scottish intensive care society

Annual Report - 2012

EDITORIAL

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

I hope that you enjoy reading the report.

The Society continues to grow its meetings becoming ever more popular. By popular demand the Winter Scientific Meeting returned to the Old course Hotel, St. Andrews, for its 21st meeting. For the last three years this has proved to be a very popular choice of venue. The Audit, Trial and EBM groups held another successful joint two day meeting in September, a format that will be used again next year.

Much of what you will read in the following pages reflects the growing influence that the Scottish Intensive Care Society has on day to day activity within Scottish Critical Care Units

I would like to thank the members of the Society and Council that have helped with this report and hope you find it suitably informative

Willis Peel

Contents

President's Report 6

Report on Scottish Intensive Care Society Meeting 2012 8

Scottish Critical Care Delivery Group 10

Treasurers Report for 2011-2012 14

Honorary Secretary's Report 15

SICSAG 18

SICS Education and Training Group 19

Scottish Critical Care Trials Group 21

SICS EBM Group 25

Scottish Transplant Group 27

SICS Trainees Group 30

Current Office Bearers 32

President's Report

Our 21st annual scientific meeting is over and nearly all survived another excellent educational and thoroughly convivial occasion. The organisers are once again to be congratulated for gathering a formidable and thought provoking speaker line up. This was confirmed by the on going discussions late in to the night!

The Society moves into 2012 in an ever stronger position. There has been a tremendous amount of hard work behind the scenes to future proof as much as possible the workings. This includes moving to a direct debit system for collection of subscriptions (if you have not already changed over I urge you to by contacting the treasurer) which allows us to collect subscriptions more efficiently. We have asked the Association of Anaesthetists to take over the contact address of the Society and they will also handle some of the administrative duties. We have updated the constitution which was ratified at the Annual General meeting ironing out some areas of contention. The election process for Office bearers for both council and the trainees group is robust and transparent. We have also created a new office bearer post, meetings secretary. These changes will not only allow the Society to continue to move forward but will also mean that the work load for the office bearers is not excessive; an increasingly important factor for those who ware thinking of becoming involved. If you are interested I urge you to try!

My thanks especially for their hard work to both Rory and Roxanne.

2012 will be a very interesting year in intensive care as the first recruitment to a single CCT programme takes place in February. As I write this there are currently none of these posts in Scotland. The take up here of stand alone posts is uncertain and we will wait to see how recruitment goes south of the border.
Most importantly a representative of the Society is on the board of the newly formed Faculty of Intensive care and the Lead Scottish Regional advisor sits on the training and education committee so Scottish opinion is well represented.

Under the stewardship of Brain Cook we have produced a set of quality indicators for Scottish critical care. The driving force for this was requests from the NHS QIS Data Advisory Group. These will be of real use to use to improve the service we provide and should help to manage to win arguments for resource as well.

As can be seen from the sub group reports the Society is busy in all aspects of critical care and I would like to thank the chairs and their members for all their hard work over the last year. I would like to give a special mention to Chris Cairns who has run the evidence based medicine group virtually single handed. The work load is considerable and so if their are any folk who wish to get involved please contact Chris.

This is my past report as President and I hand over to Mike Fried from Livingston. The Society is in good hands and I wish him well.

My thanks to all the council members whose support and hard work have kept the society moving forward.

Steve Stott
President,
Scottish Intensive Care Society

Annual Scientific Meeting

The Old Course Hotel, St Andrews 19th – 20th January 2012

The Society returned to the Old Course Hotel St. Andrews for the third time for this the 21st Annual Scientific meeting. Yet again we were able to fill the hotel, a testimony to popularity of the event. The audience were entertained by an array speakers from throughout the UK, Belgium and Ireland.

The first session of the morning was chaired by Dr Stephen Stott. The first two talks were from Professor Jean –Louis Vincent and Prof Mervyn Singer gave interesting talks on sepsis and its management. The session was concluded by a further talk from Prof Vincent who gave a thought provoking talk on evidence based Intensive care, out lining some truths and myths.

After another excellent lunch delegates were given the chance to visit the trade stands and posters. Trade support for the meeting was excellent with a mixture of interesting and new products and well worth visits.

Lunch was followed by two sessions. The first chaired by Dr David Cameron, allowed winners of the travel grant prize and best poster from the 20th scientific meeting to present. The second session was chaired by Dr Michael Fried and contained talks from Dr Andrew McIntyre from Yorkhill Hospital on the resuscitation of the critically ill child. The final presentation of the Day was the Mike Telfer Lecture, given by Prof Mervyn Singer, "Jump hard and sit on your hands".

The AGM followed for some, the bar followed for others. Some managed both! The days entertainment was concluded by the SICS Annual Dinner – Burns Supper. A truly fantastic time was had by all. Some probably more than others! The Old Course Hotel staff worked long into the night to keep us going. I am told that for some the night concluded at around 3 am.

After a hearty breakfast day two stared with a clinical update session chaired by Prof Tim Walsh. The first talk was given by Dr Mark Petrie from the Regional Heart Centre. Dr Petrie discussed the management of patients with severe heart failure and covered the use of left ventricular assist devices and heart transplantation. The second talk was given by Prof David Newby from Edinburgh and covered the diagnosis and management of acute coronary syndrome. The final talk of the session was given by three speakers, Dr Graham Nimmo, Jane McNulty and Audrey Jackson and discussed advanced critical care practitioners and the challenges associated with their role development. After coffee the last session of the morning was chaired by Dr Sarah Ramsey. Prof John Laffey from Galway spoke on gene and stem cell therapies for ALI and ARDS. This was followed by the eagerly awaited cases from the regions, which this year was won by Dr Rosie McFadden.

