Scottish Intensive Care Society

Annual Report 2012-2013

Editor's Introduction

Dr Rosie Macfadyen, Western General Hospital

Welcome to the Scottish Intensive Care Society Annual Report for 2012-2013.

2012 has been an active year for the Society. It has continued to flourish under the leadership of Mike Fried, who has ensured that the interests of Scottish ICUs are well represented within the Faculty of Intensive Care Medicine, the Intensive Care Society and the Scottish Government. He has been aided and abetted in this respect by the members of Council whose reports are contained within. We have had the pleasure of welcoming Dr David Rowney to Council as the SICS net spreads wider, quite rightly, to encompass the interests of paediatric critical care. Several new regional representatives have been appointed this year; their names, along with the rest of Council, are below. There will be further elections for regional representatives in 2013 and anyone interested in such a position should contact Dr Sarah Ramsay, Honorary Secretary, for further information.

The traditional meetings hosted by SICS, namely the Education Meeting, Annual Scientific Meeting and SICSAG/SCCTG Combined Meeting have had record attendances in 2012. The Trainee and Education and Training Groups have jointly launched a series of National Training Days for senior trainees. SICS Council members are also actively involved in workforce planning, the setting of quality indicators in ICU, provision of a safe national critical care transfer infrastructure and much much more. All these activities show what a central role SICS plays in Scottish critical care.

This is the first year the Society has published its Annual Report in electronic and paper formats. I would welcome feedback from members on both formats.

Finally I would like to take this opportunity to thank the members of Council who contributed to this Annual Report, and wish the Society every success for 2013.

Rosie Macfadyen
Editor, Annual Report

SICS Council, January 2013

Back row L –R: David Griffith, Martin Hughes, Dave Cameron, Malcolm Sim, Martyn Hawkins, Sam Moultrie, Sarah Ramsay, Steve Stott
Front row L –R: Charles Wallis, Willis Peel, Fiona McIntyre, Shelagh Winship, Rory McKenzie, Mike Fried.

SICS Council members 2013			
Elected reps	**Until AGM 2013**	**From AGM 2013**	**Contact details**
GG&C	Martin Hughes	Martin Hughes	martn.hughes2@ggc.scot.nhs.uk
	Malcolm Sim	Malcolm Sim	malcolm.sim@ggc.scot.nhs.uk
	Sarah Ramsay	Andy MacKay	andrewmackay@nhs.net
East	Sam Moultrie	Rosie Macfadyen	rosie.macfadyen@nhs.net
	David Cameron	Liz Wilson	elizabeth.s.wilson@nhslothian.scot.nhs.uk
	Charles Wallis	Charles Wallis	charles.wallis@nhslothian.scot.nhs.uk
North	John Colvin	Ian Mellor	ian.mellor@nhs.net
	Nigel Webster	Nigel Webster	n.r.webster@abdn.ac.uk
	Shelagh Winship	Shelagh Winship	swinship@nhs.net
West	Martyn Hawkins	Fiona McIlveney	fiona.mcilveney@nhs.net
	Willis Peel	Phil Korsah	p.korsah@nhs.net
	Rory Mackenzie	Jim Ruddy	jim.ruddy@lanarkshire.scot.nhs.uk
Trainees	David Griffith	David Griffith	d.griffith@nhs.net
Associate rep	Fiona McIntyre	Fiona McIntyre	fiona.mcintyre@nhs.net
Office bearers			
Treasurer	David Cameron	David Cameron	david.d.cameron@nhslothian.scot.nhs.uk
Hon Sec	Sarah Ramsay	Sarah Ramsay	sarah.ramsay@ggc.scot.nhs.uk
President	Mike Fried	Mike Fried	mike.fried@nhslothian.scot.nhs.uk
Meetings Sec	Charles Wallis	Charles Wallis	charles.wallis@nhslothian.scot.nhs.uk
Past President	Steve Stott		
President Elect		Graham Nimmo	g.nimmo@nhs.net
Ex officio			
Paediatric s	David Rowney	David Rowney	david.rowney@nhslothian.scot.nhs.uk
SCCTG	Tara Quasim	Tim Walsh	timothy.walsh@ed.ac.uk
Interhospital Transport	Mike Fried	Mike Fried	mike.fried@nhslothian.scot.nhs.uk
Website	Richard Appleton	Richard Appleton	rtdappleton@doctors.org.uk
STG	Steve Cole	Steve Cole	stephen.cole@nhs.net
SICSAG	Brian Cook	Brian Cook	brian.cook@nhslothian.scot.nhs.uk
Annual Report	Willis Peel	Rosie Macfadyen	rosie.macfadyen@nhs.net
SCCDG Chair	John Colvin	John Colvin	j.colvin@nhs.net
Education	Martin Hughes	Martin Hughes	martinhughes@aol.com

President's Report

Dr Mike Fried, St John's Hospital

It gives me enormous pleasure to write my first report as the Society's President. Having been associated with the Society for many, many years I realise, with the passage of time, how important continuity is to an organisation such as ours. I would, therefore, like to thank Council for all their hard work. I would like to thank Dr Steve Stott (frae Aberdeen), my predecessor, for handing over an organisation in fine fettle; hopefully I will have the honour of doing the same next January by handing over the reins to Dr Graham Nimmo (frae Edinburgh, though actually frae Bathgate). I would like to extend my sincere and personal thanks to Dr Sarah Ramsay (WIG), Hon Secretary, for being a soul mate and keeping the show on the road. Also a big thanks to Dr David Cameron – yes we have friends in high places! No, not that one – the one from the RIE who is the Hon Treasurer and who is good at keeping a steady hand on the piggy bank and finally bringing the Society into the 21st century by introducing Direct Debits for membership subscriptions (something I failed to do 7 years ago). Finally, a big thank you is extended to Dr Charles Wallis (WGH, Edin) for doing a sterling job as the Society's first Meetings Secretary and organising his first Annual Scientific Meeting in 2013 (see the ASM report below).

One of the central roles of the SICS President is to act as a node for the critical care community in Scotland and to represent this broad constituency consisting of consultants, academic staff, non-consultant career grades, trainees, nursing & Allied Health Professional staff both locally, to the Scottish Government Health Department (SGHD) and more widely at other UK forums. To this end I have visited most of the critical care services in Scotland and received a very warm welcome from all; for this I am thankful. At the time of writing (1.4.2013) I have still to visit the RAH in Paisley, the SGH & VIG in Glasgow and the PRI in Perth.

The SICS President is an ex-officio member of the Faculty of Intensive Care Medicine (FICM) board and the ICS (UK) Council. As a result I have come to know Terminal 5 at Heathrow better than I would have liked to. I have also come to realise in what high esteem the Scottish critical care community is held in by our compatriots in the rest of the UK. I have also come to realise that with all the changes facing the NHS in England and the independence referendum in 2014 in Scotland we are entering a perfect storm in healthcare provision in the UK. It is at time like these that collaboration and communication is pivotal.

As mentioned above the SICS is also active locally – at a Scottish level: collaborating with the Scottish Critical Care Delivery Group very ably chaired by Dr John Colvin (Ninewells) on topics such as manpower planning in ICM including the incorporation of advanced critical care nurse practitioners into the staffing mix. This April will also see the appointment of the first cohort of dual CCT ICM trainees in Scotland. We have also been involved in advising the National Services Division with regard to ECMO provision in Scotland. The Society is also represented on the National Planning Forum major trauma sub-group, which is tasked with the development of this important service provision in Scotland. The prospect of having an integrated national retrieval and transport service for all patient groups (neonates, paediatrics and adults) in Scotland is almost a reality (see Transport Group report below).

