scottish intensive care society

Annual Report - 2010

Editorial

Welcome to the Scottish Intensive Care Society Annual Report for 2010.

This is my first report as editor and I must start by thanking my predecessor, Dr Charlotte Gilhooly for her hard work in producing report of the Society's activities for the last few years.

The Society continues to grow its meetings becoming ever more popular. The winter scientific meeting moved to the Old course Hotel, St. Andrews, a very popular choice of venue and hopefully a more permanent one. The Audit, Trial and EBM groups held a 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. Its views and opinion are increasing being sought by the Scottish Government on matters relating to intensive care, most recently, H1N1.

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

After the recent Annual general meeting a trainee, who had attended for the first time, came up to me and commented that he had no idea that the Society was involved in so many different aspects of critical care in Scotland. I suspect he was actually worried because the agenda was so long he wasn't going to get to the bar! He was right to be worried as the agenda for meetings is now bigger than ever but this is not something to apologise for. The Society has evolved so that it now it has a portfolio that covers almost all aspects of critical care in Scotland. This is something to be rightly proud of. It is the work of the sub groups that make the Society what it is and I would like to thank all their chairs and members for all their hard work over the last year. More detail can be read in their individual reports.

Another year has flown by and unfortunately and to a lot of us surprisingly, influenza H1N1 added to the pressures we faced over Christmas period. Scottish critical care was extremely busy and expansion plans in many units had to be activated. It is good to know that plans put in place last year stood the test of time and no doubt will be refined further. The extra ventilators that were purchased last year have been put to good use as many units expanded beyond their traditional boundaries. But with many units having had staffing reductions over the last year this has been a very challenging period.

Both the Society and the audit group were approached by Quality Improvement Scotland to produce quality indicators for critical care in Scotland. Quality indicators exist across many other aspects of medicine and although we already collect a lot of this type of data we haven't labelled it as such. A group has met once so far and we hope to produce a final list early this year. We are very aware of the amount of data that we already collect and do not wish to add to that burden. How these will be used will need to be finalised and agreed.

We heard at the very successful annual Scientific Meeting about the newly formed Faculty of Intensive Care Medicine. Its formation is an important milestone in the development of the specialty. It is now receiving applications for foundation members and details can be obtained from the Royal College of Anaesthetists web site. How we, as a national society that is increasingly being asked for advice from the devolved administration, fit in with the new Faculty remains to be seen and we await replies to our enquiries.

Aside from the sub group work there is a lot of effort to future proof the Society with continued efforts to improve administration processes. Finances and membership issues are huge tasks and much thanks to Roxanne and Rory for their continued efforts. Their efforts will ensure the Society is in a much stronger position in subsequent years.

Finally, it is a privilege to pay tribute to my predecessor, Simon Mackenzie. Simon has been an influential figure in the development of the Society and played a pivotal role in our development. As well as serving on Council he led the Audit group with distinction and served as President. He has been extremely helpful to me in my first year and we wish him well. I am delighted that the President Elect is Dr Mike Fried from Livingston. My congratulations to him.

I wish you all a successful and fruitful 2011 and hope to see you at St Andrews next year for our 21st Annual Scientific Meeting.

Steve Stott
President,
Scottish Intensive Care Society

Annual Scientific Meeting

Another change of venue again this year with the Annual Scientific Meeting moving to the Old Course Hotel, St Andrews. It proved to be an extremely popular move. The meeting was both entertaining and informative with high quality national and international speakers.

The first session on Thursday gave an overview of the H1N1 pandemic with talks from Dr Harry Burns, Chief Medical Officer for Scotland and Professor Hugh Pennington, Emeritus Professor of Bacteriology (Aberdeen). This was followed by two very informative talks from Professor John Myburgh (Sydney) and Lt Col Rhys Thomas (HM Armed Forces) on circulatory failure and its management. Professor Myburgh's talk was a first for the Society being given over a video link from the other side of the world.

Lunch was followed by this years travel grant prize winner Dr. Kate Janossy. Dr. Janossy gave a fascinating insight in to critical care in Malawi. Spending time in Blantyre and Zomba, she highlighted the lack of advanced monitoring, oxygen and other routine care that we take for granted in the UK. She outlined the challenges facing one of the world's poorest countries, and also the opportunities that were available to provide assistance. Further information can be obtained vial the following organizations and web sites, Scotland-Malawi Partner Ship, www.scotland-malawipartnership.org and The World Federation of Societies of Anaesthesiologists (WFSA), www.anaesthesiologists.org

Professor Scholes delivered a captivating lecture on the notion of care giving in critical care.

She emphasized the importance of self care to improve our resilience, but warned against loss of empathy. The outline of resilient strategies were explained both in professional and personal capacities

This years Mike Telfer Lecture was given by Dr. Margaret Herridge. Dr Herridge talked about the affect of ICU illness and death on the families and caregivers of patients, in ICU and after their return home. She highlighted that the effects of the patient's illness also impacted on the physical and mental health of the families, and that this extended not just during the ICU stay but for prolonged periods after discharge. She emphasised that communication with the family should be thought of as a quality of care. The following articles are of interest; Psychiatric illness in the next of kin of patients who die in the intensive care unit. CCM 2008; 36: 1722-1728.

Risk of Posttraumatic Stress Symptoms in Family Members of Intensive Care Unit Patients. AJRCCM 2005; 17 :987-994

Not too long after a fantastic Burns' supper ended with many demonstrating their formidable resilience, the second day at

St Andrews kicked off very aptly with the topic of toxicology. Dr Dargan from Guy's and St Thomas toxicology unit provided a state of the art overview of three increasingly important clinical conditions: calcium channel blocker overdose, toxic alcohol ingestion and recreational drug toxicity. I don't think many of us thought we would be leaving the conference prepared to give insulin boluses of 50 units and infusions of 200 units per hour.

