor within the specialty if she wishes. We are now connecting with colleagues in other regions to help them start similar initiatives in their own regions.

## Local action

It is easy to feel demoralised about the huge challenges facing our profession, however creating SWICM has shown us the impact that simple, local action can have. By building a strong, local community of women in intensive care, we can make real impact in improving trainee experience, well-being and helping forge connections that will continue to enrich us at every stage of our career in this challenging and rewarding specialty.

## References

1. Weiss, B., The Task Force and Working Groups for Diversity and Equality of the ESICM. Statement paper on diversity for the European Society of Intensive Care Medicine (ESICM). Intensive Care Med 45, 1002–1005 (2019). https://doi.org/10.1007/s00134-019-05606-0
2. Leigh JP, Grood C, Ahmed SB, Ulrich AC, Fiest KM, Straus SE, Stelfox HT. Toward Gender Equity in Critical Care Medicine: A Qualitative Study of Perceived Drivers, Implications, and Strategies. Crit Care Med. 2019 Apr;47(4):e286-e291. doi: 10.1097/CCM.0000000000003625. PMID: 30855331.
3. Workforce Databank for Adult Critical Care. FICM. https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/workforce_data_bank_2021_-_for_release.pdf. Published May 2021
4. Appointments to substantive consultant ICM posts, FICM. https://www.ficm.ac.uk/careersworkforcerecruitment/appointments-to-substantive-consultant-icm-posts. Published 14/03/2022.

# Training, Assessment and Quality (FICMTAQ)

**Dr Sarah Clarke**
Chair FICMTAQ

The Training, Assessment and Quality Committee for the Faculty has been hard at work over the last 6 months, as always, and I cannot stress how grateful I am to each member of the committee who tirelessly work behind the scenes to enhance our standards and resources for Doctors in Training (DiTs). We have over 1,100 ICM doctors on the CCT programme, with growing numbers represented as single, dual or triple CCT. This is great for the evolution of our specialty and we appreciate and understand the strength of a multi-specialty-origin consultant workforce.

## Triple CCT

To emphasise this, we have now welcomed our first Triple CCT doctors in training onto the CCT programme. This vital pathway safeguards the future of doctors being able to train in Intensive Care Medicine and a defined group of Physician specialties, namely Acute Medicine, Renal and Respiratory Medicine.[1]

As with all new curricula, we know it will take some time to bed in, but with close liaison with the JRCPTB, trainers and the TPDs, and a continued flexible and pragmatic approach, we look forward to their progress and success at ARCPs. Further guidance, in addition to the above, and a webinar is planned.

## Resources

More developments in the curriculum centre on adding to the resources and guidance already on the website. For example, we are developing, alongside the StR Subcommittee, a new resource for the website around the curriculum's Special Skills Year (SSY) requirements, providing information and support for our DiTs and their trainers.

Another updated resource has been the improved ARCP guidance and checklist FICM Guide for ARCP and ESSR Preparation[2], with thanks to Lead RA Andrew Sharman. Amongst many other of his achievement and activities, he also lead on an ARCP audit review across the four nations' summer ICM ARCPs. Thank you to all the Regional Advisors who contributed and provided feedback on the quality, conduct and consistency of ARCPs nationally. This is just part of a vital process to try and ensure our doctors in training have transparent and comparable experiences across the programme, across the regions.

## CESR

September saw the GMC approving the ICM Specialty Specific Guidance (SSG)[3] for the new Portfolio Pathway, their project to redesign the CESR process. This has been a move away from the terminology of 'equivalence', but to align to a 'Knowledge, Skills and Experience' framework. It has been mandated by the GMC, and all colleges and faculties have been required to rewrite their guidance for applicants wishing to access the Specialist Register outside of CCT.

Importantly, regardless of terminology, I must stress that this is ***not*** a lowering of standards, and the evidence required of an ICM Portfolio Pathway applicant remains the same as before. This is not a lessening or weakening of the Faculty's position, nor of our commitment to the standards of our workforce. Following the necessary change to legislation, the Portfolio Pathway went live on 30 November 2023, and the new page on the website will be live by the time you're reading this.

## Exploring

As I've already written, our many activities go beyond this short report, but include the ongoing project with the GMC examining Differential Attainment, to look at the facts around and the reasons for certain minority groups performing less well in the FFICM exam. This is a highly impactful piece of work, and I'm grateful to Liza Keating for her continued enthusiasm and persistence, in her words to explore the 'we don't know what we don't know' issues. Once we have more insight into the unknowns, we can start to address them.

Work continues with the LLP, and we now have specific ICM DiT and Educational Supervisor representatives on the platform development group, who will help steer and improve its functionality for ICM users alongside our colleagues from the RCoA. Additional projects include a new FICM Consultant in Transition course in conjunction with SICS, and a pilot 'Reverse Mentoring' scheme, where senior Faculty members are mentored by more junior colleagues in training — see elsewhere in this very issue for more information. This project has been incredibly insightful, and will be published soon by its author, Matt Rowe outgoing Lead StR Rep (thanks Matt, for everything!)

## StR Survey

Finally, we note the results of the 2023 StR Survey,[4] published in December. We are grateful for StR engagement and completion of the surveys, and we hear you loud and clear. TAQ will be picking up and developing several new work-streams to address the issues raised. Your contributions, through the StR Subcommittee, surveys and regional representatives are steering our actions and words. You are our colleagues of the future, thank you.

