Critical Care Networks
England, Wales & Northern Ireland

Networks' Annual General Meeting 08 April 2018

Report - April 2019

This report includes the slides from the event and is 35 pages long.

1GB/ABa April 2019

National Critical Care Networks' AGM

Introduction and purpose

1. This report provides a summary of the Networks' AGM held on 8th April 2019. The day was attended by network teams comprising of 44 lead managers/directors, nurses, AHPs and medical leads. All attending were working at Network level.

2. The day provided opportunities to network, update on activities, share Network practice as well as consider common themes and solutions for Networks within multi- disciplinary and geographically /regionally diverse discussions.

Programme

3. The morning was chaired by Andrea Baldwin and the afternoon was chaired by Graham Brant. The programme for the day was designed around the prevailing issues for critical care. At the end of the day there was a table map exercise and ideas will be sent as a separate document at a later date

Topics included:

- Achievements to date by the outgoing co-chairs
- Developments in Critical Care Commissioning and the CRG
- Principles for critical care peer review and D05 gap analysis review
- Educational strategies and the national rehabilitation handover document
- Collaborating for quality with the ICS
- Impact on Critical care transfers a view from the Healthcare Safety Investigation Branch

4. The programme for the day, attendance list, presentations (in hand-out format) can be found in the following ANNEXE to this report.

With grateful thanks to all presenters and for their kind permission to share their slides.

2GB/ABa April 2019

Notes of the day

Notes from 8th April 2019 CC ODN AGM (thanks to C. Horsfield)

1. Welcome by Graham Brant. Dates for future meetings for Directors and CC3N shared

2. Sue & Angela (out-going co-chairs) presented the achievements to date. Report available.

3. Helen Morrison provided an update on critical care commissioning including;

    - DO5 – Has now gone through all the necessary approval mechanisms including the Clinical Priorities Advisory group (CPAG), who gave complimentary feedback to all those involved in its development. The document should be available on the website from this coming Friday (12th April)
    - ODNs will take a lead role in ensuring organisations implement the new service specification.
    - Compliance will be assessed by quality surveillance assurance processes using a range of QI metrics and quality dashboard data.
    - In order to address inequalities of ODNs, a standardised model of funding will be applied and NHSE are committed to ODNs in the long term and as such there will be stronger links with the national team.
    - 2019/20 funding for ODNs will remain unchanged from previous.
    - Future work plan for ODNs will ensure they meet requirements set out in a national framework, with formal agreement /contractual arrangements to be tailored regionally. These agreements will be with NHSE –Network, NHSE –Host, Host –Network, Network –members.
    - There will be regional accountability and performance management.

- There will be a service specification for networks outlining what the deliverables will be. It will include metrics.
- National programme of care, Board accountable to NHSE (Regional).
- Contract arrangements to be in place by 30th June 2019 to include; Staffing, work programme, reporting arrangements and funding.
- Collaborative commissioning is a key priority for CRG to address fragmented commissioning activities. Protocol to have one lead commissioner. Various options presented for consideration exploring capacity and activity based systems.
- For zero organ support and >4 hours delayed discharge, there will be zero payment. Pilot scheme being tested in the South.
- Jane Eddleston has be re-elected as CRG chair, and key priorities are payment reform, enhanced care model, and ensuring ACC incorporated in pathways e.g. CAR-T
- Contact: Helen.morrison@nhs.net

4. Mike Caretto: Reiterated CRG priorities as enhanced care /level 1.5 models, pricing reform and embedding ACC in relevant pathways.

5. Paul Dean: National peer review document circulated and comments received prior to the meeting. Much discussion generated and 2 schools of thought –network can agree overarching principles for peer review but allow much flexibility in terms of local processes, or should determine clear process. This could relate to the maturity of the network in terms of what is required to support improvement and what the fundamental role of the network is. Discussion took place about who owns the peer review report (ODNB, Trust, or Network?) Risk of relationship breakdown with individual trusts. No agreement reached and proposal for all to feedback to Paul and plan to host a workshop to take forward.

6. Graham Brant and Kujan Paramanantham: Presented their implementation of benchmarking the DO5 and attempting to provide some clarity for units to self-assess. Example given of 3 units who all provided the same standard of care but scored themselves differently in terms of met, partially met, and not met. The requirements for proposed DO5 compliance include;

Engagement with patients and families, leadership, consultant led care, nursing staff trained in critical care, there is a pathway for admission and discharge, clinical guidelines in place. It is hoped that there will be further detail provided within contracts to determine what constitutes compliance as some are currently ambiguous e.g. all staff trained in critical care. It is applicable to all patients, not just NHSE. In the south, they are called network visits, not peer review.

7. David Fassam HSIB. Presentation was made on the work/remit of HSIB and the process for investigation.

8. Sandy Mather: Outlined a proposed model for collaboration with networks and the work of the ICS. AB proposed working with Mike and Claire to establish 'engagement principles' to clarify want the ODNs would offer in terms of collaborative working for a 'linkman' type scheme. This was supported by those present.

9. Sam Cook: Identified the changing landscape of the critical care workforce and reductions in HEE funding. The roll out of the apprenticeship levy has caused anxiety for many and threatens critical care nurse education. Achievements of the CCNERF sub group presented including the variety of specialist competency documents now developed.

10. Karen Cotton presented the achievements of the CC3N rehab sub group and launched the rehabilitation handover document.

The day concluded by thanking the outgoing Co-Chairs for their work and support and presenting them with a token gift of appreciation.

