Minutes of SICS Council Meeting, Friday 28th September 2012, at 14:00, Ivy Hotel, Bridge of Allan

Present: Mike Fried (MF), Brian Cook (BC), Louie Plenderleith (LP; left 15:30), David Cameron (DC), Charles Wallis (CW), Steve Stott (SS), Steve Cole (SC; left 16:00), Shelagh Winship (SW), Fiona McIntyre (FM), Rory Mackenzie (RM; arrived 14:10), Willis Peel (WP), David Noble (DN; left 15:50), Sam Moultrie (SM), N Webster (NW), Martyn Hawkins (MH; arrived 15:10), David Griffith (DG), Sarah Ramsay (SR).

1.) Apologies: Malcolm Sim (MS), David Rowney (DR), Martin Hughes (MHu), John Colvin (JC), Richard Appleton (RA), Tim Walsh (TW), Tara Quasim (TQ)

2.) Minutes of previous meeting on Wednesday 18th May 2012

Accepted as a true record.

3.) Matters arising

MF ran through the action points from the previous meeting. As the agenda was very busy lay representation will be deferred to the next Council meeting. All other points were being addressed; of note Liz Wilson will take over from LP on FICMTAC, and although SICS have no remit to have a favoured candidate for future FICM elections, Scottish presence on the various work-streams remains strong and likely to remain so for some time.

AP 3.1: SR to add lay representation to Jan 2013 Council meeting agenda

AP 3.2: FICM Elections to be added to Jan 2013 SICS AGM agenda

4.) President's report – reports tabled and copies on file

ICS Council meeting (MF)

The ICS Council meeting in mid September had been difficult, with the ICS clearly feeling threatened by FICM such that membership of FICM was deemed a conflict of interest, and the mechanism of the recent election of a new ICS President causing bad feeling. The State of the Art meeting preparations were well underway, with recognition of the fact that meetings in the US were losing corporate support which might have implications for our future planning.

The World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM) 14th World Congress

MF has been approached by the SECC to consider hosting this event in Glasgow in 2019, they having initially contacted the ICS (a WFSICCM member; SICS is not) who had forwarded this to MF. WFSICCM aims to promote quality intensive care in developing countries, is backed by key respected individuals in ICM, and holds biannual well supported conferences with good attendances of 4,000-10,000 delegates. It is usually held in major cities, having suitable infrastructure, with delegates from developing areas paying reduced rates. ICS were not keen to bid, but were interested in the SICS Council view of a bid for Glasgow, an intention to bid needing to be lodged by the end of October 2012. A bidding application pack would then be made available.

Council discussion

There followed a long debate on the pros and cons of the venture. In summary the SECC would help with the bidding process and logistics of conference arrangement but the SICS would have a huge organisational commitment, including arranging the scientific programme and lobbying other societies to attend. Although 90% of any profit would come to the SICS, equally it would be held liable if it failed. This is a major undertaking for a future as yet unelected Council, and indeed an organising committee would need to be formed forthwith. Scotland has a cohesive ICM community, good research contacts and a likely successful track record with the

upcoming Commonwealth Games in Glasgow. To bid requires us to join the WFSICCM at US$5 per member pa, early indications from them suggesting they would accept our application to join.

There was general agreement that this might be a worthwhile, albeit major, venture for the Society, independent of the ICS. Caution was sounded in that we must know more, particularly our liability, before there is any commitment. It was thus decided that MF would further investigate joining the WFSICCM and MF, DC, CW & SR would meet with SECC about the bidding process, and subsequently an intention to bid lodged. The only cost incurred up to this point would be the WFSICCM joining fee (~£300).

AP 4.1: MF to contact WFSICCM to ascertain if SICS are eligible to join

AP 4.2: MF, DC, CW & SR to meet with SECC to get more understanding of the process

AP 4.3: MF to contact Tim Walsh to gauge his support for the project

FICM Board report (SR) As per written report, no questions raised. MF drew attention to the 2013 Annual FICM Meeting.

5.) Honorary Secretary's report - report tabled and copy on file

- Elections - the upcoming President Elect and regional rep elections were brought to the attention of Council, all were encouraged to drum up interest in their local areas.
- AAGBI -continue to provide a reasonable service but in time we may be better to regain control of our own database. DC keen to stay with AAGBI until website up and running well.
- Travel Insurance - with change in memberships to AAGBI & ICS we risk being underinsured; DC suggested we aim for 50% of members covered solely by us.
- Foundation Year/CT prize: there was enthusiasm for this idea, and FM keen to roll a similar prize out to AHPs in training. Likely format would be a word limit essay on a given title.