## References

1. https://www.ficm.ac.uk/dual-triple-ccts
2. https://www.ficm.ac.uk/documents/icm-arcp-guidance/introduction
3. https://www.ficm.ac.uk/trainingexams/guidance-for-icm-cesr-applicants
4. https://www.ficm.ac.uk/str-survey-2023-report-published

# Trainee Update

**Dr Matt Rowe**
Lead Trainee Representative

As my term as Lead Trainee Representative comes to an end, I find myself reflecting on what the future holds for intensivists in training. The past two years have been an enormously rewarding challenge and I'm very grateful to my colleagues, both on the FICM Board and beyond, who've worked with me in progressing the interests of trainee intensivists.

Having learnt a great deal about the systems and processes that occur on a national level to ensure the provision of high-quality critical care services throughout the four devolved nations, I am confident the future is bright as we move towards independent college status. This is in no small part due to the extraordinary amount of hard work and self-sacrifice that goes on behind the scenes by a significant number of dedicated professionals. I would also like to thank the StR Subcommittee and each of its members for their continued work over the past year.

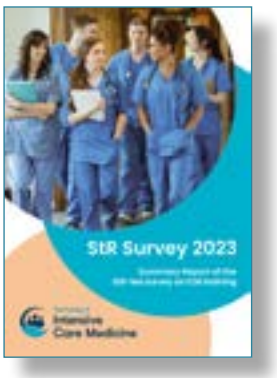
## StR Survey report

The recent StR surveys conducted by this group have confirmed that there is still much we can all do to improve the lived experiences of doctors training in ICM. We are a multi-disciplinary specialty with a diverse array of skills and expertise that should be celebrated and promoted. Furthermore, with the recent publication by the Royal College of Surgeons highlighting issues of sexual misconduct in surgery, we each have a responsibility to be respectful and kind to one another. It is imperative we support each other to call out and eradicate discriminatory or unprofessional behaviour in all its forms.

I'm proud to say that the first iteration of the FICM Reverse Mentoring project is approaching its conclusion. The project, in which trainees who identify from an ethnic minority or IMG background mentor senior consultants on their lived experiences of differential attainment, has already produced some quality action points that I believe will make a real difference to this group of colleagues. I'd like to take this opportunity to thank this group of intensivists in training, each of whom have given up their own free time to share their insights and experiences on what can be a distressing and emotive subject. Each consultant taking part has universally described their experiences as eye-opening, at times shocking and of great importance to the future of ICM training.

## Finally

Finally, it is time to hand over to my Deputy Trainee Representative Waqas. I have no doubt he will continue to do amazing work as he steps up into the lead role and welcomes a new incoming deputy.



# Regional Advisor Update

**Dr Andrew Sharman**
Lead ICM Regional Advisor

The results of the annual Regional Advisor survey are currently being analysed. It's a large piece of work but some salient points regarding training are worth sharing. There is much to celebrate with regional teaching, exam courses and excellent ARCP outcomes, with most regions offering a variety of Special Skills Years noted as real achievements. On the subject of ARCPs, the Regional Advisors ran a quality assurance review of these across the country.

They volunteered to attend another region's ARCPs, to externally assess, against predetermined criteria, the standardisation and uniformity of the process.

We are pleased to say that the trainees are being assessed appropriately against the standard set by the Faculty, across the country. One of the major reasons for a non-standard outcomes was a poorly filled out Educational Supervisors Summary Report (ESSR). We strongly recommend the Faculty guidance, found on the website; it will really help.

## LTFT

Other important points from the survey: more trainees are working less than full time (LTFT), up to 40% in one region. This is a significant change from previous surveys. It has resulted in challenges filling rotas in some regions as well as ensuring trainees get the appropriate training in the time allowed. Although the curriculum remains capability-based, actual time in training is essential to gain much needed exposure to clinical cases and hands on experience. Any reduction in training time, for whatever reason, could have an adverse effect on obtaining capabilities. The trainee and their trainers have to be totally invested to ensure any gaps are recognised and addressed, sometimes by a variety of educational resources. I can only emphasise how essential training time is. There is only one chance and it goes by very quickly.

## Feedback

The Lifelong Learning Platform (LLP) was again noted to be challenging to use. A working party is now being set up to try and feedback these issues and create solutions moving forward. Stage 2 is recognised as a challenging time, whether single, dual or triple CCT, with lots to achieve including that little hurdle called the FFICM exam.

Very relevant and topical was the impact of Advanced Critical Care Practioners (ACCPs) on training. There are over 300 ACCPs in intensive care units around the country. Mostly they are considered a major benefit to any department, complimenting the training pathways for Doctors in Training (DiT). This is reassuring as the Faculty has actively engaged in the training and career progression of this workforce, realising the importance of everyone in the multidisciplinary team (MDT).

## Workforce

All Regional Advisors were concerned with the workforce gaps and the need for more recruitment to the speciality. Retainment of the excellent trainees, consultants and everyone in the MDT is key. Retainment starts with a happy and valued workforce. I urge you all, in these trying times, to be kind and considerate to all in the MDT.

Looking forward to better New Year.

# Education Subcommittee

**Dr Sarah Marsh**
ESC Chair

The Education Subcommittee (ESC) is responsible for generating online educational material, the planning and delivery of educational events and working collaboratively with eLearning for Healthcare (eLfH) on our Intensive Care Medicine programme, e-ICM. ESC hosts the content under FICMLearning and has a number of streams including monthly ligs and clinical cases and bi-monthly podcasts and simulation scenarios.

Our committee membership has expanded this year and we welcome Dr Cat Felderhof, Dr Jonathon Wong, Dr Samantha Gaw and Dr Cathy Challifour. We have sadly said goodbye to Dr Gareth Thomas from our podcast team and thank him for his hard work and dedication to the podcast stream over the last few years.