The final session of the meeting, after lunch was chaired by Dr Louie Plenderleith. Talks were given by Prof Laffey discussing the effects of hypercapnia on mechanisms of injury and repair on ARDS and Dr Martyn Hughes, on ventilatory strategies in patients with difficult lungs.

All agreed that this had been an extremely successful meeting. Thanks must go to all who organized it and to the Old Course Hotel, the speakers and the delegates without which the meeting would have been impossible. We will return in 2013.

SCCDG REPORT

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.

Key remits for regional CCDG's include managing HDU and ICU capacity, undertaking assessment of level 2 & 3 need, coordination of winter planning, establishing critical care service strategies and development of 'outreach' processes, escalation policies and other aspects of flexible working to most efficiently manage varying and unpredictable demand.

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 and SICSAG. This has enhanced our ability as an 'umbrella' organisation, to relate to the Scottish Health Directorates and CMO's office in matters relating to critical care service delivery in Scotland.

The SCCDG continues to be engaged with a range of activities including:

There are significant risks to Critical Care, particularly Intensive Care, due to medical workforce pressures from the Government's 'Reshaping' process. These risks 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 ware gaps in rotas or deficiencies in level of experience of on-call doctors.

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 small ICU's, leading to loss of anaesthesia service, expensive increases in the number of consultant staff or risk of ICU closures.

The value of a second specialty in balancing job plans and ultimately as a potential 'escape route' from ICM because of the high impact nature of the specialty and the need to manage career progression and job plans in ICM to avoid burn out is worthy of further debate. Results from trainee questionnaires suggest that very few anaesthesia trainees would take up a singe accreditation in ICM and most would prefer a dual route, taking 81/2 years including core training.

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 CCST 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.

Transition requires careful management to maintain a continuing supply of ICM CCT holders. Given the proposals to change from a 'joint' CCT to either a single CCT in ICM or a 'dual' CCT in a parent specialty and ICM from 2012, with no further appointments to current style joint programs from 31st July 2013, SCCDG recognise the particular challenge in maintaining supply through out this long transition period. The NES Specialty Training Board are currently deciding how these changes will be implemented in Scotland, including how many posts are required for single and dual training and where the posts will arise from. They have not recommended any specific posts for the 2012 intake, though appointees to anaesthesia and other specialties will have the option of taking up dual ICM training within 18 months of appointment.

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.

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

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.

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 been raised as a risk to service sustainability in the Annual CMO Specialty Advisor report with a request that SMASAC support a working party to review this. The SGHD Workforce Medical Advisor has also been alerted to this risk and is awaiting further detail.

The Group agreed to lead a specific piece of work on scoping strategic long term planning for the provision of Critical Care in Scotland. There was 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.

HDU Needs Assessment.
Dr Sandy Binning produced a comprehensive review of current HDU provision in Scotland with input from all Chairs. This report, the main finding of which was that there were still inadequate medical HDU beds in Scotland has now been acknowledged by the CMO advisory group and SMASAC and will be used as part of the future Critical Care strategy development.

Flu planning 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.

Transport
While welcoming the principles of National Planning Forum Strategic Retrieval Services Review, the SCCDG is extremely disappointed in this reorganisation as it appears to offer no tangible improvement to provision of adult critical care transport services.

Scottish representation on Faculty of Intensive Care Medicine.
The SCCDG welcomes 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 who has become an expert at taking the minutes over the video link from Shetland. Thanks also to Dr Jennifer Armstong, Senior Medical Officer at SGHD who has supported 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, SCCDG

Treasurer and Membership Secretary Report

The Societies finances remain in a healthy position.

OSCR annual return (including the Report of the Trustees to 31st March 2011) was submitted along with prepared accounts for year ending 31st March 2011. Copies of this are available. If you require a copy please contact myself and I can forward.

Main trading activity remains the ASM. The 2011 ASM showed an overall gain of approximately £11,500.

Two Travel grants (2) totalling £2000 were awarded for the year ending March 2011and one.

Research grant award of £18502 was made to Prof John Kinsella.

Membership services are now administered by AAGBI Specialist Societies Division. Existing members and new members should now be paying by Direct Debit (DD) with the 1st payment due on 1st February 2012 and annually thereafter. Existing Standing Orders should be cancelled by individuals as the Society does not have the authority to do this. Failure to do this will result in ongoing double payment. Despite extensive efforts to 'clean up' the existing database prior to transfer to the administration of AAGBI, a small number of unidentifiable/uncontactable individuals continue to pay subscriptions. If you have not received a SICS membership number then you are not known to the society. If you are unfortunate to belong to this small group please contact your local representative or myself to rectify.

Membership continues to grow.
The current AAGBI database indicates a total of 449 members:

- 388 full members
- 54 associate members
- 7 honorary members

At present only 178 DD mandates have been completed. The move to DD will greatly improve the ability of the society to manage subscriptions so I would implore those members that have not completed a DD mandate to please do so.

Rory MacKenzie
Treasurer SICS
Rory.MacKenzie@lanarkshire.scot.nhs.uk

Honorary Secretary's Annual Report

A busy year all told for the SICS and Council - increasing membership, interhospital transfer personal insurance and many other changes to describe.

