TRAINEE EYE

THE TRAINEE MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 16 | WINTER 2022

Palliative care on the ICU

The Faculty of Intensive Care Medicine

In this issue

MAINTAINING AUTONOMY & DIGNITY

LIFELONG LEARNING PLATFORM

TOXICOLOGY ON THE ICU

The Faculty of Intensive Care Medicine

UPCOMING EVENTS

FFICM Prep Course

7-8 March 2022

ONLINE

DAY 1*:

- A digital day of lectures focusing on relevant exam topics

DAY 2*:

- A digital mock OSCE/SOE exam day

BOOKINGS OPEN 25 JAN

COST

Tier 1: £60 – Access to lectures from the online conference until the FFICM in April 2022.

Tier 2: £120 – Attendance at the live webinar on Day 1. Access to the lectures afterwards along with OSCE and SOE practice videos until the FFICM in April 2022.

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PLEASE NOTE THAT TIER 3 PLACES ARE EXTREMELY LIMITED. IF FULL, PLEASE CONTACT THE FACULTY TO ENQUIRE ABOUT THE WAITING LIST.

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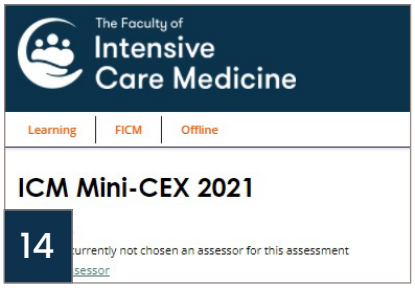

This and back issues available online at **www.ficm.ac.uk**

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New FICM website!

We're delighted to report that the brand new www.ficm.ac.uk is now live!

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

WELCOME

Dr Guy Parsons
FICM Lead Trainee Representative

This will sadly be my last Editor's letter for *Trainee Eye* as I will shortly be finishing my tenure as Lead Trainee Representative. By the time this goes out, a new Deputy will have been elected and Cat will be stepping up to take on the Lead role — I could not have hoped for a better pair of hands to entrust this to. My best wishes to her for the year ahead and many thanks to all of you for your engagement, feedback and dedication to our specialty during my tenure.

I had not expected, when first elected to the Deputy role, the chaotic onset of a global pandemic and all the disturbance and challenge it has forced upon Intensive Care — it has been, frankly, a rather horrendous two years for many of us. Amongst these challenges I have been fortunate to work with a dedicated and passionate team at the Faculty and a superb group of clinicians committed to making ICM's tomorrow better than its today. I am most grateful for all their support.

Offering support

I wish to raise two points before I go. First, many of you will have noticed a certain orchestrated malevolence towards parts of the health service over the course of this pandemic — I recall particularly the attacks on our General Practice colleagues last year. I hope you will join me in sending them our support; they have been working tirelessly throughout and they didn't deserve that vile harassment. Indeed, without a strong and supported primary care sector we're all toast. We can work to counter these negative external viewpoints through presenting a united front. So, as the burden of the pandemic continues to weigh heavily on the medical profession, as winter pressures continue, and as our reserves ebb let's keep being there for each other.

The power of representation

Second, please don't underestimate the power of representation. If you believe change is important then stand up for it — each of us has the ability to make improvements and deliver a better future; feeling like it could never be you is the first step to missing the opportunity. I have had many opportunities over the last two years to make changes — sometimes as quiet nudges and sometimes in big ways — and being there to speak up was a vital first step. We are still a young, listening specialty eager to hear more voices raised, so please consider adding yours for the future of ICM. I hope the recent FFICM examination concerns have refocused our specialty's attention on the importance of listening to those in training; while the eventual outcome was not what we worked for or would have wished, I did note a willingness to listen and to learn within the Faculty so please do keep speaking up.

I hope you enjoy this edition of *Trainee Eye* with its varied selection of articles offering insight and new perspectives. Trainee Eye is always interested in your submissions so if there's something you'd like to share please do write in. Thank you for all the important work you're doing and my best wishes for the times ahead.

Your new Lead Trainee Representative

Dr Cat Felderhof
FICM Lead Trainee Representative

It felt appropriate that I should open the introduction to this issue of *Trainee Eye* at the start of 2022 with an inspirational quote however I am not one for embracing saccharine sentiments. 2021, along with 2020, will happily be consigned to the history books for many of us and the quote "An optimist stays up until midnight to see the new year in. A pessimist stays up to make sure the old year leaves" by Bill Vaughan, US Columnist, resonated with me.

I was recently told I was too much of a pessimist by a consultant (personally I like to call it realism) and I can't deny that I was practically pushing 2021 out the door. However, I haven't completely lost the optimist in me as I always hope that there's something better around the corner even if I must dig deep for it. I've rolled up my sleeves and I'm already desperately excavating to find those 2022 positives.