The topics covered across the streams over the last 12 months have been varied and interesting. Between them they have offered a multitude of subjects from topics useful for exam preparation to valuable professional development as well as lighter, thought provoking subjects helpful for every day clinical life. If you have missed any of the workstreams, here is a quick guide to what you could catch up on via FICMLearning:

## Case Of The Month

- Major obstetric haemorrhage
- Metabolic acidosis
- Refeeding syndrome

## Blogs

- Maternal critical care
- Artificial intelligence
- Striving for patient progress – what makes a successful ward round?

## Simulation Scenarios

- Maternal cardiac arrest
- Upper GI haemorrhage
- Transfer to CT with a ventilated patient

## Podcasts

- Burns for the intensivist with Dr Sanjay Varma
- Point of care US training on the ICU with Hannah Conway
- Transfer of the critical care patient with Dr Michael Slattery

The simulation resources are a new addition to FICMLearning and are designed to help you through the process of starting up in simulation, delivering low and high fidelity simulation and facilitating an effective debrief. There are plenty of scenarios for you to download and use locally, and contain everything that you need to deliver an effective session.

## Opportunities!

We will be looking for new members for the ESC imminently, particularly for our podcast and simulation teams, so please get in touch if you would like to be involved. We would like to encourage doctors of all levels and grades to consider applying including doctors in training, specialty, associate specialist or specialist doctors, consultants and anywhere in between!

We are also always looking for more content so if you or any members of your department would like to contribute a COTM , a blog, be involved in a podcast or have a simulation scenario to share, please let us know at contact@ficm.ac.uk.

My thanks goes out to our amazing team of extremely hard working clinicians who develop and curate this material.

# ICM National Recruitment

**Dr Liz Thomas**
Recruitment Lead

This is my first article as Medical Lead for National ICM ST3 recruitment, and I am delighted to have taken over the role from Dr Tim Meekings. My name is Dr Liz Thomas and I am a consultant in Intensive Care Medicine and anaesthesia at Manchester Foundation NHS Trust (Oxford Road site). I am also one of the FICM Board members, and the joint medical lead for the Greater Manchester Critical Care Network.

We have also recently appointed a Deputy medical lead to help ensure continuity and resilience to the FICM side of the recruitment process. I would like to introduce Dr Robert Docking. Bob is a consultant in Intensive Care Medicine and anaesthesia at QEUH, Glasgow. He also sits on FICMCRW (Careers, Recruitment and Workforce) committee alongside me.

## 2024

The 2024 National ICM recruitment process opened for applications mid-November 2023 and at the time of writing is progressing as planned. The process is run by the ICM National Recruitment Office (ICMNRO) which is part of NHS England, via the West Midlands office. Bob and I work closely with ICMNRO and FICM secretariat to strive to ensure a fair, sensible and consistent process.

Although most people reading this issue will be in our ICM workforce already, I will briefly outline the recruitment process:

The first stage is online application — as you will be aware there are numerous routes into Intensive Care Medicine training, but the online documentation describes eligibility and all the requirements. After the application is submitted longlisted candidates are invited to take part in portfolio self-assessment. The self-assessment score is subsequently verified by an assessor. The final stage of the appointment process is the three station online interview, to be held early April 2024.

Frontline intensivists are the assessors and interviewers — we strongly believe that it is vitally important to involve our workforce as much as possible in recruiting the intensivists of the future. And we would also like to thank all the consultants who volunteer for assessing, reviewing appeals and interviewing — we could not run the process without you, so a huge thank you from all of us.

We try to shortlist a high proportion of applicants to attend online interview. We understand there is a lot of anxiety over recruitment from the doctors applying — the portfolio score needed is relatively low, so do not be put off by the domains. If there are any candidates needing advice then we suggest asking a local Faculy Tutor, Regional Advisor or Training Programme Director.

## 2023

The 2023 process went well. There was a good fill rate of posts (97% nationally), feedback was sought from both candidates and interviewers and any necessary changes/improvements to the process made. All the information regarding recruitment can be found on ICMNRO's website: https://icmnro.wm.hee.nhs.uk/Recruitment.

We strive to continue to recruit a high calibre of candidate to ensure the future of our specialty. I look forward to meeting the candidates online for interview and in person on commencing their ICM training.

# Careers, Recruitment and Workforce (FICMCRW)

**Dr Matt Williams**
CRW Chair

It's been a quiet few months hasn't it?! There continues to be huge pressure on the workforce, with this being a major, current focus of consideration for the Faculty. Whilst there was lukewarm acknowledgment of the long-awaited NHS Long Term Workforce Plan published in the summer, the devil is always in the detail, or perhaps the lack of. There is only limited space to highlight the work being undertaken by CRW, so I will focus on two particular areas that form the focus of much discussion at the moment.

> **The demographic of the specialty's future workforce is changing; the richness arising from this diversity should be welcomed.**

The Board as well as the StR Subcommittee have rightly questioned the apparent fall in CCT numbers appointed in the 2023 recruitment round. We will continue to challenge the stakeholders that determine (and provide funding for) the numbers each year. One of the factors that is impacting on this is the increasing use of flexibility in training, which means fewer training numbers are available to be reappointed to each year. We estimate that 25-30% of doctors are now training less than full time, or are taking out-of-programme time. CRW and TAQ are working with the Lead Dean for ICM to enable the maximisation of training places each year. We will continue to lobby NHSE and the Statuatory Education Bodies for an increase in CCT posts.

## CESR

It is clear from the survey of RAs, and the number of applications being received by the GMC this year, that the number of doctors pursuing this route to the specialist register is increasing. This is now rebranded as the Portfolio Pathway. Details on this can be found in the FICMTAQ update in this edition of *Critical Eye*. For those doctors considering this route, and those supervising them, I strongly advise reviewing the Specialty Specific Guidance on the FICM website and the CESR resources updated by Shashi Chandrashekaraiah.