Annual Scientific Meeting

Firstly I must thank Kathleen Middleton and Julie Fenton for their help with the administration for the Annual Scientific Meeting which has been held at St Andrews from 2010 to 2012. Also grateful thanks to Sam Moultrie and her merry crew for putting together a superb programme for our 21st ASM. There is no way I can accept any credit for the success of the ASM without recognising the amount of work put in and dedication these individuals have shown – it has been a privilege to be part of this team. Kathleen is set to finally enjoy her retirement which she thought she had started when I asked her to assist me in helping with the ASM so I wish her well in that! I also wish my successor Charles Wallis all the best in taking over the task of organising the ASM as Meetings Secretary. This office bearer post has been created at the Annual General Meeting in 2012, allowing the Hon Sec to concentrate on core duties.

Database Management

The administration of the SICS database has now fully passed to the Association of Anaesthetists of Great Britain and Ireland at Portland Place. Everyone is issued with a membership number which we ask you to quote when making contact with the Society and will allow you to register for meetings at reduced rates. We are still unfortunately awaiting the majority of members to complete their direct debit mandates despite emailing and postal mailing, therefore we anticipate a period of time where standing orders and direct debit collection of subscriptions will coexist. Please ensure you respond to the AAGBI in completing the direct debit mandate and keep your details up to date please. Busola Adesanya-Yusuf is the manager and contact for the Specialist Societies Division of the AAGBI and the email address for enquiries regarding membership, member numbers and direct debits is:

SICS@aagbi.org

Dual Membership

Dual membership of the European Society of Intensive Care Medicine is available at a much reduced rate with access to the journal Intensive Care Medicine, reduced registration to meetings and other benefits. See the SICS website for details.

Interhospital Transfer Insurance

The SICS now covers 136 members not already covered by the ICS(UK) and AAGBI for fatality or serious injury sustained during an interhospital transfer – for no extra charge to the subscription. The cover is identical to that offered by the ICS(UK) and AAGBI – i.e. the same company underwrites it – and is more generous than some local schemes. Further details are available on the website. It is therefore imperative to keep the SICS informed of your status with these societies so we can cover you adequately. This is open to any member of any profession in the SICS. Notably, nursing staff can find themselves not well covered by local arrangements.

Elections
Regional elections – No candidates stood against Charles Wallis and Martin Hughes for the East and GGC elections respectively, therefore they both proceed to their second term unopposed. There are no other changes in the elected representative line-up for 2012. A table of reps and email addresses is at the end of this report. Many members of Council are due to step down in early 2013 so nominations for Council will be sought around the autumn of 2012.

Associate elections – Fiona McIntyre was elected to this position after Alan Timmins decided to step down after one term on Council. Fiona is Principal Pharmacist at Ninewells hospital, Dundee.

Trainees' Group elections – David Griffith is set to succeed to the chair of the Group, with Robert Docking as secretary, Euan Black as audit lead and Laura Strachan as education liaison/meeting rep.

Representatives are now more 'visible' in that their contact details are emailed to you directly. Any items you wish to be brought up at Council meetings can go via one of your regional reps or the Honorary Secretary. They, in turn, are given data on the members in their region to assist in links with units and membership recruitment.

Council Office Bearers and Revised Constitutions
Sarah Ramsay was elected by Council to the post of Honorary Secretary in the autumn of 2011 commencing January 2012 and I wish her every success in this. David Cameron has been elected to be Honorary Treasurer and Membership Secretary, taking over from Rory MacKenzie during 2012. With ratification at the AGM as mentioned above we have not only created the Meetings Secretary post but also have ensured that Sarah will be in post for an extra year to stagger the changeover date of office bearers who currently all move on together. Her email contact is below.

The revisions to the SICS and Trainees' Group constitutions were supported by the membership both by email and by direct vote at the AGM. The revisions mainly centred around formalising elections processes and clarification of some of the structure of the SICS. Some lively debate was had at the AGM and clarification of several points occurred. Copies of the revised constitutions are to be found in this Annual Report.

Travel Grant
Open to all established members of the SICS for travel to experience critical care outwith their own ICU. £2000 can be claimed by one or shared. Submissions to the Hon Sec before the Spring Council meeting please. Details on the website.

Finally, I would personally like to thank all those who have supported and assisted me during my tenure as Hon Sec. There have been ups and downs but overall it has been a pleasure to serve the Society and its members.

Table of Elected Representatives

Region			
GGC	Martin Hughes martinhughes@aol.com GRI	Malcolm Sim Malcolm.Sim@ggc.scot.nhs.uk WIG	Sarah Ramsey Sarah@sarahramsey.com WIG
East	Sam Moultrie sam.moultrie@nhslothian.scot.nhs.uk St John's	Charles Wallis cwallis@doctors.org.uk WGH	David Cameron David.d.cameron@luht.scot.nhs.uk RIE
West	Rory MacKenzie rory.mackenzie@lanarkshire.scot.nhs.uk Monklands DGH	Willis Peel willis.peel@nhs.net Dumfries & Galloway RI	Martyn Hawkins mhawkins2@nhs.net FVRH
North	Shelagh Winship swinship@nhs.net PRI	John Colvin j.colvin@nhs.net Ninewells	Nigel Webster n.r.webster@abdn.ac.uk ARI
Associate	Fiona McIntyre fiona.mcintyre@nhs.net Ninewells		
Trainees' Group	David Griffith dmgrifith@gmail.com ERI		

Honorary Secretary details now:

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Dr Roxanna Bloomfield
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(r.bloomfield@nhs.net)

January 2012

SICSAG

SICSAG continued to grow and flourish in 2011. We were joined by 6 more HDU's and 2 cardiothoracic ICU's from Royal Infirmary, Edinburgh and The Golden Jubilee Hospital, Clydebank.
We had a number of changes in personnel over the year again. We were pleased to welcome back Catriona Haddow our statistician and Angela Kellacher (National Co-ordinator) from maternity leave.
Hazel Mackay and Moranne Macgillivray have done sterling jobs standing in over 2010/11.