So, in summary it is an enormous privilege to be associated with such a vibrant and vital society such as ours. Finally, finally many thanks to Dr Rosie Macfadyen (WGH) for editing this, her first, Annual Report.

Mike Fried
President

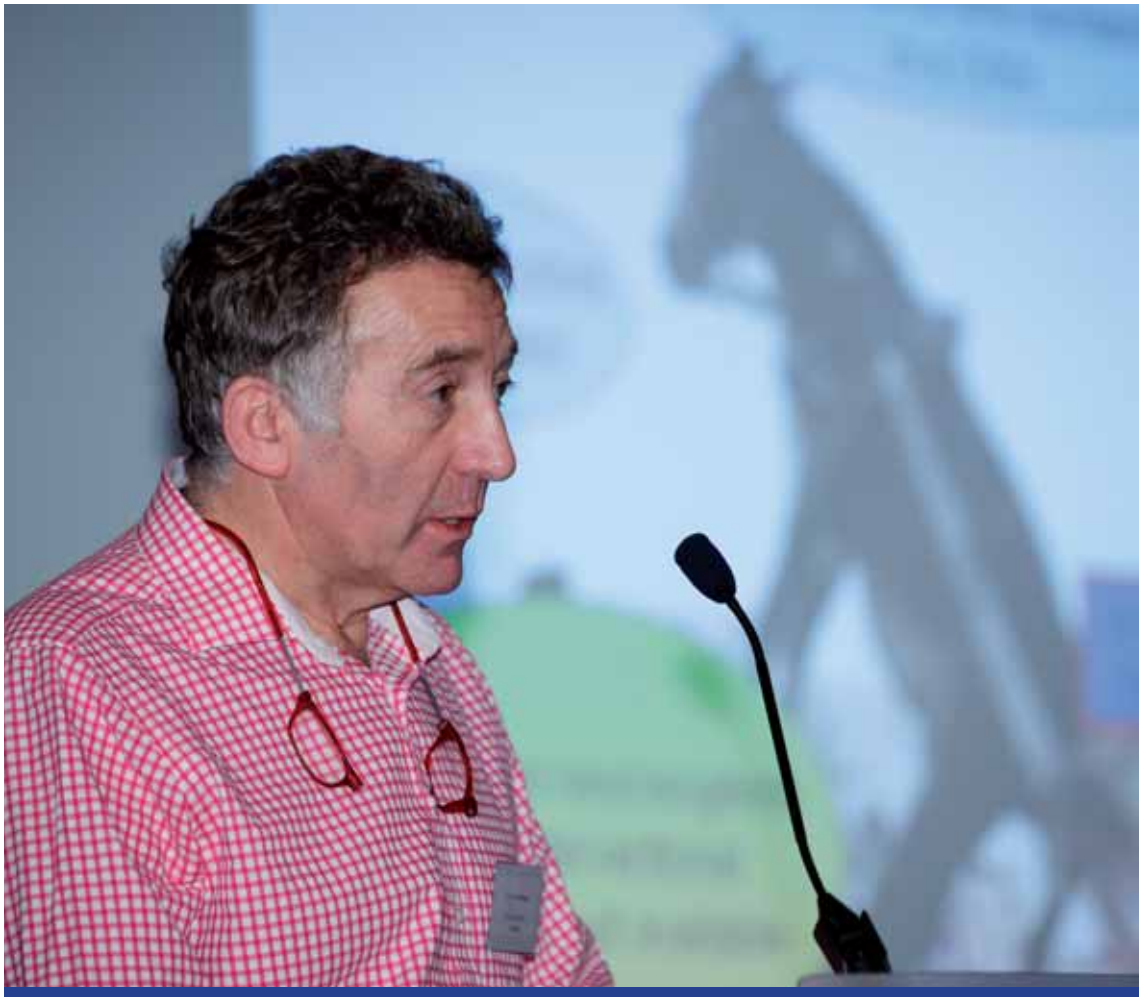
Annual Scientific Meeting 2013

Dr Charles Wallis, Western General Hospital

The society returned once again to the splendid Old Course Hotel in St. Andrews for the 22nd Annual Scientific Meeting, held on the 24th and 25th January.. Despite the severe winter weather some 230 delegates attended the meeting. The first session opened with Prof Julian Bion, the Dean of the Faculty of Intensive Care Medicine talking about the new training scheme for the speciality, a complex and rapidly changing field. Dr Carl Waldmann from Reading then spoke about his impressive follow up service for ICU patients and how they are rehabilitated back to normal life. On the theme of outcome, Dr Naz Lone, a senior ICM trainee from Edinburgh, presented findings from his PhD on the Cost and Consequences of surviving Intensive Care. Much of his work was underpinned by the SICSAG dataset, showing the importance of this audit and how it can be put to good use.

The winners of the SICS travel grants then presented their experiences. Dr Euan Black visited Aarthus (Denmark) to study echocardiography while Dr Katrina Bramley spent some time in a general intensive care unit in Cape Town. Both gave excellent presentations and showed how they had put the societies' money to good use. Over 50 abstracts were accepted by the reviewers. Seven of these were selected for oral presentation and the joint first prize winners were Mr Martin Carberry on an audit of nurse prescribing and Dr Odette Brooks on a bundle to reduce blood culture contamination. The best poster prize was awarded to Noman Shah on an audit of microbiology sampling in pneumonia. Dr Robert Docking and Dr Lauren Brodie were judged in second and third place in the posters.

Carl Waldmann spoke about his approach to sedation with use of some new agents. The eponymous Mike Telfer Lecture was given by Julian Bion on a National Strategy for Intensive Care Medicine. Much of this was about the complexities of workforce planning for the future. After the AGM delegates relaxed before putting on their finery for the annual dinner. For the first time

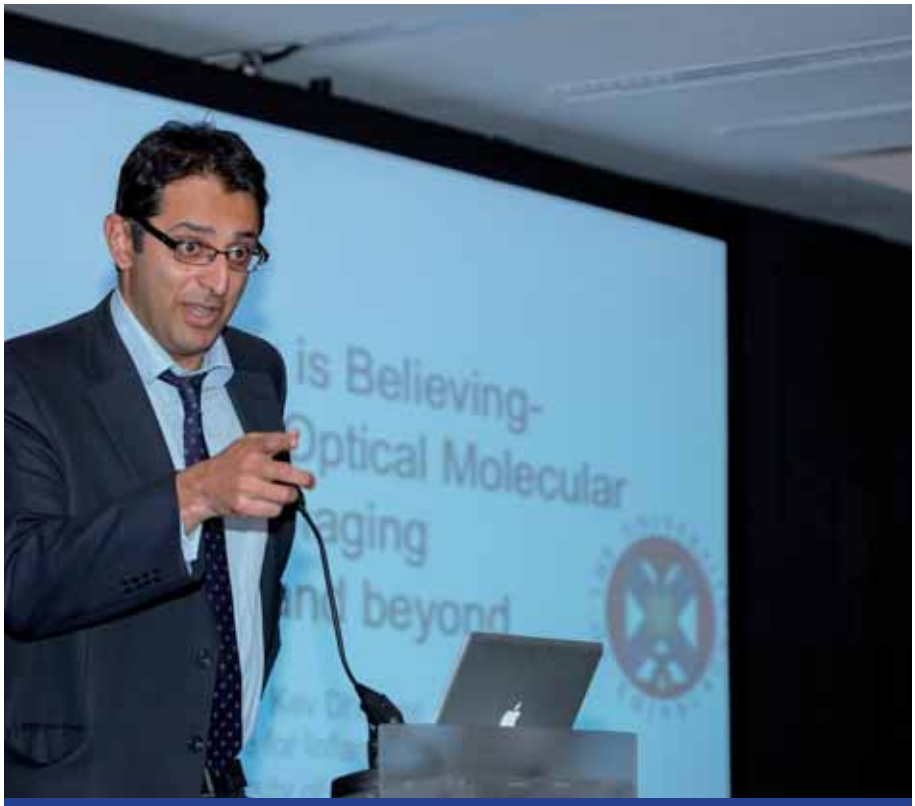


Dr Carl Waldmann

Professor Julian Bion

ever we had a ceilidh, which was a great success with many folk dancing the night away before finishing it off in the bar till the wee small hours.