## Recruitment

In the last recruitment round, 62.7% of applicants were from non-anaesthetic core training routes. The demographic of the specialty's future workforce is changing; the richness arising from this diversity should be welcomed. Having specialists with different perspectives and expertise in your own department has such a positive impact on patient care. In my own unit, we are fortunate to have intensivists from all possible backgrounds; there are significant departmental and inter-departmental benefits from this. CRW is looking at how we can better highlight the careers of non-anaesthetic intensivists. What does a job plan look like, both from an employer and employee perspective? What about the period of transition to consultant practice, including preparing for job applications? We're working with the StR Subcommittee and elected StR representatives on this agenda piece.

The recruitment round for 2024 is just underway as I pen this. This is a year-round process, led by Liz Thomas. Bob Docking has joined her team as the Deputy Lead. Good luck to the prospective applicants wishing to join our amazing specialty.

## A plea

We would respectfully ask that any consultant colleagues asked to sign the RCP's' 'Alternative Certificate Competencies' document by prospective applicants applying via the medical entry route (who have not completed a core or internal medicine training programme) consider it carefully and seek advice from their local Regional Advisor. A few such 2023 applicants were subsequently found to be ineligible to apply, and had their offer withdrawn.

## Other headlines

The 2023 census of clinical leads is just closing; Richard Porter will be analysing the data and feedback in due course.

Manish Pandey is the Specialist and Specialty Doctor (SAS) doctor lead on CRW. He represents the Faculty at the Academy of Medical Royal College's SAS committee. Led by him, we will be looking to highlight the opportunities and needs for this important group of doctors in the ICM workforce.

## Opportunities!

We will soon be seeking new committee members as some colleagues complete their tenures. Please do apply if you are interested in the areas of work undertaken by CRW. FICM represents you; you will be very much welcomed to help steer its future. My thanks, as ever, to the committee and the respective section leads, and to the Faculty secretariat staff.

# Recruitment: The ST3 Perspective

**Dr Luke Buswell**
ICM ST3

My name is Luke Buswell, I recently joined the North-West ICM training programme and am currently working in Emergency Medicine en route to completing Stage 1 ICM. My route of entry to ICM has been via core training in anaesthetics, starting ST4 anaesthetics in February 2023 then applying for and fortunately gaining a number to start ST3 ICM in August 2023. I applied for ICM hot on the heels of an (eventually) successful application to higher anaesthetics training.

The challenges in anaesthetic registrar recruitment have been well publicised and as such, before applying to ICM I'd had more experience of registrar recruitment processes than I'd have initially hoped for. Although I appreciate applicants will also be applying with previous experiences of both medical and emergency medicine application processes, which may have some differences, I hope I can share some insights that will be useful regardless of route of entry.

## The process

ICM application is a three-stage process consisting of an application form, portfolio upload, and then subsequent interview. Applications open in November for a start in the following August with an approximately 3-week window to submit an online application via Oriel. Following application submission, applicants are then invited to upload their portfolio documents via an online portal in mid-January.

Portfolio documents are assessed online as to whether they justify the submitted self-assessment score and applicants then shortlisted for interview based on this.

Shortlisted applicants will undergo an online interview in the March/April preceding their anticipated start date, with offers released a few weeks thereafter.

## Application submission

The initial application form through Oriel was straightforward to complete after locating the online job advert on Oriel. Although the portfolio upload and interview were still weeks and months away, respectively, the application form did require some careful thought as it involves the submission of your self-assessment score.

Although the window to submit the application is open for a few weeks, I found it really helpful to have already looked through the information provided on the ICM national recruitment office website (https://icmnro.wm.hee.nhs.uk/Downloads) regarding portfolio self-assessment.

Of particular help was to read both the scoring matrix and the separate document with the 'self-assessment applicant guidance'. There are aspects of the scoring matrix where I had evidence that I could have mistakenly scored in two domains, the guidance document makes clear what can and can not be used twice.

If you gain evidence to score more highly for your portfolio in between submitting the application and the portfolio upload window then reviewers can upgrade your score. Speculatively scoring yourself more highly without being certain you can produce the evidence in time for the upload window runs the risk of your score being downgraded.

## Portfolio upload

A short break from applications over Christmas led quickly into the window for uploading my portfolio via the portal provided.

Other than some differences in scoring, the portfolio upload portal will be familiar to many who have applied to anaesthetics higher training or indeed a range of core training programmes since the start of the pandemic.

Compared to the process of printing, categorising then carrying a lever arch file full of evidence to a distant city for interview, the move to an online upload certainly has its merits. On the other hand, there is no capacity to point an interviewer to evidence in your portfolio so the structure of your evidence uploads really needs to be crystal clear to avoid being marked down and to maximise your global score.

By the time it comes round to applications, you have probably ran out of time to fit in a quick PhD to increase your score and it might feel as if you can't do much to change this.

Speaking to colleagues at the time of my own application, it was clear that most people have scores that are fairly closely bunched together so a few points gained on the global score (8/44 available points) can make a big difference to your ranking. There's no one set of prescriptive advice for this but selecting evidence that demonstrates commitment to specialty will likely help your global score and a clear, well-structured portfolio with no superfluous content will only support your application.

Some deaneries run teaching sessions aided by previously successful applicants with tips on how to structure your portfolio. Attending such a session locally for the anaesthetic application process changed much of how I was structuring my evidence when it came to the ICM application and I'm certain I'd have received a poorer global score without it.

## Interview process

Those scoring highly enough with their portfolio were invited to online interview. The date for invitations to interview was publicised beforehand and interview slots at more convenient dates and times went quickly. Keeping an eye on emails (and the spam folder) on the day was worthwhile to avoid having to interview in the middle of a set of nights.

Communications from the recruitment office about the software used for the online interview were fairly detailed and I didn't have any technical issues either testing the interview software or using it on the day.

