This month in *JICS*

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These are torrid times for the NHS and those who work within it. The days of security and certainty for our job plans, salaries and pensions appear to be at an end and this loss of incentive has far reaching implications for the NHS. It is of grave concern that the medical workforce is having contracts imposed without mutual agreement, and it looks likely that legal repercussions will ensue. Nursing and allied health professionals have already felt the pain with re-banding, but more is likely to come. When combined with pension changes requiring us to work for longer, the outlook for an acute service such as intensive care is worrying. Intensive care staff have always worked seven-day weeks with consultant-led (and increasingly delivered) service provided 24 h a day, every day of the year. This takes its toll on work–life balance, physical and mental fatigue and our ability to recuperate after intense and often sleep-deprived on-calls and shifts; burn out is a major risk. If intensive care is to recruit and retain high-quality individuals, the profession needs to be able to provide for the varied requirements of both specialty and individuals at different points in their career; however, the Department of Health seems intent on using the stick rather than the carrot, and caring for its staff is clearly not on the agenda. As a result, we risk an exodus of the best from our profession into the private sector, overseas employment, early retirement or alternative careers. A healthy workforce will deliver a healthy service; currently, both are in decline.

Last year, I attended a conference on NHS innovation that opened with a speech from a political figure that was clearly meant to be inspirational to the clinical staff in attendance. The focus was on re-introducing ‘care’ into the ethos of the NHS and what we as individuals could do to aid this. I raised the point that if a business wishes to create a corporate image or ethos then it should lead by example – top down; if caring is the desired end-point, then our NHS leaders would do well by looking at the way it treated its staff. Sadly, it is clear from current events that this approach is not going to happen. Quite the opposite, a bigger stick is being wielded and with ever increasing vigour; the outcome is inevitable and is clearly desired from a political strategy perspective. Cheap health care seems to be the primary endpoint with all other factors (such as quality, innovation, and staff value and retention) being placed firmly in the wings.

A potential casualty of these changes is the loss of innovation; particularly when it comes to research, service improvement and the publication of novel findings. While these value-added duties may no longer be recognised within new contracts, we should remember their value to our patients and professional standing.

Despite all the above, the articles featuring in this issue of *JICS* highlight the dedication of our contributors, reviewers and editorial team, all of whom provide their services free of charge; seven days a week! Our opening editorial by Jules Brown provides valuable insight into the ever-changing issue of Deprivation of Liberty law when applied to the intensive care setting. We have a number of original articles covering a range of topics. Drs Tordoff and Bodenham highlight the low number of successful donations after circulatory death in patients who experienced out of hospital cardiac arrest; they discuss the practical implications of this on triggering the organ donation pathway. Meanwhile, Matthew Thomas and colleagues surveyed UK practice in the management of patients following cardiac arrest. We have two articles on the non-invasive ultrasonic cardiac output device, both authored by Luke Hodgson and colleagues. In the first, the authors compare the use of this device with the oesophageal Doppler monitor in patients undergoing abdominal surgery; in the second, they focus on the learning curve for using the device and its inter-rater reliability. In contrast to the above, Hannah Reay and colleagues undertake a further analysis of intensive care research priorities, while John MacDonald and Anthony Thomas provide an in-depth analysis of how critical incidents are reported; from the latter, they infer ways in which patient handover process could be modified to improve communication and safety.

Elsewhere, Myura Nagendran et al. provide a systematic review which places another nail in the coffin for dopamine use in septic shock. Our special articles, case reports and correspondence all add further to the breadth of topics within, and if my comments

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at the beginning of this foreword aren't cynical enough, there is always the lament of Wood and Trees' Lemmingaid for your entertainment; I sincerely hope the contents stimulate academically and

clinically. I shall finish by highlighting once again that this journal exists because of the contributions of our authors, reviewers, editorial team and, of course, our readers; my sincere thanks to you all.