Publication delay

This edition was planned for publication in October at the time of the exam results release and it was put on hold as it didn't seem right to bring it out without some acknowledgement of that situation. The outcome took far longer than we anticipated, and *Trainee Eye* fell by the wayside for a period, apologies. There is no doubt that the outcome was disappointing to many, but I am glad that there will be a free sitting for those affected. That exam sitting is far from forgotten, it has prompted some significant changes and a review of the way the exam in conducted. Additionally, it has pushed the needs and wellbeing of ICM StRs to the forefront. At FICM Board I spoke about how I feel passionately that ICM StRs are a group of highly qualified and intelligent professionals, we should be valued for all we contribute, and we are seeking to have that further recognised. FICM are keen to improve the engagement with StRs across the UK and we are working on plans together which I will share when we have something more concrete in place.

ePortfolio data download

This edition of *Trainee Eye* contains some reminders of the information on downloading files from the old ePortfolio and due to the delay in publication we asked that the deadline should be delayed from 31 December by a month. The new date is therefore **31 January 2022** and if anyone is having difficulties with this, please get in touch with the Faculty.

This month also sees Guy Parsons stepping down as Lead Rep, I will be sad to see him go. 2021 has certainly been a baptism of fire as Deputy, his support and guidance has always been welcome, and I think we made a good team. I wish him all the best as he moves on to become Vice-Chair at the Academy of Medical Royal Colleges Trainee Doctors' Group and I look forward to continuing to work with him. We welcome Matt Rowe as the new Deputy, and I am really looking forward to building a solid team over the coming year.

I was quite enjoying Bill Vaughan's aphorisms until I reached one that was derogatory of women's ability to parallel park and he plummeted in my estimation. I guess that is a sign of the times that he lived in and demonstrates how far we have come (for the most part) in society. The optimist in me is confident that we will continue to make strides forward in equality and expectations and hopefully we won't have to dig too deep to find that.

Maintaining autonomy and dignity in a time of crisis

Grace Spence Green
St Thomas' Hospitals

I was a fourth-year medical student on Thursday 18 October 2018 when I sustained a freak spinal cord injury, and suddenly I was dropped into the world of an inpatient. A hospital, a place I had felt so comfortable in the day before, was now my nightmare.

The three months I then spent as an inpatient was humbling. I received some excellent care, but at times I noticed a real lack of appreciation for my experience. I now advocate for improving patient dignity and autonomy, particularly in the acute setting when these principles are more at risk of being lost.

Fuzzy

Immediately after my injury I was rushed to the Royal London and underwent eight-hour spinal surgery. I spent two weeks in acute care; in HDU for the first five days and then moved onto a ward.

HDU was a hot, fuzzy, opioid dream. I didn't realise how ill I was at the time. There were three other patients in my bay. I didn't see them, but I remember hearing gurgling noises at night, and feeling like I was lying next to people who were dying.

I had no control of my internal or external environment. People came in and out of the bay, my blood pressure would drop without warning, and I would overheat easily. I felt like I had been dropped into the ocean and didn't know how to swim, deliriously drowning in the hot orange light.

Autonomy

At times during my stay the only way of exacting some small control over my life was the patient-controlled anaesthesia button or being able to decide the size of tablets I would be given. These choices seem so trivial looking back, but it was incredibly important to me at the time; a way to preserve some autonomy when I felt I had lost so much.

After we were given our medications in those little white paper pots, we would then have a 'shower' where a nurse or a healthcare assistant would wipe me down with a soapy wet cloth and then dry with towels. I

> "I began to understand what it felt like to be stripped of all independence, whether it was suddenly lost in my case or had diminished slowly over the course of a long illness. The ability to give patients some small sense of control over their care is so important, whether that's giving them choice when possible or a time frame that they can rely on.

remember being alone in HDU at night with a healthcare assistant I didn't feel comfortable with. I kept asking when I was going to be cleaned, and he wouldn't tell give me an answer. Swaddled in blankets in that hot, orange lit room, not knowing when I was going to be showered, was the most vulnerable I've ever felt in my life.

Control

This was a recurrent issue throughout my inpatient stay. I spent many hours lying in bed wondering if someone was ever going to come back when I asked for something, worrying that I had been forgotten. I didn't feel in control of when I would be washed, when I would get my medications, when the doctor would come to see me.

I began to understand what it felt like to be stripped of all independence, whether it was suddenly lost in my case or had diminished slowly over the course of a long illness. The ability to give patients some small sense of control over their care is so important, whether that's giving them choice when possible or a time frame that they can rely on.

Dignity

Maintaining dignity as an inpatient became very difficult. At times I felt as though I was just an object that had to be cleaned, rolled over, fed, and prepped to be seen. This was made worse when I would find myself with eight people standing around me, many that I was not introduced to, being excluded from the conversation about my care happening at the end of the bed. Sometimes I felt like I was treated as a snapshot in time, a forever patient, not a rounded human being with real concerns and desires. I wanted staff to consider the context I existed in, that I had friends, family, a workplace, and hobbies.