Dr Joyce Stewart from the Western General in Edinburgh followed next with a critical review of the very topical assessment of collaborative requesting (ACRE) study on consent rate for organ donation. The lack of clear benefit demonstrated from a collaborative approach leaves us with much thought regarding how we endeavour to increase our organ donation rates whilst utilising scarce resources efficiently.

After a brief coffee, cake (yum!) and poster viewing interlude Dr Herridge returned to the stage to share with us her experiences and enlighten us with her exceptional knowledge of recovery and rehabilitation after critical illness. Her experiences from the work she leads in the follow-up of ARDS patients is providing the intensive care community with a greater understanding of the longer term sequelae of critical illness and leaves us all reconsidering both who we admit to and how me manage within our ICUs . The recently commenced Towards RECOVER study will undoubtedly delineate both the factors contributing to patients' impaired quality of life and their rehabilitation needs following a prolonged ICU stay. We very much look forward to the publication of these results with risk stratification and phase specific approaches to rehabilitation requirements undoubtedly strategies we will be hearing much more about in the years to come.

Dr Ajith James, Consultant nephrologists from the Royal London Hospital, followed with his potentially very contentious ICU outcomes after surgery study comparing Scotland and England. His task was not made any easier by a now swelling room of home fans positioned between him and the door. Dr James provided an excellent talk really highlighting the great challenges of robust database research, and in the end a 1-1 draw drew us very nicely into the Scottish regional case presentations.

First up was Dr Jim Ruddy from Monklands Hospital sharing with us a glimpse of their unit's experience of a young patient with severe ARDS that stretched them to their limit. Perseverance, strong intensive care utilising the region's resources and perhaps NAVA eventually enabled this young lady to successfully walk out of the hospital. Next up was Dr Paul McConnell from Glasgow with a case highlighting the great challenges facing intensive care clinicians of communicating shattering information to families across different languages and culture. An insightful, cross-cultural explanation of translation with helpful guidance left most with food for thought

to take back to clinical practice. Dr Ian MacLeod from Dundee built on one of the morning's talks, sharing their unit's experience of managing two patients with severe calcium channel blocker overdose with therapies they were both unfamiliar and slightly uncomfortable with but without which they knew neither of these patients would ultimately survive. And finally into lunch Dr Martin Clark from the Queen Margaret Hospital in Dunfermline left us with the mysterious case of "reactive" hydronephrosis. And the winner of the first best regional presentation cup was … Glasgow! Congratulations also go to Dr Tony Vassalos and Mrs Jennifer McCallum who won the prizes for best research oral and poster presentations respectively.

Neurointensive care was the focus of the final afternoon session. The audience were privileged to be the first to hear the provisional findings of the soon to be published Brain Trauma Foundation consensus guidelines on the management of traumatic brain injury by Professor John Myburgh. This fascinating talk providing not only the likely findings, but also Professor Myburgh's personal reflection on the difficult process that is trying to gain consensus from a group of multi-disciplinary experts where the evidence provides few definitive answers.

Professor Peter Andrews from Edinburgh continued on the session with a state of the art overview of hypothermia in critical care and the on-going trials in this area. From the underpinning science through trials in acute stroke, cardiac arrest and traumatic brain injury Professor Andrews discussed the evidence, its failings and highlighted the need for further research to refine and advance our knowledge of hypothermia as an intervention in areas of critical illness. We wish him well with EUROTHERM.

The final speaker of the conference Dr Malcolm MacLeod, Consultant Neurologist from Edinburgh, refreshed us with a brief overview of stroke disease, the considerable evidence base behind the current interventions (thrombolysis NNT = 10) and a pertinent explanation of the integral role critical care must play in providing high quality care to sub-sets of these patients.

As the sun finally set over a magnificent St Andrews and very successful conference we leave invigorated and hopefully to return.

SCCDG REPORT

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

Medical Workforce Pressures in Critical Care. The Group recognise a serious risk to Critical Care, particularly Intensive Care sustainability due to medical workforce pressures. This risk is compounded in that Intensive Care is reliant on a range of other specialties for this middle grade medical workforce and may lose out to competing priorities because of this. It was agreed that SGHD workforce planners must be made aware of this serious risk, which was raised with CMO at our last meeting over a year ago. The Group decided that a letter should be sent to the Director of Workforce planning and to CMO to highlight these issues and to request a high level meeting to address this. 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 are being linked with UK National initiatives to ensure consistent standards, a national training programme and qualification.

HDU Needs Assessment-Final report submitted to CMO and his Advisory Group This work is being led by Sandy Binning who has prepared a comprehensive report on HDU needs assessment and implementation of SMASAC HDU report with input from all Regional Chairs.

Winter Flu and high Critical Care activity The Scottish CCDG has had considerable input in relation to several aspects around flu and high activity levels over the last winter, including providing a focal point and network in terms of monitoring activity, sharing clinical experience, contributing to escalation around equitable access and coordinating the flexible ventilator pool. Ultimately SCCDG has agreed to contributing at triage level should demand go significantly beyond a level that exceeds escalation capacity.

Specific recent work includes:
Response to UK report on 'Management of Severe Refractory Hypoxia in Critical Care in the UK in 2010'
In late December we were asked to comment on the DH/ICS expert group report on 'Management of Severe Refractory Hypoxia in Critical Care in the UK in 2010', published on the ICS and DH websites in mid-December. This was commissioned by the DH to look at management of severe respiratory failure in critical care. England is moving towards this model of tertiary critical care centres providing advanced respiratory support and a range of other rescue or adjunct therapies. Publication of this report was expedited in view of the current significant increased pressure on Intensive Care beds and saturation of ECMO capacity in

England due to H1N1 cases.
Summary of feedback from CCDG Chairs included:
The common themes, as expected, relate to concern about consistent application of best conventional practice and to questioning the efficacy of the advanced rescue therapies. The comments on both geographical and organisational differences in healthcare delivery in England are also consistent.
The comment from one colleague ' Why would we go through all the changes that this would entail and ultimate downgrading of many ICUs in order to provide two unproven therapies?' captures this well.
If HFO ventilation is a useful therapy it is not difficult to develop in the context of the bigger ICU's, particularly if developing expertise on decision-making is shared on a network basis.
The SCCDG view on provision of EMCO remains as that given to the Scottish ECMO report last year:
'It would be correct to state that the SCCDG is of the view that continued access to ECMO as an option for treatment of severe respiratory failure is important but that it is ambivalent as to where this access is provided subject to the following:
The service is commissioned to an explicit agreed national standard in all aspects and has a suitable caseload volume for skills maintenance.
There is also strong feeling from the SCCDG that the safest environment in which the service should be provided is in the context of a general Intensive Care unit offering all aspects of advanced respiratory care, or with adjacent and immediate access to intensivists with these skills.
The SCCDG also suggest that the service includes specialist retrieval including ability to transfer on EMCO.'

