ABMU HEALTH BOARD CRITICAL CARE DELIVERY PLAN

2015 REFRESH

1. BACKGROUND AND CONTEXT

"Together for Health – a Delivery Plan for the Critically Ill" was published in 2013 and provides a framework for action by health boards and NHS Trusts working together with their partners. It sets out the Welsh Government's expectations of the NHS in Wales in delivering high quality critical care ensuring the right patient has the right care at the right time. It therefore focuses on maximising efficiency and effectiveness, tackling variation in access and reducing inequalities in service provision across 5 themes.

For each theme it sets out:

- Delivery expectations to ensure the right patient, in the right care and the right time
- Specific priorities for 2013 – 2016
- Responsibility to develop and deliver actions
- Assurance measures that will be used to ensure that this plan is delivered and effective outcomes achieved.

What do we want to achieve?

The Delivery Plan sets out action to improve outcomes in the following key areas between now and 2016:

- Delivering appropriate, effective ward based care - *The Right Patient*
- Timely Admissions to Critical Care – *The Right Patient receiving the Right Care at the Right Time.*
- Effective critical care provision and utilisation – *The Right Care*
- Timely Discharge from Critical Care - The *Right Patient receiving the Right Care at the Right Time.*
- Improving information and Research

2. ABMU Health Board's Delivery Plan

The ABMU Health Board produced its first delivery plan in 2013, setting out its priorities for 2013 - 16.

<u>Delivering appropriate, effective ward based care - *The Right Patient*</u>
The priorities are:

- Ensure mortality screening of all surgical patients forms a part of the pre-op assessment service that is being developed.
- Ensure all acute admissions to hospital are reviewed by a consultant within 12 hours with a clearly documented decision about DNACPR and escalation of care. Which are regularly audited.
- Promotion of the Sepsis screening tool amongst medical staff.
- Identification of Acute Kidney Injury champions to promote early assessment of those at risk of developing AKI.

Timely Admissions to Critical Care – *The Right Patient receiving the Right Care at the Right Time*

The priorities are:

- Critical Care facilities will be utilised for patients requiring intensive (Level 3) care and /or high dependency (Level 2) care only.
- Reduction in cancelled operations
- To improve patient flow to reduce delayed transfers of care.
- Ensure acute admissions through the emergency department have designated consultants, to ensure ongoing care and improve patient flows.

Effective critical care provision and utilisation – *The Right Care*

The priorities are:

- All Critical Care patients are managed by dedicated critical care consultants and middle tier doctors
- Ensure alignment of critical care service provision with service reviews and changes
- Ensure adequate number of appropriate trained critical care staff available to transfer patients safely and effectively
- Ensure patients requiring level 1 care such as those who require non invasive ventilation or epidural management, are treated within appropriate environments outside the critical care units.

Timely Discharge from Critical Care - The *Right Patient receiving the Right Care at the Right Time.*

The priorities are:

- To prioritise critical care discharges
- To continue to monitor and report to Board level committees the percentage of discharges achieved within 4 hours
- Monitor cancelled operations and any non clinical transfers due to lack of critical care beds
- To continue to monitor out of hours transfers from critical care environments.
- Ensure adequate provision for the unmet need where patients from outside the organisation are awaiting specialised interventions eg. Pancreatic, plastics, etc.

Improving information and Research

The priorities are:

- To continue to invest in ICNARC and CCMDS data collection to promote benchmarking
- Increase critical care research to enhance recruitment and retention of staff
- Participation through National Insititute for Social Care and Research.
- Ensure regular audit to assess progress against measures that indicate effectiveness
- To ensure adequate data clerk time to extend data collection fields and ensure Cardiac Unit ICNARC data is adequately supported.

Considerable progress has been made against these priorities, examples of that progress are:

- Mortality screening of all surgical patients forms a part of the revised electronic pre-op assessment system to be implemented during the summer of 2015. A P-POSSUM calculator has been built in to the electronic system which calculates morbidity and mortality.
- Critical Care bed capacity in Morriston Hospital increased to 28 beds.
- Zero Level 1 admissions to Critical Care Beds.
- Reduction in cancelled operations where cause is unavailability of Critical Care beds following increased capacity to 28 beds in Morriston Hospital. However it should be noted that demand continues to increase and it is anticipated that this reduction is not likely to be sustained through 2015 without further increase to capacity. Further proposals have been developed in this respect which have been presented within Critical Care's IMTP.
- Appointment of two joint ITU/Emergency Department Consultant posts has improved collaborative working between ITU and ED.
- Inter-Hospital Transfer training is incorporated as a module within the Critical Care staff training programme. There is an identified cohort of staff who have undertaken the All Wales Transfer Course and a trained person is assigned to the rota of each shift in the event of a transfer being required.
- Ongoing monitoring of delayed discharges via daily escalation process involving managers and clinical leaders. Presentation of data by Critical Care to Executive level within the Health Board's Performance Scorecard.

