



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.

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.

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 been 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 Paramanatham: 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 what 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
	<i>NB. Meeting room available for Medical Leads or others until 17:00hrs</i>

5 CPD Points



Programme may be subject to change

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

ANNEX 2 Attendance

Zahid Khan Medical Lead BCCN

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 Paramanatham	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

1 National Critical Care Networks Directors/Managers' Group Summary of Achievements 2015-2019 Sue Shepherd & Angela Walsh

2 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

3 2019-20 onwards

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

4 Achievements and impact/ importance for patients

5 Achievements and impact/ importance for patients

6 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?.....

7 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

8 Priorities

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

9 Questions / comments??

Developments in Critical Care Commissioning- Helen Morison

 <h3>Developments in Critical Care Commissioning</h3> <p>CC Networks AGM, 8 April 2019</p> <p>NHS England and NHS Improvement</p> <p>1</p>	 <h3>Service Specification</h3> <ul style="list-style-type: none"> • Publication is imminent • Defines the standards of care expected from those organisations funded by NHS England to provide specialised care • Additional professional standards exist at Network and National level and are not covered in the service specification • ODNs will take a lead role in ensuring member organisations implement the new specification • Compliance will be assessed via the quality surveillance assurance process. • This will commence from the next reporting period and include an annual self-declaration against the Quality Indicators and quarterly submission of SSQD data <p>2 Developments in Critical Care Commissioning</p> <p>2</p>	 <h3>ODNs</h3> <ul style="list-style-type: none"> • Improving care is a core function of the Networks • Lead role in implementing the new service specification • NHS England desire to create stronger links with network clinical leaders • NHS England is committed to ODNs for the long term • Over time all networks will need to meet the requirements set out in a national framework and within sustainable funding arrangements. • Regional teams will need to review their approach to commissioning and managing ODNs <p>3 Developments in Critical Care Commissioning</p> <p>3</p>
 <h3>ODNs (2)</h3> <ul style="list-style-type: none"> • ODNs will not be configured as formal CQUIN schemes. • Need for a formal agreement between NHS England and each ODN • New National approach • Materials to support contractual arrangements have been sent to Regions • Will be tailored by regions to include the appropriate local details • Documents will set out the relationship between: <ul style="list-style-type: none"> ▪ NHS England and the host ▪ NHS England and the network ▪ the host and the network ▪ the network and its members <p>4 Developments in Critical Care Commissioning</p> <p>4</p>	 <h3>ODNs (3)</h3> <ul style="list-style-type: none"> • Advice on what needs to be in the standard contract • Guidance on establishing a contractual relationship between NHS England and the host provider • Guidance on establishing a contractual relationship between NHS England and the network board, setting out their responsibilities to deliver the agreed workplan <ul style="list-style-type: none"> ➢ This will include a description of regional accountability arrangements (and performance monitoring & management arrangements) • An outline service specification for each specialty to include a description of the role of the network, specific national deliverables, metrics etc. (Tailored locally by regional teams) <ul style="list-style-type: none"> ➢ This will include national requirements (derived from the recommendations and requirements of recent national reviews currently being implemented, or developed by the lead commissioner working with the CRG and national network of networks (where this exists) and the relevant national POC board) <p>5 Developments in Critical Care Commissioning</p> <p>5</p>	 <h3>ODNs (4)</h3> <ul style="list-style-type: none"> • Guidance on the requirements for MOU between network boards and member organisations • Outline generic ToR for network boards • ODN boards will be accountable to the host regional specialised commissioning team and will need to agree an annual work plan • High level, generic role descriptions for clinical leadership roles and network manager • ODN boards will be expected to produce an annual report • While networks have a responsibility for improving quality, and supporting providers in achieving high quality care, individual providers remain contractually accountable for the quality of care that they provide to their patients. <p>6 Developments in Critical Care Commissioning</p> <p>6</p>

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.

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

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 the 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

Payment Reform

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

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.

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.

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 assignment of the XC07Z HRG at Critical Care Period level.

13 | Developments in Critical Care Commissioning

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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 CCMD5 submissions, which is available from the QST portal (formerly SSQD).
- <https://www.qst.england.nhs.uk/login> (requires registration and appropriate permissions)

14 | Developments in Critical Care Commissioning

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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)

15 | Developments in Critical Care Commissioning

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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

16 | Developments in Critical Care Commissioning

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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

17 | Developments in Critical Care Commissioning

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Helen.Morrison@nhs.net

18 | Developments in Critical Care Commissioning

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D05 Gap Analysis Tool- Kujan Paramanatham & Graham Brant

**D05 Gap Analysis:
Standardising the South**

*Graham Brant – Network Manager & Lead Nurse, SW
Kujan Paramanatham – Network Manager, TV&W*

Question

“Admission must be within 4 hours from the decision to admit” – you have recently audited this measure and know that 6 out of the 100 patients audited were not admitted within 4 hours from the decision to admit.