2011 Reports
The SICSAG annual report was published later than usual in August due to pressure on personnel changes above.
This was accompanied by a joint report with Health Protection Scotland (HPS) of National Surveillance of Healthcare Associated Infections (HAI) in ICU. All ICU's contributed data to this and it represents a significant achievement. We take some reassurance that our HAI rates compare very favourably with Europe where the same methodology has been used. This dual report is planned to continue annually.
CUSUM charts gave advanced warning to two units in 2010/11 and one subsequently was highlighted as "might be different" on 2010 SMR. A full response has been received from their health board to SICSAG and the Scottish Government Health Department.
The report again highlighted the significant difficulty many units have with downstream beds and delayed discharges.

2011 Conference September
This was held in collaboration with the SICS Trials Group and Evidence Based Medicine Group in Stirling. It was again a successful venture with good feedback from those attending. This is now the third year in this format and has become an expected regular fixture of the Scottish critical care calendar. Our continued collaboration with ICNARC made it clear that work needs to be done over the coming months to recalibrate APACHE II for Scottish patients.

Quality Indicators for Critical Care in Scotland
A multidisciplinary group representing nearly all Scottish Health Boards met in 2011 to discuss and agree a set of quality indicators for Scottish Critical Care. These have been endorsed by the Scottish critical care community and Health Improvement Scotland following a consultation period over summer 2011. They will be implemented in 2012 with reporting starting in 2013.

Dr Brian Cook
Chairman, SICSAG
19th January 2012

Scottish Intensive Care Society Education and Training Group

The group continues to expand its activities. This report provides an update on what we have achieved this year.

The Education area of SICS Website and core teaching materials

SICS Induction Module Programme 2011
The induction module programme has continued to grow over the last 24 months. Four new modules (poisoning, acute kidney injury, sepsis and delirium) have been added with a current total of 13 live modules. One further module is planned. The number of modules completed per year has fallen this year. This is most likely as a result of the need for a local feedback process and because of the appearance of the website – it now looks slightly old fashioned and some of the graphics are not of a professional standard. In response to this, we are about to rewrite the modules. We also hope that we can collaborate with Sharon Drake (involved in e-learning in RCoA), who has looked at the modules and thinks that there would be people interested in developing them for use on the FICM website. We also hope to develop an automatic online feedback process.

The on-line tutorials have been designed for doctors coming through intensive care in their FY2, ACCS and early CT years. These resources are also useful to Trainee Advanced Nurse Practitioners in Intensive Care, nursing, physiotherapy and pharmacy colleagues and to medical and nursing undergraduates.

Live at

http://www.scottishintensivecare.org.uk/education/icm%20induction/index.htm

Intensive Care Training and Simulation
Our Education and Training Group has been running 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.

Trainee Run Education Meeting
The Education meeting was again held at the Royal College of Physicians in Edinburgh.

There was a good multidisciplinary attendance. The cost to delegates was £200 per day. There were no discounts available to non-medical staff, which we should review next year.

Feedback was largely positive.

We aimed to make the meeting cost neutral but made a profit of approximately £2000.

Diagnostic Error Meeting
We co-sponsored a very successful diagnostic error meeting in Edinburgh's Pollok halls in September. It was well attended and had Pat Croskerry, Mark Graber, and Kathyrn Montgomery as keynote speakers. Feedback was very positive, and Mark Graber, who chairs the planning committee for the American

Diagnostic Error meeting, was so impressed he has suggested to his committee that they bring the entire American Meeting to Scotland in 2014. They have agreed, though funding may be problematic.

Plan for the Next Year

Rewriting and updating the current modules.

We have had out initial planning meeting for a 1-2 day course on professionalism. We plan to cover ethics, clinical decision making and diagnostic error, decision making around admission and withdrawal, and clinical leadership (covering Getting the best out of the team, acting as a role model, Interactions with colleagues, Chairmanship of WR and handover, Prioritisation, Empowering trainees, Encouraging speaking up behaviour, Agenda setting, Listening, Feedback, Motivation, Emotional Intelligence, Bargaining, Promoting a cohesive unit, Conflict). These topics are currently poorly covered elsewhere, although they are essential to a highly performing consultant.

Dr Martin Hughes
on behalf of the Education and Training Group of SICS

Scottish Critical Care Trials Group - Annual Report 2011

The SCCTG continues to develop as a cohesive and functional research arm of the Scottish Intensive Care Society. We now also constitute the Scottish Critical Care Specialty Group, as recognised and supported by the Chief Scientist's Office.