However there are areas which have not seen the level of progress aimed for:

- Reduced delayed transfers of care – patient flow across hospital sites has continued to cause constraints in the discharge of patients from critical care beds.
- In Morriston Hospital, all Critical Care patients are managed by dedicated critical care consultants and middle tier doctors, however a middle tier does not exist in POWH and this is an ongoing shortfall. Proposals are currently in hand to address the gap including interim arrangements for extended consultant cover on the Unit and increased staffing plans thereafter.

In delivering critical care services, there are a number of service improvements that we have implemented locally that have had a real impact on patient care. Examples of this include:

- Development of a Follow-Up Clinic for patients in Morriston Hospital
- Secured funding for a substantive Vascular Access Service in March 2015 following a successful pilot which identified improvements in patient treatment and timeliness of discharge.
- Joint Consultant Posts developed between Critical Care and the Emergency Department – these have been successful in improving

links between areas and in the development of joint pathways for acute admissions.
- Ongoing investment in the Advanced Critical Care Practitioner (ACCP) role, current trainee's are expected to complete the qualification during 2015.

3. The vision:

For our population we want:

- Patients and clinicians to discuss and agree appropriateness of critical care and level of escalation of care in time of need.
- Patients to have timely access to (where appropriate for their condition and needs) and discharge from critical care.
- Patients to be cared for in the correct facility with highly qualified specialists.
- Patients and carers to be as involved in their care as they feel appropriate.
- Patients to receive care that is clinically effective.

4. The Drivers

There are clear reasons for critical care services remaining a priority in Wales. Patients requiring critical care are relatively low volume (around 9,000 per annum[1] for Wales) but, when critical care is required, access needs to be timely and often rapid.

Critical care provision is very expensive. The major recurring costs relate to medical and nurse staffing, and drugs. Patients requiring intensive care (ventilated or three or more organ failure) cost in the region of £1,500 to £2,000 per bed day. This is level three care. Patients requiring high dependency care (one or two organ failure not including ventilated care) cost in the region of £500 to £1,000 per bed day.

The first Annual Report for the Critically Ill was published in 2014 and stated:

- On average, there are 3.2 critical care beds per 100,000 people in Wales.
- Across Wales, we have a rapidly ageing population, with the number of elderly and, especially the very elderly (over 80 years old), increasing rapidly.
- Survival rates are improving, the number of patients transferring back to the ward after admittance to critical care is increasing. In 2012, just over 80% of patients discharged to another ward, a slight increase from 79% in 2011.
- Demand for critical care has been slowly increasing over time. In 2011 there were 8,991 admissions and in 2012 there were 9,887 admissions – an increase of 896 admissions, almost 10%.

[1] Critical Care Minimum Dataset (CCMDS)

- Readmissions to critical care within 48 hours are very low – less than 2% of all discharges, showing that ward based care and the discharge process are effective.
- Since the introduction of the critical care networks, huge improvements have been made in the safe transfer of critically ill patients who need to move between hospitals through training and continuous audit. 80% of all transfers are graded as good or excellent.

As well as illustrating how performance had improved in these areas the annual report highlighted areas were performance has not been as good as anticipated:

- The average length of stay in critical care has been increasing slowly over time from 114 hours in quarter three 2010 to 123 hours for the same period in 2013.
- 50% of patients were delayed from being discharged from critical care by over four hours in the last two quarters of 2013. This affected just over 1,100 patients.
- 107,276 critical care bed hours were lost in 2013 due to patients awaiting discharge to ward beds; this equates to 12 beds in one year.
- In 2013, 94% of all non-clinical transfers in Wales were due to a lack of a critical care bed.

Specifically within ABMU Health Board, our Annual Report identified:

***** This section is awaiting scorecard data to add further information on position for Annual Report *****

- ABMUHB is largely experiencing fewer readmissions than the All Wales picture.
- Non clinical transfers are a rare occurrence in ABMUHB which is completely in line with national intensive care standards and Welsh Government guidelines.

