Minutes of the SICS Council Meeting, Wednesday 22nd January 2014
Willie Park Suite, Old Course Hotel, St. Andrews

Present: Mike Fried (MF), David Cameron (DC), Liz Wilson (LW), Ian Mellor (IM), John Colvin (JC), Steve Cole (SC), Rosie MacFadyen (RM), Charles Wallis (CW), David Rowney (DR), David Griffith (DG), Nigel Webster (NW), Shelagh Winship (SW), Fiona McIlveney (FKM), Malcolm Sim (MS), Richard Appleton (RA), Phil Korsah (PK), Fiona McIntyre (FM), Jim Ruddy (JR), Graham Nimmo (GN) & Sarah Ramsay (SR)

1.) Apologies & introductions: Apologies were received from Andy MacKay, Brian Cook (BC) and Martin Hughes. MF welcomed Dr Anna Batchelor (AB – left at tea break), Dean of FICM, who would be able to offer valuable contributions on the topics of core standards, training, recruitment and organ donation. GN acknowledged the death of Ian Armstrong from the RIE. He had been a founding member of the SICS, and the Society's thoughts were with his wife and family at this sad time.

2.) Minutes of previous meeting on Friday 27th September 2013

SR highlighted a mistake on page 3 where '2104' should read '2014', otherwise accepted as an accurate record.

3.) Matters arising not covered elsewhere in the minutes

MF ran through the relevant action points from the previous meeting:

- AP 4.1 – MF had contacted Marcia MacDougall and dissemination of her guidance was underway
- AP 4.2 – Council was happy with the decisions made at the September Council meeting. SC noted that the template had been well received at the SICSAG Clinical Governance meeting and would be used in the future. Feedback was essential to close the loop and should be explicitly asked for in SICSAG's letter to units with outlying SMRs. CW hoped that units facing barriers to implementation of report recommendations would come to the report team for assistance
- AP 4.3 – Mark Bellamy from ICS, Paul Morgan from WICS and Andrew Ferguson from NIICS were unable to attend but all were keen to collaborate in the future
- AP 5.1 & 5.2 – The Postgraduate Bursary will be announced at the AGM on 23.01.12 and the ASM on 24.01.14
- AP 5.3 – Revamped adverts will be ready for the 2014 awards
- AP 6.1 – Nigel Webster will take over as Treasurer in April 2014
- AP 8.1 – Relevant people have been contacted and have agreed to use SICS logo on website
- AP 16.2 - Standardised drug concentrations will be raised at the next SICSAG meeting

It was assumed that all reports had been read in advance. The running order of the agenda had been changed to allow those reports usually rushed through at the end more time, and this will continue.

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

Organ donation – MF recapped on the 'Northern referral model' - this was discussed at the September Council meeting and introduced at an NHSBT meeting held in Edinburgh a few days later. MF had understood that further specifics about the proposal would be forthcoming but instead the project was launched, with the expectation of referral of all patients at the end of life. This had met with varied, often negative, responses from SICS members and it had been made clear to MF that SICS should represent all members' views on this matter. To this end MF had written to NHSBT, in effect disagreeing with SC (in his role as Regional CLOD), thereby unfortunately and unwillingly putting SC in a difficult position. As a result SC had decided to resign his roles of both Regional CLOD and SICS STG rep as it was impossible to bridge these differing positions. NHSBT had not yet replied to MF by the time of the Council meeting.

MF had asked ICS Council for their views and the majority stated they did automatic referrals, with good responses times. AB, from Newcastle, described initial similar resistance as in Scotland but over time,

with good leadership and a gentle approach, all had become more comfortable with the process, such that it was now hard to imagine not doing it .There was no sense of an external agency demanding it be done.

SC recognised that the situation was very different in Scotland and England. The Scottish ICM community was very cohesive and doing well in organ donation. It was true that 5-10 potential DBDs and 10-20 potential DCDs were missed a year, but there was concern about SNODs with no clinical responsibilities influencing end of life care and the sense that NHSBT leaders in Scotland thought that ICM were in some way deliberately missing donors. This mechanism might increase referral rate but it was not clear if it would increase donor numbers significantly. SC believed that the NHSBT had taken heed of ICM's feedback, would not mandate referrals, and did not want to damage relationships further.