Interviews are divided into three stations: a clinical scenario, task prioritisation and commitment to specialty. An email from the recruitment office beforehand with some example questions helped me to think about how I would approach scenarios on the day and were representative of the questions I eventually had.

The clinical scenario and task prioritisation both involved situations that might commonly be encountered on-call for critical care but actually didn't necessarily require specific critical care knowledge or experience. Scenarios felt as if they would have been fairly balanced for applicants from anaesthetics, emergency medicine or internal medicine.

Trying to take a calm and structured approach to the clinical scenario with a systematic A-E assessment seemed to help with answering the interviewers. Although clearly that is easier said than done in an interview setting, the scenario felt as if it was more about doing the basics well which we use in every day clinical practice rather than anything designed to trip up an applicant.

Likewise, the task prioritisation scenario certainly wouldn't be anything unfamiliar to an applicant from any acute speciality and felt as if it gave opportunities to demonstrate critical thinking, creativity and team working within the wider hospital.

## Commitment

The commitment to specialty section of the interview gave the opportunity to talk about reasons for applying to ICM and to demonstrate both commitment to specialty and reflective practice. Reading through the person specification published online beforehand helped with directing my answers and highlight any achievements or situations where I'd used reflection to change my practice.

I'm certainly glad to not have any further registrar applications to go through but as they go, the ICM recruitment process felt both easy to follow and well structured.

# Smaller & Specialist Units Advisory Group (SSUAG)

**Dr Jack Parry-Jones**
SSUAG Chair

The Faculty remains committed to supporting small and remote critical care units through out the UK. In the last six months we have advocated for these units with medical leads (AoMRC), politicians and in our FICM Clinical Leads' Meeting. Small, remote and rural units provide a vital service without which many other health care services would be unable to function. SSUAG felt we needed to better understand these units.

This included where they are, their number, their challenges, and what can we practically do to resolve or mitigate these challenges. We also asked whether the current definitions are useful.

## Viability

The viability of small and remote critical care services is raised due to centralisation of some elements of care. Critically ill patients increasingly receive their initial care in big regional centres e.g. cardiology, stroke, interventional radiology, major trauma, high risk surgeries, etc.

This centralisation is, in the main, not driven by critical care but by outcomes and the ensuing evolution of medical and surgical service delivery. The reduction in acute admissions to small and remote units impacts on their staff recruitment, retention and maintenance of core skills. These units however, often serve a patient demographic of increased obesity, social deprivation, poor overcrowded housing, drugs, alcohol, and multi-morbid older populations who still require a local critical care service[1].

### Box 1: Critical Care Networks Survey 2023 of 'small' and 'remote' units

- Small units are currently defined as those serving a population of <200,000 people, and remote units as being 30km or more from the next nearest Emergency Department.
- 7/11 critical care networks did not find the definition of small units useful.
- 9/11 critical care networks found the definition of remote units useful.
- Most Networks felt the critical care bed base should be used in the definition of small but not the number of admissions.
- *Guidelines for the Provision of Intensive Care Services* (GPICS)[2] forms the template for NHSE (National Health Service England) commissioning of critical care, and CQC (Care Quality Commission) inspection standards for critical care. GPICS recognises that how people work in small and remote units may need to meet different requirements to those working in large hospitals with multiple tertiary on-site services.

## Staffing

Staffing across the whole multi-disciplinary team was the biggest issue raised in the survey, including nurses being used to backfill gaps on general wards. We know these units struggle to recruit and retain trained intensivists. There remains a UK shortage of training places for ICM (National Training Numbers). Those with an ICM CCT are more likely to want to work in large units, often where they trained.

In small and remote units it has historically been anaesthetists covering critical care but increasingly many anaesthetists no longer feel trained, or want to do so. Onerous rotas impact on the ability of these hospitals to recruit and retain ICM-trained consultants. The solution requires more ICM NTNs combined with attracting people with an ICM CCT to work in these hospitals. Recognising that working in these remoter parts of the UK is a lifestyle choice also requires exposure to the possibilities offered.

## Hub and spoke

With notable exceptions, the decades-long call for 'hub and spoke' models of care has not in the main supported the spokes. What we have seen during and post-COVID is a radical transformation in critical care transfer services. Around 70% of critical care transfers are to the 'hub' with only 30% back to the spokes.

Care closer to home and family can be vital for wellbeing and recovery and there are also good financial and environmental reasons for delivering care locally. To enable this requires structures and processes to be implemented. These would benefit both spokes and hubs. More effective clinical communication requires digital infrastructure which facilitates clinicians access to patient records, imaging and decision making.

We cannot concentrate all critical care services, nor should we. We need small and remote units to function to allow for patients to be cared for locally and to enable other services to remain in these hospitals. To do this we need sufficient patient throughput in these units to enable staff to maintain the desire to work there and we need to give them the tools to do so safely and effectively. We need to make working in these units attractive enough to draw people in and then rewarding enough to retain them. This means access to training in these units and more ICM training numbers to stop and reverse the growing divergence in staffing.

### Box 2: Survey results from NHS Scotland, Wales and Northern Ireland and NHS England Critical Care Networks

Small Units in Northern Ireland: **2**
Remote Units in Northern Ireland: **2**
Small and Remote Units in Northern Ireland: **2** (22%)

Small Units in Scotland: **12**
Remote Units in Scotland: **15**
Small and Remote Units in Scotland: **11** (33%)

Small Units in Wales: **3**
Remote Units in Wales: **6**
Small and Remote Units in Wales: **3** (23%)

Small units in England: **28** (16.7%)
Remote units in England: **24** (14.3%)
Small and remote units in England: **18** (10.7%)

The 2023 critical care NHSE stocktake identified 22 units in England. The stocktake used a different definition of small units: those units with fewer than eight critical care beds (level 2 and level 3).

