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SUPPLEMENT

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Pres Blog

Welcome to the valedictory Pres Blog. Before collective eyes become overwhelmingly misty, some important business matters to consider.

The latest TLA is 3DN—111, the new alternative phone number for 999 for apparently less serious cases. CEM colleagues have been involved in the initial pilot work currently underway and have contributed both to the development of the principle of the number and the directory of services which sits behind the number. The (ambitious) plan is that patients—where considered appropriate and when the community service is available—will be directed accordingly. This is of course an excellent idea in principle although there are concerns regarding the time scale needed to populate the infrastructure required to provide such care in the community. Inevitably, this will not be 24/7—neither will it be needed 24/7 for a number of services. Equally inevitably, the universal default will (quite correctly) be the emergency department. Now would be a very good time indeed to establish the state of play of 111 in your area and, yet again, could I urge all emergency department lead consultants to invite themselves along to the meetings to contribute their unique perspective. One fundamental point is that this initiative should not be predicated on an assumption that it will result in any or a fixed number of reduced emergency department attendances. We have all seen the folly of such suggestions during the past decade. If some impact on emergency department attendances occurs, then so be it, but this should not be either an expectation or a target of the 111 providers. The directory of services will be invaluable for emergency department teams, providing as it will contacts in the community to facilitate discharges from emergency department/CDU back to community care.

You will have seen the correspondence between CEM and Monitor regarding the somewhat zealous initial interpretation and implementation of the quality indicators (QIs). Matthew Cooke and I met with the Monitor team back in early August and expressed our concerns that the indicators were being interpreted as targets, given the scoring system described in the Monitor compliance framework. Very pleased to report that Monitor were entirely receptive, had already recognised some of the problems arising and as such moved to a single performance measure for their scoring criteria of 95% at 4 hours. Although déjà vu all over again, in my view this represents a very reasonable and pragmatic step at this stage in the bedding in of what remain very new indicators. Crucially, Monitor emphasised the need to continue to report against other QIs, thus providing the breadth of reflection of time, quality and safety—the fundamental ethos of the QIs. Importantly also, Monitor will formally score more of the indicators in the future quarters and therefore the broad brush approach remains extant. One of the key concerns of Monitor was the reliability of data quality. CEM shares these concerns and I urged that Monitor invite all of their constituent FTs to review their emergency department IT to ensure that it is fit for purpose, preferably electronic and capable of responding to the idiosyncratic requirements of the emergency department.

The updated Way Ahead is now available on the College website. We took the decision to restrict circulated hard copy to a 4 page impact full summary of key College issues to provide focus for the readership and accepted that perhaps not everybody will read all 80 pages of what is undoubtedly a gripping read. In addition, the pace of change in the specialty is such that any printed version is likely to be out of date in the pretty near future and our green agenda will not tolerate such indulgence. In particular, the workforce agenda should change rapidly during the next 6 months as the joint workforce between the Department of Health and CEM tasks and finishes with a report due early in 2012. Without prejudging the outcome, the CEM position on workforce is clear, with an absolute need to provide high quality, safe, consistent patient care in the emergency department 24/7. This is challenging but requires consultant expansion, maintenance of a middle grade tier and a combination of junior doctors, autonomous practitioners such as ANPs and dependent practitioners such as physicians' assistants. The shape of the workforce will no longer resemble the traditional but now distinctly anachronistic pyramid to be replaced by a shape not dissimilar to a top hat—better non-sartorial geometrical descriptions welcome as ever.

This joint workforce group is a hugely welcome development and reflects a widespread acknowledgement that we are somewhat behind the curve and involved in a significant catching up exercise to ensure that our emergency departments are staffed properly—and about time too!

And finally, the end is indeed nigh. This is the final Pres Blog and my tenure in the CEM ovalish office is now concluded. It has of course gone by in the blink of a myaesthenic eye but please indulge a few reflective comments.

One of the primary objectives of the past 3 years has been to plant the emergency medicine flag at as many meetings as possible—and there have been *many* meetings. The fundamental change which I have seen has been acknowledgement and recognition of the importance of emergency medicine and the need to provide (pardon the cliché) world class 21st century emergency care in *all* of our departments. It has been tough but the tectonic shift from investing in anything but the emergency department to a recognition that our patients need *us*, given our absolutely unique presence and skills, has been incredibly rewarding. But—and it is a big but—we are still in catch-up mode and further work is required in this area…….