5. ORGANISATIONAL PROFILE

Organisational Overview

Organisational Overview

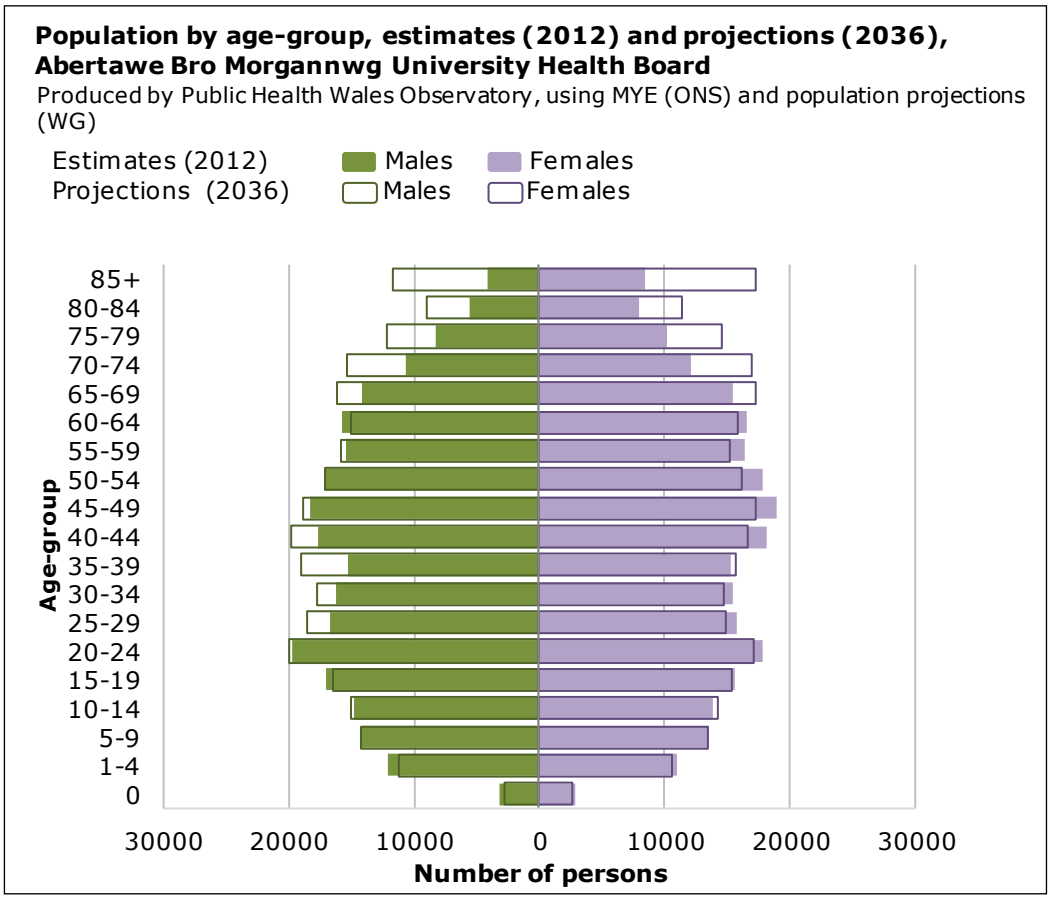
ABM University Health Board's resident population was estimated at 519,300 in the latest population estimates (2012). ABM University Health Board's population makes up around 17% of the total Wales population.

Key Messages - Population overview: -

- The population is projected to grow from 519,300 in 2012 to 563,100 in 2032, an increase of approximately 43,800 (8.4%)
- The resident population is ageing, with the numbers of over 85 yr olds set to more than double by 2030.

- Health inequalities have increased over the last ten years, with the difference in life expectancy at birth between the least and most deprived areas being 10.4 years for men, and 7.3 for women.
- Cancer, heart disease and respiratory disease remain the main causes of death in ABM, all of which are to a large degree preventable, particularly through reducing the prevalence of smoking and other lifestyle risk factors.

Population Pyramid for ABM University Health Board



An increasing overall population will mean an increase in the need and demand for health care, putting increasing pressure on limited resources. It will be necessary to ensure a robust evidence based approach to planning services and ensuring the best patient outcomes are being achieved. This will place particular pressure on Critical Care services.

<u>Overview of Local Health Need and Critical Care Challenge</u>

There are four Critical Care Units in ABMU Health Board, General ITU, Cardiac ITU, Burns ITU at Morriston Hospital and General ITU at the Princess of Wales Hospital.

Reports in respect of Cardiac and Burns Critical Care Units are attached as appendices 1 and 2.

There is a four bedded level 2 unit at Singleton Hospital, Neath Port Talbot hospital does not have HDU or ITU facilities.

The established beds and physical bed capacity is show in figure 1a.

Figure 1a

ABMU Health Board – Critical Care Beds

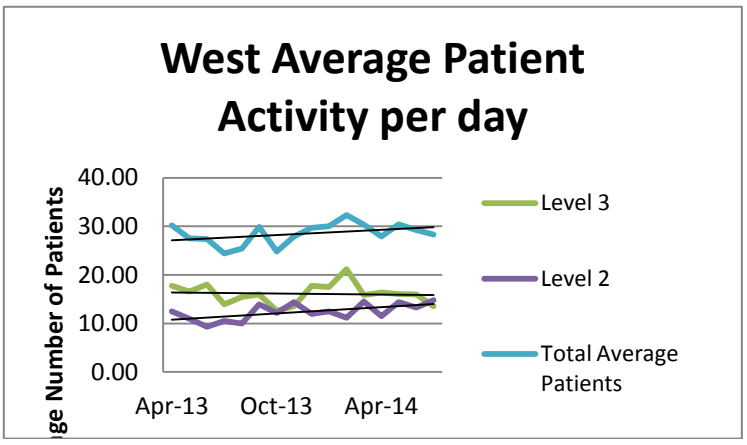
Hospital	Established Level 2	Beds ITU	Total	Physical Capacity
Morriston General ITU		28	28	28
Morriston Cardiac ITU		8	8	8
Morriston Burns ITU		3	3	10
POWH General ITU		8	8	9
Singleton Level 2 unit	4		4	4
Total	4	47	51	59

The Health Board is currently experiencing sustained pressure on its services including Critical Care. This surge in demand coincides with continually increasing activity levels within Critical Care in current and preceding years.