Communication

Communication was a big issue, particularly at the beginning when my diagnosis was first explained to me. I understood that I had sustained a life-changing injury, and what I wanted most of all is for people to be honest and transparent with me. When I asked about the future and whether I would walk again, some fell back onto euphemisms, stumbling over their words, which made it seem even worse than it was. I remember just before my surgery an anaesthetist acknowledging how tough my situation must be. The simple act of recognising that I was going through something very difficult validated my experience and gave me confidence in him.

Consent

I found the language around consent difficult during my stay. At times it felt one question meant I had consented to a whole series of actions, when it should always be a continuous conversation. It became incredibly important to me to feel as though I had clearly demarcated boundaries, not blurred lines of consent.

I recognise these are not easy tasks to take on, particularly while dealing with insufficient resources and staff, increased responsibilities and stress at work However, an honest approach to preserve patient dignity and autonomy creates more real relationships with patients, aiding in their experience of health care and ultimately their recovery.

Listen to Grace on BBC Radio 4's 'Life Changing' podcast.

Dr Gary Rodgers
ICM & Anaesthesia Trainee, West of Scotland

Toxicology for Intensive Care Medicine

Back in 2015, rather than sensibly applying for ACCS anaesthesia, in order to make an anticipated application to intensive care smooth, I applied for core anaesthesia in Liverpool. I was a bit scunnered (Scottish-ism) with medicine and was keen to get straight into anaesthesia.

Fortunately, I loved it and found, that compared to friends in medicine and surgery, my training was directed and I quickly became useful. Inevitably though, I applied for intensive care training. On being successful I had a meeting with the TPD for the West of Scotland, Dr Cat McNeill. She broke the news, "you're going to need to top-up your medicine and ICU". It was decided that I would do this from February 2020 to August 2021 [for the reader: some global events intervened].

Maximising experience

From that point on, I got thinking. I was keen to maximise my experience in medicine and knew of others who had used their time to gain skills in echo, advanced heart failure, bronchoscopy etc. I had long had an interest in toxicological admissions to ICU and unlike other aspects of critical care I had had minimal teaching on toxicology.

The Scottish Intensive Care Society had recently arranged a teaching session for trainees where one of the speakers was Dr Euan Sandilands, Director of the National Poisons Information Service (NPIS), Edinburgh. He presented a case of cardiotoxicity. His insight and thinking seemed

like that of an intensivist. His approach to the case, which consisted of a reliance on limited information and working with the physiology and pharmacology one is presented with, struck home. I contacted him and he kindly agreed to have me at the Royal Infirmary of Edinburgh working with the National Poisons Service.

Toxicology in the UK

Although everyone reading this will have used Toxbase, only some will have phoned the NPIS and fewer still will know the work of the four toxicology units. Toxicology in the UK is concentrated in four centres: Edinburgh, Newcastle, Birmingham and Cardiff. Calls to the NPIS are taken by Specialists in Poisons Information (or SPIs). They field a huge number of calls and are able to assist the vast majority of callers to the service. They are non-clinical and largely come from a science background so there are cases where further advice is sought from the consultant-on-call for the NPIS.

Edinburgh has the largest number of consultants and takes the lead for the management of Toxbase. The unit has its own dedicated 10-bed toxicology unit. All poisons admissions to South East Scotland go to this unit. It provides an enhanced-care level of provision, with monitored beds and the ability to manage patients that would be ordinarily be unsuitable for management on the regular AMU.

My time in Edinburgh was a great experience. It provided me with unrivalled exposure to an area of our practice that we encounter frequently, but is often overlooked in its importance.

A typical day

The day would typically start on the Tox Unit, co-located in the acute medical unit. Many of the patients on the round would need to go to critical care in Glasgow or wait for a long time in ED resus. The skilled management of the unconscious tox patient quickly became a priority in my learning. The ward round was efficient and the turn-over high. There are very close links with the drug and alcohol liaison teams. Their advice and input into the recreational overdoses is invaluable, and a key part of the puzzle in addressing premature deaths due to overdose.

At the end of the ward round, we would make a trip to liaison psychiatry. The relationship between psychiatry and toxicology in Edinburgh is pioneering. From the early days of the service it was recognised that for patients admitted to toxicology with self-harm intent, the traditional model of psych liaison was inadequate. The Edinburgh model involves daily discussion of all the toxicology patients with possible self-harm intent and facilitates rapid psychiatric assessment. This assessment can take place while active toxicology management is ongoing, meaning that most patients have their multifaceted issues addressed simultaneously. The toxicology team have a strong presence in the hospital and have developed good relationships with the ED and the ICU, so next on the round, we would visit each department.

In ED, we identifed tox patients who could be discharged, aided with decision-making and prioritising admissions.The daily round on the ICU was a great opportunity to see the critical end of the specialty. Mixed sedative overdoses predominate, however acute hepatic failure due to paracetamol and cardio-toxicity are also frequently present. Edinburgh has been keen to explore the use of extra-corporeal life support for the shocked toxicology patient. The expert view of the toxicologists on site are instrumental in making this system work.