Hangovers or not, Friday started with a legal theme. Mr David Green, the head procurator fiscal in Scotland gave a fascinating insight into his work and how it links with ours, illustrated by some legal vignettes. There was then a panel discussion and many questions from the audience. Dr Steve Cole, National Lead for Organ Donation then gave us an update on the recent success of the programme, with rising donor numbers.



Dr Kev Dhaliwal

In the regional case presentations Dr Lucy Hogg won the cup for the East region with an unusual case of non falciparum malaria causing ARDS.

Dr Nick Hart who runs an ICU in London for long term weaning told us how he did it his way and then about his research on that tricky problem of ICU acquired weakness. The meeting was rounded of by Dr Kevin Dhaliwal who gave us a fascinating insight into optical imaging of lung inflammation. We then all made our way home through heavy snow and the gathering gloom of a Scottish winter afternoon.

The meeting made a healthy surplus and will be returning to St Andrews on 23rd and 24th January 2014. Book your study leave now! Thanks must go to Julie Fenton for her superb administrative skills in making the meeting run so smoothly.

Charles Wallis
Meetings Secretary

Dr Naz Lone

Scottish Critical Care Delivery Group Report

Dr John Colvin, Ninewells Hospital

Following the recommendations of '***Better Critical Care***' in 2000, each Scottish Health Board established a Critical Care Delivery Group to develop a more strategic approach to regional critical care planning and to contribute to operational management of all levels of critical care. This development reflected an increasing recognition of the wider spectrum of critical care as a continuum and the need to manage all levels of critical care in a co-ordinated fashion.

The Scottish Critical Care Delivery Group, a forum of Regional CCDG Chairs, was set up in 2002 as a focal point for information sharing and pooling of expertise around these key remit areas. This Group also now includes senior medical representation from SGHD, Scottish Intensive Care Society, SICSAG and Paediatric Intensive Care. The Group supports the Scottish Health Directorates and CMO's office in matters relating to critical care service delivery in Scotland.

Long Term Strategic Planning

SCCDG is developing a specific piece of work on strategic long term planning for the provision of Critical Care in Scotland. There is a need to explore the different models of Critical Care already provided in Scotland and to consider the wide range of services supported by ICM, noting that Critical Care underpins the acute hospital in many ways. A national review of Critical Care may also be supported by SGHD National Planning Forum if requested.

Medical Workforce

There are significant risks to Critical Care, particularly Intensive Care, due to medical workforce pressures from the Government's 'Reshaping' process. A major risk is poor central government (ISD) information on consultant contribution to ICM; the gross underreporting of ICM consultants was corrected in the joint SCCDG/SICS submission to 'Reshaping'. Risks of 'Reshaping' are compounded as Intensive Care is reliant on a range of other specialties for middle grade medical workforce and may lose out to competing priorities because of this. Chairs have agreed to monitor and influence the role of Regional Workforce Groups where possible and to ensure awareness at SGHD Workforce. Specific pressures include increased demand, reduced numbers/experience of trainees, competition with other specialties and increasing out of hours requirement for consultants. Skills from ICM are felt to be increasingly demanded by many other specialties when there are gaps in rotas or deficiencies in level of experience of on-call doctors.

SCCDG notes the general trend toward delivery of more front line and out of hours work by Consultants. While supporting the quality aspects associated with this, it was agreed that there is a need to highlight pressures on consultants due to these changes in working patterns and to explore how the consultant post of the future will require a) to be balanced to include this front line work and b) will need to have explicit career progression over time. SCCDG recognises the absolute requirement to support consultants SPA time to maintain the full range of non-clinical activities required to run a safe, viable, quality service and training program.

Medical workforce planning also includes consideration of added value of CT3 in anaesthesia, developing a useful role for FY2 doctors in Critical Care and coordination of non-medical role development.

Other workforce issues

Advanced Critical Care Practitioner development continues to be viewed as part of the future solution in a number of regions. Well established programs in Lanarkshire and Lothian, recently joined by Grampian and West of Scotland are being linked with UK national initiatives to ensure consistent standards, a national training programme and qualification.

Nursing workforce is also under a variable degree of threat across Scottish Health Boards with some regions actively managing nursing numbers downwards either by reducing staffed bed provision or by re-calibrating the nursing workforce models. SCCDG are currently reviewing our 2008 nursing workforce survey

ICM Training

Recent changes to Intensive Care Training will also have significant impact. SCCDG agrees that the primary driver of future training pathways should be to meet the future Critical Care service need in Scotland as defined by SGHD and Boards. It was agreed that decisions on this must be based on a future vision and strategy of how ICM should be provided in Scotland.

It is recognised that replacing consultants who currently work in both anaesthesia and intensive care with single CCT holders in ICM will not be a viable proposition for most ICUs, leading to loss of anaesthesia service, expensive increases in the number of consultant staff or risk of ICU closures.

The SCCDG position is that while the future consultant workforce in Scotland may be provided through either dual or single CCT routes, the dual route has much more utility and relevance for most services in Scotland and indeed can provide supply for all units. As the dual CCT is currently felt to offer a viable option for most ICUs in Scotland, SCCDG should ensure that all relevant parties are made aware that this is the current preferred option from the service.

This has been partially recognised in the National Reshaping Board's recommendations for 2013 intake of 8 dual anaesthesia/ICM posts and 2 other posts to be linked with a partner specialty. The Reshaping Board did not accept our

case for more than 10 posts overall and did not recommend any stand alone posts as there is no current mechanism to identify new salaries for training posts.

Transition requires careful management to maintain a continuing supply of ICM CCT holders year on year. All regions seem to be managing this via a combination of proleptic joint appointments and creating a pro-rata share of new dual ICM/anaesthesia posts from 2013. SCCDG recognise the particular challenge in maintaining supply throughout this long transition period.

Ensuring and strengthening training opportunity in Academic ICM requires further focus; there is no easy mechanism to link training with higher Academic posts at present.

The Group are engaged in dialogue with SGHD, NES Specialty Training Board and others on the training transition issue and wider aspects of workforce. Critical Care medical workforce has again been raised as a risk to service sustainability in the Annual CMO Specialty Advisor report with a request that SMASAC (Scottish Medical and Scientific Advisory Committee) support a working party to review this. The SGHD Workforce Medical Advisor has also been alerted to this risk and is awaiting further detail.