A wide ranging discussion ensued where Council expressed their views and concerns. RA felt that this approach had the potential to be a backward step and SW felt that response times remained too long. AB explained that in Newcastle the onus was on the transplant teams to make a quick decision to maintain ICM's co-operation. IM worried about the process delaying discussions with the family, although CW felt that knowing one way or the other in advance was helpful. LW described difficulties with an ED referral that had already been discussed with the SNOD before the ICU management plan for a complex patient had been made. JC feared this might be opt out 'by the back door'. AB noted that Chris Rudge was the new chair of UKDEC and would be attending the May FICM Board, she suggested GN might like to collate questions based on these concerns for him.

GN agreed to contact John Forsyth, in his NHSBT role, to make it clear that SICS remain supportive of organ donation and await further proposals. CW will be the new SICS STG representative, separate from the Regional CLOD, and GN will inform John Forsyth, as Chair of the STG, of this. GN asked CW to attend the May FICM Board meeting when transplant will be a major agenda item.

AP 4.1: GN to email John Forsyth to introduce himself as new SICS President, to seek ongoing engagement in donation with NHSBT and to identify CW as the new SICS representative on the STG
AP 4.2: CW to collate Council concerns to raise with Chris Rudge at May FICM Board

Core Standards for Intensive Care Units – as these form the basis for commissioning in England they have been rapidly introduced. Most are good common sense but some will be problematic for Scotland, particularly 1.1.5, which has raised concerns over the viability of some services.

JC noted that the SCCDG had submitted a proposal for a review of critical care services in Scotland to the National Planning Forum, hosted by the SGHD. The review would be led by a small group from the Scottish ICM community, with the infrastructure provided by the NPF. There would be wide consultation on a number of key issues. The NPF seems supportive of the idea and it will be put to the NHS Board Chief Executives Group for approval. It seemed unlikely to be finished till after the referendum as any reconfiguration would be difficult to manage.

AB was asked how FICM would deal with units unable to meet core standards. She recapped the new structure of the NHS in England and how clinical reference groups will dictate which service specifications a hospital can derogate from. The critical care specifications are based on the core standards and are currently out for consultation. FICM will, in addition, use the core standards to develop Guidelines for Provision of Intensive Care Services (GPICS) - akin to the RCOA's Guidelines for the Provision of Anaesthetic Services (GPAS) - which will be used when assessing units.

AB was also asked how to deal with a dual on call responsibility. A FICM manpower survey suggested this was common, and it was not clear whether commissioners would just buy the service as it was, move it elsewhere or invest to make it adherent to standards, all this being complicated by major configurations of EM and surgical services. Some remote units were making use of telemedicine and cross site working. The issue of specialist hospitals was raised where it was not uncommon to provide anaesthesia and ICU cover. DR urged that the long term view of 24 hour cover be pursued, although MF noted the real and current problems for many Scottish units.

AP 4.3: JC/BC to report back on progress with the NPF review of critical care services

'British & Irish Lions' meeting – The Hon Sec of the ICSI had approached the ICS about holding a British/Irish ICU meeting in 2021. They had bid unsuccessfully for the 2019 World Federation Meeting but had received good feedback hence their proposal for 2021. This would have major repercussions for the ICS SOA meeting, but not so much the SICS ASM. In view of the financial failure of the World Federation 2013 meeting DC stated that financial responsibility must be clear at the outset. Council agreed to support the meeting if ICS agreed to go ahead.

AP 4.4: GN to feed this back to ICS Council and the ICSI

ECMO – MF recapped recent events. It appeared that despite initial enthusiasm the SGHD had decided not to proceed with a Scottish centre. DR noted this might be due to the threat of closure of the Leicester unit being lifted by the ongoing provision of paediatric cardiac services. JC felt it important that there continued to be a service available to Scottish patients. He expressed surprise that the project had been shelved, as numbers did suggest viability of the service, and that the NPF would be a way to keep up the pressure. NW preferred the concept of an acute respiratory care centre (ARCC), providing services beyond just ECMO.

AP 4.5: JC to ensure that an ARCC is part of proposed critical care review/ BC to take forward

Critical Care Leadership Forum – This comprises 17 organisations working in five different work-streams. It offers important networking opportunities and MF encouraged SICS attendance; Brian Cook and Tim Walsh were already actively involved in leadership roles.

Transport/ Shock Team – ScotSTAR now has a strong leadership team in the form of Andrew McIntyre as AMD and Carole Morton as Head of Service. The Shock Team will disband in February 2014 following the withdrawal of training recognition for the medical posts. ScotSTAR is aware that critical care transfer will require investment and manpower to provide for the whole country; DR thought this might be in the form of a third EMRS team. NW felt this might disadvantage the North East with this team busy in Glasgow and MF wondered if links will be established between the NHS and the oil industry in the north.