Increasing demand and need for increased capacity is demonstrated through the IMTP process.

Activity Background by Site (Morr/POW):

MORRISTON HOSPITAL:
This year's data shows a continuing increase in critical care need, the total average number of patients now exceeds 28 per day (Figures from CSS finance). If this trend continues the figure will reach 32 in the summer of 2015 and a permanent 4th tier of resident cover will be required.



Our Critical Care Capacity plans produced in November 2012 stated that:

> *'The 28 beds at Morriston are already insufficient to achieve bed occupancy rates below 80% or to provide for all elective surgical cases in the next 12 months.'*

This conclusion was repeated in the capacity plan of December 2013 with calculations supporting uplifting to in excess of 40 critical care beds, both documents stressing the importance of understanding that capacity is more than bed numbers alone.

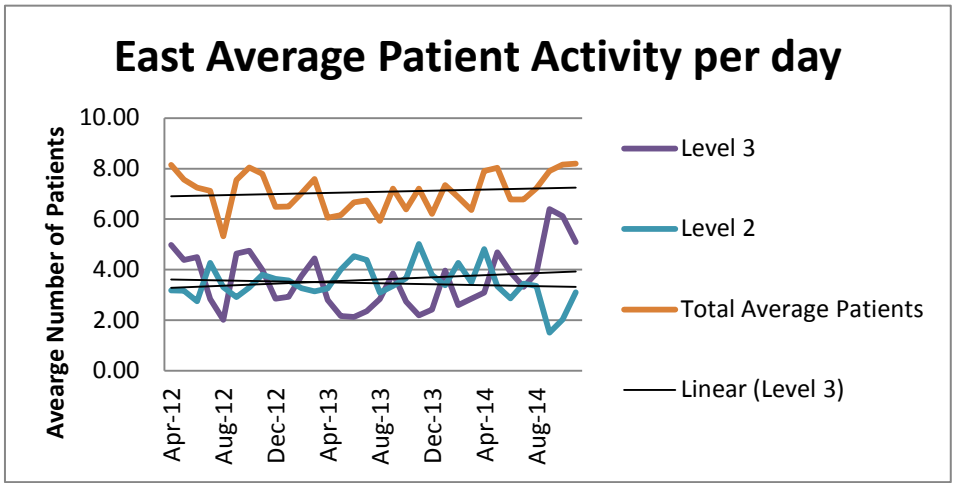
Investment in critical care capacity during 2013 showed benefits in the reduction of cancellations due to a lack of a critical care bed but the continued escalation in demand has outstripped the benefits of this and new support is necessary if elective surgical cancellations are to be minimised.

The use of theatre recovery for critical care patients is a precursor of impending bed availability problems which leads to cancellation in elective surgery. The figures below show that this is increasing again with the use of theatre recovery in Jan- Aug 2014 already exceeding the total use for 2013.

	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Totals**
	Days per month when recovery used for ITU patients												
2013	15	10	27	6	6	2	0	0	11	0	2	11	**90**
2014	7	25	17	9	18	6	5	9					**96**
	Number of individual patients nursed in recovery												
2013	11	9	27	6	4	3	0	0	12	0	2	8	**82**
2014	8	26	18	5	18	7	7	8					**97**
	Total number of ITU bed days in recovery												
2013	22	17	71	9	9	4	0	0	22	0	3	21	**178**
2014	11	60	39	17	39	10	15	14					**205**

PRINCESS OF WALES HOSPITAL:

Activity changes in POWH during 2014 have seen an increase in demand with more patients being received overall as well as an increase in patient dependency, with increased numbers of Level 3 patients and a reduction in Level 2, as demonstrated by the below graph.



This increase in demand and bed pressures within the hospital in 2014 and resulted in increased delayed transfers of care and a number of delays that took place outside of recommended transfer times.

Discussion has previously been held over the feasibility of opening Bed 9 at POWH. As further demand is anticipated in line with the trend across the preceding years, Bed 9 usage will increase and therefore a solution to maintaining its usage is under consideration.

6. DEVELOPMENT OF ABMU HEALTH BOARD LOCAL DELIVERY PLAN FOR THE CRITICALLY ILL

In response to the "Together for Health – A Delivery Plan for the Critically Ill" (2013), Health Boards are required, together with their partners, to produce and publish a detailed local service delivery plan to identify, monitor and evaluate action needed within timescales. Progress is reported formally to Boards against the milestones in the delivery plans and Health Boards are required to publish these reports on their websites at least annually.

Progress against the priorities is monitored by the Health Board's Critical Care Delivery Group, which includes membership covering all Critical Care areas within the Health Board. The revised action plan below details the ongoing and newly intended actions we have planned in response to the priorities above and reflecting recent service demands.

7. The priorities for the coming year

The Together for Health Delivery Plan sets out action to improve outcomes in some areas between now and 2016.

