CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE
ISSUE 26 | WINTER 2025

New Board members

In this issue

FICM INDEPENDENCE
COVID-19 INQUIRY MODULE 3
PORTFOLIO PATHWAY

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- Maternal Critical Care

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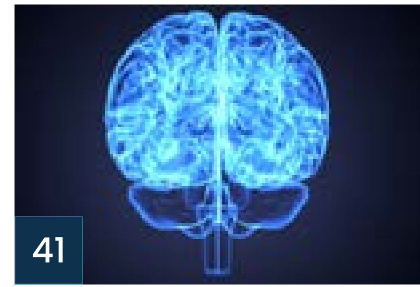
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Cover: *FICM Board January 2025, elected members and co-optees. Back Row — Dr Dhruv Parekh, Wg Cder Ian Ewington, Mr Greg Barton, Dr Dale Gardiner, Dr Shondipon Laha, Dr Pete Hersey, Dr Taqua Dahab, Dr Andrew Sharman, Dr Matt Williams, Dr Monika Beatty, Ms Pauline Elliot, Ms Carole Boulanger,, Dr Sarah Marsh; Front Row — Dr Ganesh Suntharalingam OBE, Dr Shashikumar Chandrashekaraiah, Dr Rosie Worrall, Dr Danny Bryden, Dr Jack Parry-Jones, Dr Sarah Clarke, Dr John Berridge*

WELCOME

Dr John Butler
Clinical Editor

Welcome to this winter edition of *Critical Eye*. I hope everyone has had an opportunity to spend some time with friends and family over the busy Christmas and New Year period.

Notwithstanding the increasing clinical demands for our services together with the current winter flu season, the developments within our specialty of Intensive Care medicine, led by the Faculty, move forwards at a significant pace.

As we are all aware, FICM holds the status as an equal member of the Academy of Medical Royal Colleges and just over two years ago the specialty announced its intention to form an independent College of Intensive Care Medicine. In her article, Dr Bryden outlines the significant steps the Faculty has already taken towards establishing itself as an independent college separate from the RCoA. These steps include informal discussions with the Privy council, an assessment of our viability as a standalone organisation, and work on establishing our charitable status. Independent status comes with substantial benefits allowing us the ability to decide our own priorities and providing an independent voice for our specialty on the national stage. These are very exciting times for the specialty and the Faculty alike and more details are available in the relevant sections.

In other highlights, the Covid enquiry continues with module three exploring the impact on the healthcare systems with the intention that the NHS of the future will be more prepared and resilient. In his article, Dr Parry Jones provides his personal reflections from the pandemic and also from the enquiry itself.

Recruitment into our specialty continues with the latest round of ST3 interviews due to take place in early 2025. Thanks to the hard work and persistence of a number of members of the Faculty's committees, it is now possible to be appointed to both Intensive Care medicine training and a GMC approved specialty in the same round. Applicants can now apply for dual/triple CCT Training programmes simultaneously which is something we have been striving towards for a considerable length of time. This is another important achievement in the development of our specialty. Further details are available in this issue.

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

Message From The Dean

Dr Daniele Bryden
Dean

This edition of Critical Eye arrives in the midst of winter, after a turbulent year within healthcare and six months into a new Government elected with a mandate for 'change'. So what does that mean for ICM and our patients?

The big issues for those of us working within the NHS remain finance and workforce and for patients it's also access to services.

10 year plan

The government has started to provide outlines of its vision for change in terms of development of a 10 year plan based on a shift in focus from secondary to primary care, disease prevention and greater use of digital. Their initial approach has however been to address those waiting for elective procedures. Whilst urgent and emergency care and lack of social care, the areas we know impact on acute hospitals (the growth in delayed discharges from ICU we see is just one example), are either yet to be defined or have been subject to further review. It is likely that NHS finances will also be very tight again this year

Four nation organisation

Giving evidence at the Covid Inquiry I was struck by how variations in services and health inequalities were often presented as very 'England' centric, with little exploration of the disparities that exist *within* England as well as across our nations. FICM is a four nation organisation mindful of whatever impacts on ICM and our patients. We therefore work where we can with that view; meeting with representatives of the Welsh government to support discussion of ECMO provision for Wales is one recent example. Similarly exploring the impact of poor patient flow is an area we are currently supporting RCEM and the RCN in highlighting as impacting on patient care. When the waves of delayed discharges are reaching the doors of intensive care, it doesn't catch the headlines like queues of ambulances at the front of the hospital but it indicates the serious issues we know are within.

Advocacy for ICM

Poor hospital performance and patient dissatisfaction does nothing for staff morale when finances to effect change are very tight. Workforce is at the heart of any changes needed and we continue to advocate for growth in ICM NTNs and also the support needed for those seeking Specialist registration via the portfolio pathway.

External advocacy for ICM is a key function of my role. The challenge is frequently around the external messaging, working out what might pull the levers for change within the context of a healthcare leadership system now focused on productivity. In this context the growing demand from both the increasing numbers of frail elderly people and the general decline in population health needs constant reinforcement.

As intensivists we know that we sometimes provide the generalism that many hospital specialties might appear to have lost sight of. This can be a blessing and a curse, as more and more it defaults to intensive care to provide the medical support and nursing supervision for conditions that 10 years ago would not have been considered as requiring ICM admission. One of our ongoing challenges as a medical specialty is to work across these hospital specialisms and services and support both the growth in local demand and the perception of what ICM can and should be delivering.

GPICS V3 will be published later this year and with it, a refreshed perspective of what an ICM service can and should be delivering. GPICS is the lasting legacy of, amongst others, the first FICM Vice Dean, Professor Tim Evans, a physician intensivist himself and someone acutely aware of the importance of not losing sight of quality in the drive for efficiency.

This is likely to be another difficult year across the NHS, but FICM will be pushing on your behalf and doing our best to negotiate these challenges. Let us know what more we can do for you.

FICM Independence:

Working away in the background

It's just over two years since we announced our intention to start work on forming an independent College of Intensive Care Medicine. The questions I've been asked most by members about this have been *"Why does it need to happen?"* and *"When will it occur?"* so now seems a good point to take stock of where we've got to.

Why do we need independence?

Whilst technically we're a Faculty of eight parent Royal Colleges, many of our key functions are governed by the RCoA as we're not an independent charity. This means that the RCoA oversees both our governance and finances. The fees you pay to the Faculty for membership or examination are determined by the Finance and Resources Board of the RCoA (upon which we're represented) and are ratified by the RCoA Board of Trustees (BoT) where FICM does not have a Trustee role. The BoT also oversees all matters relating to our regulations. Whatever a directly elected FICM Board may wish to do in matters of governance or finance, ultimately the RCoA Board is the final decision-making body in such matters. Financial matters such as subscription rates, exam fees and accounts are also presented at Annual General Meetings of the RCoA.

This is the main reason for change: in order to best serve the needs of our members, patients and the specialty we need to ensure self-determination.

We've always worked well with the RCoA, but as the numbers of FICM members who are not anaesthetists grows, it's important for democracy and inclusivity that all intensivists, whether single, dual or triple ICM trained have the ability to have a say in the future of their statutory professional organisation and how it impacts them. ICM and anaesthesia have diverged both in terms of 'hot button' considerations and also in terms of where we feel we can add value for our members and future healthcare. We will continue to work closely with the RCoA wherever we can, but ICM is no longer a subset of anaesthesia and both organisations recognise that.

Although FICM is an equal member of the Academy of Medical Royal Colleges, it's also apparent that many external organisations still don't understand what ICM and the people who work in the specialty do. External perception matters if we're going to continue to advocate for the specialty at the highest levels. It was brought home to me giving evidence at the Covid Inquiry on behalf of FICM, the RCoA and Association that there is

a lack of understanding of what ICM can deliver. It does not serve our future patients and the specialty well if we're perceived as a supporting medical service bearing the clinical, professional and emotional burden of difficult decisions we might not have chosen to make. ICM is at heart a medical specialty and getting into the detail of MDT working with other medical specialties and supporting advance care planning with patients is a necessary part of our future.

Becoming a medical college

Forming a medical college is not novel but each organisation has to develop an approach that works best for its members and the specialty. FICM is predominantly a doctor member organisation with a small subset of members working as ACCPs and critical care pharmacists who have chosen to link into the Faculty for our expertise in supporting education, training and curriculum design. It's not anticipated that will change going forward. However having ACCPs and pharmacists as members has been beneficial, strengthening the Faculty's outputs and demonstrating an inclusive approach to common professional matters in practice._ MDT working is explicit in the Darzi review as a fundamental component for the delivery of integrated care, and so ICM doctors need to be at the centre of an ICM MDT that, in our opinion, must always have treatment and care led by an appropriately trained ICM doctor.

I've also been garnering initial soundings from other Colleges/ Faculties and key medical leaders/organisations to understand their views of ICM and any concerns they might have. It's also been extremely valuable to understand the variety of models for representation and functioning that exist within other organisations and Colleges. Our informal explorations with the Privy Council and Department of Health and Social Care have also now given us a clearer route of the best path to take.

Initial scoping work with a business consultant demonstrated that we are viable as an independent organisation and our next step is to be able to make our own financial decisions and priorities for development. However, our move to independence should not be a barrier to improving how we work efficiently in the intervening period. We have moved a number of our activities to hybrid or fully digital, so that we can increase the benefits we're able to offer you, our members.

Next steps

Our next step is formation of a charity independent from the RCoA to give us the ability to grow, decide our own priorities and direct spending in the way that our members want sooner rather than later. Obtaining a Royal Charter is a separate, discretionary process which is time and effort-intensive. It would not be pragmatic to go through that process while we're part of RCOA, only to have to amend the Charter shortly afterwards.

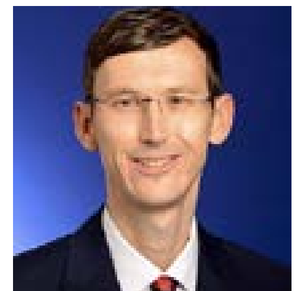
Charity formation is entirely in our collective hands and can progress at pace. We are on the way to forming that independent charity and determining the detail to achieve disaggregation from the RCoA. The key element is what that independent organisation will look like. We will work closely with the RCoA to describe that detail and in the process ensure that your views are considered, doing it in a way that achieves value for your subscriptions.

Business as usual

In my two years as Dean, although becoming independent has been a significant piece of our work, it is far from our sole focus and we have not lost sight of our primary role which is to represent you and advocate for the specialty and our patients. It's also clear to FICM Board that doing more work to support colleagues in the devolved nations and to engage more with those working in SAS, LED and new consultant roles is a Faculty goal for the coming year. Other priorities must be promoting and supporting those doing ICM research and leading training — both groups are under considerable pressure and are absolutely vital for the future standing of the specialty.

Ultimately, the journey to independence will bring challenges in terms of separating functions from the RCoA, but also provides an opportunity to consider how and where resources could be invested differently to extend the range of services and benefits we offer to you. This edition of *Critical Eye* once again illustrates just how much FICM, an organisation with a small secretariat working with clinician volunteers like you, can deliver. Just think, how much more ICM and we can all achieve in the future with a new College that supports and advocates directly for us? Our goal this year is to find out what you think that future looks like whilst continuing business as usual.

FICM Independence: Navigating a way forward



Mr Stephen Williams
Strategic Lead for FICM Independence

I was delighted to join the Faculty in September 2024 to support you with developing a new College of Intensive Care Medicine. My background is in strategy, transformation and change management in the NHS, where I worked in system roles that brought providers, commissioners and partners together to transform and integrate services, guided by a shared vision of improving population health outcomes.