Varied workload

The rest of the day was varied. A second ward round at 4pm meant we could rapidly assess, treat and discharge patients. In the meantime, I took referral calls from the hospital and worked closely with the consultant on call in receiving the national calls, via the NPIS Toxbase line. The calls tended to be very severe or unusual, often from the ED resus or ICU, varying from toxicological arrests to chemical incidents to snake bites.

In between times, the department is a hive of QI and research activity. I was able to join the editing committee in reviewing, editing and publishing advice on the database. The department also has a big educational role as the only tox department in the country. This gives the opportunity to spread the word about poisons to both under- and postgraduates.

My time in Toxicology was hugely beneficial. In Scotland, about 10% of admissions to Level 3 beds have a toxicological diagnosis. To work in ICU and not have a good knowledge of poisons, is not to know enough about 1 in 10 admissions. This is particularly prescient given the current Scottish drug deaths crisis. Toxicology is an experiential specialty and I would commend it to anyone with an interest.

"What matters most?" Palliative Care on the ICU

Dr Hannah Richards
ICM Trainee
Mersey

"I know lots about his organ failure, but nothing about who the person in this bed is." This was the advice my consultant in palliative medicine gave me that convinced me I had made the right choice in spending my SSY focusing on quality improvement in palliative care on the ICU.

As a single ICM CCT trainee from a medical background I had always had an interest in Palliative Care so when the opportunity to spend a year working on QI projects improving palliative care in ICU presented itself, I jumped at the chance. I was fortunate enough to be able to split my time between working in ICU and with the hospital specialist palliative care team (SPCT). I began my year learning the basics of specialist palliative care as well as exploring the challenges of providing palliative care in the ICU environment. Following this period I undertook two QI projects, one focusing on treatment escalation planning for patients known to the palliative care team and the other on education of both SPCT and ICU staff on palliative care in the ICU.

Managing QI projects

The process of running QI projects across two teams gave me the opportunity to develop my skills in managing a project, communicating QI to different teams and understanding change theory. It was however the clinical and team-working skills I was able to acquire that will shape me most as a clinician moving forward.

My first take away point is that our colleagues in palliative care are a gold mine of skills and resources that we can, and should, be offering to our patients. From excellent physical symptom control (it turns out ondansetron doesn't fix all nausea and vomiting!), to unpicking complex psychological distress, to the practical relief of optimising benefits, they have skills that we as intensivists cannot hope to substitute. I realised that through the SPCT, we had access to a huge team including medics, specialist nurses, physios, pharmacy, chaplaincy and admin; all of whom could offer my patients truly holistic care. I saw time and time again that

> "Our colleagues in palliative care are a gold mine of skills and resources that we can, and should, be offering to our patients.

the palliative care nurses would be able to quickly get to the root of troublesome symptoms and that patients would tell the chaplain fears that they would never voice to me. Whilst the perception of care of patients approaching the end of life is often that we do less, I was challenged to see that in fact they need more intensive input to address their complex needs. We found that by involving our palliative care colleagues early in a patient's stay we were able to address these concerns and gain much improved symptom control, as well as keeping focused on the person behind the numbers.

Programme of education

I was reminded that the ICU is an intimidating environment to those who do not visit regularly. Many SPCT staff had limited experience in the critical care environment and often felt reluctant to give advice if they did not feel they understood the management the patient was receiving. We found that a programme of education for both SPCT and ICU staff, as well as inviting both teams to shadow each other and carry out joint reviews, rapidly improved the team's confidence in the ICU environment. They quickly understood that their skills were invaluable and easily translated to the ICU. This empowered both teams to begin to working more collaboratively, sharing skills and experience and developing joint holistic management plans for patients.

The biggest thing I learnt however, was very simple; every palliative care patient is asked each day "what matters most to you today?" This simple question revealed answers I would never have considered. No-one ever asked me to "titrate my inotropes" or "replace my phosphate." There was a predictable selection of requests covering physical symptom control or seeing family alongside a huge range of other priorities. Notable requests included a visit from a cat, sorting out the car insurance, ice cream, headphones, perfume and a gin and tonic.

> "I learnt never to underestimate the privilege it is to give someone who has been stuck on CPAP for weeks the ice cream they so desperately desire before they die.

I was surprised just how often the thing that meant the most to my patient was something I would never have offered to them but was simple to do. It reminded me of how easy it is to forget that our patients are people and slip all to quickly into treating numbers and organ failure. Making an active effort to ask them what they think is most important not only allowed us to manage their holistic needs but also gave me some of the most satisfying interactions of my career. In speaking about their priorities, I learnt never to underestimate the privilege it is to give someone who has been stuck on CPAP for weeks the ice cream they so desperately desire before they die.

Simple interventions

I saw, time and time again, how effective this simple intervention is and I realised that there is no need to restrict it to those approaching the end of their lives. I wonder how different our ICUs would be if we asked all our patients what mattered most to them today, and listened to the answer? I suspect we would learn much more about the people behind the organ failure, see simple but life changing care happen on our units and remind our patients that no matter how sick they are, their humanity still matters to us.