Nuffield Trust identified 12 hospitals in England using their definition of remote as 60 minutes travel time to the next nearest hospital.[3]

## References


1. Health in Coastal Communities: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005216/cmo-annual_report-2021-health-in-coastal-communities-accessible.pdf
2. Guidelines for the Provision of Intensive Care Services (GPICS) https://www.ficm.ac.uk/standards/guidelines-for-the-provision-of-intensive-care-services
3. Nuffield Trust, https://www.nuffieldtrust.org.uk/sites/default/files/2018-10/nuffield-trust-rethinking-acute-medical-care-in-smaller-hospitals-web.pdf

# Advanced Critical Care Practitioners (ACCPs)

**Dr Gregor McNeill**
ACCP Subcommittee
Co-Chair

**Natalie Gardner**
ACCP Subcommittee
Co-Chair

It continues to be a busy time for the ACCP Sub-Committee (ASC) with various developments coming to fruition over 2023. While the updated ACCP Curriculum was published in September, we continue to move forward with accreditation of Higher Education Institutes (HEIs)who are training ACCPs to FICM standard. In parallel with this we continue to explore ways in which to ensure the ASC represents the interests of ACCPs from all across the UK.

## ACCPs are a key part of Intensive Care Medicine

The ASC is conscious that there continues to be debate in various specialties regarding the role of non-medical roles within their workforce. FICM has been involved with developing the ACCP role since its inception in 2010.

The FICM training and registration structure and skills frameworks provide recognised standards for training and a defined scope of practice for ACCPs. All ACCPs continue to be registered healthcare professionals with prior appropriate critical and/or acute care experience. The ASC continues to work with other branches of FICM to ensure the ACCP community continues to support and enhance the training of all members of the Intensive Care Medicine team. FICM registered ACCPs remain valued members of the Faculty.

## Updated ACCP curriculum

The updated 2023 version of the FICM ACCP curriculum is now live and can be found on the FICM website.[1] Once again we would like to thank the organisations and individuals who responded to the consultation as part of the development process. The ASC feel that now is the right time to update the ACCP curriculum given the new alignment of ACCPs to the National Advanced Practice agenda via the Centre for Advanced Practice. This update also includes more specific guidance around supernumerary status and reflects feedback from ACCPs, their supervisors and HEIs.

## HEI Accreditation

The ASC are delighted to announce we have successfully accredited a second HEI for FICM ACCP training. Salford University joins Plymouth University as an HEI that has successfully demonstrated it trains ACCPs to a FICM standard. Further dates for HEI accreditation visits will be announced in due course. As the number of accredited HEIs grows we are developing a simplified membership application process for those applying following completion of an Accredited ACCP Course. Any HEI that is interested in Accreditation should contact the Faculty directly at contact@ficm.ac.uk.

## Optional Skills Frameworks (OSFs)

Over recent years FICM has worked with partner organisations to develop Optional Skills Frameworks (OSFs) where a clear service need has been identified. To date the FICM ACCP Sub-committee have released three OSFs, which can be found on the FICM website.[2] OSFs are in addition to, not part of, the ACCP curriculum.

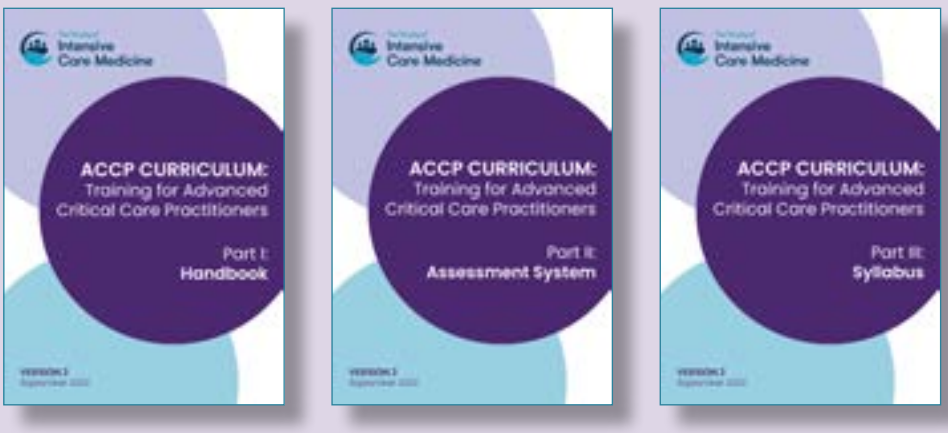
The OSFs cover Diagnosing Death for Donation after Circulatory Death, Advanced Airway Management and Inter-Hospital Transfer. The ASC are currently working on documenting the process of an OSF from initial idea to release. We hope to release these resources early in the new year, so watch this space.

## Representing ACCPs across the UK

The ASC is committed to developing the ACCP role across the UK. In September ASC members undertook their latest committee meeting in Scotland to coincide with the Scottish ACCP Conference held at the Royal College of Physicians in Edinburgh. The ASC agreed to develop specific ASC positions to represent each devolved nation. We anticipate these will be advertised in early 2024. We are particularly interested in hearing from those involved in developing the ACCP role in both Wales and Northern Ireland.

## References

1. https://www.ficm.ac.uk/careersworkforceaccps/accp-curriculum
2. https://www.ficm.ac.uk/careersworkforceaccps/optional-skills-frameworks.



# Critical Care Pharmacists

**Lorraine Moore**
Pharmacy Subcommittee Member

Two years ago I wrote about work getting underway to develop an Advanced Specialist Pharmacist curriculum. This joint venture with the Royal Pharmaceutical Society (RPS), the United Kingdom Clinical Pharmacy Association (UKCPA) and FICM has now come to fruition. Pharmacists can be credentialled to show they have the necessary knowledge and capabilities to support the wider critical care team, which facilitates GPICS compliance.