Emergency medicine is the quintessential team event and life in the College likewise. I was very fortunate indeed to have inherited the excellent foundations established by Jim Wardrope and colleagues. I hope that we have added a floor or two to the emergency medicine edifice.

Major achievements during the past 3 years or so might include the following:

- Appointment of the brilliant Gordon Miles as our first ever Chief Executive
- Purchase of the first ever home of our own—CEM HQ
- Persuading the Secretary of State not to abandon the 4 hour target (love it or loathe it—without it the specialty would be stuffed) and replacement with the excellent (yes they are excellent) QIs
- Putting emergency medicine well and truly on the parts of the map where it was previously under represented
- Turning the College public voice up to 11 with unashamed media tartness working on the principle that (almost) every time the phrase 'College of Emergency Medicine' appears is a good thing. Highlights included a few national broadsheet front pages, bonding with John Humphrys, being bounced on Five Live by Her Majesty the Queen, Barack Obama and John Terry, Talksport, Radio 4 Case Notes, File on Four and *The Sun* gardening section
- CEM team at Buckingham Palace Garden party
- Acknowledgement that we are emergency medicine in emergency departments by the DH
- 10,814 Prescem gmails—and counting
- I could go on…….(and you often do—Ed)

The singular disappointment is the continuing absence of Royal in our title for which apologies. Having pondered this at great length—and I have—I am sure we are right to regard this as deferred success and to acknowledge that inevitably the infrastructure of the College at the time of application was a disadvantage. The great work being undertaken by Gordon Miles and colleagues has already addressed this comprehensively and I am very confident indeed that our next application, in 2–3 years from HQ in EC4, will be successful.

I am delighted to thank the amazing team of people in WC1 and SO16 postcodes who have been superbly supportive and tolerant of Heyworth during his tenure. All of the College office team who undertake an incredible amount of under the surface work to ensure the College swan floats on serenely. In particular, the utterly outstanding Gerardine Beckett without whom none of the above would be possible—thank you Gerardine!

Huge and grateful thanks also to the College Officers, Committee Chairs and Committee Members for great support and frankly incredible work across a portfolio of College activity which is staggering—all unpaid of course and mostly in their own time. Thank you.

Being CEM President is jolly hard work and demands presidential presence in London on at least 2 and often 3 days most weeks. In addition, there is a distinct background hum of phone calls and emails which need to be dealt with pretty much 7 days a week every week. Inevitably, the demands of these activities are incompatible with the rota so carefully drawn up by my lead consultant and apparently therefore boss in Southampton. She and my consultant colleagues in Southampton have been infinitely patient, flexible, understanding and all round good eggs in managing my rota …….. Many thanks.

Gratitude to all the above will be expressed in traditional libation based mode at the earliest opportunity.

It is a great pleasure to hand the College baton on to Mike Clancy, confident in the knowledge that the College and the specialty will be in immensely talented and safe hands.

Emergency medicine is *the* most important specialty in all of medicine. Patients come to us in times of desperate need, usually scared and often in pain. It is our immense privilege and responsibility to be the doctors to whom they turn in their time of need. Providing excellent care for our patients offers the most fulfilling reward available professionally. We all strive to deliver great care and it is this absolute commitment to doing the very best for all of our patients that drives us onward. Sometimes it is a bit overwhelming, exhausting and emotionally draining but we all know that the emergency department is the only place to be and precisely where it is at. Emergency medicine does indeed rock!

In summary, fantastic progress. It has been an honour to be part of this great College and the most exciting, important and frankly pretty sexy specialty.

Ladies and gentlemen, Pres Blog signing out.

Thank you for reading.