I'm also a qualified accountant and member of a professional body, the Chartered Institute of Public Finance and Accountancy (CIPFA). It too has had to adapt as a membership organisation so that it can better advocate for its members, so I have experience as a member of how such challenges can be approached.

Ambitions

My time so far has been spent developing a programme of work which, with the joint support of the FICM Board and the RCoA Board of Trustees, we hope to launch in early 2025. I have been meeting with other Faculties and Colleges who have navigated similar independence journeys, to learn lessons and develop insights that can be incorporated into the programme. What is clear is that there is no 'perfect' model, and the responsibility resides with the Board and you, as members, to define what independence could look like on day one, and how this could evolve to reflect your ambitions thereafter.

What the discussions have also emphasised is that other Faculties exist along a 'horizontal continuum' with some already independent, and Colleges in all but name, at one end while others, like FICM, are currently more dependent on their parent College(s) at the other. Our shared ambition must be to move along the continuum but at a sustainable pace that allows the relationship with RCoA to evolve in a supportive way, from parent to partner.

Principles

Developing the new College will bring challenges. There will be a need to represent different views and to make decisions that are in its, and your, best interests which may not reflect the views of everyone. Given this, it's important the programme is based on shared principles to guide the way forward with the following proposed:

- **Listening to members** to reflect your views for how you want the new College to look, feel and operate.
- **Achieving value** by investing time and resources in areas that will benefit you so the new College can have the greatest impact for patients and communities.
- **Working together** with RCoA colleagues given the need to separate functions but to maintain close working relationships as the programme develops.
- **Exploring new opportunities** to work differently, maximising the potential of digital and strengthening the approach to engagement across the UK.
- **Engaging with partners,** building on the work already started, so the College has a prominent role in advocating for the specialty at the highest levels.

Programme

A three-phased approach is proposed. However, it's important to recognise this will need to be able to flex in response to any challenges, as they emerge.

Phase 1 is about 'defining' the scope of the programme and identifying the full range of functions the Faculty currently receives from RCoA together with options for their future provision. Most functions of the Faculty are delivered by the Faculty secretariat, but there are areas of cross-dependency such as exams and LLP. As members, you will directly interact with some but not others. For example, direct member-facing functions will include exams, membership renewals and the LLP while indirect functions will include supporting systems across Finance, HR, IT and Estates.

All such functions will be integral to the success of a new College. From an Estates perspective, many of you will be aware the RCoA is seeking a new home. The new College will need to decide how it wants to operate and, from which, a range of options for its future location can be developed. What is most important is that any decision follows the outlined shared principles including your views as members and achieves value.

At this stage it is important to recognise that it may not be possible to separate all functions for day one of independence, while there could be benefits from the new College formally procuring some of its functions from the RCoA. This is also evident from the discussions with other Faculties, who shared that they continue to receive, albeit on a commercial basis, certain functions from their parent College(s).

This phase also includes working jointly with both Boards to identify the full range of skills a new College will need to meet the requirements of The Charity Commission. This work has already started. For example, skills in professional areas such as Finance, Digital and HR are likely to mean the structure of the Board and the Faculty needs to transition during the separation period.

Phase 2 is about 'designing' the organisational architecture of the new College. How will it look, operate and feel to you as members and its staff? The scope of this phase will be determined by the outputs from phase one with the aim to design a structure that achieves finance and governance independence for day one and in a way that is sustainable to support future growth. This will be an exciting phase that will entail developing the new College's strategy and its cultural identity — its values and ways of working.

Based on the definition and baseline assessment of functions from phase one, this phase will see contracts formally tendered by the Faculty in its preparedness for day one as an independent entity. Importantly, this work will be underpinned by the shared principle to 'achieve value' so that all functions and services provided to you as members, directly or indirectly, are proportionate to the size of the new charity. This is with the aim of releasing and redeploying resources so that the new College can extend the range of services it offers.

Finally, phase 3 is about 'delivering' a new College, translating its strategy into clear plans and strengthening its position among key stakeholders and partners. This phase may also entail applying for Royal College status, as the new organisation becomes established, although this is not a requirement for day one. Ultimately, the aim is to grow income to deliver an expanded range of member-facing services in line with your views, and through charity governance structures, so that decisions can be taken by a Board of Trustees in the best interests of the specialty and you as its members.

Sharing your views

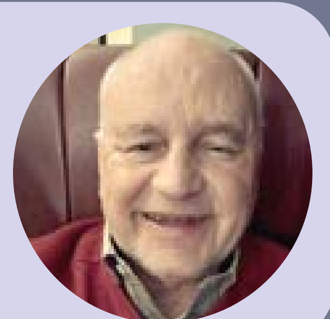
All three phases will be subject to ongoing and formal review by the Board with a key aim to strengthen member engagement throughout the process, building on the successful 'Let's Talk' event held in late 2024. In terms of next steps, we are meeting with legal experts to understand and develop organisational form options, which can then inform the *definition* work that needs to be undertaken in phase one.

Timescales need to be confirmed but the reality of an independent College can and will be realised with your support. This is an exciting time for the specialty, the Faculty and for you as its members. It's only by working together that we can navigate the best way forward, and by ensuring the programme is underpinned by shared values that include your interests as members.

Please send your thoughts on independence and how you would like the new College to look, feel and operate to contact@ficm.ac.uk

Meet your new FICM Board members

Dr John Berridge



John is a consultant in ICM in York. In a previous life he was a consultant in cardiothoracic anaesthesia and ICM in Leeds for 21 years. He is an Edinburgh graduate and got his certificate of training in anaesthesia from the University of Edinburgh in 1982. He trained in anaesthesia and medicine in Essex, Newcastle, Durham, Cambridge and Yorkshire. He is passionate about excellence in practice and training. He is looking forward to helping the specialty develop in the coming years.

Dr Ganesh Suntharalingam

Ganesh works at Northwick Park and Ealing hospitals, in a close-knit and (relative to him) youthful group of 20 dual and single specialty colleagues. He has held various local and Network roles since 2002, helping to bring together a cohesive group of DGHs and tertiary ICUs in North West London. He joined ICS Council in 2014 and ran State of the Art for four years, overseeing changes in programme, style and a move to non-London venues.

He is possibly a little accident-prone: he became CD two weeks before the (third-party) 2006 TGN1412 drug trial incident at Northwick Park, went on to chair a 2009 working group on ICU evacuation a week before the hospital caught fire, and, by way of encore, was ICS President throughout 2020. He is honoured to be elected to FICM Board and looks forward to contributing wherever useful, although given previous history readers may be forgiven for watching from a safe distance, possibly in full HAZMAT gear.

Dr Taqua Dahab

Taqua is honoured to be elected to the FICM Board as the Deputy Intensivist In Training (IiT) Representative. Building on previous role as an IMGs representative within the IiT Subcommittee, Taqua has actively collaborated with FICM and NHSE on key initiatives, including a widely welcomed guidance document for international intensivists new to UK ICM practice.

Taqua believes we are at a pivotal moment for resident doctors, navigating a medical workforce crisis and other challenges. IiTs represent the future workforce of the UK College of ICM, and she is committed to ensuring that IiT voices and views are heard throughout this journey of transition toward an independent Royal College. Taqua aims to foster a high-quality, agile College that celebrates our diversity and inclusivity, propelling us to become the best in the world. She looks forward to working closely with Lead IiT Representative Dr Rosie Worrall, to build on the excellent foundation laid by their predecessors, for the benefit of IiTs.

FICM Gold Medal winner
Dr Bruce Taylor

At the FICM Board meeting in January 2025, we were delighted to posthumously award Dr Bruce Lindsay Taylor the Faculty's Gold Medal Award, in recognition of the considerable impact he had in developing and leading the specialty of Intensive Care Medicine. We would like to thank Bruce's wife Claire and his family for accepting the award on his behalf.

Over the course of his clinical career, he made such a positive impact on the standards of care provided to adults and children in the UK and beyond, to the careers of so many doctors and healthcare professionals, and on the development and identity of the specialty.

Graduating from St Andrews and Manchester medical schools, he initially considered a surgical career. A passing interaction with the Professor of Anaesthesia led to a crossing of the blood brain barrier; he completed anaesthetic and intensive care training in 1989 via Gloucester, Cambridge, Southampton, Bristol and Exeter, with a stint working in Queensland including for the Flying Surgeon Service where he developed a variety of generic, life-long capabilities in anaesthetising patients from the very extremes of life in isolated locations and high ambient temperatures, sometimes with the aircraft pilot acting as anaesthetic assistant! Incidentally, Bruce also gained his pilot's licence during this time.

Recognising the benefits of the Australasian ICM training system, which was more developed than the UK at the time, he returned to Australia to undertake additional ICM specialist training at the Royal Children's Hospital, Melbourne and as a Locum Staff Specialist in Brisbane. During this time, he was awarded Fellowship of the Australia & New Zealand College of Anaesthetists (FANZCA) and Fellowship of the Joint Faculty of Intensive Care Medicine (FJFICM, now FCICM). Bruce would later use his experience of the Australian ICM training system to benefit the UK's own ICM training programme, in his role as a member of both the Intercollegiate Board for Training in Intensive Care Medicine (2005-2009) and the Intercollegiate Board for Training in Paediatric Intensive Care Medicine (2005-2013).

He then joined Gary Smith to build an ICU service in Portsmouth for both adults and children that developed a reputation for excellence clinically and educationally. That work has left an impressive cultural legacy within the department, which retains the drive for high quality patient care and towards excellence in education and training.

Bruce was a brilliant clinician and teacher. Quotes from colleagues illustrate just how revered and treasured he was: *"The best clinician I ever worked with"*, and *"An inspiration: I think of him often, given I have the privilege of occupying his desk"*. His mantra was of always doing the simple things well and attending to the details to ensure patients received safe care. Bruce's contributions to teaching and training are extensive whether they were in the classroom, operating room or at the bedside. He was also well published, including being a co-author of the landmark BMJ paper in 1998 on the quality of care prior to ICU.

With there being no PICU south of Great Ormond Street, Bruce was instrumental in the Portsmouth critical care service becoming recognised for its expertise in caring for very sick children. Critically ill children were often referred from surrounding hospitals, necessitating the development of a reliable, high quality transfer system to stabilise and transfer the children. He supported the drive for regionalisation of PICU services, serving on national groups to help structure these around the UK. He worked collaboratively with staff at Southampton General Hospital to develop the region's PICU service. Whilst Portsmouth no longer admitted the sickest, youngest children, the collaborative working approach taken by the department underpinned Bruce's central tenet that a patient's best interests always trumped medico-politics. That said, he continued to advocate the still relevant concerns for maintaining paediatric critical care skills so that resuscitation and stabilisation of sick children could be safely delivered in District Hospital services prior to transfer out.

Prescient to more modern history, in March 2005 Bruce was highlighting that the UK Department of Health's draft influenza pandemic contingency plan predicted over 50000 deaths, and yet had no mention of critical care at all. This led to him being invited to chair the UK Department of Health's Critical Care Contingency Planning Group to consider strategies for managing what we now recognise as surge capacity. During the H1N1 outbreak in 2009, he spoke to the House of Lords' Science & Technology Committee about his concerns for the provision of critical care in the event of a pandemic and the ethical challenges that staff would have to consider.

Gary Smith said. *"Bruce was a humble Scotsman, who failed to recognise the magnitude of his influence on medicine. He often felt an imposter on committees, even those he chaired, and expressed surprise that he could hold his own with those he regarded as superior intellects. Nevertheless, Bruce held several major positions in the UK Intensive Care Society – Council member; Chair of the ICS Standards, Safety and Quality Committee; Editor of the Journal of the ICS; ICS Honorary Secretary and ICS President."* The latter meant he sat as a co-opted member of this Board in its relative infancy. His achievements were recognised by being made an Honorary Fellow of the Royal College of Physicians and Honorary Membership of the ICS in 2012.