AP 5.1: SR to arrange President Elect and regional representative elections

AP 5.2: SR to discuss increased insurance cover with broker

AP 5.3: SR & FM to develop a proposal for FY/CT and training AHP prizes

6.) Treasurer's report - report tabled and copy on file

- Recent transition problems with RBS resolving.
- ASM - large industry contribution already for 2013 so all seems on target.
- Research Grant - the 2011 award will not be claimed because, despite significant effort, the proposed project cannot go ahead. The 2012 proposal for the award will be discussed with the SCCTG.
- Database - DC will liaise with the regional reps for a concerted effort to clean up the database.
- For interest: VAT - the Society is not registered for VAT

AP 6.1: MF to discuss 2012 Research Grant with Tim Walsh

AP 6.2: DC to contact regional reps in regards database clean-up

7.) Training update – Louie Plenderleith [Lead RA in ICM]; this included discussion on workforce planning

LP attended to give an update on training in light of the introduction of the dual/sole CCT in ICM. The sole CCT was forced on us by the GMC, although there was already some will for it.

Proposed programmes

A number of specialties other than anaesthesia have expressed interest in dual training with ICM, the length of the overall training period depends on CT experience at entry to ST level, and overlap of competencies. This will make programme planning difficult. The Anaesthesia/ICM dual training will be approximately 18 months longer than either sole training. Passing the new FICM exam will be required to progress to advanced ICM training, in addition to any other CCT mandated exams (e.g. FRCA). In time a FICM Part I will be introduced. A special skills year is part of intermediate training, for dual trainees this will be in the second speciality, with lots of options for sole ICM trainees.

Recruitment issues

In April 2012 England and Wales appointed 50 ICM trainees, 50% were anaesthesia based, and most intended to dual train. 2013 will use a similar process plus ST3-4s wanting to add ICM to an established training programme. Dual jobs make moving between deaneries difficult and candidates must apply to only one unit of training. Badging of posts (e.g. an ICM post that is only open to anaesthesia trainees) is not popular with those wanting to see ICM as a stand-alone specialty. In Scotland, however, the future workforce needs are easier to establish and badged posts with anaesthesia have been accepted. Having talked with emergency and acute medicine there is no will for badged posts with these specialties which require trained people quickly and who can contribute to on call rotas. Scotland plans to interview for at least eight dual posts (by two independent interviews) and two ICM stand-alone posts (open to all specialties). Funding for the eight posts will come from anaesthesia, for the other two is yet unclear. To ensure interim supply of trained ICM doctors proleptic appointments to old-style joint training will be made by July 2013.

Council discussion

In the ensuing discussion BC expressed concerns that the SGHD figures for future service needs were very conservative in view of the possible attrition rate of trainees starting ICM so early, and increasing critical care needs and developments requiring more manpower. LP noted that more weekend work will split jobs and could leave anaesthesia short. NW was concerned about a lack of funding for the stand-alone posts, RM mentioned that there was a proposal for two more. MH and NW spoke against linking anaesthesia with ICM, a historical association, which might discourage good trainees from more aligned specialities such as acute and emergency medicine. Funding was power and currently held by anaesthesia. LP suggested that the two stand-alone jobs will be a step towards this. DC felt a lot of conversation with other potential partner specialties will be needed in the next few years.

8.) ECMO update - David Noble [ARI]

DN attended to lobby the SICS for support for a Scottish ECMO service, with the interested parties being Aberdeen, Edinburgh and the GJNH in Glasgow. Currently there are none in Scotland, with the nearest of the 5 in England being Manchester. DN briefly described the principles, relative ease and indications for ECMO. In addition he described transport issues, cost effectiveness, and research, education and development opportunities of a Scottish centre. Commissioning by the SGHD has not moved forward due to other priorities and the ICM community need to make a stronger case, hence Aberdeen has contacted SICS and SCCDG for support.

Council discussion

CW asked what benefits there were for Scots being treated in Scotland. DN replied that as well as convenience for family, transport logistics and costs will be less, treatment costs may also be less, and a patient may be more likely to get referred (English centres have more English referrals).As technology develops ECMO may be available for more conditions, and as local clinicians gain experience confidence to refer will grow. DC stated that retrieval must form part of a bid for an ECMO centre as early ECMO seems to give maximum benefit. BC agreed there should be a Scottish centre but preferred to aim for an advanced respiratory management centre of which ECMO is one part, akin to centres already commissioned in England. Scotland is falling behind. Council felt it appropriate as a professional community to write to the SGHD in support of revisiting a Scottish centre.

AP 8.1: MF to send a letter of support to Mike Winter at NSD

9.) Critical Care Delivery Group - minutes received and copy on file

- Manpower planning was discussed during 'Training Update'.
- The outcome of the joint reply from the SCCDG & SICS to Dr Paul Padfield, SMO at SGHD is awaited.

10.) Scottish Transplant Group Report - report tabled and copy on file

- Board variability in number of donors pmp likely to be scrutinised and many factors require consideration.
- Letter regarding concerns about the PDA undergoing final revisions.
- Standardisation of brain stem death testing forms - there are many in use with associated risks, and BC noted that FICM & ICS were working on another. There was agreement that a standard form was a good idea but SICS would wait until one form was agreed before writing in support.
- New Cabinet Health Secretary may not have the enthusiasm for organ donation as the previous one.
- RM highlighted ongoing issues with delays in placing organs.