ANNEXE- **ANNEX 1 CCN AGM Programme for the day**

Critical Care National AGM Agenda
Monday 8th April 2019
The Studio, 7 Cannon Street, Birmingham, B2 5EP

TIME	TOPIC
10:00 - 10:30	**COFFEE & BACON BAPS**
10:30 – 10:35	**Welcome** Andrea Baldwin, Director - Lancs & SC ODN & Graham Brant, Manager/Lead Nurse - SW ODN
10:35 – 11:00	**Achievements to Date** Angela Walsh, Director - NW London ODN & Sue Shepherd, Director – Mid Trent ODN
11:00 – 11:30	**Developments in Critical Care Commissioning** Helen Morrison, National Programme of Care Manager Trauma - NHSE
11:30 – 11:45	**Update from the CRG** Mike Carraretto, Chair - ODN Medical Leads Forum / ACC CRG member
11:45 – 12:00	**Principles for Critical Care Peer Review** Paul Dean, Medical Lead - L&S Cumbria ODN
12:00 – 12:15	**DO5 Gap Analysis Tool – testing the water** Kujan Paramanantham, Network Manager - TV&W ODN & Graham Brant, Network Manager/Lead Nurse - SW ODN
12:15 – 12:45	**LUNCH**
12:45 – 13:15	**HSIB – impact on quality and critical care transfers** David Fassam, HSIB - National Investigator
13:15 – 13:45	**Collaborating for Quality – The ICS Approach** Sandy Mather, CEO – Intensive Care Society
13:45 – 14:15	**Educational Strategies for the Critical Care Pathway** Sam Cook, CCNERF – Chair & Julie Platten, Deputy Chair - CC3N
14:15 – 14:45	**Introducing a National Rehabilitation Handover Document** Karen Cotton, Chair - CC3N Rehabilitation sub-group
14:45 – 15:15	**Table Map** – Future Focus Discussions
15:15 – 15:30	**AOB**
15:30	**EVALUATION & CLOSE**
	NB. Meeting room available for Medical Leads or others until 17:00hrs

5 CPD Points

Programme may be subject to change

ODN AGM 2019 A Baldwin, G Brant, M Carraretto & C Horsfield

6GB/ABa April 2019

ANNEX 2 Attendance

Network / Organisation	Name	Role
Birmingham & Black Country	Emma Graham-Clarke	AHP/HSC Lead
Central England		
Cheshire & Mersey	Karen Wilson	Network Lead Nurse
Cheshire & Mersey	Sarah Clarke	Network Director
East of England Critical Care	Dr Mark Blunt	Critical Care Clinical Lead
East of England Critical Care	Karen Cotton	Critical Care Innovation and Nurse Lead
East of England Critical Care	Melanie Wright	Network Director
Greater Manchester	Victoria Parr	Network Director
Greater Manchester	Karen Berry	Lead Nurse
Greater Manchester	Dougal Atkinson	Medical lead
Greater Manchester	Daniel Nethercott	Medical lead
Greater Manchester	Sam Cook	Chair CCNERF
ICS	Sandy Mather	CEO
Lancashire & South Cumbria	Andrea Baldwin	Network Director
Lancashire & South Cumbria	Claire Horsfield	Network Lead Nurse
Lancashire & South Cumbria	Paul Dean	Clinical Lead
Mid Trent Critical Care Network	Sue Shepherd	Network Director
Mid Trent Critical Care Network	Adam Wolverson	Clinical Lead
Mid Trent Critical Care Network	Martin Mauracheea	Lead Nurse
NE & NC London	Rose Tobin	Network Manager
NE & NC London	Chris Hill	Lead Nurse
NHSE	Helen Morrison	National PoC Manager Trauma
North of England Critical Care Network	Julie Platten	Network Manager
North of England Critical Care Network	Lesley Durham	Network Director
North of England Critical Care Network	Isabel Gonzalez	Network Medical Lead (South)
North of England Critical Care Network	Dave Cressey	Network Medical Lead (North)
North Yorkshire & Humberside		
Northern Ireland	Nichola Cullen	Network Manager
Northern Ireland	Sheila Kinoulty	Lead Nurse
Northern Ireland	Dr Kara Dripps	Lead Clinician
NW London	Angela Walsh	Director
NW London	Gezz Van Zwanenberg	Nurse and Project Lead

Apologies prior to meeting and from list on day

Jonathan Walker – Medical Lead Cheshire and Mersey

Dougal Atkinson Medical Lead Greater Manchester

Chris Langrish Medical Lead South London

Tamas Szakmany Medical Lead Wales

Tim Gould ex Medical Lead South West

Sue O'Keefe Manager Wales

Andrea Berry Manager West Yorkshire

S London	Bincy Padiyara	Network Manager
S London	Chris Langrish	Network Clinical Lead
S London	Adam Reidlinger	Network Nurse Lead
South East Critical Care Network	Mike Carraretto	Medical Lead
South East Critical Care Network	Caroline Wilson	Manager/Lead Nurse
South West Critical Care Network	Graham Brant	Network Manager and Lead Nurse
South West Critical Care Network	Sam Waddy	Network Medical Lead
South West Critical Care Network	Tim Gould	Clinical Lead
Thames Valley & Wessex	Kujan Paramanantham	Network Manager
Thames Valley & Wessex	Kathy Nolan	Network Medical Lead
Thames Valley & Wessex	Gill Leaver	Network Nurse Lead
Wales	Dr Tamas Szakmany	Clinical Lead
West Yorkshire	Tina Wall	Network Manager
West Yorkshire	Simon Whiteley	Medical Lead
West Yorkshire	Alison Richmond	QIL
West Yorkshire	Samantha Rogers	Data Analyst

ANNEX 3 Slides from Presentations – by kind permission

Achievements to date- Angela Walsh and Sue Shepherd

National Critical Care Networks
Directors/Managers' Group
Summary of Achievements
2015-2019

Sue Shepherd & Angela Walsh

1

Aims of Group

- Non-statutory consultative forum
- Critical care strategic and management issues
- Facilitates sharing of information and knowledge, challenges and successes
- Patient safety prioritised always
- Operational Delivery Network role support
- Joined-up and collaborative approach across critical care

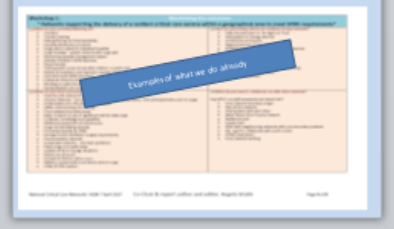
2

2019-20 onwards

- Specialised commissioner intentions for ODNs:
  - Network of Networks
- Networks
  - Operational consistency/effectiveness
  - Improving care
  - Managing patient flows

3

Achievements and impact / importance for patients



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Achievements and impact / importance for patients

5

Trust and leadership

- Trust
- Leadership
- Collaborative advantage?

or simply seen as "more done unto"

- Social pursuit with purpose
- Productive relationship
- Extent of role ….. E.G with pathways?……

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Moving forwards

- Maintain collaborative/facilitative approach to the sharing of information and knowledge
- Continue to join up the work of the national groups
- Maintain representation and two-way communication and influence with national groups
- Continue to work in partnership to improve the experience and outcomes for critically ill patients

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Priorities

- Transfers
- Coordinated commissioning (NHSE/CCG)
  - Lead (coordinating) commissioner
    - Affordability, Plan, monitor, deliver, improve service provision
    - Reduce unwarranted variation in operational and clinical performance
- Critical Care ODNs
  - Structured
  - Funding model
- Paediatrics
- Enhanced care

8

Questions / comments??