The following quotes, taken from Dr Peter McQuillan's eulogy, perfectly summarise why Bruce earned this award: *"Bruce was a hands-on doctor and a great communicator. He saved many lives and had magnificent rapport with his patients and their families. He was amazingly supportive of his colleagues. He was politically astute, a mover and shaker who made major contributions to the wider NHS."*

Adapted from the citation written and read by Dr Matt Williams, friend and FICM Board Member.

The Covid-19 Inquiry: Module 3

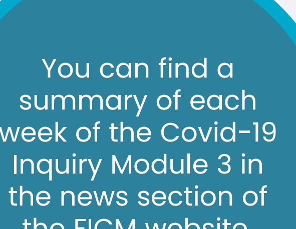
Dr Jack Parry Jones
Vice Dean

Module 3 of the Covid Inquiry looks to dissect the "Impact of Covid-19 pandemic on healthcare systems in the four nations of the UK"[1]. Many words have already been spoken and even more written, with a long way still to go before Module 3's conclusions are made public. Those conclusions will provide a marker from which the lessons and process of re-designing, or making more resilient, a post-Covid UK NHS can be mapped. For us as intensivists that relates predominantly to critical care services.

While those giving evidence from critical care, including our own Dean[2], did a valiant job for us as intensivists, I left the Inquiry with some reflections.

- Despite wide attention, I remain unconvinced that most people working outside of critical care understand what intensivists do.
- The term 'triage' is not generally useful to us. The critical care consultant is trying to make an informed decision, based on their training and experience, supplemented if and when necessary with a second opinion, on whether to admit a patient.
- We never have unlimited resources, even at the best of times.
- At the worst of times, during the height of the pandemic, we did not make decisions based on resource limitations but only because we massively expanded capacity by necessarily diluting our standards.
- Moral distress and moral injury are real — the strength of feeling that if only we had done more, can have a lasting impact, is not confined to a pandemic, and can occur unexpectedly.
- A real fear existed that we might have to limit resources by not admitting people who might benefit.
- Deciding not to admit to critical care does not mean patients won't receive care and not all patients who aren't admitted to critical care die. Some referred patients don't need critical care, some won't benefit from it, and some will be made worse by receiving it.
- The 'burden' to the patient and family of being cared for in critical care is not abstract to us but a real phenomena which we bear witness to. False hope leads to unmet, unrealistic expectations and a protracted death.
- Regional and national differences in critical care were real. Even though the UK is a relatively small country the same situation was not playing out simultaneously across the whole of the country.

> Our voice is going to be absolutely crucial in how society wants to address key issues that come with an ageing population.



- The poorest, most deprived in our society, for whatever reason including ethnicity and disability, fare worst. 'Shit-life-syndrome' exists and those with it are more likely to need critical care. We have a duty to respond to this.

A united voice

The Inquiry reinforced my belief that critical care needs to speak with a clear, united voice. I believe the move to critical care standing alone as an independent College of Intensive Care Medicine will help that voice be heard. More than that, I believe an independent College will help our patients and society, including the wider medical profession, in their understanding that Intensive Care Medicine has evolved beyond its origins in anaesthesia. A medical specialty that can map its evolutionary tree to other Colleges and Faculties but one that now needs to bring an independent voice to the table.

Our voice is going to be absolutely crucial in how society wants to address key issues that come with an ageing population. Where do we want to die, what do we want done to us when we are dying, how will we know when we are dying, how will we know when our loved ones are dying?

We need to be at that table, bringing our knowledge and experience to provide confidence and trust in what is reasonably possible with critical care interventions. Without us being there, it will be us left carrying the burden of unmet, unrealistic expectations that come at an emotional cost not just to patients and families but also to our staff, and at an exponential financial cost to society.

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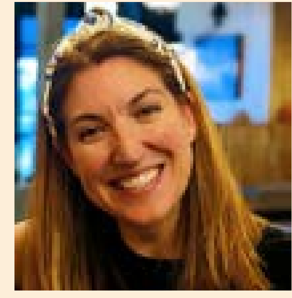
2. https://ficm.ac.uk/dr-daniele-bryden-gives-evidence-to-the-covid19-inquiry

WICS-ART: An intensive care resident research network in Wales



Dr Brigitte Baxter
WICS-ART Co-Chair

Welsh Intensive Care Society Audit and Research Trainees (WICS-ART) is the resident research network in Wales, launched at the National Research Collaborative Meeting (NRCM) in March 2023. We are passionate about providing opportunities for Intensive Care Medicine residents and ICM-affiliated clinicians in Wales; inspiring local and nationally co-ordinated research, quality improvement and audit.

Resident research networks (RRNs) are not a new concept in Wales or across the UK. To the best of my knowledge the surgical residents Welsh Barbers research group in 2011 was the first in Wales, followed by a decade of proliferation across all specialties. Within anaesthesia, the Welsh Anaesthesia Audit Research and Engagement Network (WAAREN) is our local network, feeding centrally into the Research and Audit Federation of Anaesthesia Trainees (RAFT). Intensive care is yet to develop RRNs across the different regions. This may in part be related to our historical affiliation with anaesthesia; with intensive care associated projects often being lead through anaesthesia RRNs.

Inspired by TRIC

In 2019 at the UK Critical Care Research Group meeting the National Audit and Research Cooperative of Trainees in Intensive Care (NARCoTIC) was launched, subsequently renamed the Trainee Research in Intensive Care (TRIC) network. TRIC has been an inspiring central RRN with regular engagement, a wide portfolio of projects and innovation for educational opportunities; such as the honorary digital editorship.

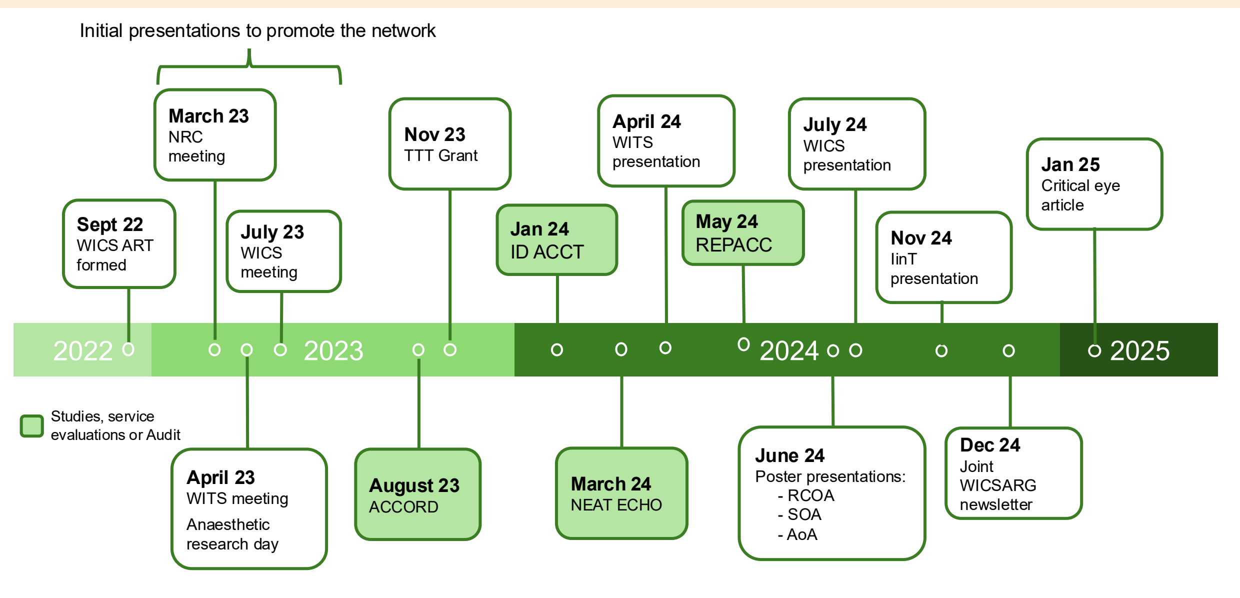
Inspired by the current TRIC network and the well established anaesthesia-associated RRNs we launched the Welsh Intensive Care Society Audit and Research Trainees (WICS-ART) research network. A group six of likeminded ICM and ICM-affiliated resident doctors came together to create a governance framework, social media and website presence, explore research and QI opportunities and most importantly discuss a name and logo (congratulations to Dr Elgarf who produced the final logo!). The timeline opposite shows our progress and projects to date. We are currently collaborating with the Welsh Audit and Research Engagement Network (WAAREN) for the Retrospective Evaluation of Post-operative Alternatives to Critical Care (REPACC) project.

Presenting our work

We were lucky enough to receive a 'Trainees Transforming Training' monetary grant, a Health Education in Wales incentive. This allowed us the support to present our work at the Association of Anesthetists' trainee conference in Glasgow and the State of the Art conference in Birmingham. We also presented our work at the WICS conference, Welsh Intensivists in training (WITS) conference, the inaugural FICM Intensivists in Training conference, RCoA College Tutors meeting, and of course where it all began at the NRCM. We have now been invited back to both WICS and WITS in 2025 to discuss our activity, disseminate ongoing research opportunities and gather current research and QI innovation.

Facilitating projects

Since WICS-ART's formation in September 2022 we have facilitated teams across 14 hospital sites, recruiting 51 site leads and over 120 collaborators. Involvement



in projects has given collaborators exposure to recruitment and data collection, site lead management and clinical governance experience. These are not only vital non-clinical research skills, but go some way to developing a research ready workforce.

It is our hope the data generated from these projects can go on to support All-Wales innovation in QI. We are very aware of the differences in sites and working patterns across Wales and are very grateful for the significant support offered by the Welsh School of Anaesthesia, Pain and Critical Care, WICS and all the clinicians and collaborators who have made these projects possible. It has been heartening to see their efforts valued in ways such as recognition in authorship by Flower et al in the NEAT ECHO study.

Dedicated research networks lend themselves to the delivery of high-quality multisite research and audit lead entirely by resident doctors. Networks encourage trainee engagement with research at all stages of training and foster peer learning and skills exchange. Forging relationships with local research and clinical governance leads helps to streamline and expedite project set up across health boards. RRNs also act as a forum to listen to the trainee research and audit agenda with projects being selected by consensus to answer the most pressing clinical questions.

Creating and running the network is not always plain-sailing. Some of the barriers that we have faced include limited funding for conference presentation and project setup, lack of time to dedicate to the network due to busy training and clinical schedules, and difficulties navigating particulars of clinical governance across different health boards. It is, however, my hope that we can inspire other regions to join us in developing local ICM RRNs and proliferate our own network across the UK. Our specialty is unique in its broad MDT involvement and potential for cross-specialty working.

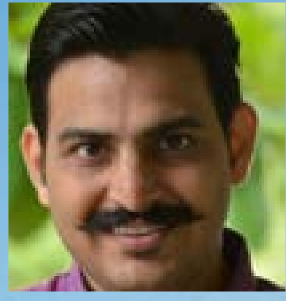
New members

It is time for some of our founding members (myself, Sarah Elgarf and Lenny Iva) to move on, as we begin consultant practice, and make way for new members of the team. Gwen Howe and James Ainsworth will join existing founding members Graham Picton, Hace White and Esther Godfrey in taking the network forward. We are excited to see how the network evolves and the opportunities it brings.

If you are a Welsh Intensive Care Medicine resident doctor, or aspiring to be, with a budding research or QI question please do let us know. Our current and future projects include an evaluation of VV-ECMO service requirements within Wales, an All-Wales QI airway sign initiative and a review of women in Intensive Care Medicine in Wales. Similarly, if you are thinking of setting up an ICM RRN in your region we would love to hear from you and share experiences.