Engage with your team

So, whether you have an active interest in palliative care or not might I suggest the following:

Go and find your palliative care team. Invite them to see your ICU patients. Remember that they have a huge range of skills and will welcome the opportunity to give their input on your patients. Offer to show them the invasive organ support your patient is receiving and discuss how this may affect them symptomatically, you will both learn more than you think. And finally, try asking your patients what matters most to them. Document it in their notes, make it part of your management plan and see the difference that knowing our patients as people makes to both you and them. You won't regret it!

Natalie Bell
FICM Board & Training Projects Manager

FICM Lifelong Learning Platform

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

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

Key Points

1. User Guide: The Guide for FICM Learners can be found here. Please read this to help you navigate the new system and to answer any immediate questions you might have. The User Guides for Supervisors are currently in development and will be published in due course. We also have video demonstrations for Learners and Supervisors on the website.

2. Downloading from NES: We have produced detailed guidance about how to download your data from the NES portfolio. We have extended the deadline until **31 January 2021** to do this. Also see our transition guide for what evidence from the NES portfolio you will need to upload to the LLP.

3. 2021 Anaes/ACCS Supervised Learning Events (SLEs) are now live in the FICM Learner tab: In October we deployed the new Anaes/ACCS 2021 curriculum assessments onto the SLE page for FICM Learners. This means you can now complete the Anaesthetic assessments for your placements in Anaesthesia and link them to your ICM Curriculum without having to download them from the RCoA website and then reupload to your FICM LLP.

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

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

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

See p.14 for detailed instructions.

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

ARCP panels can only view evidence pulled through in

completed ESSRs. You might find it helpful to create some test ESSRs in the LLP to see you how your portfolio looks when you have added some evidence to give you a feel for what an ARCP panel would be reviewing and identify any potential gaps. You can then delete any of these test ones if they're not needed. If you are on a dual Anaes and ICM programme all of your completed ESSRs from your progress against the Anaes and ICM curricula are available for your ARCP panel to view. It is therefore imperative that you give them accurate titles (e.g. Anaes ESSR/ICM ESSR) so that your ARCP panel knows which ESSR they should be reviewing.