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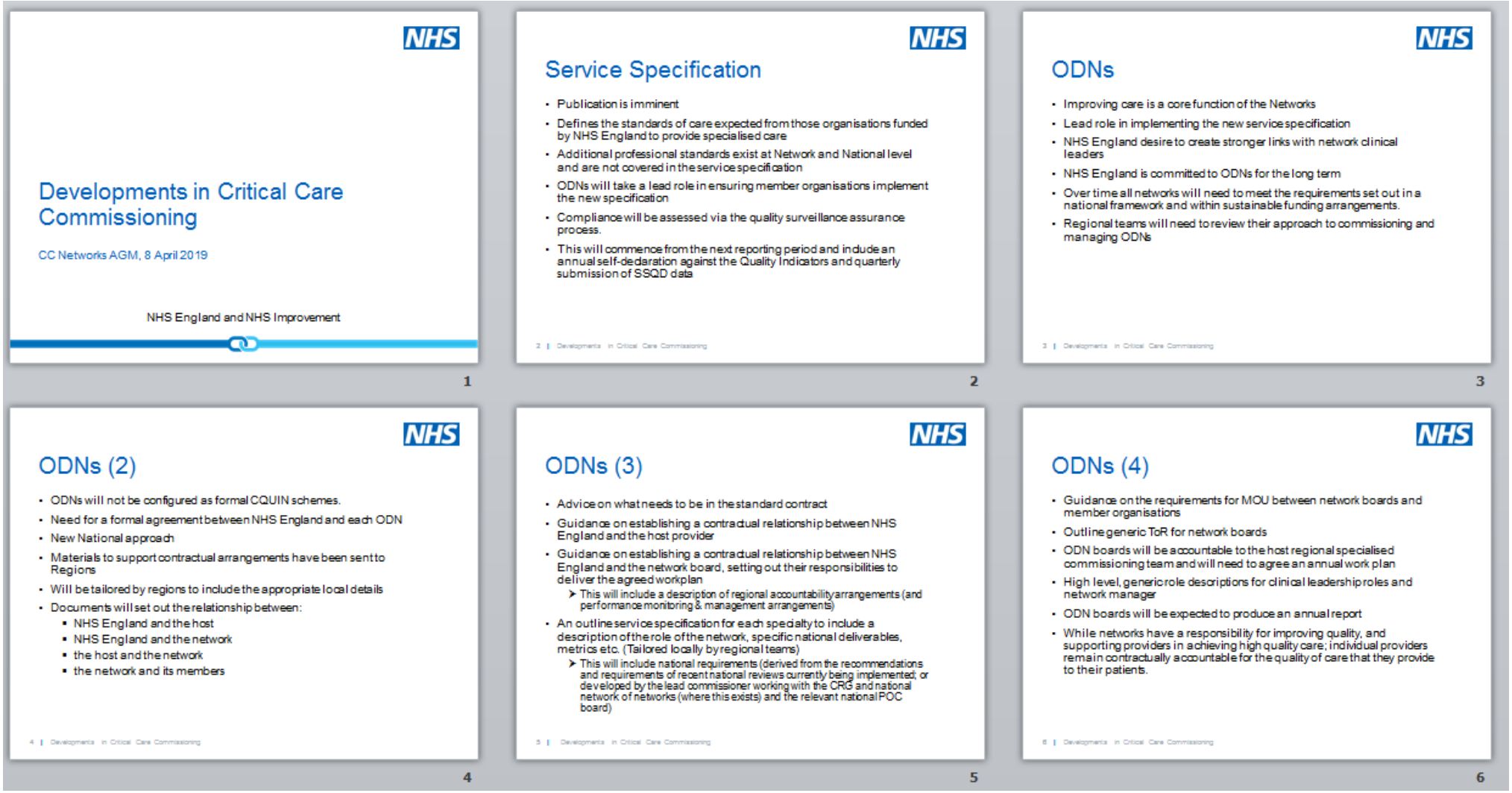
Developments in Critical Care Commissioning- Helen Morison



ODNs (5)

- Appropriate contract arrangements in place with network host organisations and network boards by 30 June 2019.
- As part of this process regional teams will need to agree staffing, work programme, reporting arrangements and funding with each network.

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Collaborative Commissioning

- Critical Care is commissioned by NHS England and CCGs
- Critical care periods are remunerated on the basis of a tariff/specialised split
- Dependent on the responsible purchaser of the underlying spell as per Identification Rules
- A single Unit is often commissioned by multiple purchasing organisations
- Commissioning activities can be fragmented.
- Protocol drawn up with aim of establishing arrangements whereby one party takes the lead as the coordinating commissioner

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Collaborative Commissioning (2)

- In terms of ACC activity, CCGs hold a majority nationally, but at Trust level, it varies significantly
- Some Trusts are 98% tariff, while others are 80% specialised.
- Need for local system leadership to design services that meet he needs of patients.
- Anecdotally: Teaching Hospitals usually NHS England; DGHs usually CCG
- CRG agreed that the ODN should take the lead in deciding which party should be the coordinating commissioner
- Unified pricing structure across the Network is essential (but difficult to achieve)!
- Request for Networks to trial the arrangement
- Aimed at driving change and Quality Improvement

9

Payment Reform

- Proposals aimed at removing barriers (dis-incentives) associated with delivery of the standards in the service specification
- CRG considered 2 options

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Option A

Blended Payment Model

- Patients assigned HRGs XC06Z (1 organ supported) or XC07Z (0 organs supported) will receive nil marginal payment in respect of the ACC portion of their spell in hospital in 2019/20. The rest of the spell remains unaffected.
- There are indicative nationally recommended Local prices for HRGs XC01Z, XC02Z, XC03Z, XC04Z, XC05Z (i.e. 2+ organs supported), reflective of estimated marginal costs. These prices should be implemented with MFF adjustments.
- The residual quantum for each provider is paid as a block in monthly 1/12ths; that is, the overall commissioner budget less expected activity x price will be paid irrespective of activity in equal payments throughout the year.