We would love to hear from you!

Portfolio Pathway: Procrastination or Self-Doubt?



As an Intensive Care Medicine consultant who successfully sailed through the Portfolio Pathway — previously known as CESR, Certificate of Eligibility for Specialist Registration — for ICM in the United Kingdom, I'm here to share my journey and inspire those of you contemplating or currently pursuing this challenging but rewarding path.

Dr Deepak Sharma
FICM Portfolio Pathway Subcommittee Member

Before arriving in the UK, I spent three and a half years working as an Intensivist in India. Thanks to a well-wisher and friend in the UK, I became aware of the CESR pathway early on and began preparing myself well before my move.

Despite this foresight, the reality of compiling competency documents for CESR while adapting to a new country, culture, different healthcare system, and a new professional environment was far more complex than I had anticipated. I vividly remember my first working day in the UK, feeling overwhelmed by the unfamiliar protocols and equipment. The weight of the CESR journey ahead felt crushing, but I reminded myself of the countless hours of preparation I'd already invested. This wasn't just a career move; it was a life-changing decision that would impact not only me but my family as well.

The process

The Portfolio Pathway requires you to systematically document every facet of your career — from clinical experience and skills to research, teaching, leadership, and management roles. It's not just an administrative requirement; it's a comprehensive assessment that ensures your knowledge, skills and experience meet the standards of a UK-trained specialist in your field.

In all my mentorship sessions to CESR aspirants, I emphasise, "This pathway tests if you're ready to work on day one as a consultant in your specialty." It's not for the faint-hearted, and many doctors, myself included, face numerous challenges, both expected and unexpected.

Challenges I faced — And how I overcame them

Understanding the requirements and navigating uncertainty.
One of my first hurdles was understanding the detailed requirements for CESR. The General Medical Council (GMC) guidelines are comprehensive, but the specific expectations for your specialty may not always be clear, leading to uncertainty and confusion.

I realised the importance of attending CESR/Portfolio workshops and seeking guidance from those who had already been through the process. However, finding mentors was tough, as everyone seemed to be in the same boat, and those who had succeeded didn't always seem eager to help others. The ICM specialty-specific guidance (SSG) provided by the Faculty was invaluable. I read it multiple times to understand some of the peculiar requirements for this pathway. I learned that contacting the GMC early for advice on unclear matters could save valuable time.

Compiling and organising evidence Gathering and organising evidence was another significant challenge. The process demands an extensive portfolio of evidence, including certificates, logbooks, appraisals, assessments, reflections, and letters of recommendation. I needed to show proof of every skill, every procedure, and every piece of research I had been involved in. Many applicants struggle with either providing too little evidence or submitting too much irrelevant material. I had to carefully curate my portfolio, focusing on quality over quantity. As I started gathering evidence early in the journey (before moving to the UK), I had the majority of domains sorted. But it was crucial to be methodical, ensuring that every piece of evidence aligned with the capabilities required by the ICM SSG.

Aligning experience with UK standards Coming from a different healthcare system, I had to ensure that my experience aligned with UK standards. This meant undertaking additional training, like paediatric critical care, and proactively seeking opportunities to teach, conduct audits, and engage in clinical governance activities. I remember feeling completely out of my depth during my first clinical audit presentation. The unfamiliar terminology and expectations nearly overwhelmed me, but the supportive nods from my colleagues gave me the courage to push through. These experiences, though challenging, were crucial in bridging the gap between my previous practice and UK standards.

Overcoming fear and building confidence The fear of failing or not meeting the standards is something many international doctors face. This fear can be exacerbated by cultural differences, language barriers, and the challenges of adapting to an unfamiliar environment. There were moments when I doubted myself and wondered if I could ever achieve the level of competency expected in the UK. I vividly recall a night shift where I felt particularly overwhelmed by the complexity of a case. As I stood there, questioning my abilities, a senior nurse noticed my hesitation and offered words of encouragement. This simple act of kindness reminded me that I wasn't alone in this journey and that building a support network was crucial for my success.

Dealing with an unsupportive work environment Not every work environment is supportive of Portfolio applicants. Some colleagues may not understand the process, while others may view it as unnecessary or even overambitious. I encountered resistance when requesting certain documents or when seeking opportunities that were critical for my portfolio. Instead of feeling discouraged, I chose to communicate openly with my colleagues, explaining why these documents and experiences were necessary. It also helped to build a rapport with supervisors and consultants who could support me by providing the evidence I needed.

Financial and social challenges Undertaking the Portfolio Pathway involves a significant financial burden, from the cost of applications and documentation to expenses for courses, workshops, and exams. As an overseas doctor, I also faced social isolation, cultural shock, and the pressure of being away from family. Finding a balance between personal and professional life, managing finances wisely, and staying connected with a support network back home helped me cope with these challenges. I also made it a point to build a community in the UK, which provided both emotional support and professional guidance.

Common challenges

Through discussions with colleagues and engagement with CESR forums, I learned that many of the challenges I faced were common among other International Medical Graduates (IMGs). Some of these are:

- **Difficulty securing relevant posts and placements:** Many applicants struggle to find positions that provide the necessary evidence. These positions may not always be readily available or may require additional sponsorship or funding, which can be hard to obtain. I feel this bottleneck is where most IMGs struggle.
- **Lack of reliable mentorship:** Navigating CESR without a mentor can be particularly challenging. Many applicants lack access to mentors who understand the process, leaving them feeling lost and unsupported. This is the main reason for me to continue as a CESR mentor and lead in helping other colleagues and fellows in this process.
- **Unfavourable contracts and lack of support**: Some IMGs face challenges related to their contracts, such as limited opportunities for professional development, lack of funding for necessary courses, or even a lack of institutional support for their CESR ambitions.
- **Fear of unfamiliar tasks and minimisation of ambition:** Many IMGs, especially those new to the UK, fear taking on unfamiliar tasks due to the potential consequences. This fear can lead to a minimisation of ambition, preventing them from pursuing opportunities that could strengthen their CESR application.

Why are you still procrastinating?

If you find yourself hesitating, ask yourself what is holding you back. The Portfolio Pathway is not a shortcut; it is a legitimate and recognised route to achieving Specialist Registration in the UK. While it is demanding, it is also immensely rewarding. Every day you delay is a day lost in achieving your goals. The sooner you start, the more time you must identify gaps, gather evidence, and build a compelling portfolio. Ask yourself:

- Are you allowing fear or uncertainty to prevent you from advancing your career?
- Are you stuck in the comfort zone of your current role, afraid to challenge yourself?
- What's the worst that could happen if you start today?
- And what's the best that could happen?

How to move forward

1. **Start with self-assessment:** Review the Faculty's requirements in the ICM SSG and assess your current capabilities against them. Identify gaps in your experience and create a plan to fill those gaps.
2. **Seek guidance and mentorship:** Find mentors who have successfully completed the process. Join forums, attend workshops, and connect with others on the same journey. A good mentor can provide insights that will save you time and minimise effort.
3. **Be organised:** Document everything from day one. Keep detailed records of all your professional activities, from clinical work to research and teaching. Use digital tools to organise your documents systematically.
4. **Prepare for challenges:** Understand that setbacks are part of the journey. Use every piece of feedback constructively and be prepared to revise and resubmit your documents. Persistence is key.
5. **Stay motivated and focused:** Keep your end goal in sight. Remind yourself regularly of why you started this journey and what you stand to gain by completing it.
6. **Devote time:** Make a habit of devoting at least a couple of hours every day to your portfolio. This routine will save you from last-minute hassles in collecting or arranging evidence.
7. **Family support:** Family support is the most important element in your success in this pathway, so don't underestimate that. Communicate openly with your loved ones about the challenges and rewards of this journey.

Take action today

The Portfolio Pathway is challenging, but it is achievable. It requires determination, hard work, and strategic planning, but the rewards are immense. If you are serious about advancing your career in the UK, stop procrastinating and start taking action today. Every step forward brings you closer to your goal. Remember, the journey of a thousand miles begins with a single step. So I ask one last time: why are you still procrastinating? Start today — your future self will thank you.

Education and Events

Dr Sarah Marsh
Chair FICMESC

It's been a busy 12 months for the Education Subcommittee thanks to the hard work of both our committee members and intensivists across the country contributing to our educational outputs. The ESC hosts the content under FICMLearning and has a number of work streams including monthly blogs and clinical cases, and bi-monthly podcasts and simulation scenarios. 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

- The shocked patient
- Pulmonary hypertension
- Heatstroke
- Haemophagocytic Lymphohistiocytosis
- Nephrogenic DI
- A sugar high
- Major burn injury

Blogs

- Beyond binary: critical care through a transgender lens
- The rules of email etiquette
- The special skills year
- Collaborative autonomy in organ donation project work
- Fire! Fire!
- My experience of ESICM LIVES

Simulation Scenarios

- Acute on chronic liver failure
- End of life & palliative care in ICU
- CCOT – assessing a patient for discharge
- Paediatric status epilepticus
- Fire safety evacuation scenarios

Podcasts

- Treatment escalation planning with Dr Sonya Daniel
- FICM Training, Assessment and quality committee workstreams with Dr Sarah Clarke and Dr Shashi Chandrasekhariah
- Perioperative medicine – the past, the present and the future with Prof Ramani Moonsinghe, Dr David Murray and Dr Luke Flower

2024 Annual Meeting

The ESC hosted last year's Annual Meeting for FICM. The day commenced with an update from Dr Danny Bryden on the Future of the FICM including the move towards college status. The rest of the day was divided into four parts.

The first centred around research and innovation with talks from Prof Ramani Moonsinghe (The development of perioperative medicine in the UK, how it impacts upon and involves

FFICM Online Exam Course
Access until 17 March 2025
£75 online

Above: *Happy Diplomates, FICM Dean and FFICM Examiners at RCoA Diplomates Day 2024.*

critical care), Dr David Murray (The impact of NELA on intensive care medicine) and Dr Luke Flower (TRIC network — review of projects incl NEAT-ECHO). Dr Monika Beatty oversaw the Legal and Ethical Unit session featuring presentations from Dr Sonya Daniel (DNACPR and treatment escalation planning), Mr Ben Troke (Recent cases at the Court of Protection relevant to ICM) and Mr Alex Ruck Keene KC (When patients refuse treatment).

The afternoon had six quick fire talks from a select group of committee chairs at the FICM to update on current works including from the Training, Assessment and Quality Committee, Professional Affairs and Safety Committee, Careers Recruitment and Workforce, and Smaller and Specialist Units Advisory Group.

The final session of the day featured IiTs delivering pitches on "What technology should the NHS invest in in critical care?". This was won by Dr Waqas Akhtar for his presentation on extracorporeal cardiopulmonary resuscitation.

The Annual Meeting has evolved into our FICMEducation: Hot Topics event. In 2025, this will be an online event on 22 May and will cover topics such as Diagnosing Death Using Neurological Criteria, Maternal Critical Care and Critical Care Rehab. We hope you will join us.

FICM Prep Course

The FICM FFICM exam preparation course was held at Churchill House in the spring and made its return to Leeds in the autumn. A new style of pre-exam preparation is being trialled with access to 24 hot topics video lectures available for approximately two months prior to the exam. The in-person SOE and OSCE mock exam format continues and our thanks go to all the

examiners who worked very hard all day to get the candidates through the questions. The next course will be held on 4 March 2025.

Content submissions

We are always looking for content contributors, so if you or any members of your department would like to contribute a Case of the Month (COTM), a blog, be involved in a podcast or have a simulation scenario to share, please contact the Faculty. We would like to encourage doctors of all levels and grades to get in touch including doctors in training, specialty, associate specialist or specialist doctors, consultants and anywhere in-between as well as ACCPs and pharmacists.