For 2015/16 the following national priorities have been agreed:

- Reducing Delayed Transfers of Care by 10% per quarter.
- Deliver integrated end of life planning for patients.
- Reconfiguration of critical care service to meet the standards cited in the Strategic Vision for Wales.

In addition to these national priorities ABMU Health Board highlights the following priorities for 2015/16 which reflect the needs of the local population.

Delivering appropriate, effective ward based care - *The Right Patient*

The priorities for 2015-16 are:

- Critical Care facilities will continue to be utilised for patients requiring intensive (Level 3) care and /or high dependency (Level 2) care only.
- To improve patient flow to reduce delayed transfers of care.
- Ensure mortality screening of all surgical patients forms a part of the pre-op assessment service that is being developed.

Timely Admissions to Critical Care – *The Right Patient receiving the Right Care at the Right Time*

The priorities for 2015-16 are:

- Sustain the achieved level of reduction in cancelled operations.
- Progress plans for increase in critical care capacity in order to achieve a sustainable reduction in cancelled operations

Effective critical care provision and utilisation – *The Right Care*

The priorities for 2015-16 are:

- Recruitment of medical and nursing staffing – look at innovative ways of recruiting in collaboration with Universities etc.
- Ensure alignment of critical care service provision with service reviews and changes
- Ensure adequate number of appropriate trained critical care staff available to transfer patients safely and effectively
- Ensure patients requiring level 1 care such as those who require non invasive ventilation or epidural management, are treated within appropriate environments outside the critical care units.

Timely Discharge from Critical Care - The *Right Patient receiving the Right Care at the Right Time.*

The priorities for 2015-16 are:

- To reduce the number of hours lost to DTOC by 10% every quarter until we reach a position of no more than 5% of bed occupancy lost to DTOC.

Improving information and Research

The priorities for 2015-16 continue to be:

- To continue to invest in ICNARC and CCMDS data collection to promote benchmarking
- Ongoing increase of critical care research to enhance recruitment and retention of staff
- Participation through National Insititute for Social Care and Research.
- Ensure regular audit to assess progress against measures that indicate effectiveness.

- To ensure adequate data clerk time to extend data collection fields.

8. PERFORMANCE MEASURES/MANAGEMENT

The Welsh Government's Delivery Plan for The Critically Ill (2013) contained an outline description of the national metrics that LHBs and other organisations will publish:

- Outcome indicators which will demonstrate success in delivering positive changes in outcome for the population of Wales.
- NHS assurance measures which will quantify an organisation's progress with implementing key areas of the delivery plan.

Progress with these outcome indicators will form the basis of ABMU health board's annual report on the Critically Ill. The first of these annual reports was published in 2014 and the next one will be published in May 2015.

ABMU health board also reports progress against the local delivery plan milestones to the Board annually and via our website.

9. Action Plan

Delivery Theme 1. Delivering appropriate, effective care – The Right Patient receiving the Right Care at the Right Time				
Patients, for whom critical care is appropriate, are identified in a timely manner so they have the best chance of a good outcome.				
Patients for whom critical care is not appropriate are discussed and agreed pre-referral to critical care so they have the best chance to the correct outcome.				
Priority	Action required	Lead	Due date	Progress
Ensure all acute admissions to hospital are reviewed by a consultant within 12 hours with a clearly documented decision about DNACPR and escalation of care.	7 day working initiative contained within Health Board IMTP – to progress actions to achieve this. To continue reviewing all deaths on ITU to identify issues of suitability of ITU treatment. Implementation of the All Wales DNAR Policy. Continue with the Health Board's Mortality Review process. Metric to be developed to enable data capturing appropriate discussion to be collected in real time / audit of notes to identify whether compliant and ongoing training of medical staff in documentation.	Divisional Medical Directors Lead Clinician, ITU Divisional Medical Directors AMD Patient Safety Medical Director Department	Ongoing No End Date April 2016 Ongoing Ongoing	A new Management structur is being created and the Divisional Medical Directors will be in place by October 2015

Clinicians to instigate and record a discussion regarding escalation of treatment with all appropriate unscheduled care patients and families on admission to include decision re DNACPR.				
Priority	Action required	Lead	Due date	Progress
	Audit of DNAR forms via Resuscitation Service Manager The RESUS committee continue to audit cardiac arrests. Audit clinical notes to identify whether end of life pathways have been considered / rejected. As above, Mortality review process.	Resus. Service Manager	No end date	
Implement NICE CG50				
Priority	Action required	Lead	Due date	Progress
Fully compliant	Continue with existing audit process	HoN / Corporate Nursing Team	No end date	

All surgical patients should be screened for risk of mortality pre-operatively.				
Priority	Action required	Lead	Due date	Progress
Ensure mortality screening of all surgical patients forms a part of the pre-op assessment service that is being developed.	Implementation of revised service model for Pre Operative assessment which includes launch of Electronic-POA system where the P-POSSUM calculator has been built in to the electronic system which calculates morbidity and mortality.	Clinical Lead Anaesthetist (POA)	September 2015	Trialling of system and final revisions currently underway.