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Option B:

System-wide Control Total

- To achieve zero-expected revenue impact in 2019/20, the block payment is calculated as the current combined commissioner budget for agreed ACC capacity.
- Joint work will be carried out during 2019/20 to benchmark local costs, to understand variation, and address unwarranted variation in activity and cost
- The commissioner and provider will monitor the actual ACC budget and spend and share the impact of fluctuations in spend, the detail of which is to be agreed locally.

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Mandatory elements

Zero-organ episodes

- Stays in ACC that are grouped to unbundled HRG XC07Z shall receive zero marginal reimbursement and zero risk-share payment (pertaining to each option, respectively).
  - In practice, this means that zero-organ spells are set to a *per diem* price of £0.
  - Providers retain the relevant portion of their infrastructure block payment as this is non-contingent on activity.
  - The unit of activity to be zero-priced is the organ-day, which follows from the assignation of the XC07Z HRG at Critical Care Period level.

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Mandatory elements (2)

Delayed discharges

- ACC Stays that continue beyond 4 hours from the consultant's declaration that the patient is fit for discharge (DFD) will receive zero marginal payment in 2019/20 for days post-DFD, in line with national standards.
- This follows a successful implementation of the Adult Critical Care Timely Discharge CQUIN in 2016/17 and 2017/18.
- The relevant payment rule is this: for each patient that is discharged from Adult Critical Care any time after 4 hours from DFD – who thereby suffers a delayed discharge – payment will be reduced by the equivalent of one day's payment. This will be deducted from the monthly 1/12th block payment, appropriately apportioned.
- Implementation will require data that is derived from ICNARC CCMDS submissions, which is available from the QST portal (formerly SSQD).
- https://www.qst.england.nhs.uk/login (requires registration and appropriate permissions)

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Payment Reform

- In a nutshell…..
- **Capacity** payment on the basis of the number of open beds. This will take the form of a block.
- **Activity** payment based on the existing currency, with an amended pricing model that sets 0, 1 organ patient to zero pricing and higher organ patients to estimated incremental-cost prices over the cost of delivering lower organ care.
- This involves a standardisation of prices, but no change in funding (the capacity block accounts for the residual expected).
- It will be mandatory that:
  - zero-organ critical care periods are zero priced.
  - discharge 4-hour post-DFD penalty is applied as a monthly block reduction (from quarterly QST reports)

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Way forward

- CRG supported the case for change
- Proposals need to be piloted/tested
- Both options require the collaborative commissioning model to be in place (option B more so)
- In terms of delivering change, the lead commissioner would need to have the support of Clinician(s) and Finance Director
- All need to be involved in contractual discussions
- This will remain as a pilot to be tested in the South Region.
- Clarification being sought in relation to mandatory elements

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Future work

- Trauma Programme of Care Board is agreeing CRG strategic priorities
- 3-year work programme
- For Adult Critical Care the priorities include:
  - ➢ Continuing to work with colleagues on payment reform
  - ➢ Development of a model for enhanced care (Level 1.5)
  - ➢ Ensure ACC is integrated in to relevant pathways, e.g. CAR-T
  - ➢ Supporting the work of the National Clinical Frailty Programme

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Helen.Morrison@nhs.net

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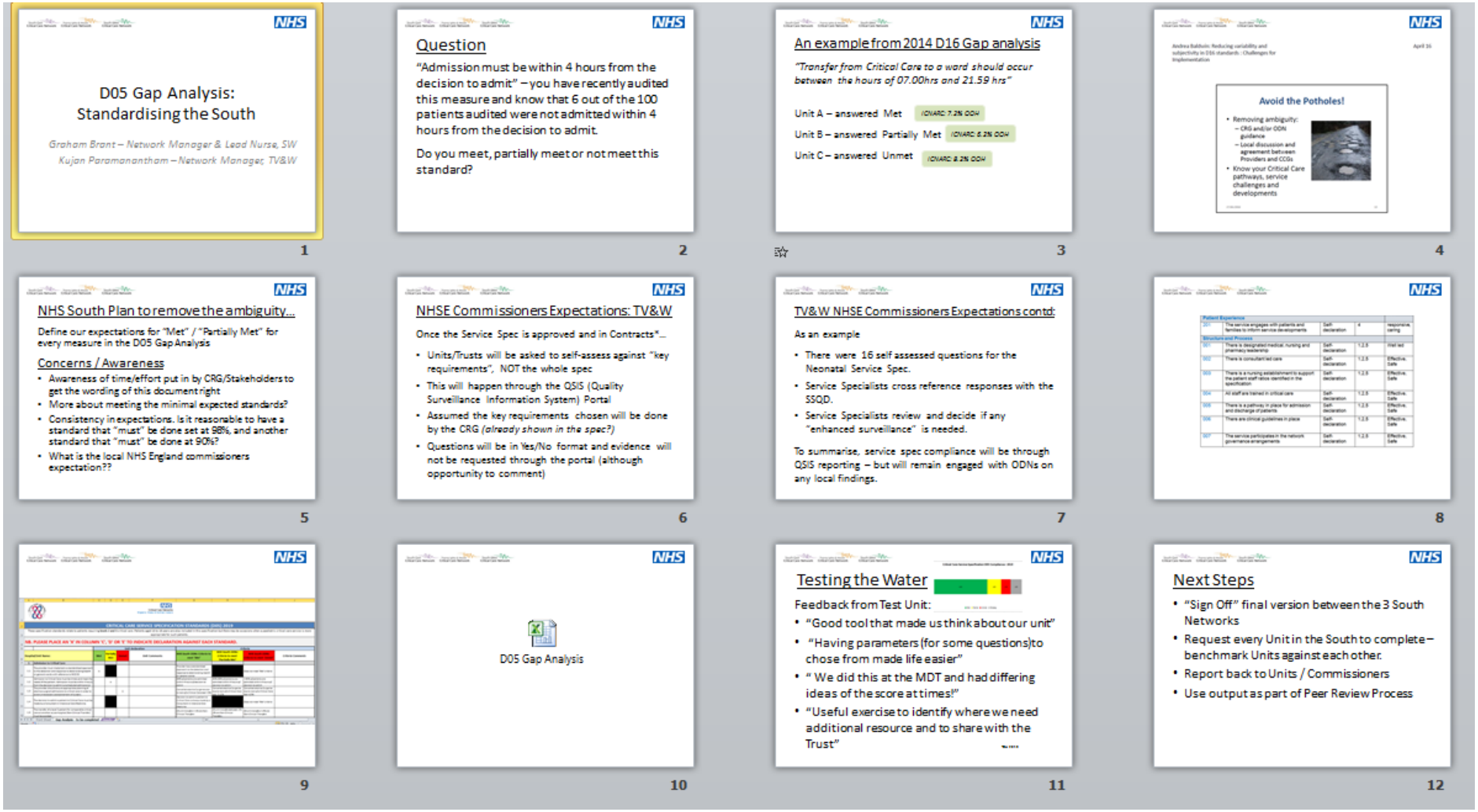
D05 Gap Analysis Tool- Kujan Paramanantham & Graham Brant



HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

Accident investigation in healthcare

Critical Care ODN AGM

Dave Fassam
National Investigator

@hsib_org

Investigating clinical incidents

"In this paper we suggest that [learning] would be most effectively achieved by the creation of a small, permanent independent agency, charged with coordinating major inquiries and safety investigations in the NHS."

Independent inquiries

- Each start afresh and determine own unique approach
- Teams are short-lived and dissolved once the report is complete
- No capacity to review progress against recommendations
- Rare, costly, conducted years after the events occurred, no capacity to drive organisational change

WWW.HSIB.ORG.UK

Investigations in other industries

AAIB Air Accidents Investigation Branch — 1915 — 1912 Brooklands Flanders monoplane crash (2)

MAIB MARINE ACCIDENT INVESTIGATION BRANCH — 1989 — 1987 Herald of Free Enterprise (193)

RAIB Rail Accident Investigation Branch — 2005 — 1999 Paddington rail crash (31/520)

Healthcare?

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Drivers for HSIB's establishment

- Five public inquiries between 2010 and 2015
- All identified fundamental issues compromising safety, public accountability, professional culture in the health service, and the rights of patients
- Significant cost

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Public Inquiries into NHS Hospital Care

- The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary (2001)
- Mid Staffordshire NHS Trust Public Inquiry (2013)
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (2013)
- Freedom to Speak Up (2015)
- Morecambe Bay Investigation (2015)

www.hsib.org.uk

PHSO investigation into Sam Morrish 2016

- Sam was 3 years old and died from Sepsis in December 2010.
- 2014 investigation found that had Sam received appropriate care he would have survived
- BUT the investigation failed to explain why he died
- PHSO found the investigation not fit for purpose in that it failed to identify extensive series of errors
- Didn't focus on learning or span organisational and hierarchical barriers
- Investigation excluded the family and many staff

A Global First Health Accident Investigation Branch is Born

www.hsib.org.uk

HSIB team (national)

- Functionally independent
- 12 investigators: clinical, air accident, military accident, **human factors**
- 3 Principal National Investigators
- Up to 30 investigations per year
  - 1.8m+ reports on NRLS
  - 24,000+ serious incident reports
- Improving the standard of investigations across the NHS

www.hsib.org.uk

Expanded remit

- In November 2017, the Secretary of State for Health and Social Care announced a new maternity safety strategy detailing plans for HSIB to undertake **~1000** independent safety investigations
- The investigation element is part of an overall strategy to improve maternity safety
- A maternity implementation team was set up to develop the approach, methodology, and recruit investigation teams
- Programme roll out began in **April 2018**, with full national coverage by **April 2019**

HSIB Principles

- **Objectivity**

Recommendations are for learning and improvement not to attribute blame or liability

- **Transparency**

Reflecting a model of openness through genuine engagement

- **Independent in action, thought and judgement**

Operating without fear or favour and exercising independence when investigating any area of patient safety

- **Expertise**

Staffed by investigation experts with a range of backgrounds

- **Learning for improvement**

Use findings to deliver practical solutions, address causes and contributory factors and provide support to increase the capability within local NHS systems

Challenges

- What should we investigate?
- How do we involve families?
- How do we engage with NHS organisations?
- How do we engage with other statutory bodies?

HSIB criteria

Outcome Impact

- **People:** physical, psychological, loss of trust
- **Service:** quality and reliability, capacity and capability
- **Public:** confidence, political attention, media profile

Systemic Risk

- **Systemic safety deficiency:** range of care settings; geographic/specialist spread; scale through system structures; complexity of interactions
- **Dormancy period:** time taken to identify risk; route of discovery
- **Persistence and expansion:** Permanence; potential for escalation and spread

Learning Potential

- **Potential for increased knowledge:** new knowledge; gap in current knowledge;
- **Potential for systemic improvement:** opportunity to positively influence system, practices, safety culture
- **Practicality of action:** feasibility of conducting effective investigation; practicality of issuing influential recommendations
- **Value of intervention:** adequacy and scope of safety actions by others; potential to develop HSIB capacity and capability

Investigation principles

- System wide safety issues
- Systems, not individuals
- Insights from **human factors** science
- A Just Culture approach
- Safe Space principles
- Learning from near misses as well as serious harm

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HSIB Investigation selection

- Individual incidents are the basis of our investigations
- Safety Awareness Notice open to all, public professionals, NHS organisations, external organisations such as Police
- Intelligence Unit review incident reporting systems identify potential investigations
- Identification of themes of national importance and then identifying incidents to initiate an investigation

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Investigation themes

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Recommendations

Investigation into the implantation of wrong prostheses during joint replacement surgery

1. **Recommendation 2018/001:** NHS Improvement amends the national Prosthesis Verification Standard to incorporate the specific aspects of verification practice developed to mitigate error identified in this investigation.
2. **Recommendation 2018/002:** The British Standards Institute amends existing standards for prosthesis labels to include details of design that make them easier to read in operating theatres. The American Society for Testing and Materials' 'Standard Guide for Presentation of End User Information for Musculoskeletal Implants' is a useful reference.
3. **Recommendation 2018/003:** The National Joint Registry changes the response when data is entered into the registry suggesting the wrong prosthesis has been implanted due to incompatible manufacturers, so that it is consistent with the response when data indicates the wrong size or side has been implanted.
4. **Recommendation 2018/004:** The Department of Health and Social Care expands the remit of the working group consisting of Derby Teaching Hospitals NHS Foundation Trust's ScanMSafety Programme, the National Joint Registry, and the Medicines Healthcare products Regulatory Agency to include alerts to identify wrong prostheses prior to implantation.
5. **Recommendation 2018/005:** The Department of Health and Social Care commissions the development and implementation of an interim basic scanning system to identify wrong prostheses prior to implantation.