ESC Membership

The ESC would like to send huge thanks to our outgoing members Dr David Melia (Deputy chair) and Dr Rik Bell (podcasts) Dr Kyle Gibson (CoM and eICM) and Ms Sonya Stone (eICM) for their hard work over the years for the ESC — we wish them all the best for their future endeavours. We'd also like to welcome Dr Lina Grauslyte Dr Elaine Yip, Dr Emily Reynolds and Dr Nikki Faulkner on to the committee as well as Emma Taylor who has been co-opted from our Pharmacy Subcommittee, and Emma Duane from our ACCP sub committee. Dr Gilly Fleming will step in to the Deputy Chair role.

Workstream Leads

- **COTM:** Dr Ram Matsa, Dr Cat Felderhof
- **Blogs:** Dr Cathy Challifour, Dr Elaine Yip
- **Simulation:** Dr Lina Grauslyte, Dr Jonathon Wong
- **Podcasts:** Dr Gilly Fleming, Dr Samantha Gaw
- **Events:** Dr Ram Matsa, Dr Emily Reynolds, Dr Nikki Faulkner

Above: *Workshops, lectures, coaching sessions and networking at the 2024 Future Intensivists Conference.*

Training, Assessment and Quality (FICMTAQ)

Dr Sarah Clarke
Chair FICMTAQ

Once again TAQ has had an action-packed agenda since the last edition of *Critical Eye* and I am eternally grateful to all of the committee members for their dedication and behind the scenes efforts and productivity. I cannot just give credit to all the individuals, but a main focus of TAQ activity is to ensure that we are inclusive of all of the Faculty's membership, throughout the four nations, and it has been rewarding to have the Lead Regional Advisors from Scotland (Neil Young), Wales (Teresa Evans) and Northern Ireland (Esther Davis) joining Andrew Sharman, FICM Lead RA, being so active on the committee, supporting all our workstreams.

Where were we?

To continue where I left off with the last edition, where I said we are listening, a significant aspect of the year's activities evolved from the Intensivists in Training (IiT) survey[1] and the 2024 action plan. Exposing the differential treatment of various groups of IiTs depending on their core training programme has been a bitter pill to swallow, and something to which we strongly object.

The strength of our programme, and indeed our specialty, is the rich diverse training backgrounds of all colleagues. The joint RCoA/FICM publication of *Best Practice for the Management of Intensivists in Training* is just one development, alongside further guidance on Keeping in Touch Days, Protected Airway Training, and other supporting documents to assist IiTs and Trainers. These can all be found on the FICM website.[2] Additionally, work with the LLP and efforts to address inequities of access continues unabated.

New workstreams

Further TAQ output from the survey action plan is to publish guidance on rotations and optimising training. We expect this to be out in Spring 2025. Whilst the Faculty is responsible for setting the curriculum, it is for the regions and Deaneries to implement. This document will support the flexible and pragmatic delivery of the curriculum by sharing good practice examples from across the four nations.

An additional workstream has been to introduce guidance for assessing the training capacity of units. This aims to support local and lead trainers in ensuring the appropriate, recognised and job-planned supervision of our IiTs, residents and ACCPs on our Units. We hope you will find it useful.

Analysis of the 2024 IiT Survey is currently underway. I'm grateful to the outgoing IiT Lead Representative, Dr Waqas Akhtar for the collaborative approach to its design, to ensure we receive further relevant quality and actionable data. As we say thank you and goodbye to Waqas for all his work on TAQ, we say hello to Dr Rosie Worrall as the new Lead IiT, and her Deputy Dr Taqua Dahab.

Examination changes

The Court of Examiners must be thanked for their continued efforts and success in delivering the FFICM exam; as numbers of candidates continue to climb, we welcomed 15 enthusiastic new examiners in the October 2024 diet, with a further appointment round due in 2025.

Changes to the FFICM, following the (lengthy) GMC approval process include the removal of the standard error of measurement (SEM) in the MCQ. Following expert advice, this aligns with other Colleges and will be enacted from the June 2025 sitting. Further details can be found in Dr Robson's FFICM update.

Business as usual

Core TAQ projects and subcommittees continue their vital work. We push for further insight into differential attainment, not only in the FFICM exam, but also in training progress. Recent stark data highlights that IMG doctors perform less well across all aspects; this is being explored further, in training support, candidate preparation and exam experience. The Education Subcommittee remain incredibly productive, their outputs on FICMLearning are invaluable to all.

Due to the ever-increasing TAQ initiatives, a recent development is the publication of the *Training Digest* after TAQ meetings, so that trainers and IiTs can be appraised of updates in real time.

What next?

We will continue to ensure that we have a Curriculum and CCT fit for purpose (further best practice guidance and clarifications imminent), and are working towards the publication of the first postgraduate medical curriculum that incorporates climate change and a sustainability agenda. This is eagerly anticipated in 2025, and I'm ever grateful to the sustainable curriculum working group for their collaboration.

My thanks to the FICM team for their tireless responsiveness to not only myself, but the whole membership; with over 6,000 encounters a year through the contact@ficm.ac.uk, where would we be without them?!

References

1. https://ficm.ac.uk/training-exams-intensivists-in-training-iit/2024-training-guide-for-iits-trainers
2. https://ficm.ac.uk/icm-training-best-practice-statements

FFICM Examinations

Dr Victoria Robson
Chair of Examiners

The first FFICM examination was held in 2013; there have been two sittings each year (except for one cancellation during the first Covid pandemic 'lockdown') and candidate numbers have increased from approximately 100 attempting the oral components in 2013 to more than 400 in 2024. The exam is a key component of the ICM CCT Training Programme's Assessment Strategy, being the only summative assessment on topics not selected by the Intensivist in Training (IiT).

It is assessed by a body of examiners who are not involved in the training of that individual, all of whom have been trained in assessment and audited on their practice. As such, it has an important patient safety role, ensuring the high standard of those who go onto become ICM consultants.

Regulation changes

A number of regulation changes have occurred in recent years, mostly to increase the flexibility for candidates within training programmes. Those in the ICM training programme can now enter the Multiple Choice Questions (MCQ) exam at any point during ICM Stage 1 training, if they feel adequately prepared (but cannot enter the oral examinations until they are in Stage 2) and those who are not in the training programme can enter after one year of UK ICM training which may be in six-month blocks. The primary qualification expiration after 10 years has been removed and extensions of expiration dates of exam components for maternity/paternity/adoption leave or less than full time training have been added.[1] It is important to note that the *standard* of the exam has *not* changed; it is still set at the end of Stage 2 training, and all components of the training programme up to the end of Stage 2 (including Anaesthesia, Medicine, Cardio-, Neuro- and Paediatric-ICM) will be tested.

Several other changes have been made, some in response to the 2023 independent review of all RCoA-delivered examinations, which is available on the RCoA website.[2]

Resources

A comprehensive webpage of resources for candidates now exists on the FICM website[3]. This contains videos showing good and borderline performances in OSCE and SOE stations and guidance on answering certain question types e.g. simulation. More sample exam questions and lists of topics that were not answered well by candidates in previous exams and lists of revision resources have been added, and a comprehensive exam syllabus has also been published. In addition, a more informative and useful letter for candidates who fail an oral component has been designed.

Process changes

Changes in the administrative process have occurred, and two new members of staff with specific responsibility for delivering Faculties' exams (FICM and FPM) have been employed. The oral exams have been transferred to electronic platforms. Pure knowledge components in oral questions (of which there were few) are being moved to the MCQ.

Currently the MCQ pass mark is set by the Angoff process with one standard error then subtracted. As recommended in the Independent Review, this subtraction of standard error will cease from June 2025. Looking at the performance of candidates in their first attempt at oral examinations, the cohort of candidates who passed the MCQ only because of the standard error subtraction, had a very low pass rate in the oral components compared to those whose score was above the Angoff-derived pass mark.

Differential attainment

We are aware there is differential attainment in exam success by certain groups of doctors, including those from minority ethnic groups and those whose undergraduate qualification was obtained outside EEA and UK. Work is ongoing within the Faculty and GMC to try to address this. A group of candidates with a particularly low success rate in the FFICM examination is those who are in non-training posts. These are a heterogeneous group, but many have trained outside the UK and have not benefited from the breadth of experience, teaching, training and supervision that the UK ICM CCT training programme offers.

New oral examination

A review of the FFICM exam has been carried out and a new oral examination (to replace the SOE and OSCE components) is being planned. The details have not been finalised, and will need GMC approval, but the current plan is for an exam called 'Assessment of Clinical Reasoning (ACRE)', that will consist of a sequence of stations reflecting the clinical encounters an ICM doctor might expect in daily practice, such as a referral of a patient from the Emergency Department, a ward round patient review, dealing with a clinical problem in critical care, a discussion with a patient, relative or health professional. The exam standard will remain the end of Stage 2 training. Further details and sample questions will be uploaded onto the FICM website when available and will be published at least one year before the first sitting of the new oral exam, which will not start before 2027.

The design of the new oral exam and writing of a new question bank is being undertaken by the FFICM examiners, who are all volunteers; my thanks go to them for this as well as for continuing to examine candidates and writing and revising exam questions for the current exam. My thanks also go to the staff of Royal College of Anaesthetists' Exams Department who administer this exam.

References

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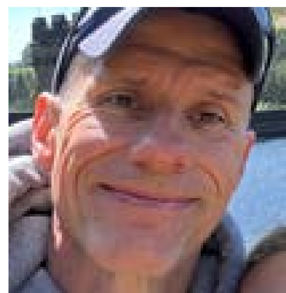
2. https://www.rcoa.ac.uk/examinations/examination-reports-statistics/independent-review-assessment-processes-rcoa
3. https://www.ficm.ac.uk/trainingexamsexaminations/resources-for-candidates

FFICM Exam Calendar

	FFICM MCQ	FFICM OSCE/SOE	FFICM MCQ	FFICM OSCE/SOE
Applications and fees not accepted before	23 Sep 2024	9 Dec 2024	10 March 2025	23 June 2025
Closing date for exam applications	21 Nov 2024	31 Jan 2024	24 April 2025	4 Aug 2025
Examination date	**8 Jan 2025**	**17-20 March 2025**	**26 June 2025**	**29 Sep-3 Oct 2025**
Examination fees	£580	Both — £720 OSCE — £400 SOE — £360	£580	*Fees TBC*
Results released	29 Jan 2025	28 October 2025	15 July 2025	28 Oct 2025

Regional Advisors



Dr Andrew Sharman
Lead RA

Time flies. Another year has passed. We welcome the new IiTs who joined us in August. I hope you have settled in and are enjoying the many facets of ICM. Exam time has come and gone which inevitably means there were happy outcomes and disappointing ones. Well done to those who passed this important milestone. It will have taught more than it tested. To those who need to resit, take heart. There is no shame in needing more than one attempt.

Exams have cost, in both finances and time. Having sat four postgraduate exams and now as a trainer and examiner, I can honestly say, all my exams taught me so much that I would not have known without them. They allowed me to do my job, with a confidence and surety. I am not certain I would have said that at the time of sitting them, but the advice of experienced trainers turned out to be absolutely spot on.

Diverse experiences

Similarly, the diverse experiences I gained through clinical practice and training at numerous hospitals, as well as from the trainers who taught me, would not have been possible without a rotational programme. Sometimes, we cannot appreciate the training we are given amidst the unnecessary work hardships we face. Car parking, lockers, computers that work, good induction, good food etc, all need to be in place and must be seen as a priority. Discontent with training is directly linked to these basic requirements and the most recent training survey tells us these needs are not met in so many regions. This is unacceptable. Addressing these issues is critical for IiTs to get the most from their training. I urge Clinical Directors and Heads of Services, to ensure their hospital is meeting these basic needs so that IiTs can get the most out of their training.