FIN

John Heyworth

Update on training in intensive care medicine

INTRODUCTION

The foundation of the Faculty of Intensive Care Medicine (FICM) in 2010 marked an important milestone in the development of the speciality. Supported by the parent medical, surgical, anaesthetic and emergency medical colleges of the UK and the devolved nations, in addition to the Intensive Care Societies, the Faculty's primary goal has been the development of a new speciality training programme for ICM to run either as a single or dual CCT programme.[1] Implementation of the new ICM curriculum from August 2012 represents the next significant stage in the development of the speciality and offers a logical point at which to provide the latest information to trainees in emergency medicine who are considering ICM as a potential career choice.

EXISTING ICM JOINT TRAINING PROGRAMME

The existing joint training programme requires a national training number (NTN) in a base speciality in order to train towards joint accreditation with ICM. The base specialties comprise emergency medicine, anaesthetics, medicine and surgery. The ICM portion of the training is divided into three stages (basic, intermediate and advanced) and there is also a period of complementary speciality training. To obtain full joint accreditation requires undertaking a minimum of 21 months of approved ICM training across the three stages, along with 12 months of complementary speciality training. Recruitment to ICM posts is currently carried out on a regional basis with competitive interview for advanced training programme places.

Recruitment to the existing joint ICM programme will continue until the 31 July 2013, after which entry to the new ICM training programme will be the only route available.[2] Eligibility for the joint programme will still be dependent on meeting the requirements of the appointment and therefore this route will only be available to trainees who have already reached ST2/CT2 by August 2011. These individuals will be able to be appointed to the joint programme regardless of the timing of their advanced training year provided the appointment occurs before the 31 July 2013. Figure 1 illustrates the existing ICM joint training programme with emergency medicine as the speciality of primary appointment.

NEW ICM TRAINING PROGRAMME

The new ICM programme will commence from August 2012 and enable training to take place either solely in ICM (single CTT) or in combination with another speciality (dual CCT). Entrance to the single CCT ICM training programme will be at ST3 level and training will last for 5 years. Entrance criteria will include completion of one of the acute core training programmes, including ACCS(EM), and the MCEM part A (or alternatively the primary FRCA or full MRCP).

Those trainees wishing to undertake dual CCT training will need to compete competitively in each speciality appointment process. In emergency medicine this will entail entry to ST4 for emergency medicine and ST3 for ICM. Subsequent to appointment, trainees undertaking dual training will spend longer obtaining the necessary competencies and training than either single CCT programme. The length of time this takes will depend on the second speciality and the amount of transferrable competencies and approved training time that may be counted towards both specialities. For emergency medicine, the total training time to complete dual CCT training is expected to be approximately 8.5 years (from ST1 level) compared with 7 years for the either the single ICM or 6 years for the single emergency medicine programme.

Recruitment to ICM training programmes will take place through a national process run by a lead deanery (yet to be confirmed). Applicants wishing to pursue dual training will probably be required to compete separately in each speciality and be successful in both in order to be appointed. Applicants already in ST3 posts or beyond will be eligible to apply for the new ICM programmes provided they meet the requirements laid out in future personal specifications. Such individuals, if appointed, may be able to have their previously achieved competencies counted towards the ICM training, thus shortening their potential training period.

Figure 2 illustrates the new ICM training programme with emergency medicine ACCS as a starting point.

THE DICM AND NEW EXAMINATION STRUCTURE

The last opportunity to sit the current UK Diploma in Intensive Care Medicine examination will be in July 2012. There will be no opportunity for candidates failing the DICM at this sitting to re-sit. The new Fellowship examination for the