Investigation into administering a wrong site nerve block

1. **Recommendation 2019/012:** The Royal College of Anaesthetists establishes a specialist working group to evaluate the current practices used to reduce wrong site block incidents. This group should consider how safety initiatives to reduce wrong site blocks can be standardised in anaesthesia training and practice.
   It is recommended that the specialist working group consider the impact of: the patient's state of consciousness, changes in a patient's position and the prevalence of wrong site block incidents compared to the number of blocks administered.
2. **Recommendation 2019/013:** The Royal College of Anaesthetists ensures any further work identified by the specialist working group to reduce wrong site block incidents is subject to human factors-based testing and evaluation.

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Observations

The national serious incident reporting system does not require inclusion of data regarding human factors such as environmental conditions, and individual and team factors. It would be beneficial for future developments to the system to collect such data.

The development of patient safety initiatives should incorporate human factors and safety science specialism. This can help ensure that appropriate planning, testing, and evaluation take place to ensure a strong evidential basis for patient safety initiatives.

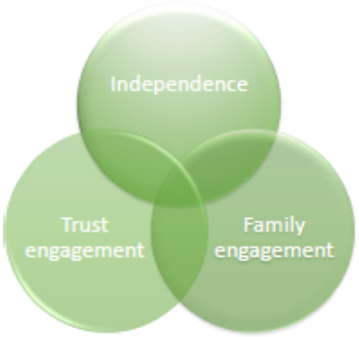
How do we involve families?

- Critically important for HSIB, given the history of NHS investigations
- What level of involvement?
- How do we maintain our independence?
- Head of Family Engagement
- Now ensuring that family engagement is considered at the earliest stages of each investigation
- Model of engagement will develop over time

Engagement with NHS organisations

- Mixed response so far
- Some NHS Trusts are wary of us; are we another regulator?
- Investigation teams understand that these relationships are critical for future success
- No powers so far but ensures investigation teams take a collaborative approach
- Independence!

Essential investigation ingredients



Engagement with statutory bodies

- NHS regulators, CQC, NHSI
- Coroner
- HSE
- Police

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Transfer of critically ill adults investigation

Reference Event

- 54 year old male
- Gym – weights
- 18:00 Sudden onset chest pain – radiated through to his back
- 20:04 Arrived at hospital
- 00:01 CT scan
- 01:06 Results reported – aortic dissection confirmed
- 01:57 Ambulance departs
- 02:09 Respiratory arrest
- 03:15 Pronounced dead

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Identified Transfer Issues

Pre-Alerts
- Delivery and receipt standards
- Training
- Pre-alert delegation

Patient Transfer
- Varying standards of transfer of Level 2/3 patients
- Medical escorts

ODN Governance
- Varying standards of governance identified nationally

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Wider Investigation

- ED visits
- Days with ambulance crews
- Network meetings
- Engagement and advice from SMEs

Recommendations

- The Department of Health and Social Care should co-ordinate the development of national guidance, with the arm's length bodies, for the transfer of critically ill adults, both in planned and emergency situations.
- The Association of Ambulance Chief Executives should work with partners to define best practice standards for the criteria, format, delivery and receipt of ambulance service pre-alerts.

Observation

It would be beneficial for formal governance arrangements to be established to oversee the transfers of critically ill patients.

Reaction to report

Recommendations accepted

Organisations not specifically named or involved have contacted HSIB and requested that they be involved or have presentations to further understanding.


HSIB
Questions?
www.hsib.org.uk
https://www.hsib.org.uk/investigations-cases/transfer-of-critically-ill-adults/
WWW.HSIB.ORG.UK

Collaborating for Quality – Sandy Mather

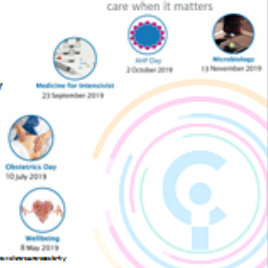
Your Society – our Strategy (2019-2023)

- Elected Council and Divisions - members and managers collaborating
- Four strategic priorities (SP)
  - SP 1 Your voice- our influence
    - Public Affairs Division
  - SP2 Your region – our network
    - Professional Affairs Division
  - SP3 Your patients – our research-based care
    - Research Division
    - Standards Division
  - SP4 Your professional practice – our education
    - Learning Division

7

Overview

- Collaboration
- Your Society – Our Strategy
- **Getting to know ICS as a charity**
- Collaboration



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Getting to know ICS as a charity

- To advance and promote the care and safety of critically ill patients by
  - the **advancement** and **promotion** of those branches of **medical science** concerned with **critical care**; and
  - the **promotion** of **study** and **research** into critical care and the **publication** of the useful results of such study and research.

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Getting to know ICS as a charity

- To be recognised as a charity we have to demonstrate that we satisfy the 'Public Benefit' requirement as set out in S4(1), Charities Act (2011)
- To satisfy the 'public aspect' of public benefit the purpose must
  - benefit the public in general, or a sufficient section of the public
  - not give rise to more than incidental personal benefit
- To satisfy the 'benefit aspect' of public benefit the purpose must
  - be beneficial (who do we help? Who are our beneficiaries?)
  - any detriment or harm that results from the purpose must not outweigh the benefit (what harm could result from our charitable activities?)

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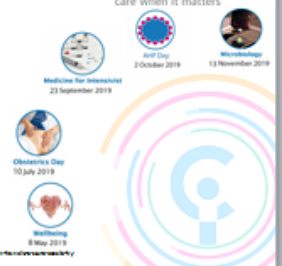
Getting to know ICS as a charity

- Accountability and impact
  - Our members
  - The public
  - The regulators
    - Charity Commission for England and Wales
    - The Office of the Scottish Regulator
    - Companies House
  - Annual independent professional audit by Macintyre Hudson
  - Trustees Annual Report

11

Overview

- Collaboration
- Your Society – Our Strategy
- Getting to know ICS as a charity
- **Collaboration**



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Collaboration

- Choosing to Collaborate, The Charity Commission, 2009
  - "Collaborative working describes joint working by two or more organisations in order to better fulfil their purposes, while remaining as separate organisations."
  - "encourages charities to look regularly and imaginatively at what more they can achieve for their beneficiaries by working with others. The ultimate aim of any charity must be the provision of the very best services for those who benefit from its work and one way that this can be achieved is by joint working."