Excellent trainers

At least I know we have excellent trainers across the country. The ICM Faculty Tutors and Regional Advisors are committed to supporting and helping the IiTs and I would like to extend my thanks for all they do. The Annual Regional Advisors Survey demonstrated how much excellent work is ongoing across the country. Exam courses, regional teaching courses, mentoring programmes, and offering a variety of Special Skill Years are just some examples of an ever-growing list of successes.. The survey again highlighted the inadequate recognition and support, both financial and otherwise, that many trainers receive. It is concerning to see experienced trainers stepping away each year as a result. Trainers are indispensable to the success of any unit, as they are essential for supporting IiTs. I have been fortunate to have had truly inspirational trainers whose guidance continues to influence me during challenging clinical situations. It is crucial that we collectively ensure this invaluable group feels appreciated and supported.

MDT support

The survey also showed the unity that exists between the multidisciplinary team (MDT). ACCPs were a positive attribute to training and allowed IiTs opportunities to enhance their training. In an ever more complex intensive care environment, we will need the support of the MDT. Our role is to lead it and be the final decision maker. We are, without a doubt, stronger working together. It is one of intensive care's true strengths and one not to be taken for granted.

Intensivists in Training

Dr Waqas Akhtar
Lead IiT Representative

The representation of intensivists in training (IiTs) at the Faculty has seen sustained strengthening in recent years. What began as a single Board representative has evolved into a fully-fledged national committee, reflecting the diversity of our profession. This expansion has been bolstered by the integration of a network of regional representatives across the UK.

Through initiatives like our national reporting system, we've created a flow of national intelligence and ideas embedding a culture of sustained improvement into the Faculty, ensuring that transformative changes to the training programme continue across the UK.

Collaboration

Collaboration has been key to these advancements. We've worked closely with the Trainee Advisory Group in the Intensive Care Society and partnered with resident doctor committees from the RCoA, RCEM and the RCP, as well as the Academy of Medical Royal Colleges where I also had the privilege of chairing the Resident Doctors Committee this year.

This year we've aligned our terminology to 'Intensivists in Training' for those in training in ICM and 'resident' for the broader workforce. This reset in language reflects a commitment to fostering a more respectful and professional relationship between resident doctors and the healthcare system during these challenging times.

Changes

Flexibility in training has been a cornerstone of our efforts, and several pivotal changes have been introduced to enhance this. We've issued best practice guidance empowering trainers and residents to leverage diverse experiences, rotations, and techniques to meet training capabilities, such as obtaining specialist intensive care experience in Stage 3.

The eligibility for the FFICM examinations has been shifted to Stage 1, national guidance has been issued for early completion of the CCT and this year we saw the introduction of simultaneous recruitment for dual and triple CCT intensivists in training. Looking ahead, we will soon publish guidance on minimising the impact of rotational training and a national training impact assessment framework.

This year also marked the inaugural National Intensivists in Training Conference, with over 150 in-person attendees and 100 online participants. It was the best attended event since before the pandemic at Churchill House, and a true testament to the energy and engagement within our community.

Identity

We find ourselves in an extraordinary period of change. With a new government and a 10-year NHS plan promising significant reform, and the planned independent College of Intensive Care Medicine reshaping our identity as a specialty, we are witnessing a redefinition of who we are and how we will deliver care for years to come. The strength of IiT representation at FICM is vital to ensure that the voices of future are heard and shape FICM into a dynamic and responsive institution, safeguarding the evolution and excellence of Intensive Care Medicine in the UK.

Dr Matt Williams
FICMCRW Chair

Careers, Recruitment and Workforce (FICMCRW)

I write this article as the first proper cold snap of winter has arrived, and as the 2025 recruitment round has just opened. Good luck to those applying to train in the best specialty; I hope you feel the warmth of welcome that FICM extends!

The big news this year is that, after 10+ years of lobbying, applicants can now apply for dual/triple CCT training programmes simultaneously. There may well be teething problems, but it is good to have finally secured agreement for this. It is still the case that applicants can only take up dual/triple CCT training programmes in the same region. Further information and FAQs can be found on the FICM recruitment pages and these also have a wealth of other updated information pieces to help applicants and trainers.

Background specialties

The background of applicants is steadily changing as evidenced by the numbers applying and being appointed from each eligible core training route. There is an increasing proportion of doctors choosing to train in ICM from, and with, emergency medicine and medical specialties. This heterogeneity in the critical care medical workforce is welcome and enrichens services. I sense this also reflects how I more often hear colleagues identify themselves primarily as intensivists.

Workforce gaps

Workforce is a leading concern for our members. The 2023 census of clinical leads again revealed that nearly 60% of units have at least one consultant gap on their rota. Thank you to members who completed the recent survey of the FICM membership that has just closed; this looked to gather information on the workforce's background, demographics, job plans, career plans and wellbeing and we aim to report results ASAP.

The workforce group continues to seek triangulating data on where recruiting for ICM consultant posts is most difficult and is predicted to remain so. It does appear that certain geographical parts of the UK and less urban centres find this most challenging. The information helps in the discussions we hold with key stakeholders regarding seeking additional provision for ICM training numbers and where they are best located. It has long been recognised that doctors usually take up consultant posts in the same region they train in. This theme continues to underpin policy at a national level, as has been seen in the modelling behind the NHS's Long-Term Workforce Plan and siting of medical schools. Key figures in central workforce planning are keen to hear where the need for ICM specialists is, and that there is educational capacity to train doctors placed there.

The number of doctors completing the training programme with an ICM CCT in 2024 (by the time of writing in mid-November) is at its annual highest ever (142). Along with increasing numbers of applicants joining the specialist register via the portfolio pathway, there is a welcome growing pipeline of doctors joining the consultant workforce. But and it is a big ***BUT***, we must be able to retain doctors in the workforce. The *Critical Staffing* series provides useful information to be considered to sustain the medical workforce of ICUs.

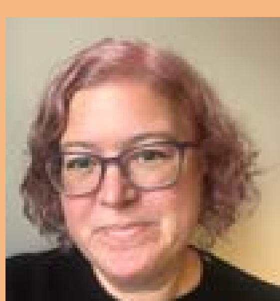
Job planning

Members of the committee helped to facilitate a careers workshop at the recent inaugural Future Intensivist Conference organised by the Intensivists in Training (IiT) representatives. IiTs are finding the prospective job market bewildering, with those not training with Anaesthesia particularly concerned for securing their employment aspirations of job plan and location. My thanks to Andy Martin, Rosie Worrall and Taqua Dahab for facilitating the workshop and adding very useful resources to the website. These illustrate the possibilities and advantages for prospective employers appointing the best Intensivist for the post, regardless of background. It is possible, necessary and positive to make this happen, through varying job plans across the ICU consultant workforce that will likely change over each doctor's career.

Thank you

Thanks, as ever to the committee and the respective section leads. We will be seeking new members in early 2025 — keep an eye on the Faculty website for details. Please do apply if you are interested in contributing to the work undertaken by CRW.

ICM National Recruitment



Dr Liz Thomas
Medical Lead for National Recruitment

My name is Liz Thomas and I am the medical lead for National ST3 ICM recruitment. I work as an intensivist at Manchester Royal Infirmary. I am very proud to be involved in ICM ST3 recruitment as it is truly an honour to help select and appoint the intensivists of the future.

We are lucky that we have a good number of frontline intensivists who volunteer to be assessors and interviewers assessing and selecting the intensivists of the future. We strongly believe that it is vitally important to involve our current senior medical workforce as much as possible. I would like to take this opportunity to thank all the consultants, SAS and senior Intensivists in Training who volunteer for assessing, reviewing appeals, writing questions and interviewing; we couldn't run the process without you, so a huge thank you from me and the team at ICMNRO.

Simultaneous recruitment

The 2025 national ICM recruitment process closed on 5 December 2024 The process is run by the ICM National Recruitment Office (ICMNRO) — which is part of Health Education England, via the West Midlands office. Dr Robert Docking (deputy medical lead) and I work closely with ICMNRO and the FICM secretariat to strive to ensure a fair, sensible and consistent process.

This cycle we have had a major change which Intensivists in Training have been requesting for many years. It is now possible to be appointed to Intensive Care Medicine training and a GMC-approved partner specialty in the same round — simultaneous recruitment.

The two training posts must be in the same geographical region and the posts must be on the list of approved partner specialties as constrained by the GMC and Medical and Dental Recruitment and Selection (MDRS) programme. We have put together a fact sheet which explains the changes and addresses Frequently Asked Questions. This document can be found on the FICM website. All other information regarding recruitment can be found on ICMNRO's website.

Feedback

The doctors appointed to the 2024 round started work in August and the feedback from the round was extremely positive – both from candidates and interviewers/assessors. To aid the 'onboarding' process, successful candidates will receive a deanery specific letter regarding what pre-employment checks are needed and how to submit the evidence to their new employer at the time of offer. This has been trialled with the London and KSS LETBs/Deaneries this year and has been effective and has been offered to all LETBs/Deaneries for the 2025 round.

We constantly review the appointment process and make improvements wherever possible — we are planning an online event with potential applicants for 2025, probably in October, before the application window opens for 2026 so we can answer questions and demystify the process to help future Intensivists in Training.

Smaller & Specialist Units Advisory Group (SSUAG)

Dr Jack Parry Jones
SSUAG Chair

The Small Specialist Units Advisory Group (SSUAG) seeks to represent small units (those serving a population of fewer than 200,000 people) and remote units (those over 30 Km away from the next nearest unit). The group also has representation from specialist units — cardio-thoracic critical care in the form of the Association of Cardio Thoracic Anaesthesia and Critical Care (ACTACC) and the Neuro Anaesthesia and Critical Care Society (NACCS).

SSUAG representation

In various surveys, the two major issues raised by small, remote, and small and remote units remains firstly staffing and secondly retention of skills and of people. With this in mind the Faculty Board agreed that there should be representation from SSUAG members onto the three major Faculty committees — Careers, Recruitment and Workforce, Training Assessment and Quality, and Professional Affairs and Safety Committee. This has helped bring the particular issues faced by small and remote units to the committees' chairs and members. In return, it has also helped the SSUAG group better understand the work done by those three committees.

Clinical Leads

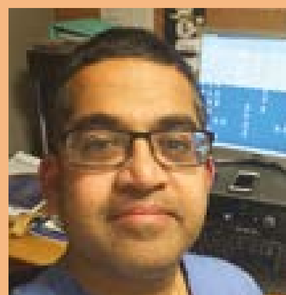
I was kindly asked to speak at the Faculty Clinical Leads meeting on the 7 November 2024. This gave me the opportunity to ask those present 10 questions. The representation of leads from small, remote and small and remote units, to large DGH, to teaching hospital is fairly representative of English units.

There were 48 clinical leads at the meeting. The answers are interesting. Of note, it is useful to know that:

- 84% of clinical leads feel that they could appoint a single ICM CCT, or one dual trained with ICM but without anaesthesia. We need to work to get that to 100%.
- It is also useful to know that 84% of respondents felt that formal identification by the Faculty of units as small, remote or small and remote would be useful. This is something for SSUAG to look into how we do this and how we present it to health boards and hospital trusts.
- 100% of respondents felt they could train a non-anaesthesia ICM resident on their unit.
- 100% of respondents felt that the ability to digitalise records and access them remotely

Finally, I would like to repeat the call for anyone interested in being on SSUAG to contact me via the Faculty. We have representation from across the UK, with biannual virtual meetings.

Equality, Diversity and Inclusivity



Dr Som Sarkar
FICM EDI Lead

Here at the Faculty, we are looking to progress the way we recognise and continue to make equality, equity, diversity and inclusion part of everyday business. Leading on from the horrific events over last Summer, we are keen to ensure that we enact the 'so what and now what' following our response to the riots.