Do you meet, partially meet or not meet this standard?

An example from 2014 D16 Gap analysis

“Transfer from Critical Care to a ward should occur between the hours of 07.00hrs and 21.59 hrs”

Unit A – answered Met (OVARC 7.2% OOV)


Unit B – answered Partially Met (OVARC 6.2% OOV)

Unit C – answered Unmet (OVARC 8.2% OOV)

April 15

Avoid the Potholes!

- Removing ambiguity:
 - CRG and/or GDM guidance
 - Local discussion and agreement between Providers and CCUs
- Know your Critical Care pathway, service challenges and developments



NHS South Plan to remove the ambiguity...

Define our expectations for “Met” / “Partially Met” for every measure in the D05 Gap Analysis

Concerns / Awareness

- Awareness of time/effort put in by CRG/Stakeholders to get the wording of this document right
- More about meeting the minimal expected standards?
- Consistency in expectations. Is it reasonable to have a standard that “must” be done set at 98% and another standard that “must” be done at 90%?
- What is the local NHS England commissioners expectation??

NHSE Commissioners Expectations: TV&W

Once the Service Spec is approved and in Contracts...

- Units/Trusts will be asked to self-assess against “key requirements”, NOT the whole spec
- This will happen through the QSIS (Quality Surveillance Information System) Portal
- Assumed the key requirements chosen will be done by the CRG (already shown in the spec?)
- Questions will be in Yes/No format and evidence will not be requested through the portal (although opportunity to comment)


TV&W NHSE Commissioners Expectations contd:


As an example

- There were 16 self assessed questions for the Neonatal Service Spec.
- Service Specialists cross reference responses with the SSQD.
- Service Specialists review and decide if any “enhanced surveillance” is needed.

To summarise, service spec compliance will be through QSIS reporting – but will remain engaged with ODNs on any local findings.

Item	Requirement	Self-declaration	Score	Opportunity
101	The service engages with patients and families to inform service development	Self-declaration	4	opportunity rating
102	There is integrated medical, nursing and pharmacy leadership	Self-declaration	12.0	Not set
103	There is consultant led care	Self-declaration	12.0	Effective
104	There is a nursing establishment to support the patient call team overnight in the SSQD.	Self-declaration	12.0	Effective
105	There is a nursing establishment to support the patient call team overnight in the SSQD.	Self-declaration	12.0	Effective
106	There is a pathway in place for admission and discharge of patients	Self-declaration	12.0	Effective
107	There are clinical guidelines in place	Self-declaration	12.0	Effective
108	The service participates in the national governance arrangements	Self-declaration	12.0	Effective





D05 Gap Analysis

Testing the Water

Feedback from Test Unit:

- “Good tool that made us think about our unit”
- “Having parameters (for some questions) to chose from made life easier”
- “We did this at the MDT and had differing ideas of the score at times!”
- “Useful exercise to identify where we need additional resource and to share with the Trust”

Next Steps

- “Sign Off” final version between the 3 South Networks
- Request every Unit in the South to complete – benchmark Units against each other.
- Report back to Units / Commissioners
- Use output as part of Peer Review Process