The Charity Commission, (2009) Choosing to collaborate: helping you succeed. *The Charity Commission*, London. Available: https://www.gov.uk/government/publications/choosing-to-collaborate-how-to-succeed Accessed: 16th, 2019

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Collaboration

- National – some current ICS collaborations
  - With AACBI – Fire Safety Standards
  - With FICM
    - AHP Critical Care Professional Development Framework
    - CPICS (due 2019)
  - With NHSBT - Peri-Mortem Interventions in Potential Organ Donors
  - With NOrF/CC3N – Critical Care Outreach Practitioner Competencies and Professional Development Framework

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Collaboration

- Global
  - Network for Improving Critical Care Systems and Training: Sri Lanka, India and Pakistan
  - Zhejiang Health and Family Planning Commission, China
- Collaborating for efficiency, effectiveness and economy
  - ICNARC – shared staff training, meeting rooms etc
  - RCOA – leaseholders for shared office and meeting room space
  - UKCCRG – MoU–jointly promote research – on a practical level hold and disburse UKCCRG funds on their behalf

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Collaboration

- With Operational Delivery Networks
  - Sharing data to inform guidance development, for example
    - Transfer of the critically ill adult (NB ICS provide personal accident travel insurance for upto £1,000,000 for members)
  - ICS has endorsed ODN guidance, for example
    - National Critical Care Networks coordinated response to recent Regulation 28 publications from UK Coroners relating to critical care capacity and immediate life preserving interventions (Jan 2019)
  - We have co-developed guidance together, for example
    - Principals for the repatriation of critically ill patients from international hospitals to UK critical care units (Due 2019)
  - Chair of National Medical Leads group and Chair of Network Directors group on ICS Council and ICS Standards Division
  - What else? What more?
- Proposal
  - Collaborate even more for mutually beneficial outcomes

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Collaboration - proposal

Your voice
- Surveys, workforce, issues that matter to you, ICS newsletters, website, publicity

Your region
- ODNs, critical care units, knowledge exchange, MDT, 3,300 ICS members

Your patients
- Research, standards, CPICS, audit tools, QI tools, JICS free and open access

Your professional practice
- Educational events, podcasts, remote learning, webinars

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Collaboration - proposal

- Some examples of the sorts of things we could all benefit from knowing on a national level
  - Is there a 7 day service for AHP staff?
  - What service levels are funded by critical care? i.e. is it as per CPICS V1?
  - Challenges around pensions
  - Caring for patients who are unconscious and in whom you wanted to remove life saving intervention but you have been prevented from doing so by a Court of Protection ruling?
  - To what extent do hospitals offer sabbaticals to staff - paid or unpaid? MDT variation?
  - Incidence of having to act down overnight (and be resident) to covers junior rota?
  - Variation in vacancy levels for nurses?
- Who would be the key ICS contact for each ODN?

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Collaboration

- Knowledge exchange is both ways
- Strength in numbers – stronger voice
- ICS could promote ODN activities in our newsletters, website, LinkedIn, Instagram, Twitter, FB
- Education and networking events – local promotion
- Improved impact
- Better use of limited resources and value for money
- Improved support for the all members of the MDT

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Summary

- Collaboration
- Your Society – Our Strategy
- Getting to know ICS as a charity
- Collaboration

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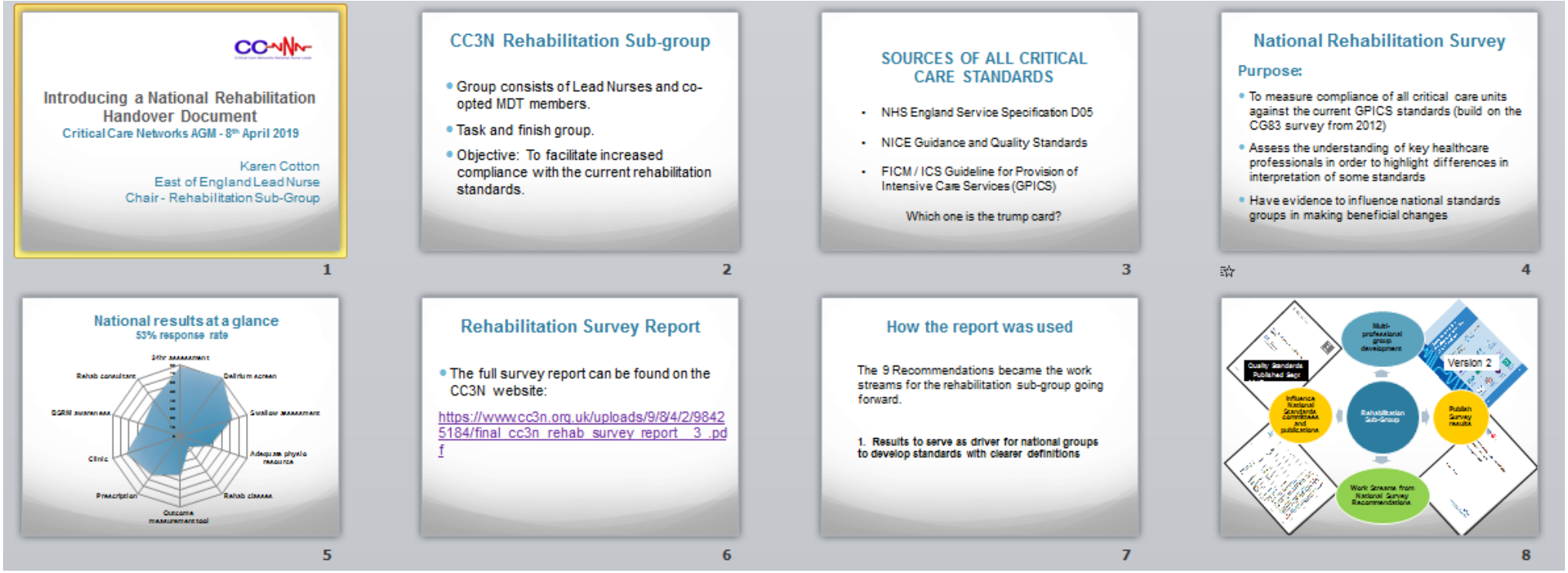
Educational Strategies for the Critical Care Pathway- Sam Cook

Introducing a National Rehabilitation Handover Document- Karen Cotton



How the report was used

The 9 Recommendations became the work streams for the rehabilitation sub-group going forward.