Much of the work trying to identify and address inequalities is embedded in the oversight of EDI at NHS strategic level and focuses on a lot of what we see in our own units — increasing later stage disease presenting as critical illness, crisis mental health admissions, increasing frailty and admissions associated with deprivation, differing outcomes dependent on race.

So ultimately, even if you think this doesn't affect you, it does, in the way you demonstrate allyship, leadership, supervision, advocacy and ultimately patient care.

Diverse population

We understand the true diversity of our population, and we are keen to reflect this in our work towards our EDI strategy. As such, this will focus on three parts, the internal work of FICM, you as the membership, and most importantly the patients and population we serve.

There is an ongoing workstream around differential attainment being undertaken following work done by the Faculty. In addition, we are looking at how we can support improving and increasing underrepresentation of those within protected characteristics in leadership positions locally, regionally and nationally.

Next steps

Moving forward, we would like to improve our representation in different forums, developing an inclusive and representative EDI committee, and ensuring that our strategic direction encompasses the right thing to do.

Part of this will be an ask to our membership around what you think needs to be done and how we can include your expertise to guide our journey. We will be asking for representation, particularly for people who have lived experience of protected characteristics particularly LGBTQIA+, people with disabilities and the growing awareness of neurodivergence through the *Dean's Digest* later this Spring.

FICM Clinical Leads Census

Dr Richard Porter
FICM Census Lead

In 2023, the Careers, Recruitment and Workforce Committee surveyed the clinical leads within Intensive Care across the United Kingdom to ascertain their current working patterns and to assist with workforce planning. We received a total of 96 responses from clinical leads.

We achieved a wide geographical area from which responses are seen. Table 1 demonstrates the geographical variation of responses. This would indicate we have a representative sample of the UK. The median number of beds was 17 (mean 21) with the minimum reported of 5 and maximum of 90.

On-call

A total of 96 units provided data for on-call frequencies, ranging between 1 in 4 to 1 in 23. Figure 1 demonstrates the relative frequencies of the on-call frequency. Nine (9.4%) of 96 units had a resident on-call consultant. 13 (13.5%) had more than one consultant on-call non-resident. Of the 83 respondents 78 (94.0%) had a separate ICM on-call rota.

The pie-chart in Figure 2 demonstrates the relative frequency as to which specialty provides on-call airway cover (outside of theatre).

Figures 3 and 4 opposite provide data on the number of resident consultants that are present weekdays and weekends respectively by bed base. Most frequent on call rotas are between 1 in 8 and 1 in 10. It is noted there are still higher frequency ICU on-call rotas which may provide challenges on both sustainability of working within ICU and wellbeing of senior clinicians in a high stress specialty.

Anaesthesia services still provide the most airway cover for critical care specialties. A limitation of this data is it does not breakdown in which area airway cover is provided. Future surveys could investigate, for example, who provides airway cover in the Emergency Department.

Unit cover

The majority of units now have separate cover for ICM. As can be seen in Figures 3 and 4, increasing bed base is associated with higher numbers of resident consultants during the day. This is to be expected, and is in-line with GPICS recommendations, but does indicate the need for high levels of consultant recruitment (and the preceding training) to maintain and develop both the current and future workforces needed to deliver Intensive Care Medicine.

Key

Line of best fit
Number of resident Consultants

Region	Frequency	Percentage
East Midlands	7	7.1
East of England	6	6.1
Kent, Surrey, Sussex (KSS)	5	5.1
London (North East and Central)	4	4.1
London (North West)	3	3.1
London (South)	5	5.1
North East England and North Cumbria	7	7.1
North West England (including Mersey)	17	17.4
Northern Ireland	3	3.1
Scotland	14	14.3
Severn	3	3.1
South West Peninsula	3	3.1
Thames Valley	4	4.1
Wales	2	2.0
Wessex	5	5.1
West Midlands	4	4.1
Yorkshire & the Humber	6	6.1

Table 1. *Geographical location of responses*

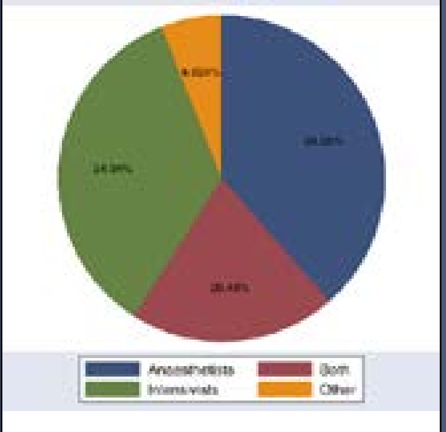


Figure 2. *Relative frequencies of who provides on-call airway cover*

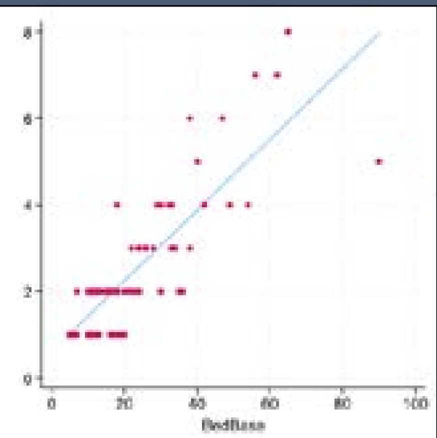


Figure 3. *Number of resident consultants on weekdays by bed base*

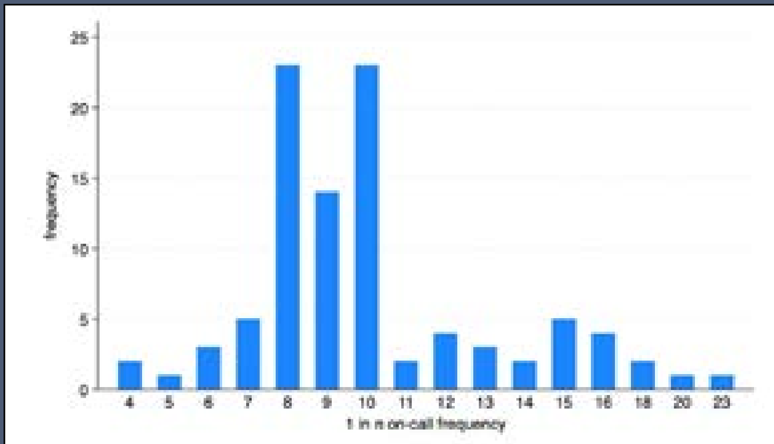


Figure 1. *Graph demonstrating frequency of on-call duties*

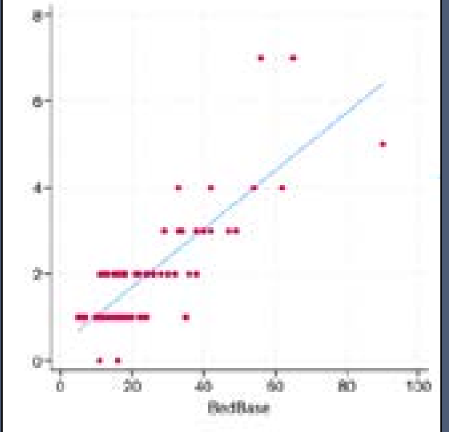


Figure 4. *Number of resident consultants on weekends by bed base*

Advanced Critical Care Practitioners: A Year in Review

Natalie Gardner
Co-Chair ACCPSC

Dr Gregor McNeill
Co-Chair ACCPSC

2024 marked another year of substantial progress for the Advanced Critical Care Practitioner Subcommittee (ACCPSC). The FICM continues to endorse ACCPs as vital contributors to intensive care teams, providing safe, high-quality care across the UK.

Strengthening representation and standards

This year, the ACCPSC prioritised broadening national representation to ensure voices from all UK regions shape FICM's strategic vision for ACCPs. New roles for representatives from Wales and Northern Ireland were created and successfully appointed, fostering improved engagement and advocacy across the UK.

Maintaining high standards remains crucial as FICM addresses ongoing dialogue around ACCP roles. The release of updated statements and FAQs this year underscored the unique qualifications ACCPs bring to intensive care, bolstering professional credibility and addressing any misconceptions within the wider clinical community.

Expanding educational accreditation

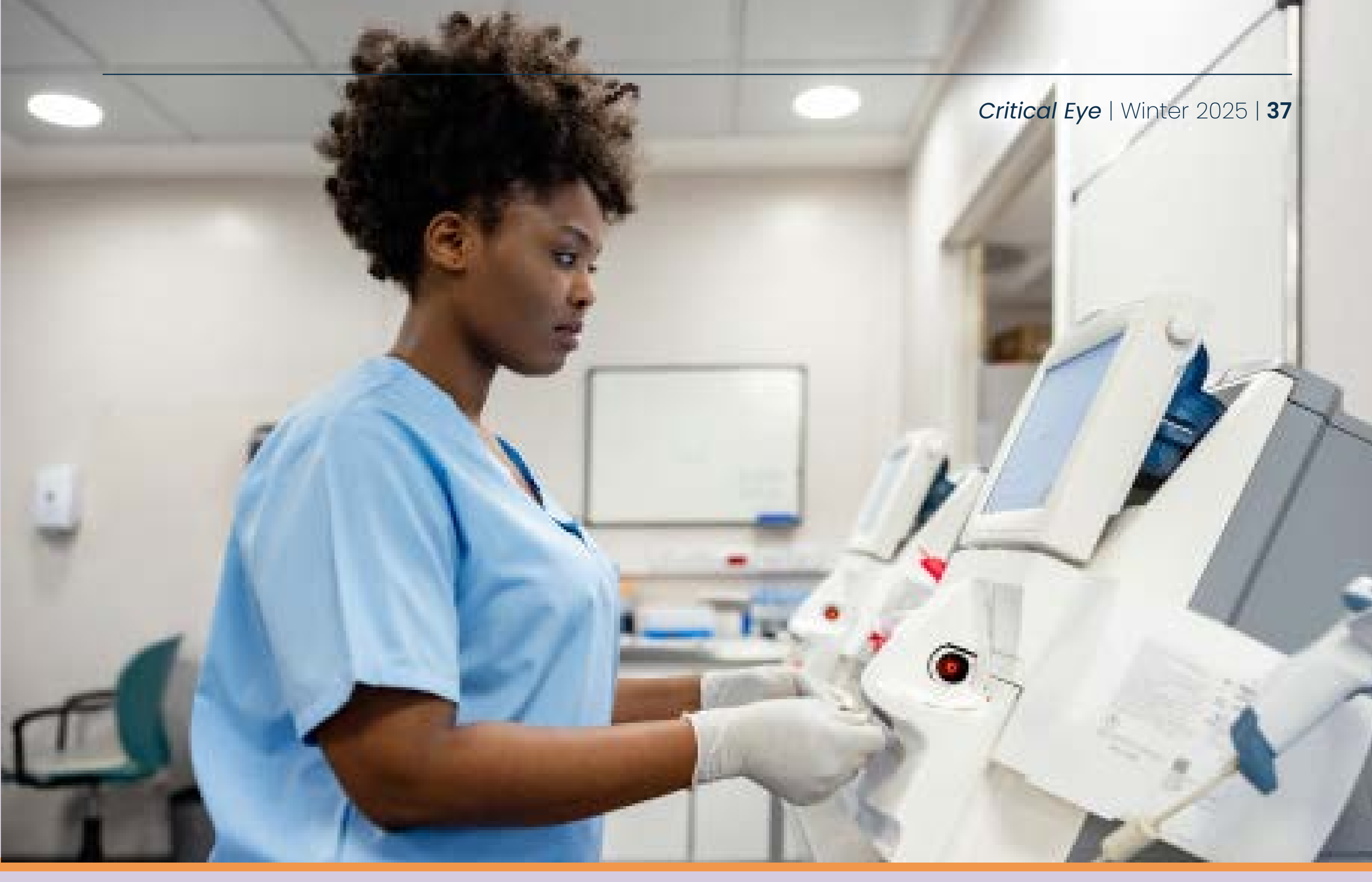
Accrediting higher education institutions (HEIs) that deliver FICM-standard ACCP training continued, and 2024 saw a third HEI commence the accreditation process. Accreditation continues to contribute to a robust national network of FICM-accredited programmes that uphold stringent clinical standards.