Surge Capacity and Critical Care

The Scottish CCDG has again had input to flu planning with SGHD. The SCCDG role includes providing a network in terms of monitoring activity, sharing clinical experience, contributing to escalation around assurance of capacity and equitable access, and coordinating the flexible ventilator pool. Effects of escalation up to double baseline capacity on reducing elective operating activity and risks of diluting standards are of concern and require to be explicitly acknowledged. Ultimately SCCDG has agreed to contribute at triage level should demand go significantly beyond a level that exceeds escalation capacity though unlike the last winter, early signs are of low activity so far.

The SCCDG continues to provide co-ordination of the flexible shared resource of 43 adult ventilators to support escalation beyond our 'normal' local arrangements. The agreed mechanism to access these ventilators is via your regional CCDG Chair who has the distribution list of the ventilator pool. Contact should then be made directly either with the relevant local CCDG Chair or ICU consultant on-call for the unit where you wish to source the ventilator.

ECMO

The SCCDG position is that ECMO as a recognised intensive care modality should be available to Scottish patients when clinically indicated and to a consistent nationally agreed standard. Recent Scottish bids to the UK Commissioning group to extend ECMO services had all been rejected. The current provider of ECMO to Scottish patients continues to be based in Leicester though Aberdeen continues to provide capacity via the Leicester referral service if required. Following representation from the Aberdeen clinicians, SCCDG has agreed to re-consider whether there is specific support for a Scottish Centre, based on an updated activity analysis currently in preparation.

SCCDG recognise that ECMO is only one aspect of a range of advanced ventilation strategies; noting that this is leading to significant service change in England. SCCDG is considering this in the context of Scottish provision.

Transport

Implementation of the National Planning Forum Strategic Retrieval Services Review was welcomed by SCCDG, noting the continuing disappointment of the Critical Care community at the lack of tangible investment in provision of adult critical care transport services. Concerns on viability of current 'SHOCK Team' arrangements in the West of Scotland require further exploration.

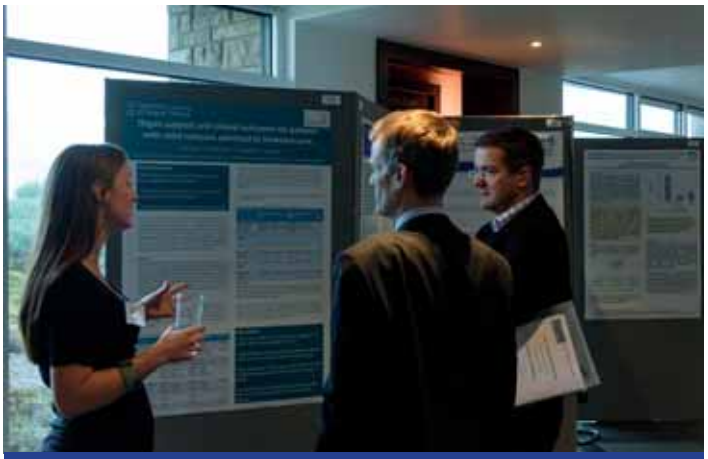
Quality Indicators

SCCDG welcomes and endorses the introduction of the SICS/HIS Quality Indicators for ICM.

The SCCDG continues to support the position agreed between the RCoA Scottish Board and SICS to ensure the specialty in Scotland is well represented within the new Faculty, with the SICS President sitting on the Faculty Board and an RCoA Scottish Board representative (Scottish Lead RA) on the FICM training committee.

My personal thanks to the ongoing enthusiastic support from all CCDG Chairs, particularly our Hon Sec, Dr Catriona Barr. Thanks also to Dr Sara Davies, Senior Medical Officer at SGHD who supports our effective links with CMO and Government Workforce. SCCDG supports and values the work of SICSAG and the wider Patient Safety and Quality initiatives in Scottish Critical Care. The effective network of the SCCDG continues to be recognised and appreciated by SGHD Workforce, Resilience and National Planning teams and allows direct and meaningful input from the specialty into Scottish Health planning and delivery.

John R Colvin
Chair
Scottish Critical Care Delivery Group



Poster Judging

Treasurer's Report

Dr David Cameron, Royal Infirmary of Edinburgh

The current balances operated by the SICS maintain a favourable and stable condition (year end December 2012):

Main Account	**£168074.00**
Education	**£43432.64**
Direct Reserve Account	**£54128.58**

The SICS continues to maintain its charity status following submission of the OSCR (Office of the Scottish Charity Regulator) annual return in conjunction with the Report of the Trustees (31st March 2012).

Copies of the Report of Trustees 2012 were available for members at the AGM and remain available. Should you require a copy please contact myself.

Current forms of trading are exempt from tax liability due to charitable status.

The SICS maintains the services of a professional accountancy firm for preparation of ongoing accounts.

After due diligence professional advice recommended that registration for VAT would not confer any benefit to the Society but this should be reviewed on a regular basis.

The Society continues to have commitments to:

Research:

Engaging with Patients and relatives to understand and Improve the Critical Illness Journey: the EPIC project (£19,525)

Education:

Travel grants awarded	£1,250
Education prizes ASM	£750
Study co-funded	£630

Insurance.

Membership Inter-hospital Transfers

Reviewed covered	£1944.89.

Membership:

The current membership database continues to be administrated by the AAGBI Specialist Societies Division .This relation appears to function well at present and I had the pleasure of meeting the named individuals responsible for the SICS database.

The transition from Standing Order to Direct Debit is now in its 2nd year and appears to have caused minimal disruption.

All new member applications over the past year have been approved with a membership of 473 including 7 honorary members.

Any further information or queries can be addressed to me at

david.d.cameron@luht.scot.nhs.uk

David Cameron
Treasurer, Scottish Intensive Care Society

Honorary Secretary's Report

Dr Sarah Ramsay, Western Infirmary

I would like to start by thanking my predecessor, Roxy Bloomfield, for all her guidance and support in my first year as Honorary Secretary of the SICS. She has been a great help and a hard act to follow. Council meetings have been well attended and fruitful, as witnessed by the contents of this Annual Report.

The SICS database

The Association of Anaesthetists of Great Britain and Ireland Specialist Society Office is currently managing our members' database, including the collection of annual subscriptions by direct debit. It is important that members cancel any pre-existing standing orders themselves with their bank; the Society is not able to do this on members' behalf. For any queries or to notify a change in your personal details you can contact them directly at SICS@aagbi.org; otherwise David Cameron or I would be happy to do this for you.

Inter-hospital Transfer Insurance

The SICS has decided to continue with this insurance policy which covers fatality or serious injury sustained during an inter-hospital transfer. The policy is open to any SICS member of any profession, and is included in our membership fee. Our policy only covers members not also covered by a similar policy provided as a benefit of membership of the AABGI and the ICS. All members are kindly requested to keep the Society informed of any change in their membership of these bodies. Details of the policy cover are available on the SICS website.

Dual membership

SICS membership entitles our members to 'dual' membership of the European Society of Intensive Care Medicine at a much reduced rate (currently €100) with access to the journal Intensive Care Medicine, reduced registration to meetings and other benefits. See the SICS or the ESICM websites for details.

Travel Grant

Last year's travel grant was shared between two trainee members who both presented their experiences at the 2013 ASM. The travel grant will again be offered in 2013. This is available to any established member for travel to experience critical care in a different setting to their norm, with a value of up to £2000. It can be awarded whole or shared between two winners. To ensure a fair and transparent award process a marking scheme has been developed; this and further details of the award are available on the website.

Foundation Years and Nursing/AHP student Prizes

In order to encourage an early awareness of the specialty of critical care the Society is developing an essay competition for the above groups with the winners' prize being paid attendance at the Education Meeting in November. Further details will be on the website soon.