Meetings

The SCCTG executive committee has met either in face or by teleconference every 3-4 months throughout the year to review ongoing Scottish projects, support of other "portfolio" research, and new studies. We use these meetings to report on activities within the four major health board regions. The group is now organised as follows:

NORTH/GRAMPIAN
Nigel Webster (ARI);
Jonathan Whiteside (Raigmore)

TAYSIDE/EAST:
Steve Cole (Ninewells)/
SRI (Chris Cairns)
QMH (Marcia McDougall)

LOTHIAN:
Tim Walsh (RIE);
Peter Andrews (WGH)

GREATER GLASGOW & CLYDE
Tara Quasim (GRI);
Sandy Binning (WIG);
Alan Davidson(Victoria);
Jim Ruddie (Lanarkshire hospitals);
Paul Jeffferson (Dumfries)

Other co-opted members are Mairi Pollock (Glasgow); Janice Rattray (Dundee); and Pam Ramsay (Lothian).

Janice and Pam represent the SCCIRL group of nursing and AHP researchers, who are now recognised as part of both the SCCTG and a grouping within then SICS. The annual meeting was integrated into the combined September SICSAG, EBM, and SCCTG meeting, which was a great success. Presentation included completed projects on pandemic flu (GenISIS; Ken Baillie), and transfusion triggers (RELIEVE; Tim Walsh), a funded Scottish project on sedation (DESIST; Tim Walsh), and a new proposal for a nutrition study (TRACE; Peter Andrews). The format appears to work well and is also a venue for break out meetings for sub groups such as SCCIRL and for specific projects. The SCCTG held an AGM during the meeting.

The SCCTG Company

We had previously formed a company with charitable status to manage grants and unrestricted donations from industry. With changes in patterns of research funding, this company has become redundant for the group. It was formally "wound up" during 2011 and the outstanding funds were transferred to the main SICS funds, which also now has charitable status.

Prizes and Awards

The SCCTG managed the medical and nursing/AHP award competition. The winner of the medical award was Dr Naz Lone, CSO PhD Fellow in Edinburgh, for his paper entitled "Readmissions to Intensive Care Units in Scotland: Epidemiology, Risk Factors and Outcomes". This work used the enormous and unique potential

of the SICSAG data set linked to other national data bases to provide high quality data about re-admission rates during the years following an index ICU admission. Naz presented his data at the September meeting. There were no submissions for the NMHAP award which was disappointing. The SCCIRL group has taken on the management of this award in the hope that we will receive more applications during 2012 from nurses or allied professionals. We know there is excellent work going on and encourage SICS members to submit it for the excellent prize of attendance at the ASM at the expense of the society.

SICS Research Grant

This year SICS offered a £20K grant to a member for a clinical project, ideally involving a range of ICUs in Scotland. The agreed judging was through peer review within the SICS, external reviewers, and a vote of the attendees at the September meeting. John Kinsella led a project entitled: "The incidence and outcomes of ARDS and ALI in Scottish Intensive Care Units – a prospective audit", which was presented at the meeting. After critical discussion and review, the members voted in favour of supporting the proposal, and the first SICS research grant was awarded! John and his collaborators will be developing the project during 2012.

Clinical Trials Diploma Bursary

David Hope (Research Coordinator in Edinburgh) was awarded the Clinical trials Diploma bursary to support a distance learning course at the London School of Tropical Medicine and Hygiene in 2009. He completed and passed the diploma during 2011, and will hopefully be able to use the skills obtained to contribute to the high quality work going on in Scotland.

Current SCCTG Projects

Development and Evaluation of Strategies to Improve Sedation practice in Intensive Care (DESIST). This quality improvement project in 8 Scottish ICUs is funded by the CSO and GE healthcare, and started in January 2012, lasting for 2 years. The project will evaluate the effect of education, process feedback, and a novel monitoring technology on sedation quality, and includes the development and validation of a new sedation quality tool.

Age of Blood Evaluation Trial (ABLE). This international study is funded in the UK by the HTA, is run from Edinburgh, and will involve 12 ICUs in the UK. In Scotland Edinburgh Royal and Ninewells are participating units. The UK part of the trial started in January 2012.

Other activities include a national survey of resuscitation strategies in Emergency Medicine and Critical Care (in collaboration with Emergency Medicine)

Other Portfolio Research

Scotland has traditionally provided strong and impressive support to UK wide portfolio research, and this continues. The Fungal Risk Evaluation (FIRE) study, run by ICNARC, is the largest ICU study ever

done in the UK (60 000 patients). 90% of Scottish ICUs took part and we recruited close to 20% of the participants; this performance despite comprising <10% of UK ICUs. The HARP II study (statins in acute lung injury) is ongoing in 4 Scottish ICUs, again contributing well to UK recruitment. Peter Andrews is leading the EuroTherm study in head injuries, with three Scottish participating. Other ICUs have made important contributions to genetics study (GAINS) and OSCAR (trial of HFOC versus conventional ventilation). Our major contribution to UK critical care research is widely recognised both nationally and internationally.

Funding

The SCCTG/Critical Care Specialty group now receives funding from CSO (via R&D departments towards a research coordinator, who is Dawn Campbell, based with Tim Walsh in Edinburgh. She combines this role with a local administrator role in the Edinburgh Critical Care Research Group, and a national role as PA to Tim in his role as Chair of the UK wide Specialty Group. This administration support has greatly improved our ability to organise teleconferences and meetings and keep paperwork in order. Dawn can be contacted at Dawn.Campbell@ed.ac.uk or 0131 242 6395. Any enquiries and queries about the group should be directed through her.