7. Develop a standardised national rehabilitation prescription

9

Critical Care Rehabilitation Handover

Advisory Document

QS158 Number 2

10

Rehabilitation Handover

Quality Standard No. 2. Adults at risk of morbidity have a formal handover of care, including their agreed individualised structured rehabilitation programme, when they transfer from critical care to a general ward

- Addition to medical and nursing discharge summaries
- It is a programme. In that it provides pointers for on-going rehabilitation – it can be kept brief by referring to therapy notes and prompting to making referrals
- It ensures the right people are involved as early as possible – MDT

11

Guide for completion of the Critical Care Rehabilitation Handover Document

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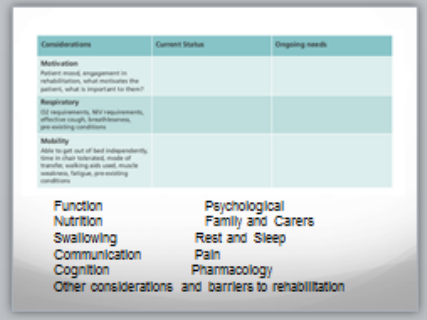

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Summery of Rehabilitation Handover

- Likely to be completed by nurse
- No repetition
- Important to point to individual MDT notes, where the specific goal setting can be found
- Important to make the necessary referrals
- Contact information

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Thank you For Listening

Any Questions?

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ODN Critical Care Networks AGM 8th April 2019

Table Mat discussions

1.What are the key issues that need to be addressed within the 3 national ODN forums (Directors, Medical Leads & CC3N)?

FORM & FUNCTION

- Future of the ODNs
- Continuation of agile effective ODNs,
- Concern regarding the role of specialised commissioners in governing/directing ODNS
- What is the remit of the ODN?
- Clarity regarding the roles of FICM/ICS/ODN forums; seems to be an overlap.
- Peer Review
- To take the 'best of the best' within our collective ODNs
- To avoid becoming a delivery service for NHE/ICS

COMMISSIONING

- DO5 and the split between CCG and specialist beds
- DO5 Implementation
- How can ODN's support service specification contracts?

GB/ABa April 2019

WORKFORCE

- Education within the CC3N
- Absence of AHP representation in networks generally – how are they heard?
- Nurse Education and funding
- Consultant pensions
- Funding CPD for MDTs

CLINICAL PRACTICE

- Patient safety
- Early decision making
- Referral and repatriation process and specialist pathways – the data needed to support this.
- Role clarity around the information for transfer and requests in order to manage expectations.
- Deteriorating patient pathway,
- Transfers
- Roll out the rehabilitation document and survey/audit the uptake of it.

COMMUNICATION

- Improve collaborative relationships
- Increase awareness
- To ensure joining up of group priorities

1. **Why are these issues important?**

- Fundamental to delivering quality care.
- Clear direction.
- Visibility, value and impact.
- To maintain effective patient care and network models that are able to be responsive to local needs.
- We should focus and share the good work the ODN's do.
- 60 professional groups involved in Critical Care but not directly involved in ODNs at their level.
- Avoid a 'tick box' compliance.
- Limited time and capacity to provide accurate information from units meaning more demand on services.
- Should be clearer about what ODN forums should achieve.
- Workforce – multifactorial stressors. No workforce means no service.
- Peer Review – expectation of the ODN.
- We need to raise awareness to prevent us being told what to do in external agenda's.

2. <u>What is the vision that needs to be realised?</u>

- Improved service provision and managed expectation. Patient is at the centre of decisions and investment.
- Keeping patient focussed and improving experience and outcomes for critically ill patients.
- Patient focussed.
- System focus.
- Equity of care.
- Standardisation.
- Peer review common standards/principles.
- Flexibility, agility and responsiveness to change.
- Equality of commissioning for all CC patients.
- 7 day working for all.
- Access to high quality CC services.
- Improvement in service, reduction in work.
- Workforce that can provide equity of care.
- Attainment of comprehensive, expert and passionate workforce.
- Not to lose good behaviour and good will that is in place.
- National Critical Care ODN Website/Twitter.
- Seems to be more coming our way!

3. <u>What should the forums focus on in the coming 12 months?</u>

- Staff morale and welfare.
- Front line engagement.
- Workforce strategy.
- Workforce and Education.
- Gap analysis for educational needs in senior MDT roles in critical care.
- Clinical standardisation.

- Enhanced Care.
- Consistency.
- PICU liaison.
- Paediatric CC and the interface to Adult CC.
- Building links – influence national decisions.
- Making groups.
- Medical Leads should actively foster multi-professional working.

4. <u>Who should we collaborate with to ensure success?</u>

- Broad range of stakeholders
- Front line staff
- Service users
- Commissioners
- ICS
- FICM
- NHS England
- HSIB
- RCoA
- RCP
- Enhanced care developers
- All MDT national professional bodies
- CRG and Trauma Programme of Care
- RCN via UKCCNA
- Paediatric colleagues
- PICU Networks

5. **What will be the benefits of this response for the various stakeholders?**

- An overall broad spectrum approach that will ensure ODN inclusivity and representation in all developments.
- Ensure co-ordinated process of improvement
- Avoid repetition of work.
- Proactive engagement rather than reactive.
- Improving patient outcomes.
- Recognition of requirements for transition/future.

Additional comments

- What is the point of having a provider host under the new arrangements?
- We must not become commissioning QUANGO's.
- With regards to enhanced care, I understand that FICM were to look at definitions of levels of care including level 1+, are there any developments to date?
- How will CCG commissioned components be represented/included in a new system, particularly if ODNs are to be directly accountable to specialised commissioners? Concern that this aspect is not being considered.