All Local Health Boards to review their level 2 capacity to accommodate all patients with > 10 % mortality risk post-operatively.				
Priority	Action required	Lead	Due date	Progress
Ensure mortality screening of all surgical patients forms a part of the pre-op assessment service that is being developed.	Linked to point above regarding revision of Pre Operative Assessment model and the Health Board's Critical Care Capacity Plan.	Clinical Lead Anaesthetist (POA) / ADGM / ACD Critical Care	Capacity review complete. Full revision of POA model - September 2015	Complete.

All Local Health Boards to participate fully RRAILS. All acutely unwell patients are screened for sepsis and appropriate care pathway delivered where indicated.				
Priority	Action required	Lead	Due date	Progress
RRAILS has been implemented fully within the Health Board. Sepsis training has been delivered across the Health Board. The Health Board is working with the 1000 Lives Improvement Team Sepsis Lead. The Health Board has set up a "Spotting the Sick Patient" Steering Group. A Project Team were established in Singleton Hospital to review the NEWS scoring and Sepsis screening process.	To continue to promote RRAILS concept in its entirety and monitor progress. Ongoing training for medical staff and audit to identify non-compliance with training. Steering Group to complete review of NEWS/Sepsis Screening process. Following review, new pathways and protocols to be developed and rolled out across the Health Board.	CD's & HoN's AMD Patient Safety AMD Patient Safety	No end date No end date July 2015 December 2016	

Ensure all acute admissions are assessed for the risk of developing acute kidney injury.				
Priority	Action required	Lead	Due date	Progress
Identification of Acute Kidney Injury champions to promote early assessment of those at risk of developing AKI.	Development of a protocol for the Health Board has been overtaken by an All Wales “pilot” which is currently in progress for such a protocol in Cwm Taf and ABHB. Action will therefore be to implement the model being piloted once confirmed. Other initiatives progressing, including: (a) AKI Action plan (b) Implementation of the all Wales LIMS for Laboratory Medicine which will mean full alignment of ABMU with national Welsh AKI electronic warning protocols.	AKI Champion / CD’s	Review June 2015 December 2014 End March 2015	Complete and ongoing review of “live” document.

Delivery Theme 2. Timely Admissions to Critical Care – The Right Patient receiving the Right Care at the Right Time				
Patients, for whom care is appropriate, are admitted, to an appropriately staffed critical care unit in a timely manner so they have the best chance of a good outcome.				
Each Local Health Board must assess what level of critical care it can safely provide in each hospital (see Appendix 1 of Delivery plan and audit each unit using the quality requirements audit tool)				
Priority	Action required	Lead	Due date	Progress
Critical Care facilities will continue to be utilised for patients requiring intensive (Level 3) care and /or high dependency (Level 2) care only.	To ensure delayed transfers of care remain high on the agenda. To continue to identify any delayed admissions due to capacity. Revision of the Term of reference for the Health Board's General, Cardiac & Burn Critical Care Steering Group which receives concerns around critical care delivery. Capacity Plans have been presented highlighting service gaps and these are included within the Critical Care IMTP.	ACD Critical Care / ADGM DGM CSS ACD Critical Care / ADGM CSS	Ongoing Complete Complete	Escalation mechanism in place which ensures involvement of senior management team / Senior Nurse and ITU consultants working alongside site management teams in decision-making over capacity on a daily basis.

Ensure systems are in place to provide prompt access to critical care and, if not available on site, to quickly and safely transfer patients.				
Priority	Action required	Lead	Due date	Progress
Critical Care facilities will continue to be utilised for patients requiring intensive (Level 3) care and /or high dependency (Level 2) care only.	Business Continuity Plans identify additional capacity – annual review of these.	ACDs Critical Care / ADGM / Lead Nurse	Annual Review	Complete Jan/Feb 2015
Progress plans for increase in critical care capacity in order to achieve a sustainable reduction in cancelled operations	Linked to above actions in respect of Capacity Planning / IMTP.			

Critical care facilities will be utilised for patients requiring intensive (Level 3) care and/or high dependency (Level2) care only.				
Priority	Action required	Lead	Due date	Progress
To reduce the number of hours lost to DTOC by 10% every quarter until we reach a position of no more than 5% of bed occupancy lost to DTOC.	Continue to report the delayed discharges to the: • Executive Team • Directorate Teams of the delayed patients • Site Management Teams	CSS Senior Team at Escalation Performance Review Process	No End Date	Escalation Protocol reviewed regularly and is flexed-up to increase priority / frequency of cross-site meetings as required.
Develop mechanisms to monitor delayed admissions to critical care and the impact of the delay; for example, out of hours discharges.				
Priority	Action required	Lead	Due date	Progress
As previous section	Robust monitoring mechanisms already in place.			