11.) SICSAG Report Including Collaborating for Quality meeting

- BC will finish his second term as Chairman next year. His replacement will be voted for by the Audit Leads as per the SICSAG constitution, with the result available by the September joint meeting.
- Future of SICSAG - Diana Beard has left ISD, and her work there was recognised. An impact assessment showed SICSAG was valued by ISD and the SGHD and funding will continue.
- Scottish Health Informatics Programme (SHIP) - is a large bank of anonymised patient data available to researchers, which might take SICSAG data.
- BC has joined the FICM Professional Standards Committee which seems to be working cooperatively with the ICS Standards & Safety and Quality of Care Committee (SSQ), and are currently beginning the daunting task of introducing HAI surveillance in all ICUs in England.
- Collaborating for Quality meeting - many stakeholders in the future of critical care in the UK met recently for a workshop chaired by Sir John Temple. These included ICS, FICM, ICNARC, SICS/SICSAG, WICS, BACCN, NIHR etc. Each gave a short presentation and the Scottish quality improvement programme encompassing SPSP, funded national audit that retains professional control and HAI

surveillance were lauded. The Chair will now meet with individual groups aiming to produce recommendations about patient care by January 2013.

- BC expressed concern that Scotland is drifting apart professionally from England and Wales. The CFQ meeting proved that our work is respected, and we must stay strong as a Society and maintain strong links with FICM, particularly as Scottish representation on the Board will decline in time.

12.) SICS meetings/ASM Report

- Preparations for 2013 ASM on target, although the Procurator Fiscal talk will need a replacement.

- Call for 2014 Organising Committee to start early in Feb 2013, volunteers do not need to be on Council.

- Industry sponsorship - one company had asked to take the option of using their logo on interim slides. It was felt by some to be a little overbearing, and by others not to be worth the money offered. In future years it might be acceptable if the cost was raised.

AP 12.1: Anyone interested in joining the 2013 ASM Organising Committee to contact CW

13.) Scottish Critical Care Trials Group (SCCTG) Report - report tabled and copy on file

- The proposed changes to the constitution were ratified, including the election of a vice chair and the stipulation that one SCCTG regional rep should be within 5 years of becoming a consultant to ensure young talent is captured.

- It was unclear how the SICS regional reps were to help with identifying regional members for SCCTG.

AP 13.1: MF to contact TW to inform him of ratification of changes and clarify what was required of SICS regional reps

14.) Paediatric Intensive Care Report - no report

15.) Education Group Report - report tabled and copy on file

- All council members were asked to publicise the Education meeting in November.

16.) Trainees' Report - report tabled and copy on file

- Audit - much interest in using the Trainee Committee to facilitate individual's national audits necessitating a more formal application process with deadlines.

17.) Associate Members Report - report tabled and copy on file

- Increasing membership - the ASM flyer had been distributed to various AHP groups and FM asked that regional reps raise awareness of associate membership locally. Links with ACCPs would offer opportunities for more members.

- Standardised drug concentrations project - FM briefly introduced the project performed by Liam O'Neill and Martin Gall. FM was keen to take a pharmacy lead and asked for a consultant intensivist champion. There ensued a long discussion about the credibility, benefits, drawbacks and implementation difficulties of the project. CW agreed to take on the task with FM, using the audit leads and the adult critical care pharmacy group as starting points.

AP 17.1: Regional reps to highlight benefits of associate membership locally

AP 17.2: FM & CW to take drug concentration project forward

18.) Transport issues

- RM described recent problems with the Shock Team, and poor communication regarding this. Medical and nursing recruitment difficulties are causing short term problems but a longer term issue looms with the opening of the new SGH. If disbanded due to lack of need within GG&C this will have a major impact on feeder users into GG&C. SR stated that there are indeed many problems at doctor, nurse and ambulance level but the intention was to try to keep it running, including the use of locum medics.

- ScotSTAR - this was not discussed in great detail due to shortage of time. MF noted that inter-hospital transport of adult critically ill patients is not currently in ScotSTAR's remit but in time might offer a catalyst to reorganise all forms of critical care transport.

19.) Website Report - report tabled and copy on file

- SR reported that there were quotes in for four out of five companies. Once all in she would collate and compare the quotes and distribute to Council for comment. The aim was to preview the new website at the 2013 ASM.

AP 19.1: SR to collate website proposals and recommend the next steps

20.) AOCB

- ACCPs – written report from Graham Nimmo (GN) on the FICM ACCP group noted. BC stated that the project had been rather high-jacked by England. In Scotland the ACCP project was well developed and coherent and there should be more national input from Scottish nurses with expertise and resources to share. RM queried whether existing ACCPs will need to sit an exam just to get a badge and suggested merit in a legacy qualification.

AP 20.1: RM to discuss legacy award with GN, and encourage involvement of Scottish nurse educators in the national group

- Annual Report - if all are happy with their contributions then WP will send to the publishers. There has still been no postage bill for the 2010 report.

Date of Next Meeting: Wednesday 23rd January 2013,

Old Course Hotel, St Andrews