## The curriculum

The critical care curriculum in tandem with the core advanced curriculum bridges existing foundation and consultant frameworks (see diagram). Each follows the same format where candidates are required to build an ePortfolio using the five domains of person centred care and collaboration, professional practice, leadership and management, education, and research. The submitted portfolio is assessed by an expert panel and each domain given one of three outcomes: standard met, insufficient evidence provided, or standard not met.

I'd like to share my journey through the consultant portfolio, giving insight to what's involved as both a mentor and a mentee.

## My Journey

I became a critical care pharmacist in 2007. In 2019 I finally realised the importance of credentialing and signed up for the consultant framework. The portfolio development platform is free to access with a fee paid on submission. Candidates are encouraged to seek mentors from any profession to support them on their journey.

I chose five mentors — one for each domain — so the burden for each mentor would not be too onerous. It is possible to a have a single mentor cover multiple domains. My mentors were a mix of professions, each chosen because I trusted them to give me honest, constructive feedback. Pharmacist peers supported me through both leadership and management, and research. Intensivists were perfect for professional practice and person-centred care. An acute medic (and previous Training Programme Director) was my education mentor.

The portfolio was built using examples of previous work completed, e.g. guidelines and publications, as well the recognised tools including Acute Care Assessment Tools (ACATs), Case-based Discussions (CbDs), Clinical Evaluation Exercises (Mini-CEX) and Multi-Source Feedback (MSFs). Patient feedback is essential to the portfolio and one of my most challenging areas: Not many patients remember the pharmacist adjusting their medication during their hospital stay, but pharmacists have an important role supporting patients through their rehab journey too, and this is not to be underestimated.

I submitted my portfolio in April 2023 and received the outcome in June: consultant level standards met in three domains. I still have work to do on the other two but detailed feedback and mentor support means I know what I need to do to succeed next time. FICM has provided me the opportunity to develop my leadership skills, become involved in areas I'm passionate about and positively influence my profession. Developing our mentoring service will allow others to learn from my experiences.


## Being a mentor

I am now the mentor for a pharmacist working through their Core portfolio. I meet them bi-monthly for a catch up on progress, discuss how to build their portfolio and adopt an educational supervisor role in their education domain. Candidates are self-motivated and the process is rewarding.

Please do encourage your pharmacists to undertake credentialling. The Pharmacy Subcommittee can provide advice on supporting you as a mentor or members working through their portfolio. Either get in touch directly or via contact@ficm.ac.uk.

# Women in Intensive Care Medicine (WICM)

**Dr Liz Thomas**
WICM Past Chair

**Dr Cath Roberts**
WICM Chair

The Women in Intensive Care Subcommittee continues to promote ICM as a career for all. We have many active workstreams and are always receptive to new ideas! WICM is six years old now and recently there have been quite a few changes to our committee.

## Committee membership

Firstly we say goodbye to Dr Sarah Marsh — she has been Deputy Chair since WICM was founded, six years ago. We have also said goodbye to Dr Christine Watson and Dr Ingi Elsayed — thank you to all our members for their hard work over their time on the Subcommittee.

I have finished my term as Chair — having held this role for 3 years I feel it is time to pass it on. I am lucky enough to be staying on for a year, as a co-opted immediate Past Chair. Dr Manni Wairach has also been on the committee for two terms, but is staying on for 12 months to ensure comprehensive WICMEL handover. This gives me great delight to introduce our new WICM Chair — Dr Catherine Roberts. Catherine is a consultant in ICM and Emergency Medicine at Lancashire Teaching Hospitals NHS Trust and will chair WICM for the next 3 years.

## Wider WICM

The WICM Wider Group is a network of people who want to hear more about our work and support the aims of WICM. If you would like to join the WWG mailing list (all genders welcome!) then please email wicm@ficm.ac.uk.

## WICMEL fellows

The third cycle of the Women in ICM emerging leadership fellowship (WICMEL) started in September — we have three consultants and one SAS doctor as our fellows this time. The programme involves being mentored by one of the FICM Board members, attending two FICM committee meetings, taking a turn to chair a WICMEL fellows meeting and a FutureLearn module. The eight fellows who have participated in the first two cycles have all gone onto taking leadership roles. Dr Aoife Quinn is now leading the project for WICM, and she was in the last cohort of fellows.

## Thrive mentoring

WICM host the FICM mentoring project Thrive. We have been providing mentoring for consultants in their first five years of their consultant post, and soon we will be expanding our scheme to offer mentoring to SAS/AS colleagues. We are always looking for new mentors — the training is online and only takes an hour! The info is on the FICM website.

# Professional Affairs and Safety (FICMPAS)

**Dr Dale Gardner**
FICMPAS Chair

The two major focuses of work for FICMPAS are, as our name suggests: professional affairs and safety. Since my last update in *Critical Eye*, Safety Bulletins #8 and #9 have been published. My thanks to Dr Peter Hersey and his leadership in this area. Pete has written a more extensive update in this issue of *Critical Eye* and outlined the FICM Safety Strategy.

The topic dominating my thinking at the moment is GPICS V3. As FICMPAS Chair I am one of two Lead Editors, the other being Dr Paul Dean from the ICS. GPICS V3 is intended to be an evolution and build off the strong and respected foundations the previous editions laid. At the time you are first reading this update, Paul and I, along with the GPICS Section Editors, will be expectantly waiting for our first look at the draft chapters.