Reduce cancelled operations due to lack of critical care beds.				
Priority	Action required	Lead	Due date	Progress
Sustain the achieved level of reduction in cancelled operations.	Continue use of Escalation Process as set out above. Regular meetings with Executive Lead around admission to Critical Care where refused admission may lead to cancellation. Request to all surgeons to communicate with colleagues not to ensure over-burdening of days of the week with elective activity where there are gaps elsewhere in the week.	CSS Senior Team CD's	No End Date	
Reduce non-clinical transfers due to lack of critical care beds.				
Priority	Action required	Lead	Due date	Progress
N/A	None – there are no non-clinical transfers			

Delivery Theme 3. Effective critical care provision and utilisation – Right Patient receiving the Right Care at the Right Time				
Critical care patients receive care from dedicated critical care medical staff in critical care units which are aligned to the hospitals acute services.				
Critical care patients will receive evidence based care in the form of compliance with care bundles, national guidance and care pathways, etc.				
Patients will receive the right level of care in the right environment.				
Ensure that critical care patients are managed by dedicated critical care consultants and middle tier doctors, as outlined in Appendix 1.				
Priority	Action required	Lead	Due date	Progress

Recruitment of medical and nursing staffing – look at innovative ways of recruiting in collaboration with Universities etc. Ensure alignment of critical care service provision with service reviews and changes Ensure adequate number of appropriate trained critical care staff available to transfer patients safely and effectively	Compliant across all but POWH sites where Middle Tier cover is not in place. This is contained within IMTP and as a result of Deanery concerns, further measures for cover introduced during March 2015. Review of medium and long term options for medical staffing at POWH.	Lead Critical Care Consultant POWH	March 2015 End April 2015	Interim increase in medical cover.
The sub-consultant level doctor should have no other responsibilities except for resuscitation within the hospital.				
Priority	Action required	Lead	Due date	Progress
Ensure adequate number of appropriate trained critical care staff available to transfer patients safely and effectively	Ongoing support for completion of training for current ACCP trainee's. Further ACCP recruitment in 2015/16. Review of capacity for ACCP trainee's in POWH.	Clinical Leads, Critical Care Morriston / POWH	September 2015	

Work with 1000 Lives Plus to implement service improvements whilst monitoring compliance with care bundles, national guidance, etc.				
Priority	Action required	Lead	Due date	Progress
Ensure alignment of critical care service provision with service reviews and changes	Ongoing representation of Critical Care within 1000 lives programmes via identified lead.	Dave Hope	No End Date	In place, Lead provides updates departmentally.
Minimise number of level 1 patients admitted to critical care units (as criterion 10).				
Priority	Action required	Lead	Due date	Progress
Ensure patients requiring level 1 care such as those who require non invasive ventilation or epidural management, are treated within appropriate environments outside the critical care units.	Maintain no level 1 admissions.			

Increase provision or enhancing services to care for level 1 patients outside of critical care where appropriate.				
Priority	Action required	Lead	Due date	Progress
Ensure patients requiring level 1 care such as those who require non invasive ventilation or epidural management, are treated within appropriate environments outside the critical care units.	Ongoing support of Outreach Services – inclusion of expansion options within Critical Care IMTP. Provision of Level 1 services across hospital sites to be progressed. Progress development of Lines Service.	CD's / DGM's ACD, Critical Care Morriston / ADGM	Throughout 2015 September 2015	Critical Care has pressed for regular meetings with Swansea Locality to progress NIV beds to reduce NIV admissions to Critical Care beds. Critical Care piloted Venous Access Project and has secured funding to set up a Lines Service which with further support care outside of Critical Care. Plastic Level 1 Unit being used flexibly for surgical cases involving plastics
All critical care transfers should be graded good or excellent in quality.				
Priority	Action required	Lead	Due date	Progress
N/A	Ongoing training of staff to ensure good compliance with transfer guidelines and standards.	Critical Care Transfer Leads	Monthly data provided via network	Audit data fed back to MDT meetings and GBCCCSG to identify learning points and provide actions to improve compliance were required.

Delivery Theme 4. Timely Discharge from Critical Care – The Right Patient receiving the Right Care at the Right Time.				
Patients are discharged from critical care in a timely manner so they have the best chance of early rehabilitation.				
Patients requiring critical care will have improved access due to improved flow through the units.				
95% of patients will be discharged within 4 hours of being ready for discharge and the bed being requested.				
Priority	Action required	Lead	Due date	Progress
To reduce the number of hours lost to DTOC by 10% every quarter until we reach a position of no more than 5% of bed occupancy lost to DTOC.	Data provided monthly. Escalation Process in place as detailed above includes constant communication between bed management / site management / critical care leads and directorate management team. Patients discharged out of hours are subject to reporting via Datix system.	Critical Care Lead Consultants / Lead Nurses	No End Date	

Monitor and report to Board level committees the percentage of discharges achieved within 4 hours.				
Priority	Action required	Lead	Due date	Progress
To reduce the number of hours lost to DTOC by 10% every quarter until we reach a position of no more than 5% of bed occupancy lost to DTOC.	Ongoing reporting via GBCCCSG / Performance Review / Performance Scorecard Benchmarking of other HB's management of delayed discharges.	DGM / ADGM / HoN / ACD's Critical Care	No End Date	
Develop mechanisms to undertake ongoing assessment of impact of DToCs: to patients whose discharge is delayed and to those who are prevented from accessing critical care due to lack of critical care bed.				
Priority	Action required	Lead	Due date	Progress
To reduce the number of hours lost to DTOC by 10% every quarter until we reach a position of no more than 5% of bed occupancy lost to DTOC.	Review of ICNARC reporting. Ongoing reporting arrangements of delayed discharges.	ACD's / Clinical Leads	No End Date	Reviews as required where delayed discharges result in cancellation of operations.