Post meeting note – The office bearers have decided to ask Andrew McIntyre to be a corresponding member of Council, inviting him to the September 2014 meeting and thereafter only if required.

AP 4.6: MF to contact AMcI and introduce GN, and invite him to September Council Meeting

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

- SR welcomed the newly elected members of Council – Richard Appleton as GG&C rep, Kallirroi Kefala as East rep and Ruth Forrest as Associate rep – all starting as of the AGM on 23.01.14.
- The transfer insurance, travel and other grants will again be available in 2014. The postgraduate bursary will be introduced.
- AAGBI Specialist Society running costs will increase this year, and this expenditure will need to be kept under review.
- The Website will go live soon. RA offered to share the prototype site link with Council (this was done immediately at the end of the meeting).

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

- Membership remains healthy.
- The annual accounts and OSCR report have been submitted. The current account balance remained at twice the meeting costs, and the low risk reserve account continued to offer the best option.
- Ongoing costs: As mentioned in item 5 the AAGBI Specialist Societies offered a good and necessary service but costs would need to be kept under review. The website would incur maintenance costs.
- NW asked if the issue of standing orders had been resolved, DC stated these were now in single figures.

- DC will hand over to NW in April. He thanked Council for the opportunity to be involved over the past six years, noting that there were challenges ahead but the SICS was in a good place to meet these. MF thanked DC for his efforts and wisdom over this time.

7.) SICS meetings/ASM Report

- All was ready for the 2014 ASM; speakers' declaration of interest will be improved for next year.
- Volunteers were sought for the 2015 ASM with a planning meeting to be held on 14.03.14.
- (Under AOCB) – SW noted that the joint FICM/ICS meeting had made a £27,000 profit from 70 delegates (see item 4.1 President's report) and hoped SICS would not follow this route. NW stated that this was unacceptable to the Charity Commissions, should be called 'unexpected surplus' and ploughed back into education. DC thought the Old Course Hotel offered a very reasonable deal, and Council agreed they were keen to continue hosting the ASM there. DC noted there was interest from financial companies for next year's meeting.

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

- Work continues to increase the associate membership, and the results of the members' survey was summarised with many preferring to continue with a joint meeting.
- FM will hand over to Ruth Forrest, incoming Associate Rep, to ensure continued progress.
- FM thanked MF and SR for their support and MF offered thanks on behalf of Council to FM.

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

- A new trainee committee will be announced at the AGM.
- Membership remains healthy at 147. A recent survey on job intentions had a 50% response rate, with most planning to joint or dual train.
- The education meeting had been a success with particular thanks due to Laura Strachan. RM asked who will now be involved in the training days, DG agreed to clarify.
- Euan Black had presented the 2012 audit and was writing up the 2013 audit which was completed in December.
- DG thanked his Trainees Committee and Council for their support. MF in turn thanked them for being well engaged.

  AP 9.1 DG will confirm involvement in training days with Martin Hughes and new Trainees' Committee and get back to RM ASAP

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

- No matters arising from the submitted report.

11.) Paediatric Intensive Care Report - report tabled and copy on file

- DR drew Council's attention to the PICAnet report which demonstrated that PICU beds were underprovided for, with potential impact on adult units waiting to transfer a patient to PICU.
- LW asked how many children were heading for transition into adult care. DR replied that it was hard to know as there was no database, but improvements in neonatal care and beyond meant many more children with complex disabilities were surviving to adulthood. LW noted that the adult ICU was also challenging for the families of such children.
- DR thanked Council for involving PICM and introduced Neil Spenceley as his replacement. MF thanked DR for his input noting that this was proving to be a fruitful collaboration.

12.) Critical Care Delivery Group - report tabled and copy on file

- Many of the current issues had been covered in item 4. JC reiterated that the NPF review will be a major piece of work for 2014 and will need Council's support. The surge capacity ventilators remain available for use.
- JC thanked the SCCDG and Council for their support over the years and was pleased to hand over to BC; MF in turn thanked JC for all his hard work and excellent reports to Council, and congratulated BC as his successor.