The CSO is undergoing a radical change in the way it uses its funds, largely through disembedding them from clinical service and using them more visibly for research. Important new initiatives include National research Scotland (NRS) awards for NHS clinicians (including non-medics) for dedicated research sessions in their job plans. These are being awarded at health board level rather than nationally through local competitions, and can fund 2-3 days per week of research for 2-3 years, the idea being to allow younger consultants and researchers to establish themselves through grants and a track record. This is a great opportunity that will be run for several years at least. Recent and new consultants with research aspirations, or non-medical research interested individuals should look closely at these awards. The first round will be awarded in spring 2012 to be included in job plans for 2012-13.

The CSO is committed to providing NHS support costs for research for any study on the national research portfolio. This is a key issue, because for critical care research it provides funding for the screening and consent process by research nurses, as well as some time for data collection through the R&D departments in addition to the funding requested in the grant. This emphasises the importance of a study being on the research portfolio, which means it must be funded by and eligible funder such as the CSO, MRC, HTA, the major charities, or any grant giving body approved by CSO. This funding is starting to revolutionise critical care research in Scotland as we traditionally received little if any support for this activity. CSO will

also remunerate R&D departments in part according to the numbers of patients entered into portfolio research studies; this "performance related" funding has been successful In England and offers us real opportunities with the large studies we are planning.

Industry Funded Research

The CSO and R&D boards, and the UK and Scottish governments, are very keen to see more commercial research undertaken in the UK. Activity has fallen off in recent years, and the UK has become seen as an expensive inefficient environment to commercial research. Through the SCCTG and our community, with the support of the R&D departments, we have the opportunity to engage more actively in this type of work, which is often interesting and well-supported financially. A key goal for 2012 will be to try to engage more ICUs in participating in this type of activity.

Overall, we continue to "punch above our weight" in critical care research. This is largely because of the collaboration, friendship and cohesiveness within Scottish Critical Care. Hopefully, despite the impending pressures on our budgets and time we can maintain our momentum.

Tim Walsh
Chairman, Scottish Critical Care Trials Group
January 2012

SICS EBM Group

2011 has been a mixed year for the EBM group. As you can see from the list below the number of publication supported by the group through its involvement with JICS remains healthy.

The web site is in need of an update both in terms of content and style. Despite a call for help at the last AGM no offers have been forth coming.

I have made initial approaches to the South East Scotland advanced ICM trainees group to explore the possibility of widening the group's membership. The current "one man band" is not sustainable.

I would welcome advances from any interested parties. There would be no prerequisite for any web site expertise!

The aim of the next year must be to expand the editorial board of the EBM group (from one) and to encourage greater participation from both trainees and consultants from within the SICS in terms of submissions (CATs and review), revising the CAT format, enhancing our participation in the SICSAG / Trials group / EBM meeting, editing and developing the group as a whole.

Unfortunately I am unable to make this years meeting but would be delighted to hear from any volunteers.

Dr Chris Cairns
Chair, SICS EBMG
January 2012

SICS EBM Group
Publications From the EBM Group:

JICS Volume 12 no.1, January:

- Jenkinson E, et al. Tranexamic Acid improves mortality in trauma patients with suspected ongoing blood loss. JICS 2011, 12 (1) 43 – 44
- Potter EK, Kirk-Bayley J. Crystalloid or colloid for fluid resuscitation in paediatrics? JICS 2011, 12 (1) 45- 46

JICS Volume 12 no.2, April:

- Mcilmoyle K, Chest compression-omy CPR improves mortality compared with standard CPR. JICS 2011, 12 (2) 145-146
- Harlow G, Johnston AM, A protocol of no sedation for critically ill patients receiving mechanical ventilation: a randomized trial. JICS 2011, 12 (2) 147-148
- Hornsby J, Intensity of renal replacement therapy: effects on mortality and renal recovery. JICS 2011, 12 (2) 149-150
- Nebulised heparin is associated with fewer days of mechanical ventilation in critically ill patients. Gross J. JICS 2011 12 (2) 151-152
- Horner D, Cairns C, Early neuromuscular blockade in severe ARDS. JICS 2011 12 (2) 153- 154.

JICS Volume 12 no.3, July:

- Pratt T, Bromilow J, Use of LMA during percutaneous tracheostomy. JICS 2011 12 (3) 238-239
- Denison Davies E, CT scanning in polytraumas. JICS 2011 12 (3) 242-243.
- Clark S, Ezra M, Use of dexamedetomidaye as a sedative and analgesic agent in critically ill adult patients. JICS 2011 12 (3) 244-245.
- Jenkinson E, Tulloch L, Tunnicliffe W, A randomized trial on the treatment of refractory status epilepticus. JICS 2011 12(3) 246-247.

JICS Volume 12 no.4, October:

- Prasad L, Parekh N, Influence of shoulder position on central venous catheter tip location during cannulation. JICS 2011 12 (4) 331-332.
- Cheung M, Mullhi R, Parekh N, C-reactive protein as a predictor of poor outcome after dischrge from intensive care: a prospective observational study. JICS 2011 12 (4) 333-334.

Dr Chris Cairns
Chair, SICS EBMG
January 2012

Scottish Transplant Group Report

Deceased Organ Donation within Intensive Care in Scotland remains a very high priority for the Scottish Government Health Department. In the year at the end of 2011 there was a further incremental increase in the number of deceased organ donors from intensive care. In total this is an increase of 29% since the start of the Task Force recommendations at the beginning of 2008 and we are well on the way to achieving a 50% increase within five years as per the ODTF recommendations.