<div data-bbox="241 491 412 619" data-label="Image"> </div> <div data-bbox="488 427 898 485" data-label="Section-Header"> <h3>Accident investigation in healthcare Critical Care ODN AGM</h3> </div> <div data-bbox="488 568 629 614" data-label="Text"> <p>Dave Fassam National Investigator</p> </div> <div data-bbox="495 707 593 730" data-label="Text"> <p>@hsib_org</p> </div>	<div data-bbox="1059 395 1525 435" data-label="Section-Header"> <h3>Investigating clinical incidents</h3> </div> <div data-bbox="1659 370 1771 448" data-label="Image"> </div> <div data-bbox="1055 458 1279 764" data-label="Image"> </div> <div data-bbox="1305 504 1762 584" data-label="Text"> <p><i>"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."</i></p> </div> <div data-bbox="1305 600 1767 715" data-label="List-Group"> <p>Independent inquiries</p> <ul style="list-style-type: none"> • 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 </div> <div data-bbox="1570 772 1675 788" data-label="Text"> <p>WWW.HSIB.ORG.UK</p> </div>
<div data-bbox="232 874 748 914" data-label="Section-Header"> <h3>Investigations in other industries</h3> </div> <div data-bbox="846 849 958 927" data-label="Image"> </div> <div data-bbox="203 940 405 997" data-label="Image"> </div> <div data-bbox="427 943 797 963" data-label="Text"> <p>1915 1912 Brooklands Flanders monoplane crash (2)</p> </div> <div data-bbox="815 928 954 1023" data-label="Image"> </div> <div data-bbox="203 1037 405 1083" data-label="Image"> </div> <div data-bbox="427 1035 730 1058" data-label="Text"> <p>1989 1987 Herald of Free Enterprise (193)</p> </div> <div data-bbox="815 1023 954 1117" data-label="Image"> </div> <div data-bbox="203 1117 405 1187" data-label="Image"> </div> <div data-bbox="427 1131 725 1153" data-label="Text"> <p>2005 1999 Paddington rail crash (31/520)</p> </div> <div data-bbox="815 1117 954 1212" data-label="Image"> </div> <div data-bbox="203 1220 338 1248" data-label="Text"> <p>Healthcare?</p> </div> <div data-bbox="757 1251 853 1267" data-label="Text"> <p>WWW.HSIB.ORG.UK</p> </div>	<div data-bbox="1059 874 1559 914" data-label="Section-Header"> <h3>Drivers for HSIB's establishment</h3> </div> <div data-bbox="1659 849 1771 927" data-label="Image"> </div> <div data-bbox="1059 948 1718 1098" data-label="List-Group"> <ul style="list-style-type: none"> • 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 </div> <div data-bbox="1570 1251 1675 1267" data-label="Text"> <p>WWW.HSIB.ORG.UK</p> </div>

Public Inquiries into NHS Hospital Care



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

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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

WWW.HSIB.ORG.UK

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?

WWW.HSIB.ORG.UK

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

WWW.HSIB.ORG.UK

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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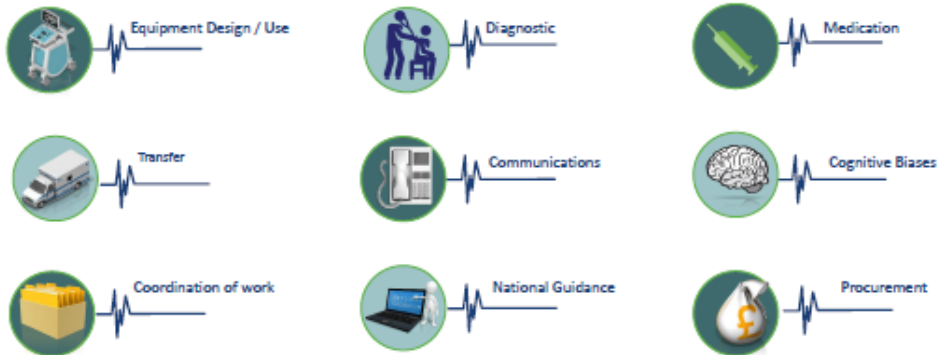
HSIB Investigation selection



- 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 2016/001: [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 ScanSafety 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 2016/012: 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 anaesthetic 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 2018/013: 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.

www.hsib.org.uk

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

www.hsib.org.uk

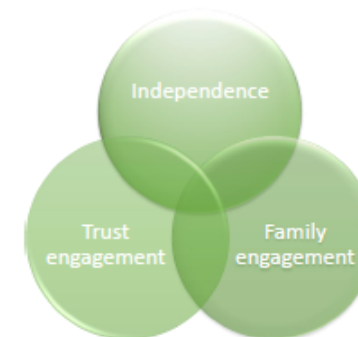
Engagement with NHS organisations



- 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!

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Essential investigation ingredients



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Engagement with statutory bodies



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

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Transfer of critically ill adults investigation



TRANSFER OF CRITICALLY ILL ADULTS

Healthcare Safety Investigation 1007/0024

January 2019 Edition

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

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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.

www.hsib.org.uk

Observation



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

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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.

www.hsib.org.uk



Questions?

www.hsib.org.uk

<https://www.hsib.org.uk/investigations-cases/transfer-of-critically-ill-adults/>

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Collaborating for Quality – Sandy Mather



Collaborating for quality: the ICS way


Sandy Mather
Chief Executive, Intensive Care Society

What about before ICS?
PhD, MSc (Mgt), MSc (Res), DMS, DMU, DCR(R)
Previously: radiographer, paediatric sonographer, membership professional, researcher, civil servant, policy maker, and senior manager in: health regulation, international development, charities and international membership.
I love learning. Let's connect on twitter @polygmather