Key points for recent focus by SCCDG are:
Promoting universal application of 'best' conventional ventilation in ALI/ARDS
You will be aware of recent initial work on ensuring consistent application of conventional best practice using Patient Safety/Improvement methodology. The first cut on this was done by Malcolm Booth, Sally Crofts and Kevin Rooney They provided a draft proposal by 6th January for comment by CCDG Chairs over the following week or so. Initial high response rate included a large majority of positive feedback for the principles of doing this also includes some helpful specific suggestions on improving the algorithm. Some noted concern around the apparent rush to develop and implement this. Please be re-assured that this is primarily an initiative to support units in delivering their considered best practice ventilation strategies in the context of ALI and ARDS.
Responses from Scottish CCDG Chairs on the Report showed a high degree of recognition of the value protective lung ventilation and a remarkably consistent view that most of us thought we are not delivering it consistently. This is therefore primarily an initiative to apply improvement methodology to drive

change in a largely agreed direction, subject obviously to clinical judgement in individual patients.
In keeping with this relatively high degree of consensus and in view of the high priority or 'signature' nature of the condition amongst ICU clinicians, there has been general agreement that there is a place for relatively rapid change, including wide but rapid consultation across all CCDG's and ongoing refinement of the clinical algorithm and measurement strategy.
The Scottish Patient Safety Program has recognised and agreed to support this work. This work requires further development from the Critical Care community generally.

Can SGHD be assured that all units still have a robust escalation policy as per the previous centrally submitted arrangements to double capacity?
A letter went out last winter to all Health Board CEO's, looking for re-assurance around Critical Care Escalation as flu and winter pressures continue to increase. This was also circulated via SCCDG to ensure that accurate feedback was available from all Boards in the tight timescale requested. Generally all regions have their consolidated escalation plans for ICU, as prepared for the first wave of pandemic flu last year, from which to draw much of this information. Reassurance that we can double ICU capacity in all units was agreed last year. Effects of this escalation on reducing elective capacity and risks of diluting standards are of concern and require to be explicitly acknowledged.

Management of flexible ventilator pool –The SCCDG continues to provide co-ordination of this 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.

Thanks to all the SCCDG Chairs and to many other Scottish Intensive Care consultants for ongoing contributions to the high level of responsiveness of Chairs to all the flu related communication generally. The effective network of the SCCDG is recognised and very much appreciated by SGHD flu planning and resilience teams and allows direct and meaningful input into both Scottish and UK work on this.

John R Colvin
Chair, SCCDG
5th May 2011

Treasurer and Membership Secretary Report

The Society's finances remain in a healthy position.

OSCR annual return (including the Report of the Trustees to 31st March 2010) was submitted along with prepared accounts for year ending 31st March 2010. Copies of this are available. If you require a copy please contact myself and I can forward.
Adoption of Gift Aid was considered by Council with a decision not to pursue due to rules around members benefits.
The main activity remains the ASM. The 2010 ASM showed a loss that would be mainly attributable to high speaker costs and administrative support.
The collection of subscriptions is currently by standing order. Moving to affordable direct debit remains a priority and much time and effort in updating the payment and membership status of individuals has taken place.
Membership continues to grow and 2010 has seen a greater number of new members than in the recent past. The membership database indicates 361 paid up members in 2010, 56 new members in 2010 (8 Associate)

Rory MacKenzie
Treasurer SICS
Rory.MacKenzie@lanarkshire.scot.nhs.uk
Jan 2011

Honorary Secretary's Annual Report

ASM

The 2011 meeting is just over and although the feedback isn't fully processed we hope everyone had a productive meeting and a good time. Some talks will be available on the website soon. Again Kathleen Middleton has provided invaluable help on the administrative side along with Julie Fenton, making a great team for me to work with.

The 2012 meeting will be the Society's 21st in its current guise as the Annual Scientific Meeting. We are hoping that we can provide another programme of interest and current trends while still retaining the social atmosphere and opportunity to catch up with friends and colleagues. Dates are the 19th and 20th January 2012.

Elections

The new President Elect is Mike Fried of St John's Hospital who will commence his presidency in 2012.
New North representatives are Nigel Webster (Aberdeen RI) and Shelagh Winship (Perth RI). The new Greater Glasgow and Clyde representative is Malcolm Sim (Western) and Sarah Ramsay was re-elected. All other regions remain the same and a complete table is below.

There is to be greater involvement of the elected Council members in taking on roles and liaising with subcommittees. Regional representatives are also keen to keep contact by email with members within a region and this will commence this year. If you wish to get in touch with any of the representatives in order to raise an issue at Council meetings you can contact them direct or via myself.

Travel grant

A total of up to £2000 is awarded in whole or part to one or more applicants who will be undergoing travel to study or experience critical care in another environment/location. The grant is accessible to established SICS members of any profession and any grade. To apply send a summary (maximum length - one side of A4 only) of your proposed project and anticipated costs to the Secretary at the address below or by email. Applications will be considered once per year at the spring Council meeting therefore the closing date is the end of March each year. Details are also on the website.