Website

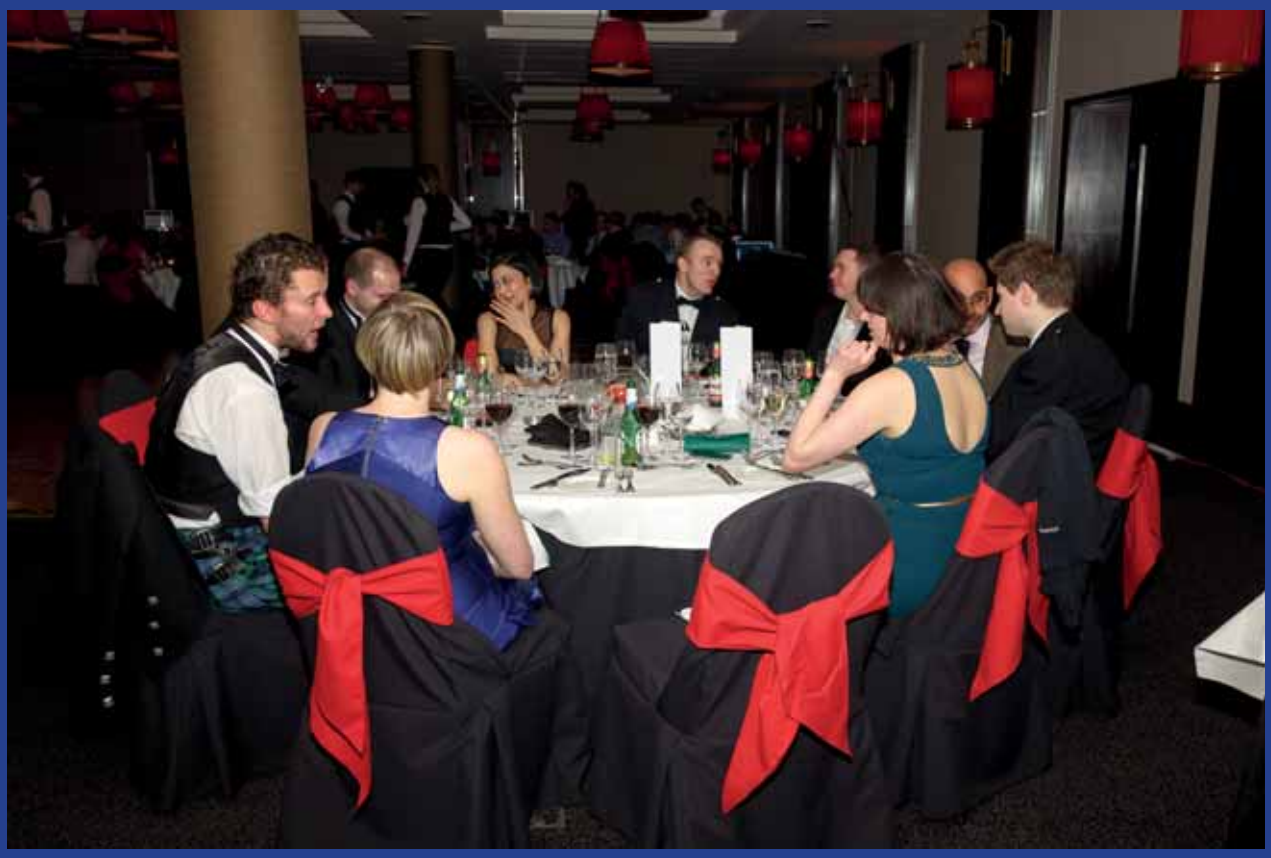
The website is clearly an important link between the Society and its members and indeed the wider ICM community. Richard Appleton and I are currently in the process of redeveloping the SICS website, using a website design company. The brief for the new site includes redesign to update the look, renewal of content, an improved content management system, increased functionality (such as database management, members' secure areas, better education modules, on-line meeting booking, mobile site and social networking). Ongoing maintenance of the site & servers, plus training for future SICS members responsible for the site should allow the site to remain dynamic and useful to members.

Elections

There were a number of elections in the last six months with Graham Nimmo being appointed as President Elect, and Andy Mackay, Fiona McIlveney, Phil Korsah, Jim Ruddy, Liz Wilson, Rosie Macfadyen, and Ian Mellor joining Council as regional representatives, all starting as of the AGM 2013. Malcolm Sim, Shelagh Winship and Nigel Webster were re-elected as regional reps for a second term. The input of regional reps is highly valued at Council meetings, and hopefully the broad nature of topics discussed will provide them with useful information and updates to take back to their regions. Equally they can bring topics to Council from members in their region. All elected rep contacts are given on page three. Many thanks are due to those Council members who demitted office at the AGM. Later in 2013 there will be elections for an East and a GG&C regional rep, plus associate and trainee reps. If you would like any information about any of these positions, or any other matters related to the Society, please feel free to contact me.

Sarah Ramsay
Honorary Secretary
Scottish Intensive Care Society

David Scott, David Green and Jim Rodger, SICS ASM, January 2013



SICS ASM Dinner, January 2013

Scottish Intensive Care Society Audit Group Report

Dr Brian Cook, Royal Infirmary of Edinburgh

SICSAG continues to grow and evolve. In Scotland we have achieved a co-ordinated quality improvement programme for critical care. Audit data on activity and outcomes are linked to healthcare associated infection (HAI) rates and measures of process with our well established care bundles and the Scottish Patient Safety Programme (SPSP). We are seen as an example of what others in the UK are striving to achieve: see "Collaborating for Quality" below.

This has been strengthened by the implementation from 1st January 2012 of Quality Indicators, to make clear expectations of what a quality critical care service should look like.

Updates from 2011:

APACHE II recalibration has been carried out by our analyst Catriona Haddow helped by Naz Lone. This allows a more accurate comparison of units taking into account how outcomes and practice have changed over the many years since the APACHE II model was first introduced. The overall Scottish SMR will be very close to 1.0 as expected with recalibration of diagnosis mortality predictions against recent data. Most units' SMRs should rise accordingly. We will retain the historical co-efficients to allow national and single unit comparisons with themselves, through time.

SPSP Care Bundles: VAP prevention and CVC insertion. These were reviewed with HPS and minor modifications made. They have been distributed to units and published on the SICSAG website.

SICSAG Reports 2012

The SICSAG report and our joint report with Health Protection Scotland (HPS) Surveillance of HAI's in Scottish Intensive Care Units were published in August. Both are available on the SICSAG website. Raw and case mix adjusted mortality continues to fall and HAI incidence is comparable with the best in Europe. In 2013 the report will include quality indicators performance for all units.

Annual Conference September 2012

Thanks to the organisers (Dewi Williams, Jim Ruddy, Charles Wallis with help from Angela, Moranne and Julie) for another successful 2 day meeting in Stirling in collaboration with the SCCTG and EBMG.

A very modest profit has been used to sponsor free places at the SICS ASM January 2013.

"Collaborating for Quality"

The advent of the Faculty of Intensive Care Medicine (FICM) has generated some debate and tension about who is the quality and standard setting body in the UK for critical care. This has previously by default been the Intensive Care Society (ICS).