It is often forgotten that this would not be possible without the continued support and enthusiasm of the critical care community

A lot of activity on a number of fronts has taken place in 2011, NICE has recently published guidance for the management of deceased Organ Donation and while NICE guidelines apply absolutely to England and Wales only, they are usually accepted and implemented in Scotland.

The important thing to highlight about the NICE guidelines is that for the first time that there is recognition of trigger points for the (required) referral of patients for potential organ donation. Although this was one of the ODTF recommendations it has not been implemented to date. Council may wish to express a view on this.

The link to the guidance is http://guidance.nice.org.uk/CG135 and I attach the summary document at the end of this paper.

Also in December of 2011, the Academy of Medical Royal Colleges Donation Ethics Committee produced a final version of the Ethical Guidance to the Management of the Patient for Donation after Circulatory Death.

Council and the wider SICS membership had the opportunity to contribute to the production of this document and a number of submissions were received. Most of this guidance dovetails very well with other guidance produced by the ICS and British Transplant Society and specifically reiterates the recommendation for two doctors both to document that further treatment is not in a patient's best interest prior to treatment withdrawal for DCD.

The full document can be downloaded at http://aomrc.org.uk

Finally the BJA has published a detailed and informative supplement on deceased organ donation this month which identifies progress and looks at some of the remaining challenges.

The Potential Donor Audit (PDA) which members will recall 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 by a group chaired by Alex Manara, it seeks to address some of the

concerns which have been raised within the Critical Care community. Sarah Ramsey and Brodie Patterson (EM consultant) were members of the review group from Scotland.

The revised PDA is currently being piloted with a view to implementation at the beginning of April 2012. I have to say that in spite of good Scottish representation, I do have significant concerns that it will fail to address many of the issues raised. However, the revised PDA does say quite clearly in the first line that the potential donor audit is a tool for audit and quality improvement and not a tool for performance management and as such the continued publication at Board level of funnel plots for numbers of brain stem and DCD donors, using the PDA data is at best unhelpful.

NHSBT is an organisation without a patient population; the organisation has received a very significant tranche of funding from the UK Department of Health and as such needs to demonstrate that this funding is being well spent. One of the ways it is seeking to do this is through the development of what are termed as Key Performance Indicators. These indicators look across a raft of measures which are designed to show that the Special Health Authority is fit for purpose. A key performance target is the absolute number of deceased organ donors per year, it has been pointed out that within Critical Care circles this is felt to be an unhelpful target and that perhaps it would be better to consider direction of travel or trajectory year on year rather than absolute donor numbers.

A successful one day meeting was held in June in Edinburgh entitled “Further Measures” The meeting sought opinion from Intensivists, Transplant Surgeons, Fiscals and Board Chief Executives about what else is necessary in order to ensure that the increase in deceased organ donation achieved to date becomes embedded as a routine part of practice.

We looked at the specific development of deceased organ donation from Emergency Medicine of those patients who currently go down the Liverpool Care Pathway and die in the EM department.

We discussed the separate possibility for the development of a programme of deceased organ donation from patients in Maastricht 1 & 2 criteria. 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. There are however, as you might expect a few outstanding legal and ethical issues to overcome

We also looked at feedback from Transplant Surgeons to Intensivists and the possibility of rapid response teams particularly from the Cardiothoracic Service to attend the patient after the diagnosis of brain stem death to support the unit and to ensure the cardiac function of patients was optimised prior to organ retrieval. This is still a matter of ongoing debate and discussion.

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 three occasions. Dr Stuart and Dr Cole have been appointed through a competitive interview process as the joint clinical leads 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. The number of cases in which the fiscal refuses to permit deceased organ donation has fallen to a very low level in 2011.

Stephen Cole
STEPHEN.COLE@NHS.NET

SICS Trainees' Group Annual Report

Committee
Chairman - Rosie Macfadyen (SE Scotland)
Secretary - Neil Stewart (North of Scotland)
Audit lead - Alistair Meikle (West of Scotland)
Education lead - Dan Holmes (West of Scotland)

Chairman and Secretary's Report
This has been another busy year for the Trainee Committee. Paul McConnell, Peter O'Brien and Andy Mackay all stood down in January 2011 after serving two year terms. The present committee would like to thank them for their hard work and wish them luck in their new consultant appointments at Crosshouse Hospital and the Victoria Infirmary.

Dan Holmes, Alistair Meikle and Neil Stewart were appointed following elections in late 2010. Rosie Macfadyen continued on the committee for a second year. Since Dan, Neil and Alistair all receive their CCT in the next few months and Rosie has already served 2 years on the Trainee Committee, all 4 positions will be vacated at the end of the year. Elections for new committee members will be held in December 2011 via a secure online voting system.

We have tried to improve communication between trainees in Scotland with an interest in ICM. David Griffiths, a West of Scotland trainee currently training in Edinburgh has been co-opted onto the committee as Communications Officer. He has overseen the setting up of a regional Linkman scheme to help raise awareness of SICS activities amongst. A Facebook group ('SICS Trainees') has been set up and has already gained over 40 members. This page can be used to advertise educational events relevant to ICM training as well as serving as a social forum. Now that the AAGBI specialist society services are managing the SICS members database we hope this will let us keep a more accurate record of SICS trainee members.