GGC	West	North	East
Sarah Ramsay (WIG)	Rory MacKenzie (Monklands)	John Colvin (Ninewells)	Sam Moultrie (St. John's)
Malcolm Sim (WIG)	Willis Peel (D&GRI)	Nigel Webster (ARI)	David Cameron (RIE)
Martin Hughes (GRI)	Martyn Hawkins (SRI/FVRH)	Shelagh Winship (PRI)	Charles Wallis (WGH)

Database

The intention is to hand over the database for third party management this year most likely by a subdivision of the AAGBI. The cleanup I commenced just under a year ago is still awaiting completion so if you haven't sent in updated details to me please do. If you are a member and are not receiving emails from me then you are not updated! Keeping current details also makes elections far more transparent and fair with all those eligible being able to stand or vote. A surprising number of people have moved/changed name/location of work/email address since the last update so if you suspect you are being left out do get in touch. You will get notification this year of your membership number.

Honorary Members

I am pleased to announce that at the Annual General Meeting in 2010 Honorary Memberships were awarded to Alfred Shearer of Dundee and Ian S Grant of Edinburgh. In 2011 Cameron Howie of Glasgow and James Dougall of Glasgow also were awarded Honorary Membership.

There is not enough room to do justice to the contribution these gentlemen have made not only to the SICS but to the profile of Scottish intensive care beyond the Society. All have been presidents and have contributed to advancing the SICS to the position we find ourselves in today. We hope they will continue to be a part of the Society in their respective retirements and look forward to their presence at meetings in the future.

Dr Roxanna Bloomfield
Consultant in Anaesthesia & Intensive Care
Intensive Care Unit
Aberdeen Royal Infirmary
Foresterhill
Aberdeen AB25 2ZN
(r.bloomfield@nhs.net)

SICSAG

The Scottish Intensive Care Society Audit Group continues to flourish and made significant achievements in 2010. The audit office moved to new accommodation at the Gyle in January.

The audit was reviewed by the newly formed National Clinical Data for Quality Improvement Advisory Group. This group which is part of NHS Quality Improvement Scotland has a remit to look at how patient data is used for quality improvement and to make recommendations to the Scottish Government on future funding of national audits such as SICSAG. I am delighted to report that after extensive scrutiny of our audit, the Advisory Group recommended it continue with its' current funding and management through ISD.

We had a number of changes in personnel over the year. Catriona Haddow our statistician is on maternity leave and has been replaced by Hazel Mackay. Angela Kellacher (National Co-ordinator) is also on maternity leave and Moranne Macgillivray (Quality Assurance Manager) is standing in for her till next summer. Moranne has assumed this extra responsibility very efficiently and many of you will not have been aware of any changes to how the audit runs. The Steering Group changed with the resignation of Roger White (Crosshouse Hospital) due to impending retirement. I thank Roger for the many years of interest and involvement he has given. New consultant members joined us: Chris Cairns (Stirling) and Phil Korsah (Crosshouse). We were also joined for the first time by two nursing representatives: Shaun Maher (Stirling) and Duncan Ford (Dunfermline).

My first three year term as Chairman finished in 2010 and my thanks go to the SICS membership for their confidence in allowing me to have a second term of office unopposed in a call for election in summer 2010. Steve Cole was also re-elected as Vice Chair for a further three year term in November 2010.

2010 Report
This was published as is now customary in July. Outcomes continue to improve reflecting our developing commitment to quality improvement strategies throughout Scottish Critical Care. Two units were identified as SMR outliers and their health boards and managers were informed. Reports have been received from them in response to this. Of note, advanced warning to one unit had been given as it was the only unit which triggered on the CUSUM charts in 2009.

2010 Conference September
This was held in collaboration with the SICS Trials Group and Evidence Based Medicine Group for the second year. It was again a successful venture with good feedback from those attending. With tighter financial control, the conference did not incur any loss this year.

Monthly Reports
During 2010, we have switched for a period of 6 months to reporting HDU data quality. It is intended that ICU data quality reporting will resume in early 2011. CUSUM charts will continue to be produced during this.

Health Protection Scotland ICU Acquired Infection Project and Report
This has continued to develop significantly. The first national report is planned for publication in February 2011 when validations are complete. It is recognised by all involved that the considerable work of data collection and validation has been an enormous challenge. This first report is still a partial national picture as many units were still developing their data collection during 2009-10. However, it is remarkable that we will have a complete national dataset being collected by SICS units in 2011 and we plan to publish national reports jointly with HPS to coincide with the SICSAG annual report.

H1N1 Aftermath
Scottish Critical Care coped with and contributed significantly to national strategy for the pandemic. SICSAG was central to rapid dissemination of information and collation of responses from individual units and health boards. Part of this was installation of the WardWatcher bed bureau in St Andrews House in Edinburgh for the Scottish Government.

2011
The annual report will be delayed into August in 2011 as we need to allow Angela time to settle in to work and catch up after her maternity leave. We intend to hold the annual conference in September as usual however.

I am currently trying to organise a Quality Improvement Group for SICS and SICSAG which has members drawn from both. This will meet in early 2011 to look at Quality Indicators for Critical Care.

Dr Brian Cook
Chairman, SICSAG
19th January 2011

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 2009/2010.

The induction module programme has continued to grow over the last 12 months. Four new modules (poisoning, acute kidney injury, sepsis and delirium) have been added with a current total of 13 live modules. The total number of modules planned is 16. The number of modules completed per year has continued to increase from 378 in 2007/8, 638 in 2008/9 to 1067 completed in 2009/10. Approximately 65% of the modules are completed by candidates from Scottish ICUs, 15% from English ICUs and during this list year Northern Irish ICUs have began to participate in the programme and have contributed almost 20% of the completed modules. The majority of the modules (approximately 90%) were completed by foundation doctors and specialty trainees though increasing numbers of medical students are completing them and this year paramedics with the Emergency Medical Retrieval Service have begun completing the modules as part of their continuing professional development. The feedback remains consistently very positive with over 90% of candidates stating they either agreed or strongly agreed that the modules met their expectations.

The SICS education and training group aims to complete the induction module programme during 2011.

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.
The tutorials can be viewed 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. Simulation training for more advanced trainees is planned over the next year.