In an effort to resolve these issues, an independent process of "Collaborating for Quality" has been commissioned under the independent leadership of Professor Sir John Temple and Dr Judith Hulf. I attended a meeting at the RCoA in September representing SICS and SICSAG to describe our structures and functions. FICM, ICS, BACCN, WICS, UKCCTG and others were represented. It is clear we are well ahead on the quality agenda, well organised and well connected both within our specialty in Scotland, and with our government health department through the Scottish Critical Care Delivery Group and via ISD through SICSAG. England are in the early stages of trying to set up HAI surveillance nationally with the Health Protection Agency and Quality Indicators are being debated- the Scottish ones are being looked at with others from ICS and ESICM. They have many similarities.

Mike Fried and I spoke with Sir John and Dr Hulf again in November as a follow up to the joint meeting. Their recommendations should be made in early 2013. We have expressed that we hope to retain strong professional links and representation with the rest of the UK in the face of growing diversity of health services in the devolved nations.

Information Services Division (ISD) Changes

The audit is highly valued by the Scottish Government Health Department and we rated very well on a health and financial impact assessment carried out by ISD in 2012.

We are going through some more personnel changes: Angela Khan is on maternity leave and her role as National Co-ordinator is being temporarily filled by Anita Pritchard, Moranne MacGillivray continues as Quality Assurance Manager. Catriona Haddow our analyst is also moving on. Many thanks to her for major clean ups of the database, linkage and APACHE recalibration work.

Our audit is in very good health. The structure, governance processes and organisation have been in no small part due to the efforts of Diana Beard who left ISD in 2012. Diana was ISD programme manager overseeing SICSAG since 2006. On behalf of all of us in SICS I thank her once again. Her position has been taken over by Stuart Baird.

SICSAG Chair 2013

My second term as chair ends in 2013. I will be in touch to elect a successor in the Spring.

My thanks to all on the Steering Group for your help and support over the years.

A particular thank you to Angela Khan and Steve Cole as vice-chair.

Brian Cook
Chairman
Scottish Intensive Care Society Audit Group

Dr Euan Black and Dr Katrina Bramley, winners of the SICS Travel Grant 2012

Education and Training Group Annual Report

Dr Martin Hughes, Glasgow Royal Infrmary

Education area of SICS Website and core teaching materials:

We have updated the text of nine of the SICS modules – these modules remain unchanged on the website and we are waiting for discussions with the new web designer, once appointed, before completing this process. At that point we plan to proceed with updated modules and enhanced interactivity. I would hope that by the end of the year we would be up and running with a more modern, professional and interactive product.

Intensive Care training and simulation:

The Education and Training Group continues to provide regular courses in the Scottish Clinical Simulation Centre for trainees attached to Intensive Care. These PICT courses (Principles of Intensive Care: Training) utilise the SAINT learning modules and are suitable for FY2, ACCS, ST1, ST2 trainees. We hope to run a two day PICT course 3 times a year for new ICU trainees in Scotland.

Trainee run education meeting:

The trainees' meeting was a great success. Feedback was almost universally positive. In particular, the venue location was well received. This was the first time we had held the meeting in Glasgow, and it would certainly be possible to return in the future. We plan to rotate the venue, but this will depend on availability and costs. The meeting made a moderate profit.

Senior trainee education:

We now have agreement from all regions to allow trainees to attend a course for senior trainees. After feedback, we have made the course 4 full days over a year. The first day was held in Glasgow in March 2013, and was an interesting and educational experience. There were 25 delegates, 8 of whom were in senior ICU training posts. There were some topics aimed toward examination (including practice vivas for those delegates sitting the new exam) and some which dealt with professionalism. Catering and travel expenses were provided from Education and Training group funds. Feedback was positive.

Martin Hughes
Chairman
Education and Training Group

Odette Brooks and Martin Carberry, joint winners of the Research Oral Prize, SICS ASM 2013

Scottish Critical Care Trials Group Report

Dr Tara Quasim, Glasgow Royal Infirmary

Since the last SCCTG meeting, Tim Walsh has been on a sabbatical in Canada and in the interim I have been taking on some of the roles of the chair.

SCCTG Executive Committee:

With help from the SICS regional representatives we have now managed to appoint new executive committee members from each region. Again we have tried to ensure that at least one committee member from each region has been appointed within the last 5 years. The next elections will be in late 2015. We will have discussions at the SCCTG exec committee meeting on the 25th January how we will appoint the next chair.

Research:

Tim has been representing our group at CSO (Chief Scientific Officer) meetings and there is an acknowledgment that critical care is organising itself very well and gaining more recognition as a specialty. All the regions are actively participating in commercial, as well as non commercial, research and great efforts have been made with local R&Ds to support critical care research. This has been particularly apparent with the recruitment and availability of research nurses. This has only been possible by the group working cohesively. We continue to identify suitable ICU portfolio studies and disseminate the information to units as appropriate, for their consideration. Tim as chair of the NIHR has prepared a document on co-enrolment into studies. This has been circulated to the exec committee but if anyone else wants a copy I would be happy to forward it on.

SICS Research Award:

The 2012 SICS Research Award went to Pam Ramsay for the EPIC Project, and Council look forward to receiving regular progress updates on the work.

Dr Nick Hart, SICS ASM January 2013

National Institute for Health Research:

In England and Wales critical care research has had a very successful voice through its specialty group. As it has been working so well, specialty groups are now to be disbanded and rationalised from over 100 groups to 15! This process is currently ongoing, but clearly there is a concern as to where critical care will 'sit' in the future. There does appear to be a natural leaning towards a group encompassing 'acute specialties' and Tim is preparing a document on behalf of the group which has to be submitted by the beginning of February 2013.

Tara Quasim
Interim Chair
Scottish Critical Care Trials Group

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SICS Transport Group Annual Report

Dr Mike Fried, St John's Hospital

The developments in this area beautifully illustrate NHS management's reactive approach. Healthcare planners have been aware of the inter-hospital transport (IHT) 'iceberg' for a number of years but have not responded because it's in the too difficult/ too expensive box. Following the recent difficulties with Glasgow Shock Team's staffing, which revealed the workload and the dependency of a number of the hospitals in Ayrshire/Lanarkshire and Greater Glasgow on the team – a change of heart has ensued: IHT is now 'in scope' in the nascent ScotSTAR (Scottish Specialist Transport & Retrieval) service.

The good news is that ScotSTAR is going ahead. It will eventually amalgamate neonatal, paediatric and adult primary to tertiary transport activity under one roof, which is going to be located at Glasgow airport. This base will be a state of the art facility co-locating fixed, rotary wing air ambulances and land ambulances. It will also accommodate all the clinical teams, pilots and Scottish Ambulance Service personnel. This will lead to a much more responsive and efficient service. It will also offer great opportunities for teaching, training and audit. Back room functions, such as triage and tasking are also being augmented so that we will have senior paramedics, who will provide the first clinical interface, having access to senior clinicians (consultants) to help scrutinise referrals from referring clinicians. This will include teleconferencing facilities for the remote and rural clinicians. The above paramedics will be adjacent to the air service logisticians hopefully resulting in a more appropriate, timely and harmonious service. The reader may find it surprising that to date the system has not had live real time locational awareness of its air assets! This has also been addressed. In due course we are planning to introduce a cohort of transport practitioners who will be able to escort more complex patients than they currently are able to – as is the case in other parts of the world. An associate Medical Director (0.5 WTE) who will be managerially responsible for the service's clinical activity is going to be appointed in the next few months. This position will be within the SAS and will answer to the SAS's medical director.

More recent developments include the introduction of a charity helicopter in Tayside, which will be based at Perth airport and will be operated by Bond Helicopter services. Bond also provides the rotary wing services for the Scottish Air Ambulance Service. The Tayside helicopter will also come under SAAS's triage and tasking system. In due course we may even develop a North of Scotland ScotSTAR base. You never know!