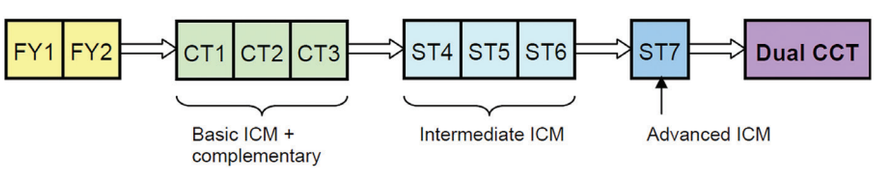

Figure 1

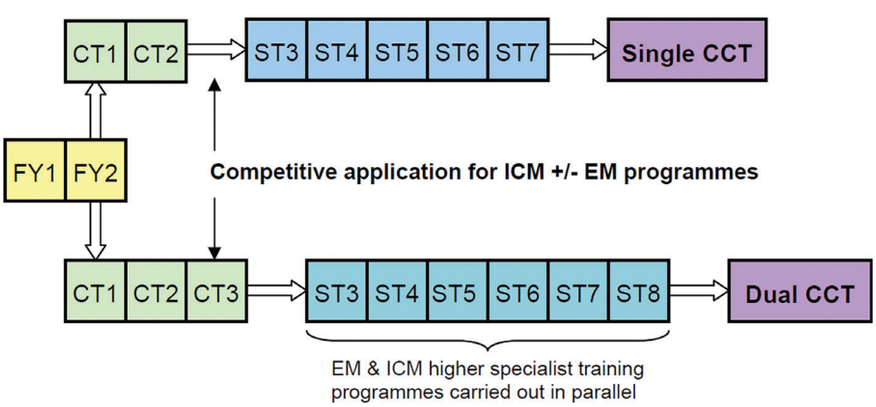

Figure 2

FICM will involve two parts: the part 1, or 'primary', is planned to be sat during CT1/CT2 with exemption given to those holding primary FRCA, MRCP (including paces) and MCEM part A. Part 2 will be sat during ST5/6 and will be a mandatory component of the new CCT. It will consist of an MCQ followed by an OSCE and a series of Structured Oral Examinations (SOEs). Individuals training under the old joint CCT scheme will be able to sit this examination in order to obtain the qualification of FFICM although this will *not* be compulsory in order to attain the joint CCT itself.

The first sitting of part 1 FFICM is not yet planned. The first sitting of the part 2 FFICM will be in November 2012.

SUMMARY

ICM training is undergoing a series of fundamental changes, and over the coming months more information will be available. Both a single speciality and dual training route to obtaining a CCT in ICM will be available to trainees already in emergency medicine training programmes. Application to the 'old style' joint training programme will no longer be available after July 2013. Trainees wishing to undertake training in ICM, via either route, should contact their regional advisor in ICM for further advice and guidance. A list of regional advisors can be found via the training section of the FICM website. Due to the pace of ongoing developments, it is also recommended that trainees should check the FICM (www.ficm.ac.uk) and ICS (www.ics.ac.uk) websites for further updates, as information is subject to change at short notice.

The ICS trainee committee will be organising a careers day, currently planned for the 9 November 2011 in Manchester, which aims to provide the most up to date information and offer guidance to current and future ICM trainees prior to the new applications process later this year. The careers day will also be advertised via the ICS website.

REFERENCES

1. Intercollegiate Board for Training in Intensive Care Medicine. Future of the CCT in Intensive Care Medicine. Available at: www.ficm.ac.uk/ _ assets/ pdf/latest _ news/future%20of%20icm%20 cct%20statement%20(may%2010).pdf (accessed 11 August 2011).
2. Intensive Care Society Trainee Committee. Update on current plans for Intensive Care Medicine training from August 2012. Available at: www. ics.ac.uk/education/update _ on _ current _ training _ plans _ 2012 (accessed 11 August 2011).

Dr Paul Hunt, SpR EM and ICM, Northern Deanery, EM rep to ICS Trainee Committee, UK;

Dr Chris Booth, SpR ICM, North Western Deanery, Chair ICS Trainee Committee, UK

Two wheels for prehospital care

One doctor, two wheels and 21,000 miles for charity. Chris Targett, currently an A&E doctor, is undertaking a 21,000 mile solo and unsupported motorcycle adventure for air ambulance charity 'Magpas' and Africa motorcycle healthcare charity 'Riders for health'. The trip is called Tigger's Travels after Chris's boyhood nickname. He leaves in January 2012 after his interview for ACCS training and will journey from the Helimedix helicopter base in Cambridgeshire to Cape Town in South Africa down the continent's east coast. From there he flies himself and his motorcycle (a KTM 990 called Sir Humphrey Bikelby) to Kathmandu in Nepal and starts the long road back via India, Pakistan, Iran, Turkey and Europe. He will be doing all of this in just 6 months and without any backup or support crew. The trip's website **(www.tiggerstravels.org)** is well worth a look and is where you can donate online. Any companies wishing to advertise with Chris or sponsor the adventure can contact him via the website.