Trainee run education meeting
The Education meeting was again held at the Royal College of Physicians in Edinburgh.
There were 48 delegates in attendance on the 25th, and 44 on the 26th. We had 6 consultant attendees. The cost to delegates was £200 for both days. There were no discounts available to non-medical staff. Feedback was largely positive. We aimed to

make the meeting cost neutral but made a profit of approximately £3000.

Office Bearers

Dr Martin Hughes has replaced Dr Graham Nimmo as chair of the group. Dr Nimmo has been an outstanding chair of the group, and has been tireless in his efforts to improve the training and education of trainees in Scotland. The group would like to express their gratitude for all his efforts, and fully expect him to stay heavily involved in ongoing group activities. Dr Mo Al Haddad has replaced Dr Hughes as Secretary and Treasurer for the group;

Plan for the Next Year

Our main focus over the upcoming year is to develop training for senior ICU trainees. The group had divided into 2: one subgroup will deal with exam preparation, while the other subgroup will provide education related to professionalism. In order to reduce course fatigue, we have initially hijacked some sessions at this year's trainees meeting. One will deal with clinical decision making and diagnosis, the other will explore the reasons for the different approaches to ICU admission and withdrawal of care.

The trainees meeting will be run along similar lines to the previous successful meetings and the organisation is being led by Dr Dan Holmes.

The SICS Education and Training group are also co-sponsoring (with RCP and Scottish Clinical Skills Network) the UK's first conference on Diagnostic Error where leading world authorities (for example Mark Graber and Pat Croskerry) will be plenary speakers for an audience of clinicians of all specialities, educators and policy makers.

Dr Martin Hughes

on behalf of the Education and Training Group of SICS January 2011

Report from the Scottish Critical Care Trials Group

The Scottish Critical Care Trials Group now has an established network of local representatives spread around the Health Boards, and a nomination structure that means that each SICS region can nominate representatives. We have had meetings or teleconferences every 3-4 months to keep up with changes in research funding (see below) and improve coordination of research activity. The AGM is now held at the combined SICSAG/SCCTG/EBM meeting in September.

Funding for research in Scotland
There are ongoing changes to the funding and organisation of research in Scotland. The Chief Scientist's Office are re-organising the way they will use funds and several key differences may be useful to critical care. Their drivers are to see R&D funding used more effectively to support research and to increase the recruitment of patients and participants to clinical studies. This process is ongoing and occurring in stages, but some key developments are:

- CSO have created "Specialty groups" to mirror the structure created through the National Institute of Healthcare Research in England. Critical Care is now a specialty group, and we have agreed with CSO that the SCCTG will essentially take on this function. The SCCTG representatives are known the various R&D departments as local research leads through this group. We should consider this the start of a formally funded network, and we have some funding to support part of the salary of a coordinator, who is Dawn Campbell (my PA in Edinburgh!). In addition, we propose that an emerging group of nursing and allied health professional researchers ("SCIRRL group") will sit as a parallel group with SCCTG within the Specialty group. The intention is to enable this NMHAP group to run sessions in parallel to the main programme at the September meeting. This is going to happen in 2011.
- There is far greater willingness for R&D departments to provide support for critical care studies through research nurse/coordinator time, either as stand alone posts or by providing time from Clinical Research Facility nurses. This has been particularly successful in Glasgow (thanks to Alan Davidson, Marie Pollock and others), but has also generated support in many other ICUs. We need to maintain activity and recruitment to studies to keep this resource. In many cases it has been a case of "going and asking", especially if a specific study is in mind
- Funding has been placed in several Academic Health Science Centres to support research. Edinburgh has done especially well in bidding for nursing salaries from this route. Again it is largely a case of pushing locally for support
- There may be greater flexibility for R&D directors to provide "Researcher support" to develop and support studies through time in job plans. Again the important thing is to ask and make a case at a local level

- It is highly likely that resource from 2012 will be in part dictated by the numbers of cases enrolled into trials and studies. This "activity based funding" has worked as a strong incentive in England and increased numbers of patients entering research studies by about 40% over the past 2-3 years. Again this means it will be extremely important for us to track our recruitment to studies and ensure that our R&D departments have an accurate record. It also means we should try to plan activity going forward to maintain activity.

Research Activity

Scotland has made tremendous contributions to UK portfolio studies, which places us in an extremely good position with the R&D departments. The attached figure shows numbers of patients enrolled in critical care studies across the UK regions. Scotland is the top region, so we should celebrate. Much of this relates to the Fungal Risk Evaluation study (FIRE), which was very effectively done in Scotland and we should see as a bridge to greater things. Other highlights are:

- The SIGNET study was published in the BMJ (BMJ 2011;342:doi:10.1136/bmj.d1542)
- The "DESIST" study (Development and Evaluation of Strategies to Improve Sedation Practice in Intensive Care) has been funded by CSO to take place in 8 Scottish ICUs. It will start in 2011.
- The "RELIEVE" study (Restrictive versus Liberal transfusion for patients requiring prolonged mechanical ventilation) was completed and will be presented at the 2011 meeting
- The TRAPPHIC trial was completed and presented by Sandy Binning at the research meeting in 2010.

Overall research activity continues to strengthen in Scottish Critical Care. Opportunities to take part in high quality research either led from Scotland or other UK centres are increasing. Hopefully, these activities will result in research that will improve our evidence base.

Tim Walsh

Chairman, Scottish Critical Care Trials Group and Speciality Group Lead for Critical Care.

Transport Update

Progess has been made in the last year with the continued introduction of the CCT6 trolley. Currently the CCT6 trolley is able to harness a 12v supply or 240v from the ambulance assuming the ambulance has an inverter and therefore can provide a 240v supply.