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

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

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

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

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

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

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

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

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

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

Further development

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

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

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

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

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

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

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

Image 1

Image 2

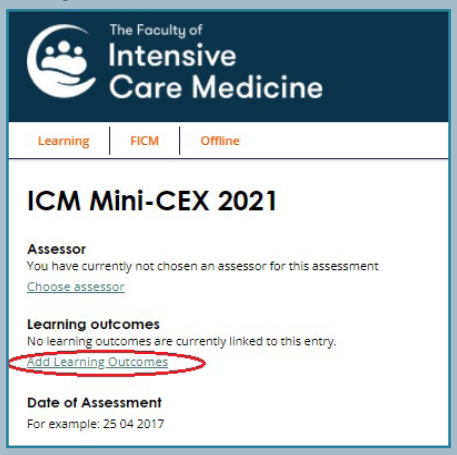


Image 3

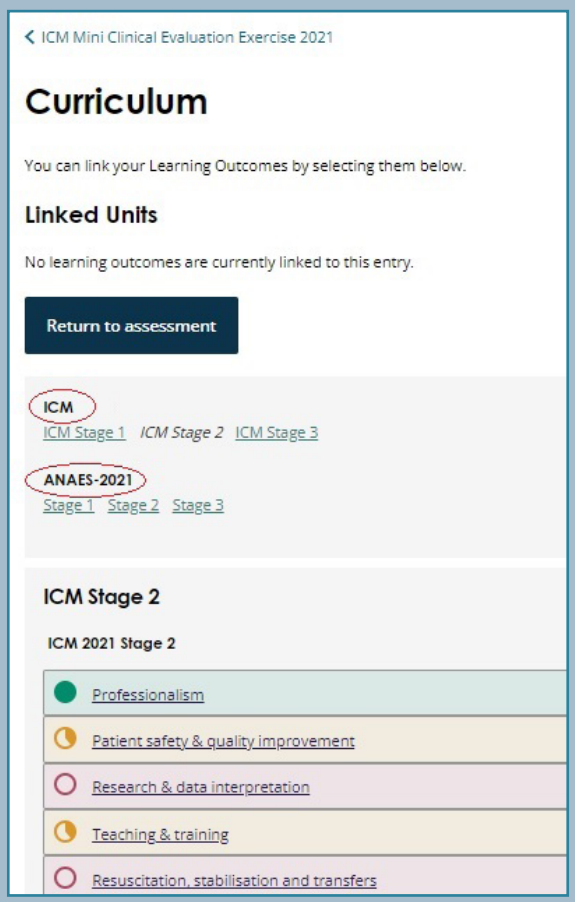
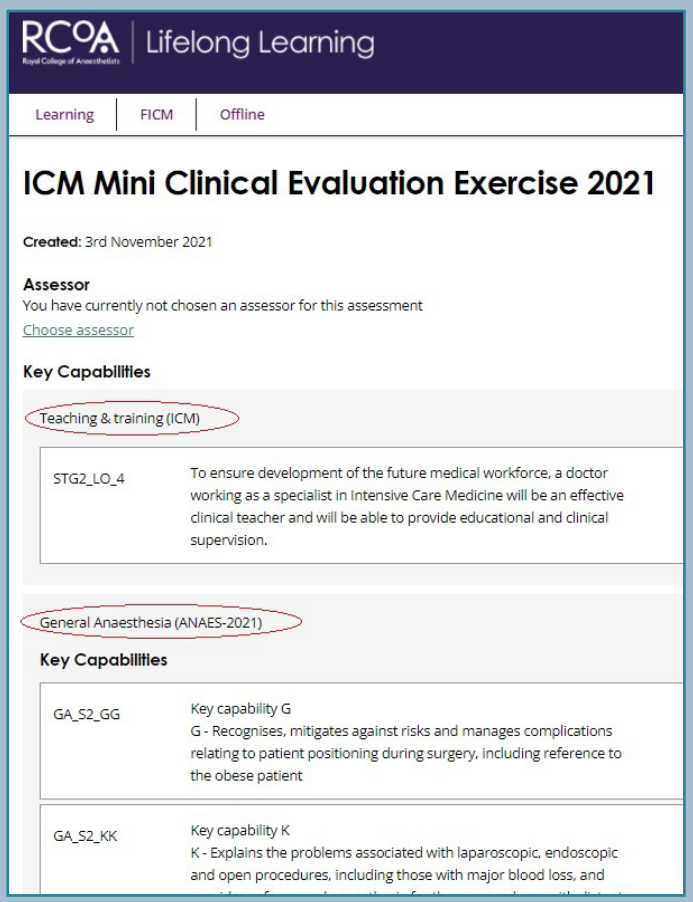


Image 4



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

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

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

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

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

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

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

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

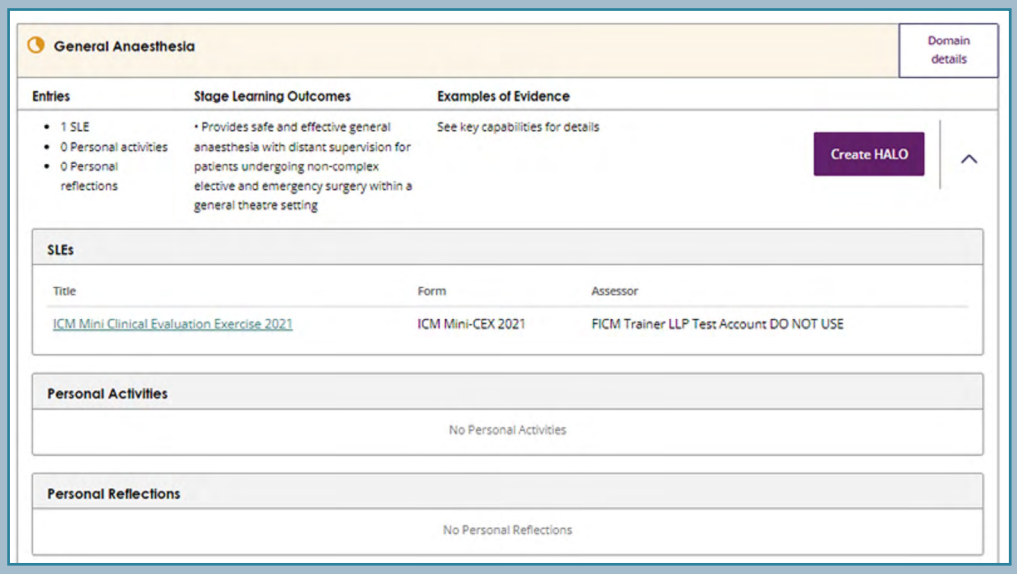
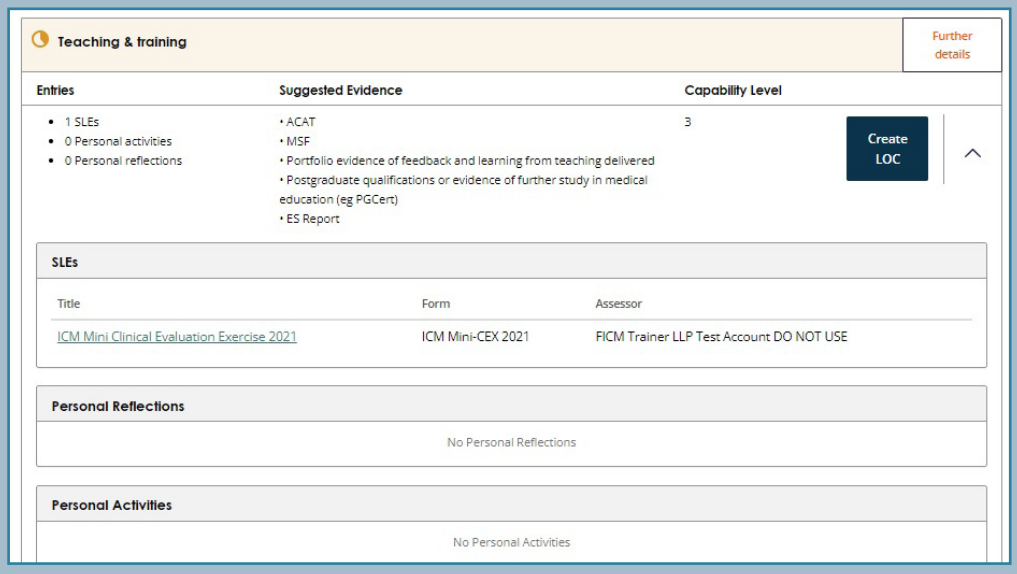