Finally, we are working on developing a more robust system of transporting the highly complex and vulnerable patients on ECMO. Until recently a very informal arrangement involving the EMRS and the Yorkhill team existed for the transportation of ECMO patients. This has stretched the EMRS team since only 25% of their consultants are anaesthetist/intensivists and the remainder are EM physicians who feel unable to manage this very 'delicate' cohort of patients. The Leicester service is becoming progressively more precarious. For all those reasons the Scottish Government Health Department is becoming more interested in developing a funded ECMO provision in Scotland and the transport of these patients will be linked to this service.

Mike Fried
Clinical adviser to ScotSTAR

Scottish Transplant Group Report

Dr Steve Cole, Ninewells Hospital

In January 2008 the Organ Donation Task Force published the report "***Organs for Transplant***". This report listed 14 recommendations which if implemented in full would (they hoped) lead to a 50% increase in deceased organ donation over a 5 year period.

It is very pleasing to report that thanks in the main to the enthusiasm, hard work and engagement by the critical care community in Scotland that this 50% increase was achieved ahead of schedule in 2012. To date no other part of the UK has achieved this although most are close.

Much of this increase is the result of 3 specific developments.

1. The recognition and referral of patients from ICU and Emergency Medicine for consideration of donation after circulatory death. NICE Guidelines have been published in 2011 which support this process. The Chief Medical Officer has also released a letter in 2012 which helpfully seeks to clarify who may be referred.
2. The gold standard of deceased organ donation is the patient who has been brain stem tested and met the criteria for the diagnosis of brain stem death. Scotland is unique in the countries of the UK in that the numbers of patients diagnosed BSD year on year has remained constant. Other regions of the UK have seen a decline.
3. The increased referral and acceptance of patients from Emergency Medicine who are on the organ donor register but in whom life sustaining treatment is felt to be futile by the referring team. Such patients would previously have died in the EM department and are now considered for ICU admission purely to allow time to explore donation potential.

Deceased Organ Donation remains a very high priority for the Scottish Government Health Department. Further measures are being looked at to build on and reinforce the successes of the last 5 years. Nationally a vision of the next steps in organ donation up until 2020 is being finalised by the Program Delivery Board of the UK DOH and NHS BT.

With Scotland a pilot programme of Maastricht Category 2 Donation after Circulatory Death is being finalised in the Emergency Medicine department of the Royal Infirmary of Edinburgh. These are patients who are currently pronounced "dead on arrival" to hospital and there is no critical care involvement in the management of these patients. The expected start date for this is February 2013. The numbers will be very small, approximately 2-3 patients per year but the development of such a programme does raise a number of ethical and legal issues.

In November 2012, the Academy of Medical Royal Colleges Donation Ethics Committee started to look at the ethical rationale for interventions such as the use of heparin and management of the potential organ donor at the end of life. The specific ethical

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issues around extubation are being carefully looked at. A one day meeting on 1st March 2013 is being finalised and Council will be represented.

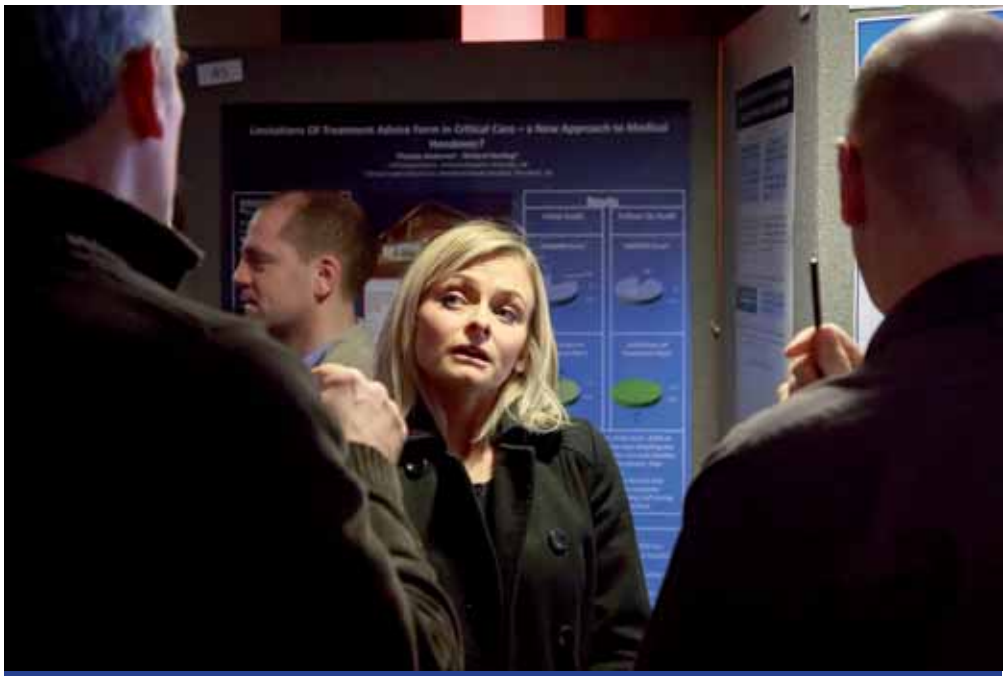
The Potential Donor Audit (PDA) which is carried out on a monthly basis in all Intensive Care Units and EM departments within Scotland has been a cause of ongoing disquiet and concern. On the back of these concerns a detailed review of the PDA has now been completed, It seeks to address some of the concerns which have been raised within the Critical Care community. It is disappointing to note that the full implementation of this review has been de-prioritised and delayed until at least April 2014. Council have expressed our frustration and disquiet at these developments which were unilaterally taken by NHSBT without any consultation with the devolved administrations or any other stakeholders. Until these flaws in the PDA are addressed any figures produced at board level in terms of missed donors or comparative performances are simply not credible. The numbers of donors and the numbers of organs retrieved are robust, hard data but all else is suspect. This is in marked contrast to the confidence of the SICSAG dataset in the Scottish critical care community.

A successful one day meeting was held in May 2012 in Edinburgh entitled 'Further Measures: Challenges around a Category 2 DCD Pilot'. The meeting sought opinion from Emergency Medicine, Intensivists, Transplant Surgeons, Fiscals and Board Chief Executives about the feasibility of a DCD Category 2 pilot in Edinburgh of deceased organ donation from Emergency Medicine of those patients who are currently pronounced dead on arrival to hospital. See above. This does not currently happen in Scotland and is in my view not going to impact on critical care. It is however, an important factor in the success of the Spanish deceased organ donation programme. This group are patients are pronounced dead on arrival in the Emergency Medicine Department. Aggressive cannulation, cooling and infusion of cardioplegia solution is carried out by EM staff with a view to rapid organ retrieval. This is really only a practical proposition in centres which have a dedicated Transplant Unit immediately available on site such as the Royal Infirmary Edinburgh. A pilot project for this is planned to start in the near future.

A Scotland wide organ donation collaborative has been formed bringing together medical and nursing staff from critical care, emergency medicine and NHSBT and has now met on five occasions. Dr Cole has been appointed through a competitive interview process as the clinical lead for this National Programme.

Finally, revised guidance for the police and procurator fiscal service has been published to update them on recent legal developments and to build on the increasingly supportive stance that has been seen in 2011. A one day meeting was held at Tullyallen Police College for police, fiscals and forensic pathologists. The number of cases in which the fiscal refuses to permit deceased organ donation has fallen to a low level in 2012.