The SAS's perspective is that the mid-tier ambulances (which house inverters) are not being used for IHT frequently enough to justify their continued production. The SAS is proposing that all front line vehicles will be fitted with an auxiliary battery which can power an inverter fitted to the CCT6. The original assumption was that the purchase and fitting of the inverter would be the individual health board's/ unit's responsibility. Negotiation between Peter Curry, myself, SAS and Ferno are currently ongoing and the current status of the negotiations is that Ferno and Merlin are designing an inverter which will fit under the patient platform. The SAS will purchase and provide the inverters for the current CCT6 in service and the individual medical physics departments will fit them with Ferno's instructions. A 2kw inverter would be capable of powering all the required medical equipment on the trolley.

Specialist Transport Services Strategic Review

The Scottish Government Health Department's (SGHD) Specialist Transport Services Strategic Review is continuing. All the specialist transport teams are included. Currently we are reviewing triage and tasking models for all the retrieval requests: neonatal paediatric and adult. The next stage will be options, financial modelling of options and then option appraisal in late Spring.

SAS Air Ambulance Re-procurement

The SAS Air Re-procurement process has received the clinical specification and requirements. Currently it is at the stage of tender specification ready for tendering from various air service providers later this year.

Emergency Medical Retrieval Service

As of October 2010 the EMRS has been tasked with providing a retrieval service for all Scotland's remote and rural areas including Western & Northern Isles from their base in Glasgow. They have 2 consultant led teams on simultaneously. They have a total of 15 consultants from Emergency Medicine & Anaesthesia/ICM. They also attract trainees from the above specialties. There is increasing collaboration between the EMRS and the West of Scotland Paediatric Retrieval Team.

Transport of ECMO patients

Due to the recent spike in H1N1, and the transfer of a patient from Wishaw to Aberdeen on ECMO, discussions have taken place between the SGHD, NSD, Scottish Critical Care Delivery Group, EMRS, Shock Team, ECMO providers at Yorkhill and the SAS.

SHOCK Team

The Shock Team is consolidating its activity in Glasgow and its environs.

SICS EBM Group
Publications From the EBM Group:

JICS Vol 11 No.1 January 2010

- ECMO for severe respiratory failure by C Hawthorne, P McConnell, C Cairns.
- Efficacy and economic assessment of conventional ventilatory support versus extracorporeal membrane oxygenation for severe adult respiratory failure (CESAR): a multicentre randomised controlled trial. Giles J Peek, Miranda Mugford, Ravindranath Tiryvoipati et al. The Lancet 2009; 374: 1351-1363.
- Procalcitonin(PCT) to guide duration of antibiotic therapy in intensive care patients: a randomized prospective controlled trial by V Gopal, S Nallapareddy.
- Marcel Hochreiter, Thomas Köhle, Anna Maria Schweiger, Fritz Sixtus Keck, Berthold Bein, Tilman von Spiegel and Stefan Schroeder. Procalcitonin to guide duration of antibiotic therapy in intensive care patients: a randomized prospective controlled trial. Critical Care 2009. 13:R83 (doi: 10.1186/cc7903)
- High Intensity CRRT does not improve mortality in Critically Ill Patients by J Hornsby.
- The RENAL Replacement Therapy Study Investigators, Intensity of Continuous Renal-Replacement Therapy in Critically Ill Patients. N Engl J Med 2009;361:1627-38

JICS Vol 11 No.2 April 2010

- Routine proning does not improve survival in ARDS by M Wilkes.
- Taccone P, et al. Prone positioning in patients with moderate and severe acute respiratory distress syndrome: a randomized controlled trial. JAMA. 2009 Nov 11;302(18):1977-84.
- Therapeutic hypothermia for neuroprotection in adults after cardiopulmonary resuscitation by R MacFadyen.
- Arrich J, Holzer M, Herkner H, Müllner M. Hypothermia for neuroprotection in adults after cardiopulmonary resuscitation. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD004128. DOI: 10.1002/14651858.CD004128.pub2.
- Effects of steroids on reintubation and postextubation stridor in adults: meta-analysis of randomized controlled trials by S Nallapareddy, V Gopal.
- Samir Jaber, Boris Jung, Gérald Chanques, Francis Bonnet and Emmanuel Marret: Critical Care 2009, 13:R49 (doi:10.1186/cc7772)
- Nurse led intensive care follow-up clinics: their impact on quality of life and cost effectiveness by P O'Brien, S Cole.
- Cuthbertson B H, Rattray J, Campbell M K et al. The PRaCTICal study of nurse led, intensive care follow-up programmes for improving long term outcomes from critical illness: a pragmatic randomised controlled trial. BMJ 2009;339;b3723

JICS Vol 11 No.3 July 2010

- Conventional vs low tidal volume ventilation in patients without pre-existing acute lung injury – effects on pulmonary inflammation and development of acute lung injury by G Boyes, A Miller. Determann M, Royakkers A, Wolthuis E et al. Ventilation with lower tidal volumes as compared to conventional tidal volumes for patients without acute lung injury – a preventive randomised controlled trial. Critical Care. 2010 Jan 7;14(1):R1. doi:10.1186/cc8230
- Blood glucose control in patients on corticosteroids – does it affect mortality? By N Crutchley.
- Annane D et al: Corticosteroid treatment and intensive insulin therapy for septic shock in adults. JAMA 2010 303 (4): 341 – 8
- Noninvasive ventilation with helium-oxygen mixture in COPD by A Dalton.
- Maurizio M et al. A multicenter, randomised trial of noninvasive ventilation with helium-oxygen mixture in exacerbations of chronic obstructive lung disease. Crit Care Med 2010; 38:145-151
- Early physical and occupational therapy in mechanically ventilated medical ICU patients improves return to independent functional status at hospital discharge by R Appleton.
- Schweickert WD, Pohlman MC, Pohlman AS et al. Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomised controlled trial. Lancet 2009; 373:1874-82.
- Lactate clearance as a marker of effective resuscitation in early septic shock by N Crutchley, C Cairns.
- Jones AE, Shapiro NI et al: Lactate clearance vs central venous oxygen saturation as goals of early sepsis therapy. JAMA 2010; 303 (8): 739-46

JICS Vol 11 No.4 October 2010

- Prophylactic magnesium supplementation in patients with aneurysmal SAH reduces delayed ischaemic infarction, but confers no proven mortality or morbidity benefit by D Horner.
- Westermaier T, Stetter C, Vince GH, Pham M, Tejon JP, Eriskat J, Kunze E, Matthies C, Ernestus RI, Solymosi L, Roosen K. Prophylactic intravenous magnesium sulfate for the treatment of aneurysmal subarachnoid haemorrhage: A randomized, placebo-controlled, clinical study. Crit Care Med 2010;38(5):1284-1290
- There is no significant difference between patients treated with dopamine compared with norepinephrine in the treatment of shock by H Ebrahim, T Torlinski.
- De Backer D et al. Comparison of dopamine and norepinephrine in the treatment of shock. New Eng J Med. 2010;36:779-789.