13.) ICM Recruitment and Training Report - report tabled and copy on file

- **Update:** LW thanked DG for the trainees' survey and recapped the current situation. She explained possible reasons for the worrying under-fill of Scottish training posts in 2013. The majority of applicants for the England & Wales 2013 posts intended to dual train with anaesthesia offering reassurance that the training scheme would continue to provide for workforce needs. All this was put to the SGHD in July but no reply had been received.
- **2014 recruitment:** The deadline for UK recruitment adverts had passed and that for SMT was on 22.01.14 so it had been decided to advertise 11 badged and two unbagded posts (for those with an NTN in a partner speciality). AB was happy for these posts to be advertised on the FICM website. The difficulties of getting applicants from partner specialities was discussed at length. It was clear that the support of deans and local TPDs was lacking. JC noted that 'Reshaping the Medical Workforce' figures identified the need for two ICU posts (out of 60 new jobs) but funding remained a problem. ***AP 13.1: LW to contact FICM to place advert for Scottish jobs on their website***
- **Academic Training:** this remained a problem as trainees cannot do three 'specialties'. Trainees may do pure research (and so are not available to either dual speciality) and in due course try to 'drop' one of their NTNs. The system currently does not allow this but this has not yet been challenged.
- **Falling appeal of ICM as a career:** difficulties in training (longer time, double exams) will lead to attrition, longer working lives and changing working conditions will affect consultant ambitions. NW noted that FICM was considering how to deal with the need to change work practices for older consultants.
- **PICU:** DR asked when the dual trainees will be coming to PICU. LW replied that this would take about two years, although they would be doing their higher anaesthesia block at the same time.
- **ACCPs**: the second national ACCP meeting will be held in Edinburgh on 26.06.14 at the RCPE. It is hoped that the new curriculum will be accepted for award of a qualification by higher education institutes, with FICM running the exam. To recognise equivalence of those already in practice FICM will offer affiliate membership. It was agreed that a national programme would avoid the current problem of ACCPs moving from training units (who bear this cost) to non-training units. RA asked about current numbers of ACCPs. Lothian have 13 trained, 3 in training, 3 posts advertised and another 5 planned. Across the UK there are over 60 trained ACCPs. JR cautioned that some return to nursing and for all ongoing funding was a major issue.

14.) CMO's Advisor in ICM Report

- Work continues on workforce pressures and training post numbers (see item 13 above).

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

- Many of the current issues had been covered in item 4. SC noted that the transplant services were severely stretched with the current increase in donor numbers. He urged ICM in Scotland to remain engaged with donation.
- SC thanked Council for the opportunity to represent SICS on the STG and wished CW well as his successor. MF in turn thanked SC for his talent and diplomatic abilities in this difficult role, and reiterated support to CW going forward. He reassured Council that involvement would continue, recognising that SICS must represent the broad views of all members.

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

- MS reported that encouragingly more units are getting involved in studies. There are further changes in funding methods ahead. The Group intends to develop its website, linking in with the new SICS site.
- SR noted that Prof Peter Andrews had been in touch with the results of the 2012 Delphi study into research priorities, and she will put him in touch with MS.
  AP 16.1: SR to introduce MS to Peter Andrews by email

17.) SICSAG Report - report tabled and copy on file

- CW has been appointed Vice Chair of SICSAG.
- In line with SGHD health strategy SICSAG will need to improve clinical governance, particular in relation to process measures, and the quality indicators will also need to be revisited to align them with the rest of the UK.
- Wardwatcher has served SICSAG well but is person dependent. It will need to be replaced in the next few years with something more sustainable and with adequate data protection standards as mandated by the GMC.
- SICSAG continues to be well thought of down south, and BC is building on this with his work on the CCLF and the ICNARC Data Access Advisory Group. SICSAG data has been run through the ICNARC Case-Mix Programme with results to be published later this year.

18.) AOCB

- **Annual Report** – RM will use the reports for the AGM as the basis of the Annual Report content, aiming to publish in May 2014. There was general agreement that the electronic format of the 2013 report had worked well with no negative feedback, although some Council members were keen to have a paper copy. Concerns were expressed about the potential loss of digital data. There will therefore be a hard copy print run this year with exact numbers to be finalised in due course.
  AP 18.1: RM to collate information and liaise with publishers as per last year
  AP 18.2: RM and SR to decide on final number for print run
- **FICM Annual Meeting** – GN drew Council's attention to the meeting to be held on 07.03.14.

MF closed the meeting by offering thanks to a fantastic and cohesive team of Council members over his two year presidency and welcomed GN, the first physician intensivist to become SICS President. GN replied by thanking MF, feeling privileged to take over, but with a lot to live up to.

Date of Next Meeting: Friday 16th May 2014, 13:30 for 14:00
Royal Hotel, Bridge of Allan