Image 6 As an SLE in the ICM Curriculum under the Teaching and Training HiLLO



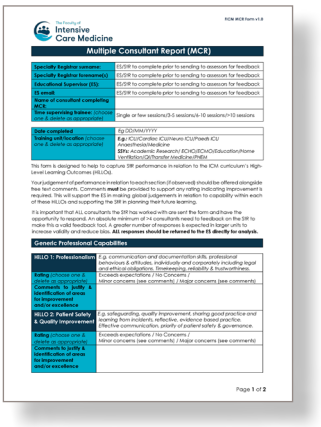
documents if necessary.

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

10. As this is a 'Dual SLE' it will appear in both of your dashboards (RCoA and FICM) in your 'Recent Activity' boxes. Once your supervisor has approved the form you can then see that it appears as evidence towards attainment of the respective outcomes in both curricula (e.g. **Images 5 and 6**).

You can also see this functionality demonstrated in our most recent webinar for StRs, held on 30 September 2021 and available online. It appears at around the 22 minute mark.

This guidance is also available on the FICM website.



NEW: Multiple Consultant Report pilot

FICM are introducing an additional assessment tool: the Multiple Consultant Report (MCR), to be piloted over the next 12-18 months.

With the recent transition to the 2021 ICM Curriculum: Supporting Excellence, and the change to an outcomes-based approach to determining progression through specialist training, there is more of an onus on the Educational Supervisors (ESs) to make overarching, holistic judgements on whether the expected curriculum outcomes are being met at the relevant stage of training.

To help support this decision making, the Curriculum Implementation Group have worked on producing a tool that seeks triangulating information from as many consultants as possible that the doctor has been working with.

Other Colleges have a similar approach. With input from educationalists, the FICM's Multiple Consultant Report (MCR) Form has been refined to collect data that informs judgements on each of the 14 HiLLOs, whilst keeping it as concise as possible.

Expected workflow

1. Before sending the MCR Form to consultants for feedback, Specialty Registrars (StRs) or ESs should complete the first four boxes (including their names and the ES's email address) so they know who they are evaluating and where to send their feedback.

2. The MCR Form should be sent by the local ES (or Clinical Supervisor (CS), if the ES is remote to the hospital) to all the consultants in the unit the StR is working at to minimise bias.

3. Completed MCR Forms should be emailed directly to the ES/CS for collation. This should be done in good time ahead of the ES needing to make HiLLO judgments and/or write an ESSR (or end of placement report in the case of a CS).

4. The MCR Summary Report including a collation of all the consultant feedback received should be created by the ES (we would recommend you keep adding to an e-master copy until the feedback exercise is considered complete).

5. The ES will use the findings to help make their HiLLO judgements and write an ESSR (or for a CS to write an end of placement report).

6. The final MCR Summary Report should be sent by the ES as a signed PDF copy to the StR, having first discussed it with them, so it can be uploaded to their LLP

7. StRs should save the MCR Summary Report as a Personal Activity under the Activity Type 'Consultant Feedback' and link it to any relevant HiLLOs in the curriculum. They should ensure the Personal Activity is saved so that is visible on any future ESSRs.

Next steps

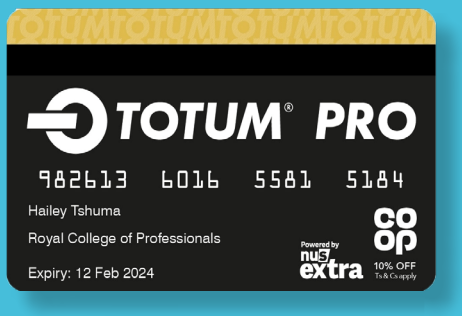
The FICM requests that the MCR is used by all regions as their means of obtaining triangulating consultant faculty views. FICMTAQ will be evaluating the pilot and refining the form and process over the next 12-18 months.
If considered successful, the information gathered will inform a request to the GMC to add to FICM's Assessment Strategy for the new curriculum, and subsequently the LLP ePortfolio.

Click here for more information.