Dr Chris Cairns
Chair, SICS EBMG
January 2011

Scottish Transplant Group Report AGM 2011

Deceased organ donation continues to increase in Scotland due in no small part to the ongoing support and engagement of the Scottish Critical Care Community. This year has seen an increase of 19% in the number of deceased organ donors with the largest rise coming from patients referred following donation after cardiac death. Scotland is well on the way to meeting the ODTF target of a 50% increase in Organ Donation in 5 years.

Organ donation maintains a very high profile within the Scottish Government and work continues to raise public awareness and to encourage people to consider signing up to the organ donor register (ODR). This has been achieved through radio, TV and press advertising campaigns. The Scottish Government has also funded the development and publication of a schools pack sent out this year to all secondary schools in Scotland. Currently 36% of the adult Scottish population have signed the ODR. However, in the 16-24 year old age group this figure is over 80%. Members may be aware of recent developments on the DVLA driving licence application form where the question about the joining the Organ Donor Register has been changed to exclude the answer "No". This is a subtle but significant change.

The Welsh assembly has just last week started to debate legislation that will if successful result in Wales adopting a soft presumed consent system.

The UK Donation Ethics Committee has been formed following an independent competitive interview process hosted by the Appointments Commission. The committee is chaired by Sir Peter Simpson (past president RCOA) and hosted by the Academy of Royal Colleges. Following a wide consultation with stakeholders (including the SICS) it was felt that there was an urgent need to address some of the ethical issues around Donation after Circulatory Death (DCD). A position statement and report entitled "An Ethical Framework for Controlled Donation after Circulatory Death" has been finalised and published for consultation on the 10th January 2011.

A Consensus statement about Donation after Circulatory Death has also been published this month by the Intensive Care Society and the British Transplant Society with the support of the UK department of Health

Both these documents recommend changes that will result in the process of donation after circulatory death becoming more aligned to that which already occurs after Brain Stem Death. I would welcome any comments on these consultation documents from the membership before the end of February 2011.

The role of the potential donor audit (PDA) has caused some concern over the past year. This is an NHSBT UK wide monthly

Stephen Cole
STEPHEN.COLE@NHS.NET
15TH JANUARY 2011

audit of all deaths occurring in ICU and in Emergency medicine departments. The PDA looks in detail at all deaths to see if a potential multi organ donor has been missed or not referred. Close collaboration is needed between intensivists and donor coordinators to ensure that this data does not erroneously inflate the deceased organ donor potential. This data is published at six monthly intervals and disseminated to board chief executives and donation committee chairs. Funnel plots are also produced to show one boards performance in comparison to others. At present the data is anonymous but I think that this will soon change.

There is an increasing acceptance by NHSBT that the PDA is in many ways flawed and needs to be extensively revised and that the ICU and EM communities need to have confidence in the data. NHSBT have a number of advisory groups and the Donation Advisory Group have been tasked with this work.

Specific recommendations of the taskforce report were to establish a network of Clinical Leads for Organ Donation and to establish donation committees at board level in Scotland. This has been achieved; the donation committees meet regularly and support local practice. Donation committees also have a major role in promoting changes in practice in the recognition of potential organ and tissue donors and can effect these changes locally and at board level.

Scottish Intensive Care Society Nutrition Group

The SICS Nutrition Network meets three times a year, usually in Dunfermline. We have also used video-conferencing. The group welcomes dieticians, nutrition nurses, pharmacists, intensivists and biochemists.

The group discusses practical aspects of ICU feeding and promotes education in nutrition. A number of best practice statements have been formulated and are on the website (Adding water to feeds, Size descriptors and drug dosing, and Use of MAC in ICU) along with links to international guidelines.

The group was also involved in the organisation of two education meetings open to all ICU staff, one in February in Bridge of Allan, and one in May at Stirling Management Centre, where there were many interesting talks by national nutrition experts. The first meeting included presentations on pancreatitis, nutrition teams, ERAS and micronutrients, and the second focussed on bariatric surgery and its nutritional aspects.

In 2011 there have been difficulties in participants obtaining study leave for meetings and the group has been less active; there are plans for further best practice statements, distribution of nutritional information to key individuals in each hospital, and for a monthly report of ICU nutrition-related articles to be distributed among the group.

It would be very helpful to have more doctors involved in the group; if you are interested please contact Marcia McDougall at marcia.mcdougall@nhs.net

Marcia McDougall
Scottish Intensive Care Society Nutrition Group

SICS Trainees' Group Annual Report

The Trainees' group continues to go from strength to strength with another productive year.

Membership and communication
2009-2010 has seen an increased interest in the trainees' group. A mailing list has been set up now with over 50 participants. This has allowed us to update members on training related events and opportunities. It has also increased awareness of the SICS as a whole and resulted in many new members. With the success of this e-mailing list, we are hoping 2011 will prove to be year of "Trainees' v2.0". A new member is being co-opted into our group to improve information dissemination and bring a more interactive dimension to our web resources through the use of social media technology. Combining this with plans for a traditional "link" system, we can ensure a strong and coordinated trainee presence within the organisation for years to come.