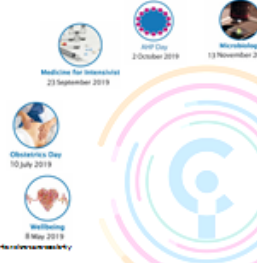
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1

Overview




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




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2

Collaboration



- Collaborating at individual level
 - President and Chief Executive
- Collaborating at team/group level
 - Trustee Board, Council, Executive Committee, Divisions and Management Team
- Collaborating at organisational level
 - WICS, SICS, UKOCRO, UKCCNA, PICS, ODNs, NOF, NIICS, NHSST, Network Medical Leads, Network Directors, ICNARC, FICM, CC3N, AAGBI, etc etc.



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4

Your Society – our Strategy (2019-2023)



- The Society's **vision** is a world where every member of the multi professional critical care team has a voice and plays a part in research, education and standards-development.



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5

Your Society – our Strategy (2019-2023)



Our Values define our culture and are at the very heart of the Intensive Care Society—who we are, what we do and how we do it.

1. **Collaboration** - we work with others to maximise our impact.
2. **Freedom of expression** - we are bold in our actions and words and encourage diversity of views.
3. **Accept and respect** - we treat everyone with dignity and respect and accept differences delivering our mission more effectively.

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6

Your Society – our Strategy (2019-2023)

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care when it matters

- 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

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Overview

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- Collaboration
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Medicine for Immobility 23 September 2019
 AICF Day 2 October 2019
 Resuscitation 13 November 2019
 Obstetrics Day 10 July 2019
 Wellbeing 8 May 2019

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Getting to know ICS as a charity

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- 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

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- 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

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- 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

2018 FACTS & FIGURES
 (SELECTED JOB ROLES FROM 2018)
 OVER 1700 DELEGATES
 101 SPEAKERS
 6 AWARDS PRESENTED | 37 EDUCATIONAL SESSIONS
 16 000 TWITTER FOLLOWERS | 360 ABSTRACTS PRESENTED
 8000 ABSTRACTS PRESENTED | 5 CONCURRENT STREAMS
 FROM OVER 37 COUNTRIES
 WHERE OUR DELEGATES COME FROM

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Overview

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Collaboration



care when it matters

- 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 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/344116/16_0501_2019.pdf

13

Collaboration




care when it matters

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



14

Collaboration




care when it matters

- 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
 - UKCCRC – MoU-jointly promote research – on a practical level hold and disburse UKCCRC funds on their behalf

15

Collaboration




care when it matters

- 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
 - Principles 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

16


Collaboration - proposal



care when it matters

17

Collaboration - proposal



care when it matters

- 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 GRICS 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 set down overnight (and be resident) to cover junior rota?
 - Variation in vacancy levels for nurses?
- Who would be the key ICS contact for each ODN?

18

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



19

10 Steps to Happiness

1. Hate less, love more
2. Worry less, dance more
3. Take less, give more
4. Consume less, create more
5. Frown less, smile more
6. Talk less, listen more
7. Fear less, try more
8. Judge less, accept more
9. Watch less, do more
10. Complain less, appreciate more

@sylvia.duckworth

Summary

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



20

Educational Strategies for the Critical Care Pathway- Sam Cook



Critical Care Nurse Education Review Forum (CCNERF) Work Streams 2019

Samantha Cook
Chair CCNERF

1

Critical Care Nurse Education Forum

Who are we? – Group of 33 interested senior nurses, educators and lecturers from critical care with a shared vision:

“Critical Care nurses should have access to high quality post registration education which develops staff to be competent practitioners and is fully transferable between units across the UK”



2

Changing Landscape of Critical Care Workforce

- “Old the Old” – thinking about the a different generation
- “New the Old” – new critical care can support and nurture future generation of staff

Reduction of Funding from Health Education England (HEE)

- Impact on Continuous Professional Development (CPD)
- Change to CPD provision in Higher Educational Institutions (HEI)

National Introduction of Apprenticeship Levy

- Part of “Modernising Professional Skills” from HE
- Institute for Apprenticeships (IfA)

CPIC V2 Standard 50% of Nursing Staff will hold a recognised Post Registration Critical Care Certificate

3



4

CPD Group



Aims to:

- Maintain momentum in lobbying for long term sufficient provision of CPD funding or equivalent for CC nurse education
- Communicate effectively the concerns of the national group to executive leads
- Highlight the importance of keeping CPD funding or establishing a sustainable alternative