Audit Lead Report
This year we decided as a group to investigate delirium in Scottish ICUs.

Our intention is to determine what the incidence of unrecognised delirium is and also to establish what the current practice is with regards screening for delirium. In order to establish whether a patient is delirious or not then a validated screening tool known as CAM-ICU will be used.

Data collection forms have been completed and a website has been designed (https://sites.google.com/site/sicstraineeaudit2011/) to act as a portal through which local study co-ordinators can access the study protocols, data collection forms and educational material relating to delirium. In addition to providing the study documentation this website will act as a useful educational resource for trainees and raise awareness of ICU delirium.

We have recruited local co-ordinators who will act as the data collectors at each site. Local data collectors will be educated on how to undertake CAM-ICU scoring

through use of the educational materials on the study website and meeting with regional co-ordinators.

The study is intended to be a point prevalence 'snap-shot' of the entire Scottish ICU patient population and once local co-ordinators have been finalised we will set a date to commence the data collection process.

Education lead Report

This year's Education Meeting took place on 10-11th November at the Royal College of Physicians in Edinburgh. The cost of the meeting had been frozen from the previous year and we were delighted to welcome over 50 delegates to the meeting, an increase from last year. 20% of attendees were consultants and the remainder were medical trainees. We decided as a committee not to have trade support this year, as this could be perceived as skewing the educational aims of the meeting. The RCoA approved the event for 10 CPD points.

Thursday opened with a session from Dr Bryce Randalls on Military Critical Care. We moved onto renal physiology and support, presented by Ian McLeod and Chris Isles. Alistair Hay delivered a thought-provoking lecture on evidence based medicine, Andrew McCulloch spoke to us on cardiology in the ICU and the day closed with an entertaining and informative talk by Drew Inglis on his experiences with EMRS.

The opening speaker on Friday was Dr Nick Barrett, Director of ECMO Services at Guy's and St Thomas' Hospital in London. He joined with Mike Gillies later on to provide a workshop session on advanced respiratory support. A separate stream of workshops introduced the more junior delegates to critical care ultrasound, and fluid and electrolyte problems. We all sat in rapt silence as Stefano Rinaldi, a senior solicitor for NHS Scotland Central Legal Office gave us a glimpse of what to expect if we were ever to find ourselves giving evidence at a Fatal Accident Inquiry. The meeting culminated with a vigorous debate between Martin Hughes and Anthony Bateman over whether 'this house believes that intensive care should be rationed'. Anthony Bateman, speaking for the motion, triumphed over the gracious-in-defeat Dr Hughes.

Feedback from the meeting has been very positive and we will strive to continue to make this event the best ICU educational meeting in the country.

Rosie Macfadyen
Chair, Trainees' Group

The Scottish Intensive Care Society

Office Bearers

Steve Stott .... President
Mike Fried .... President Elect
Rory MacKenzie .... Treasurer
Roxanna Bloomfield .... Honorary Secretary

Ex officio

Brian Cook .... SICSAG Chairman
Chris Cairns .... Evidence Based Medicine Group
Mike Fried .... Inter-Hospital Transport
Mo Al Haddad .... Website Administrator
Paul McConnell .... Trainee Representative
Stephen Cole .... Scottish Transplant Group Liaison
Tim Walsh .... Scottish Critical Care Trials Group
Graham Nimmo .... Education Representative
Willis Peel .... Newsletter and Annual Report
John Colvin .... Critical Care Delivery Group Chair

Regional council members

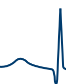
GGC .... Martin Hughes
GGC .... Sarah Ramsay
GGC .... Malcolm Sim

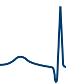
East .... David Cameron
East .... Charles Wallis
East .... Sam Moultrie

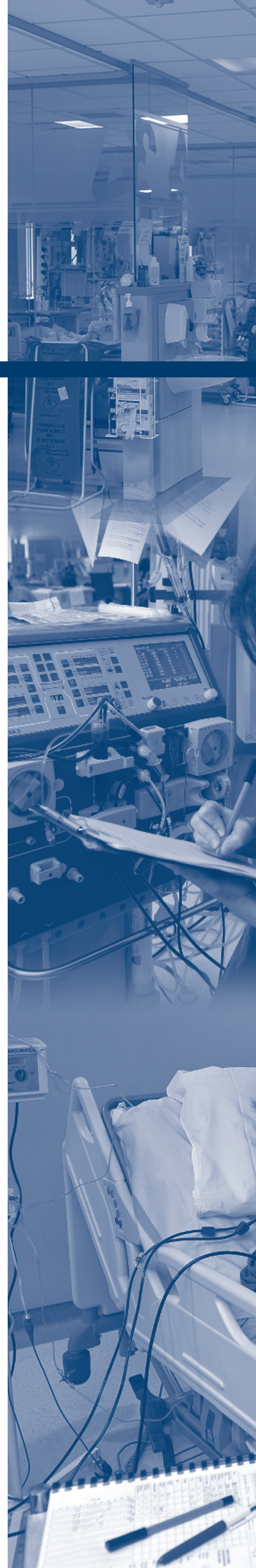
North .... John Colvin
North .... Nigel Webster
North .... Shelagh Winship

West .... Rory MacKenzie
West .... Martyn Hawkins
West .... Willis Peel

Associate Member .... Alan Timmins







The Scottish Intensive Care Society is a Charity registered in Scotland, number: SC040669

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