Education
For a second year our annual education meeting was held at the Royal College of Physicians in Edinburgh. The salubrious surroundings hosted an eclectic programme which included lectures on core topics such as inotrope use, renal replacement therapy, burns and use of hypothermia as well as small group teaching on percutaneous tracheostomy, oscillators, echocardiography and altitude medicine. The two day meeting concluded with a debate on whether the super-morbidly obese should be excluded from intensive care, with Dr. Brian Cook from Edinburgh Royal Infirmary proposing the motion and Dr. Nick Kennedy, the Chair of the Society of Bariatric Anaesthetists opposing it. Thankfully for all of us who perhaps enjoyed the Christmas cheer and turkey a little too much, Dr. Kennedy was successful. The Trainees' committee would like to take this opportunity to thank all members who took part and contributed their time to making this meeting a resounding success.

Audit
This year the Trainees' group has audited the achievement of nutritional targets in all the Scottish ICUs. Data collection is now complete and our audit lead is currently preparing a presentation of the results for this years SICSAG meeting.

Last years audit on the impact of alcohol on ICU admission in Scotland has now been completed and presented at several meetings. A write up and paper is now in production.

A paper has also been completed and submitted for publication from our audit from 2 years ago on the use of Activated Protein C in Scottish ICUs.

We are now starting to plan our audit for 2011, and if any department has piloted a small audit which they feel would be suitable to be repeated on a national basis, please contact a member of our committee.

The Trainees' page also contains an "Audit Share". We would encourage all departments and in particular all trainees upon completion of an audit (or even audit cycle), to post their protocol and contact details (no results) here. We hope to build up a resource which will catalogue the various audits being performed around Scotland, giving an opportunity to cross share audit ideas between departments and also allow trainees to see what has been done in departments before and build on these, closing loops (which may not always be possible during a three month rotation).

We would once again like to thank all those who assisted in data collection and analysis on all our national projects.

Paul McConnell
Chair, Trainees' Group

Obituary

The Society is sad to report the death of Dr. William Richard Easy.

Born Jan 23, 1944 - Died from a glioblastoma June 1, 2010

The death of Bill Easy is a sad loss for our Society. He was a boy in Kent, studied medicine in Edinburgh in between rugby matches, and after qualifying in 1970, jaunted round the world serving in the RAF. Outwith his duties he enjoyed sailing and mountaineering.

On leaving the RAF he was appointed Consultant Anaesthetist at the Vale of Leven Hospital in 1989, retiring as the senior consultant in 2006. So it was early in his Consultant career that Bill became active in the formative years of the SICS. He served on Council for a number of years from 1997, initially two terms as a West of Scotland representative and then subsequently taking over editing the Annual Newsletter. This may have been a modest publication by today's standards but Bill expanded it from a news sheet to a more professional glossy pamphlet. He was also involved with the Audit Group.

He was a kind, gentle doctor, highly regarded by both patients and colleagues, and committed to quality patient care. He viewed the Society as one focus for developing this in Scotland.

Bill was a multi-dimensional character, as his e-mail address farmerbill@.. suggests. He had bought a farm near Gartocharn on his appointment to the Vale, and was well respected amongst the farming community. He took his farming seriously - no mere hobby farmer. In addition to these 2 major pursuits he loved shooting, angling, gardening, elegant motor cars, opera, and an occasional game of golf.

His ready, impish smile and laugh, usually accompanied by a raising of the eyebrows, are well remembered. So too is his modest, self effacing demeanor, and his readiness to help others and contribute. He was the antithesis of self promotion and at times almost shy.

Bill was the most affable of men and a true gentleman, befitting of his signature bow tie.

He will be most fondly remembered by his friends in Scottish Intensive Care.

Bill is survived by his wife Karen and his two sons from his first marriage.

J R Dougall

The Scottish Intensive Care Society

Office Bearers

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

Ex officio

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Stephen Cole	Scottish Transplant Group Liaison
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John Colvin	Critical Care Delivery Group Chair

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GGC	Sarah Ramsay
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East	Charles Wallis
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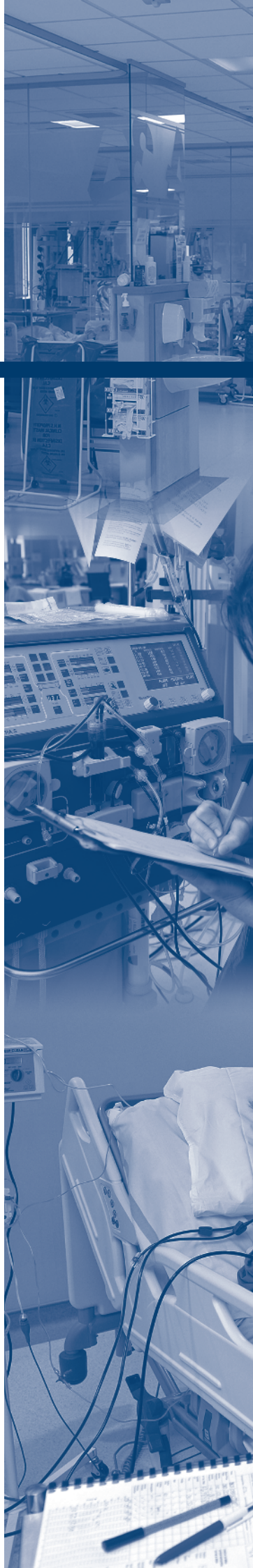
North	John Colvin
North	Nigel Webster
North	Shelagh Winship
West	Rory MacKenzie
West	Martyn Hawkins
West	Willis Peel
Associate Member	Alan Timmins



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

Secretary: Dr Roxanna Bloomfield
Honorary Secretary Scottish Intensive Care Society,
Consultant in Anaesthesia and Intensive Care,
Intensive Care Unit,
Aberdeen Royal Infirmary,
Foresterhill,
ABERDEEN
AB25 2ZN

Telephone: 08454 566 000 Page: 3223
Extension: 58812 Direct Dial: 01224 558812
Fax: 01224 550724

Web: www.scottishintensivecare.org.uk
and www.sicsebm.org.uk