FFICM Exam Calendar

FFICM FINAL MCQ	
Exam applications open	Monday 4 October 2021
Exam applications close	Thursday 25 November 2021
EXAM DATE	11 January 2022
Fee	£510
Results	27 January 2022

FFICM FINAL OCSE/SOE	
Exam applications open	Monday 10 January 2022
Exam applications close	Monday 28 February 2022
EXAM DATE	25-28 April 2022 29 April 2022 TBC
Fee	£635 (both) £355 (OSCE) £320 (SOE)
Results	13 May 2022



TOTUM PRO is the only discount card available for professional learners to purchase giving discounts from a wide range of high street and online retailers.

Discounts range from travel and eating out, to health, technology and fashion. Professionals using the card are able to benefit from a whole host of exclusive discounts.

To apply e-mail contact@ficm.ac.uk.

FICM Thrive

The FICMThrive mentoring scheme, led by the Women In intensive Care medicine sub-committee, is now live! The launch phase is focused on new consultants in ICM, in their first 5 years post-appointment.

Please read the guidance and application materials online. Please try to make any application detailed and specific so you can be best matched to a mentor or mentee.

Click here for more information.

The latest *Critical Eye* is now available on the FICM website. Click here to read the full issue.

If you would like to contribute to future issues, please get in touch at contact@ficm.ac.uk.

The latest edition of our *Safety Incidents in Critical Care* bulletin is now available on the FICM website.

Click here to read the full issue.

CESR-CP Update

We would like to take this opportunity to update you on the further guidance published by the GMC on the CESR Combined Programme (CESR-CP). On 11 June 2021, the GMC announced that they are now able to issue a certificate of completion of training (CCT) to doctors on a CESR combined programme (CESR-CP) – this is effective from 1 January 2021.

The requirement for doctors in training to meet the minimum training time in ICM has now been removed from legislation as a result of the UK's exit from the European Union.

Doctors entering or who have entered the ICM training programme on a combined programme taking into consideration prior unapproved training posts will now be eligible for a CCT.

FICM OOPT/R Form

The Faculty have now produced a new form for both single and dual trainees wishing to count their OOPT/R experience towards their CCT/CESR (CP) in ICM or a dual programme with ICM.

Click here for more.


Application for Prospective Approval for Out of Programme Training or Research [OOPT/R]

FICMLearning webinars are here!

FICMLearning is now offering webinar content! These will be released over the year and are from our previous events such as the Annual Meeting, the ACCP conference, Striking the Balance and Clinical Leads Meeting.

Right now, we have two fantastic talks already available. Webinars that are from events approved for CPD points can be counted towards CPD. You will need to self-certify you have watched the webinars. 1 CPD credit per 1 hour of educational content.

- **The Patient Perspective:** Professor Grant McIntyre discusses his experience as a critically ill COVID patient during the pandemic and his ongoing recovery after 128 days in hospital.
- **Who wants to live forever?** The future of and limits to longevity Professor Hugh Montgomery lectures on the future of longevity; could humans live forever? Would we want to?

More webinars will be released soon!

Beyond webinars we're still producing fantastic podcasts, blogs and cases of the month. Recent additions include:

- **Lecture:** Mentoring: What's in it for me?
- **Case of the Month:** Case #23 | Case #24 | Case #25
- **Blogs:** Clinical informatics in the ICU in a Pandemic | Nutrition Protocols | Music, the ICU and me! My Year as a Clinical Fellow in ICM
- **Podcasts:** Artificial Intelligence | Palliative Care in Intensive Care

If you fancy writing for FICMLearning, do get in touch with us, **contact@ficm.ac.uk**!

National Deceased Donation Course for ICM Trainees

All course centres suitable for trainees in adult intensive care medicine
For paediatric trainees: choose Newcastle or London centres
Priority given to Stage 2 & 3 (ST5+)

DEVELOPED WITH FICM AND ICS ENGAGEMENT

COVERING FICM SYLLABUS DOMAIN 8 END OF LIFE CARE.

"One of the best courses I have attended, high quality is mainly driven by the enthusiasm and great knowledge of the faculty members and the presence of national experts and leads in the subject of organ donation."

Lectures & simulation training to gain knowledge and skills in:

- Organ donation principles and practice
- Safely diagnosing death
- End of life & family donation discussions
- Withdrawal of life sustaining treatment in DCD
- The capacity to make informed ethical and legal choices in the context of organ donation and wider ICM practice.
- The ability to work productively with others, particularly Specialist Nurses

- COVID safe measures
- Free 2 day national course
- Includes accommodation & meals
- Experienced & expert faculty
- Consistently evaluated as excellent

2021/22 Dates:

2021	Nov 2nd & 3rd	**Newcastle**	Full
2021	Nov 22nd & 23rd	**London**	Full
2022	Jan 11th 12th	**Newcastle**	**Places**
2022	March 1st & 2nd	**Salford**	Full
2022	April 6th & 7th	**Cardiff**	**Places**

For more details and applications contact:

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