Stephen Cole
Chair
Scottish Transplant Group



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Scottish Paediatric Intensive Care Service Annual Report

Dr David Rowney, Royal Hospital for Sick Children, Edinburgh

It is my pleasure to provide the first report on the Scottish Paediatric Intensive Care Service to SICS. I would like to thank President, Dr Mike Fried for strengthening the links between Adult and Paediatric Intensive Care (PIC) in Scotland. I took up the new position of ex officio SICS council member representing PIC in January 2012 and will hand over to Neil Spenceley, Glasgow PICU, in January 2014. The position will alternate every two years between the two PICUs.

Paediatric Intensive Care

The following is taken from the recently published 2012 PICANet (UK and Ireland Paediatric Intensive Care Audit Network) National Report for Scotland, covering January 2009 to December 2011 (www.picanet.org.uk).

The prevalence of PIC admissions has remained steady at around 1.5 per 1000 Scottish children, with a median age of less than 2 years and median length of PIC stay ranging from less than 1 day for older children to 4 days for infants under 1 year, giving a total of almost 24,000 bed days over the 3 years. Predictable spikes in activity during the winter months of infants under 1 year of age with respiratory illness continue to stretch available PIC resource to the limit, threatening elective surgical workload including the national major surgery programmes; Cardiac (Glasgow) and Scoliosis (Edinburgh). The delivery of Critical Care (Intensive and High Dependency) to Scotland's one million children is uniquely challenging. The children reside in a wide variety of situations from inner-city and urban (central belt including Glasgow and Edinburgh) to extreme remote and rural locations (Highlands and Islands) many hours journey from the nearest PIC facility. The PICUs in Edinburgh and Glasgow are commissioned as a single national service. Currently four Health Boards have Paediatric High Dependency Units, two linked to the PICUs in Glasgow and Edinburgh, the other two in Aberdeen and Dundee.

It is testament to the skill and commitment of all staff involved in the delivery of PIC to Scottish children that the crude mortality is very low and falling (overall 2.3%, falling from 2.9% in 2009 to 1.8% in 2011). The unadjusted and adjusted SMRs for the Scottish units are comfortably within the acceptable limits of the funnel plots for this time period.

Paediatric Intensive Care Transport:

The nationally commissioned PIC Retrieval Service, which operates out of both PICUs in Glasgow and Edinburgh, is undergoing a process of harmonisation with Neonatal and Adult specialist transport services and the Scottish Ambulance Service to form ScotSTAR. The vision is that ScotSTAR will evolve into a single specialist transport service which can respond and adapt to the varied and changing demands faced in Scotland. It will provide high-quality clinical decision support through video-conferencing and a rapid dispatch of an appropriately skilled team in the optimal mode of transport (road, rotary, fixed-wing) for each leg of the journey, stabilising and delivering the patient to the most appropriate intensive care unit.

PICANet has recently launched the transport and referral dataset, integrated into the new web-based data entry system which will prove invaluable in the development of the paediatric component of ScotSTAR. These data will ensure we continue to provide the highest quality of transport service to children during the tricky harmonisation process.

Scottish Paediatric Critical Care Network:

A national initiative in Scotland is underway to deliver high-dependency care, closer to home, through a national network. This network must have PIC at its core, for clinical support and education, and be supported by ScotSTAR to facilitate safe patient movement. This type of model will likely evolve over time throughout the UK. Robust clinical audit to improve patient outcomes by providing information on delivery of care and an evidence base for clinical governance will be essential for the success of this initiative.

David Rowney
Scottish Paediatric Intensive Care and Retrieval Services

SICS Trainee Committee Annual Report

Dr David Griffith, Royal Infirmary of Edinburgh

Current members of Trainee Committee:

David Griffith (Chair) **Bob Docking** (Secretary) **Euan Black** (Audit) **Laura Strachan** (Education)

This year has been productive for the trainees group with a successful and well organised audit project, an interesting and well run education meeting, and significant progress made with contacting ICU interested parties across all feeding specialties.

In addition, we have recruited some motivated trainee linkmen who have been pivotal in organising data collectors for the national audit, spreading information about the education meeting, and helping with the running of the education meeting on the day.

I would like to formally thank Bob, Euan and Laura for their hard work and enthusiasm over the past 12 months. I look forward to a second year working with them. In addition, I would like to thank the newly appointed Linkmen – John Allan, Yvonne Bramma, Alistair Gibson, Pauline Austin, and Andy Clarkin for their significant contributions and hope that most will be able to continue for the next year.

Membership / Communication

From a secretarial point of view, contact with all the Anaesthetic secretaries has been relatively smooth for spreading news of events. Sterling work by the various linkmen has opened up channels of communication to non-Anaesthetic/Critical Care groups although attendance at events has been mainly traditional groups.

The Facebook page continues to be a useful format for sharing news, with 47 confirmed members and several people using it to advertise upcoming meetings as well as ongoing educational events.

Audit

The audit group has successfully completed its audit on renal replacement therapy in Scottish ICUs this year. Data on 156 24-hour renal replacement therapy sessions in 56 patients were collected. The results of this audit have been submitted in abstract form to the International Symposium in Intensive Care and Emergency Medicine in Brussels (March), and the British Renal Society Annual Meeting in May.

In addition, the SICS trainees group assisted in the data collection for a second national audit on platelet use in Scottish ICUs. Data collection has been completed and Dr Mike MacMahon will submit a report to the trainees committee in early February. The role of the SICS trainees group in this project will be acknowledged in future dissemination.

Education

The education meeting was both profitable and well received according to feedback and generally regarded as good (24%) or excellent (76%). Particular highlights amongst delegates were a session on liver disease in ICU by Drs Lindsay Donaldson and Ewan Forrest, a session on HIV by Dr Alisdair MacConnachie, a session on the comatose patient by Dr Martin Hughes, and a light hearted Pro/Con debate on Clinical Guidelines by Prof John Kinsella and Dr Paul McConnell.

David Griffith
Chairman
Scottish Intensive Care Society Trainee Committee

Dr Lucy Hogg, SICS ASM January 2013

Associate Member Annual Report

Fiona B McIntyre, Ninewells Hospital

Following my election in January 2012, information on the existence of and key personnel linked with any associate professional critical care interest groups within Scotland was gathered. In the summer, letters detailing the benefits of SICS membership and encouraging communication of relevant issues, were sent out to the following groups:

- Scottish Adult Critical Care Pharmacists Network
- SICS Nutrition Group
- Critical Care Physiotherapists Network in Scotland
- Scottish Critical Care Interdisciplinary Research and Liaison group, Scotland
- Acute Care Advanced Practice (ACAP) Scotland
- BACCN Scotland
- GGC Complex Nutrition Support Dietitians Group

Associate membership has increased from 53 in May 2012 to the present level of 67.

In September, following presentation at the Scottish Adult Critical Care Pharmacists Network, the risks associated with non-standard concentrations of drugs in Scottish ICUs were discussed at SICS Council. It was decided to work alongside the SICSAG audit leads network to try to encourage work to be undertaken in individual units.

Plans for 2013 include work to improve the channels of communication with the associate membership and develop opportunities for allied health professionals within the spectrum of awards available through SICS.

Fiona B McIntyre
Associate Member Representative

Ceilidh, SICS ASM January 2013

SCOTTISH INTENSIVE CARE SOCIETY

www.scottishintensivecare.org.uk