The accreditation process was further refined to incorporate NHS England's Advanced Practice standards, requiring future HEIs to secure NHS accreditation prior to FICM approval. This integration aligns ACCP training with national advanced practice criteria, demonstrating FICM's commitment to quality and consistency.

The ACCPSC is also enhancing quality assurance within the accreditation timeline. Following the FICM Board's recommendation, the proposal includes a digital collection of core data, enabling streamlined, continuous feedback from trainees and supervisors through accessible QR-coded forms.

Enhancing career sustainability and member engagement

To support sustainable ACCP careers, the ACCPSC have been reviewing and refining the ACCP *Sustainable Careers* document, incorporating recent feedback. The updated document, due for release this year, clarifies critical role descriptions to bolster recruitment, retention, and satisfaction within critical care settings. A suite of new resources aims to strengthen ACCP member engagement. An infographic which illustrates key ACCP competencies and the integral role they play in intensive care teams was released in late 2024. Additionally, the ACCP newsletter launched a 'Meet the Sub-Committee' segment, intent on fostering a closer connection between the ACCPSC and ACCP community members.



ACCP Conference

The ACCP National Conference took place in Plymouth in June 2024, with an exciting line-up of speakers covering all four pillars of advanced practice, and interesting sessions on the use of AI in healthcare. Details for the 2025 Conference are being finalised now, details will be released later this year.

Professional Development

The ACCP Diagnosing Death for Donation after Circulatory Death (DCD) Optional Skills Framework (OSF) was revised based on feedback from regional critical care networks. This updated DCD OSF is under review by NHS Blood and Transplant (NHSBT), with a 2025 launch anticipated pending final approval.

To enhance recognition of ACCP qualifications, ACCPSC maintains an active partnership with the Centre for Advanced Practice, encouraging ACCPs to obtain the Advanced Practice Digital Badge. While its value among employers is yet to be fully determined, possession of the badge positions ACCPs well within evolving professional standards.

Addressing regional and sector-specific challenges

The ACCPSC remains responsive to UK wide updates and sector-specific issues. For example, NHS Wales recently introduced a Professional Framework for Enhanced, Advanced, and Consultant Clinical Practice with input from two ACCPs. In Scotland, the ACCP role has been excluded from the Medical Associate Professions commission. The visibility of the ACCP role continues to develop with ACCP representation incorporated into the Scottish Critical Care Specialty Delivery Group from August 2024.

For military ACCPs, the Army launched a trial ACCP register, initially limited to nursing backgrounds. This register serves as a significant step towards formal recognition of ACCP contributions within military healthcare.

Looking ahead

The ACCPSC remains dedicated to representing and advancing the ACCP profession. Our ongoing initiatives are strengthened by the unwavering commitment of ACCPs and our broader critical care community. Together, we look forward to building on last year's achievements to continue delivering exceptional patient care across the UK.

Critical Care Pharmacists

Greg Barton
Chair FICMPSC

It's with great pleasure we welcome two new members, Alan Timmins and Odran Farrell, to the committee expanding the Pharmacy Subcommittee (PSC) from six to eight. The reason to take this step is twofold. The existing subcommittee is formed of the founding members and adding to this group will not only bring in fresh ideas but also allow existing committee members to step down with some overlap for continuity with the PSC.

Although this increase is probably temporary and the subcommittee will eventually return to six members, it does coincides with the PSC becoming more involved in wider FICM workstreams. It will enable us to fully integrate, supporting not just the pharmacy workforce in critical care but the medical and ACCP members as well.

Committee involvement

In addition to supporting the production of the *Safety Bulletin*, we now have a member of PSC on the Education Subcommittee (ESC). Emma Taylor is working with the ESC to support the production of blogs, cases of the month and increasing pharmacy visibility at FICM's Annual Meeting.

Dr Richard Bourne is working with the ESC to develop a multi-professional ward round 'tabletop' exercise that, similar to the simulation resources, can be used at a local unit level to support and develop the workforce — watch this space!

Pharmacy is also represented in the production of the latest edition of GPICS, as I am working as Section Editor on the Clinical Care chapter. It has been a pleasure working with the FICM, the ICS and the multiprofessional chapter authors on the guidance and I'm certain the finished article with support the Pharmacy profession as a whole, working alongside critical care colleagues.

Advanced Practice Curriculum

The PSC has had the pleasure of working with the Royal Pharmaceutical Society (RPS) and the United Kingdom Clinical Pharmacy Association (UKCPA) to develop this pioneering curriculum. Along with Mental Health, it is one of the first two specialist curricula which sits clearly in the pathway of educational development of the clinical pharmacist. , starting with undergraduate practice and ending with the consultant pharmacist role.

I co-chaired the development group with a representative from the RPS and although it has been a long process to get to launch it has been well worth it. This curriculum describes entry level to advanced pharmacist practice in critical care and will support pharmacists to not only develop in the specialty but also provide evidence and assurance of the level of practice to patients, the public and the wider healthcare community.

The curriculum as well as two introductory webinars can be found on the RPS website.

Future projects

The PSC is developing exemplars of advanced practice and consultant pharmacist job plans. These will be published the Pharmacy Resources page on the FICM website adding to the existing workforce development toolkit for critical care pharmacists developed in conjunction with NHSE.

RESIDENT EYE

Our magazine for Intensivists in Training has a new name! In the latest issue:

- New members on the IiT Subcommittee
- Tabletop simulation in intensive care
- The Medical Year
- Future Intensivists Conference 2024
- Supporting IMGs in ICM
- Updated training resources for IiTs

www.ficm.ac.uk/residenteye

FICM Thrive is a Career Mentoring and Personal Development Programme intended for consultants in their first five years post appointment. Thrive facilitates a strong productive mentoring relationship based on mutual, equal and collaborative development and learning between mentors and mentees.

Our mentors are ICM consultants from a broad range of backgrounds and are interested in providing support and guidance to colleagues. We welcome applications from consultants with two years or more experience from all ICM backgrounds, including both single specialty and dual trained. Find out more at:

www.ficm.ac.uk/careersworkforce/ficm-thrive

Professional Affairs and Safety (FICMPAS)

Dr Dale Gardiner
FICMPAS Chair

My thanks go to Dr Peyton Davis, Dr Irfan Chaudry and Dr Jamie Yarwood who are all demitting from FICMPAS in December after 6 years (two terms). We welcome as new members to the Committee, Dr Dougal Atkinson (Manchester), Dr Namrata Maheshwari (Medway), Dr Sanjay Wijayatilake (London) and Dr Matthew Needham (Sheffield).

Dr Needham will also become FICMPAS's Quality Improvement Lead taking over form Dr Chaudry. While I am sad to say goodbye to some Committee members, I am very excited to welcome the new members. Further membership changes will be occurring in 2025 and I will update in the next *Critical Eye*.

Safety

I hope you have been following the *Safety Bulletin* is led by Dr Peter Hersey. Issue 11 was published in June and Issue 12 in October[1]. The *Safety Bulletin* is the main way we will share safety news and bring to your attention relevant Regulation 28 reports. The ambition is to hold a safety conference in 2025 — watch this space.

Artificial Intelligence

In 2024 FICMPAS co-opted Dr Joseph Alderman onto the committee to advise on Digital Technologies. Joe authored this FICM Board approved, *Position statement on medical artificial intelligence from the Faculty of Intensive Care Medicine.* This is an important statement which helps those of us who are early adopters, as well as those of us who are nervous of this new technology, navigate the complexities. The emphasis in the statement is on approaching medical AI positively as a transformative technology but also encouraging a degree of caution before adopting into practice. As the statement says, "The path from cutting-edge research concept to usable medical product requires robust evaluation."[2] We do not want this technology to cause or contribute to even more endemic discrimination, bias, and health inequity. I urge you to read it.

GPICS V3

GPICS V3 chapter reviews continue. Expect a consultation draft of the whole document in early 2025. My thanks to the GPICS 3 Editorial Board and most importantly all the chapter authors. Apologies for my and Paul Dean's (ICS Co-Lead Editor) red pen and tracked changes.

References

1. www.ficm.ac.uk/safety-bulletin
2. www.ficm.ac.uk/standardssafetyguidelinesclinicalquality/ficm-postition-statement-on-medical-ai

Diagnosing Death using Neurological Criteria

The Academy of Medical Royal College (AoMRC) has published an updated 2025 Code of Practice for the Diagnosis and Confirmation of Death, with this work led by the Faculty.

The updated version is available on the AoMRC website and replaces the 2008 Code, which had reached the grand old age for medical guidelines of 17 years. The website contains valuable information of what you need to do and know. On the topic of Neurological Criteria, the Legal, Ethical and Policy Unit (LEPU), a subcommittee of FICM PAS has updated two of its *Midnight Laws* on refusal to accept diagnosis of death according to neurological criteria and maintaining safety and confident in diagnosing death using neurological criteria. Visit www.ficm.ac.uk/midnightlaws for more information.

1. Age Categories	< 37 weeks DNC cannot be confidently made. 37 weeks – 2 years same as per adults with 3 caveats: i. 24 hrs before testing ii. 24 hrs between testing iii. No ancillary investigation. 2 years and above Criteria as per adults.
2. Apnoea Test	Start $PaCO2 \geq 5.3$ KPa End $PaCO2 \geq 8.0$ kPa, $pH < 7.3$ + Rise $PaCO2 \geq 2.7$ kPa Time Minimum 5 minutes This change will more closely align the UK to international practice.
3. Time of Death	The 2025 Code times death to the time when the healthcare professionals making the diagnosis are satisfied all the relevant criteria are met. This would ordinarily be at the completion of the second set of clinical tests, unless ancillary investigation after clinical testing is used.
4. Minimum Temperature	The core temperature should be greater than or equal to 36°C at the time of clinical testing.
5. Eyes and ears examination	Both eyes, both ears must be examinable. In the case of an inability to examine both eyes or both ears, for whatever reason, ancillary investigation will be required.

Consultant Intensivist Transition Course 15–16 May 2025

Location: Cardiff

Fee: £400, £470

This course is designed for senior trainees, CESR candidates and consultants in the first two years following CCT. It explores the challenges and rewards of non-clinical consultant work and aims to equip attendees with the knowledge, skills and attitudes to ease the transition to consultant life.

This course has a limited number of places available, with a high faculty:delegate ratio to maximise opportunity for learning. We are lucky to welcome an experienced and four nation faculty for the delivery of sessions.

Bookings now open! **www.ficm.ac.uk/events**

The Faculty of Intensive Care Medicine

Safety Bulletin

June 2024 | Issue 11

Introduction

Case 1 | The distracting presentation

Comment

Case 2 | Pulmonary artery catheter entrapment

Comment

Cases 3 | Displaced endotracheal tube

Comment

The Faculty of Intensive Care Medicine

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Introduction

Case 1 | Oesophageal intubation (Prevention of Future Deaths Report)

Comment

Cases 2 and 3 | Pericardial drainage

Comment

NEW SAFETY BULLETIN OUT NOW!

The 11th and 12th issues of the *Safety 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.

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