Work with Welsh Ambulance Service Trust to monitor and ensure timely inter-hospital transfers with agreed Standard Operating Procedures.				
Priority	Action required	Lead	Due date	Progress
N/A	Transfer protocols in place which are in-keeping with All Wales Standard.			

Delivery Theme 5. Improving information and Research				
Information systems to support high quality care and performance, clinical audit and review to drive service improvement. Critical Care research in Wales should be supported to drive forward improvements in care and outcomes.				
Local Health Boards must use effective ways of finding out patient's views and using these to plan and deliver better critical care. (NB this includes an annual survey of carers using the ICS carer's questionnaire).				
Priority	Action required	Lead	Due date	Progress

To continue to invest in ICNARC and CCMDS data collection to promote benchmarking Ongoing increase of critical care research to enhance recruitment and retention of staff Participation through National Insititute for Social Care and Research. Ensure regular audit to assess progress against measures that indicate effectiveness. To ensure adequate data clerk time to extend data collection fields.	Close working with Health Board's Patient Experience teams and PALS departments to develop appropriate mechanisms for capture of patient experience. Implementation of SNAP11 across all sites in 2015 – including Critical Care. Follow Up Clinic within Morriston Hospital's Critical Care Unit has identified patients who share their views. Patient/Carers stories in development for presentation.	Patient Experience / Lead Nurses / ADGM ACD, Critical Care Lead Nurse / ITU Governance Manager	August 2015 Ongoing From April 2015	
Ensure 100% participation in mandatory national clinical audits, report key findings to the Local Health Boards and ensure that findings are acted on.				

Priority	Action required	Lead	Due date	Progress
As all above	Ongoing participation in NICE 50 / 83	Lead Clinicians / Lead Nurses	No End Date	
Full participation in ICNARC condition management programme (NB this means complying with timeframes for submitting and validating data).				
Priority	Action required	Lead	Due date	Progress
As all above	Compliant with Data Submission requirements. Validation of Data to be reviewed. Regular feedback of data from both Morriston and POWH to GBCCCSG.	Clinical Leads for ICNARC – Linda Middleton Morriston / Richard Self POWH	No End Date June 2015	
Full participation in the National Critical Care Minimum Dataset.				
Priority	Action required	Lead	Due date	Progress
	NO ACTION REQUIRED – FULLY COMPLIANT			

Develop mechanisms to ensure full case history available electronically.				
Priority	Action required	Lead	Due date	Progress
As all above	Uncompliant – Consideration of introduction of electronic medical notes containing critical care case history.	AMD IM&T	Ongoing	Visited Birmingham and reviewed their development of electronic systems. Commencement of Electronic Prescribing and Electronic Discharging.
Actively support research participation through Research and Development and NISCHR.				
Priority	Action required	Lead	Due date	Progress
As all above	Continue to support research through R&D and NISCHR	Critical Care Leads	No End Date	Research project updated shared via departmental meetings.

Appendix 1		
Measure	**Source**	**Reporting Frequency**
Hospital Mortality measure	RAMI for acute hospitals	6 monthly
Percentage of patients who have a NEWS completed and documented	Representative audit of eligible patients – each acute ward	6 monthly
Percentage of acute admissions to hospital where the patient has a documented decision regarding escalation of treatment.	Representative audit of eligible patients	6 monthly
Percentage of patients who had an assessment for acute kidney injury on admission and the risk of developing acute kidney injury post admission.	Representative audit of eligible patients	6 months
ICNARC reports on LHB and All Wales level	ICNARC report	Annual
Bed occupancy levels	ICNARC report	6 monthly
Number of cancelled operations due to lack of a critical care bed	National cancelled Admitted Procedures (All Wales)	6 monthly

Number of units compliant with dedicated critical care consultants and middle tier doctors at all times	Audit of units and staffing levels	Annual
Percent compliance with care bundles (both within and out with critical care)	Audit of the following bundles- VAP, skin, sepsis six, CVP insertion and maintenance.	6 months
Number of CCMDS critical care admissions for Level 1 care “episodes where L2 and L3 = 0”	CCMDS data	6 months
All critical care transfers should be graded good or excellent in quality	Robust all Wales process in place hosted by the Networks.	6 months
95% critical care discharges within 4 hours ready for discharge time.	CCMDS data	6 months
100% participation in ICNARC and CCDMS	ICNARC status reports (this requires submitting and validating data within ICNARC time frame)	6 months