5

Specialist Competencies – designed to compliment Step Documents



6

APPRENTICESHIP

- The Richard Review (2012)
- Apprenticeship Levy
- IfA and HEE – a confusing and contradictory journey
- CCNERF submitted a proposal April 2018

2019:

- Agreement that a “Specialist Practitioner” Apprenticeship Proposal could be the way forward.....
- A generic apprenticeship standard which all “specialisms” could use

7

Education Survey



- The change in HEE funding has created changes in the provision of post reg education
- Anecdotal evidence from CCNERF group about how organisations are responding to this suggests there is wide variation in critical care nurse education
- The Education Survey set out to find out what the provision for critical care nurse education looked like across the country

8

HEE / HEI Response



- HEI there were 5 responses only 1 was from a HEE
- HEI – 17 responses

HEE: HE, HEE, Cumbria, Southampton, Huddersfield, City of London, Northumbria, Central Lancashire, Warrington, 20th Institute, Middlesex, Brunel, St George, Keele, Herford, England, Lifford, Newcastle, Brunel, 2020



9

Trust Responses



70 units responded (23% response rate)

- 99% have Clinical Educator
- Only 9 units (12%) did not meet the standard of 1 educator for 75 staff.
- Average number of staff with Critical Care Award 42% (with a range of 0% - 79%)
- 7 units have 0 staff with Critical Care Award (60 credits)

10

Promotion / Publication



CCNERF Members have been successful in promoting the activities and publications of the group at various conferences and with a journal article:

- Article written and published in JICS 2017
- Winners for “Best Workshop” at BACCN Conference 2016 and 2017
- Posters at ICS “State of the Art” Conference 2015 and RCN Education Conference 2019

11

NOF **intensive care society** 

CRITICAL CARE OUTREACH PRACTITIONER NATIONAL CREDENTIAL AND CAREER FRAMEWORK COLLABORATIVE WORKING GROUP


Aim to develop:

1. CRITICAL CARE OUTREACH PROFESSIONAL DEVELOPMENT FRAMEWORK
2. CRITICAL CARE OUTREACH (SPECIALIST) PRACTITIONER COMPETENCY FRAMEWORK

Time Frame: June 2020

12

Introducing a National Rehabilitation Handover Document- Karen Cotton



Introducing a National Rehabilitation Handover Document
Critical Care Networks AGM - 8th April 2019

Karen Cotton
East of England Lead Nurse
Chair - Rehabilitation Sub-Group

1

CC3N Rehabilitation Sub-group

- Group consists of Lead Nurses and co-opted MDT members.
- Task and finish group.
- Objective: To facilitate increased compliance with the current rehabilitation standards.

2

SOURCES OF ALL CRITICAL CARE STANDARDS

- NHS England Service Specification D05
- NICE Guidance and Quality Standards
- FICM / ICS Guideline for Provision of Intensive Care Services (GPICS)

Which one is the trump card?

3


National Rehabilitation Survey

Purpose:

- To measure compliance of all critical care units against the current GPICS standards (built on the CG83 survey from 2012)
- Assess the understanding of key healthcare professionals in order to highlight differences in interpretation of some standards
- Have evidence to influence national standards groups in making beneficial changes

4

National results at a glance
53% response rate



5

Rehabilitation Survey Report

- The full survey report can be found on the CC3N website:
https://www.cc3n.org.uk/uploads/9/8/4/2/98425184/final_cc3n_rehab_survey_report_3.pdf


6

How the report was used

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

1. Results to serve as driver for national groups to develop standards with clearer definitions

7



8

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

12



Critical Care Rehabilitation Handover

Form fields for patient name, date of discharge, length of stay, and MDT involvement checkboxes for Physiotherapy, Occupational Therapy, Speech & Language Therapy (SLT), Dietitian, and Psychological/Mental Health.

13

Considerations	Current Status	Ongoing needs
Medication Patient aware, engagement in rehabilitation, what medicines the patient, what is important to them?		
Respiratory O2 requirements, SPO2 requirements, effective cough, breathlessness, sputum/secretions		
Mobility Able to get out of bed independently, able to stand, walking with aid, muscle weakness, fatigue, pre-existing conditions		
Function Nutrition Swallowing Communication Cognition Other considerations and barriers to rehabilitation	Psychological Family and Carers Rest and Sleep Pain Pharmacology	

14

Summary 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

15

Thank you
For Listening

Any Questions?

16



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?

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. What is the vision that needs to be realised?

- 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. What should the forums focus on in the coming 12 months?

- 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. Who should we collaborate with to ensure success?

- 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.