So, you may ask — what will be different in GPICS V3? We have some key aims in this regard:

## Greater author diversity

As we established the GPICS Editorial Board we knew this was one of our goals. Dr Sekina Bakare was appointed as our equality, diversity and inclusivity lead for GPICS V3. Sekina has kept us focused not only on gender and ethnicity but diversity in large and small units, geography, four nation representation and mixing new and old authors.

## Fewer but stronger standards and recommendations

Some of the feedback we have received on GPICS V2 and V2.1 is that there are too many standards, resulting in not all standards being as equally important and some not as enforceable or taken as seriously as others. Similarly, some recommendations do not have enough 'teeth' to drive improvements. In GPICS V3 we will be seeking to reduce the number of standards and recommendations for each GPICS chapter.

Our hope is that the standards and recommendations will be interpretable with current healthcare inspection ratings across the UK. Standards should be regarded as 'minimum standard expected' for the safe provision of critical care services relevant to the chapter. While recommendations when met, should be able to be used as evidence that the intensive care service is providing a high-quality service (e.g., interpretable as CQC good or outstanding).

This is why the job of the Editorial Board is to ensure that in GPCS V3:

- Standards are genuinely 'must do' statements.
- That standards and recommendations have a good scientific evidence base or be supported by an appropriate professional or consensus document.
- That recommendations balance aspirational improvement vs realistic deliverability.
- That GPICS V3 does not become a clinical guideline, so the focus is always on what is required for the provision of intensive care services in the UK (e.g., infrastructure, people, process).

There will of course be an opportunity for you to comment during the consultation process. I look forward to reading your feedback on how you think we are achieving our ambitions for GPICS V3.

# FICM Safety Strategy

**Dr Peter Hersey**
FICM Safety Lead

As part of our strategic aim to improve care for our patients and their relatives, the Faculty of Intensive Care Medicine is committed to the safety of our intensive care units. To better define our work in this area, we are pleased to announce the launch of the FICM Safety Strategy. The strategy describes our activity in four key areas. Visit www.ficm.ac.uk/safety for more.

## Collaborating with and providing specialist opinion to the wider NHS community

Our partnerships with NHS England and the Medicines and Healthcare Products Regulatory Agency (MHRA) mean that both organisations have co-opted membership of our FICMPAS Committee. We provide specialist ICM opinion to inform NHSE guidance and MHRA safety alerts and work together when an ICM opinion is required. The review of incidents we undertake to produce the Safety Bulletin helps inform future NHSE and MHRA workstreams. We provide a stakeholder function for the National Institute for Health and Care Excellence (NICE) when guidance is of relevance to ICM.

We also represent the ICM community via:

- SHOT (Serious Hazards of Transfusion) expert working group
- NELA (National Emergency Laparotomy Audit) steering group
- Co-opted membership of the RCoA/AoA Safe Anaesthesia Liaison Group (SALG).

## Communicating risk to the critical care community

Our Safety Bulletin highlights patient safety incidents that are rare or important, and those where the risk is perhaps something we accept in our usual practice. Via the bulletin, we also communicate relevant safety news from the wider NHS.

## Facilitating and promoting learning

Our ICM CCT curriculum requires doctors in training to consider safe practice throughout their training. High Level Learning Outcomes (HiLOs) require doctors to address the patient safety and quality improvement domain 6 of the GMC Generic Professional Capabilities Framework. Our Education Subcommittee provides guidance and resources to facilitate simulation with the aim of improving patient safety.

We also encourage engagement with the NHS patient safety syllabus training programme (available via eLearning for Healthcare) and highlight free learning opportunities made available by the Healthcare Safety Investigation Branch.

## Facilitating a quality improvement approach to patient safety

GPICS is the definitive reference source for planning and delivery of UK intensive care services. Standards and recommendations exist to improve delivery of care and therefore safety. Guidelines and initiatives endorsed by FICM are an important means of improving patient safety in our intensive care units. Endorsement provides assurance that FICM has had direct involvement or representation throughout the writing process.

We are always welcoming of input into our safety work; if you would like to get in touch, please email contact@ficm.ac.uk.


The eighth and ninth issues of the *Safety Incidents in Critical Care Bulletin* are out now, summarising NHSE/I-sourced data on critical care incidents classified as moderate or severe in patients above the age of two in a more digestible and readily available form for doctors, nurses and AHPs working in critical care.

**www.ficm.ac.uk/safety/safety-bulletin**

The Faculty of Intensive Care Medicine

SICS
scottish intensive care society

# Consultant Intensivist Transition (CIT) Course 2024

Tuesday 21st & Wednesday 22nd May 2024

St Leonard's Hall, Pollock Estate, Edinburgh

Course Fee - £395

- Aimed at senior registrars, CESR candidates and those within the first 2 years of a Consultant post in intensive care medicine
- Explores the rewards and challenges of consultant life in critical care and aims to equip you with a range of knowledge and skills in order to establish yourself in your first Consultant Post.
- Limited places available
- Experienced international faculty with a high faculty : delegate ratio

For further information or to book a course place, email ukcitcourse@gmail.com

# FICMLearning

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**FICMLearning is a free and open access educational material (#FOAMed) hub for FICM.**

### e-ICM

A joint venture between the Faculty and e-Learning for Healthcare (e-LfH). Nine modules of resources, free to all NHS staff members and students.

### Case of the Month

Whilst primarily written for trainees preparing for the FFICM examination, these short articles can be used as 'quick CPD' by anyone.

### Simulation

Supporting development of basic or more advanced technical skills and capabilities at all levels of experience, in both individual and team-based practice.

### Podcasts

The FICM podcast is available on the FICM website as well as via Apple Podcasts (iTunes) and Spotify.

### Blogs

Blogs are released every month in rotation with WICM and cover all apects of ICM. Blogs are written by subject matter experts.

**Are you taking advantage of FICMLearning yet? Visit the website for regular updates.**

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