South West Critical Care Network

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2014

Clinical Reference Group
Adult Critical Care
Services Commissioning(DofH)
April 2014

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D16
NHS STANDARD CONTRACT
FOR ADULT CRITICAL CARE

SCHEDULE 2 – THE SERVICES – A. SERVICE SPECIFICATIONS

Service Specification No.	D16
Service	Adult Critical Care
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

Core Standards for
Intensive Care Units
(ICS/FICM/CC3N/
BACCN/RCN/GPICS)
November 2013

Core Standards for Intensive Care Units

1. STAFFING�1.1. Medical Staff

1.2. Nursing Staff

1.3. Therapy Team

1.4.Pharmacy

1.5. Dietitians

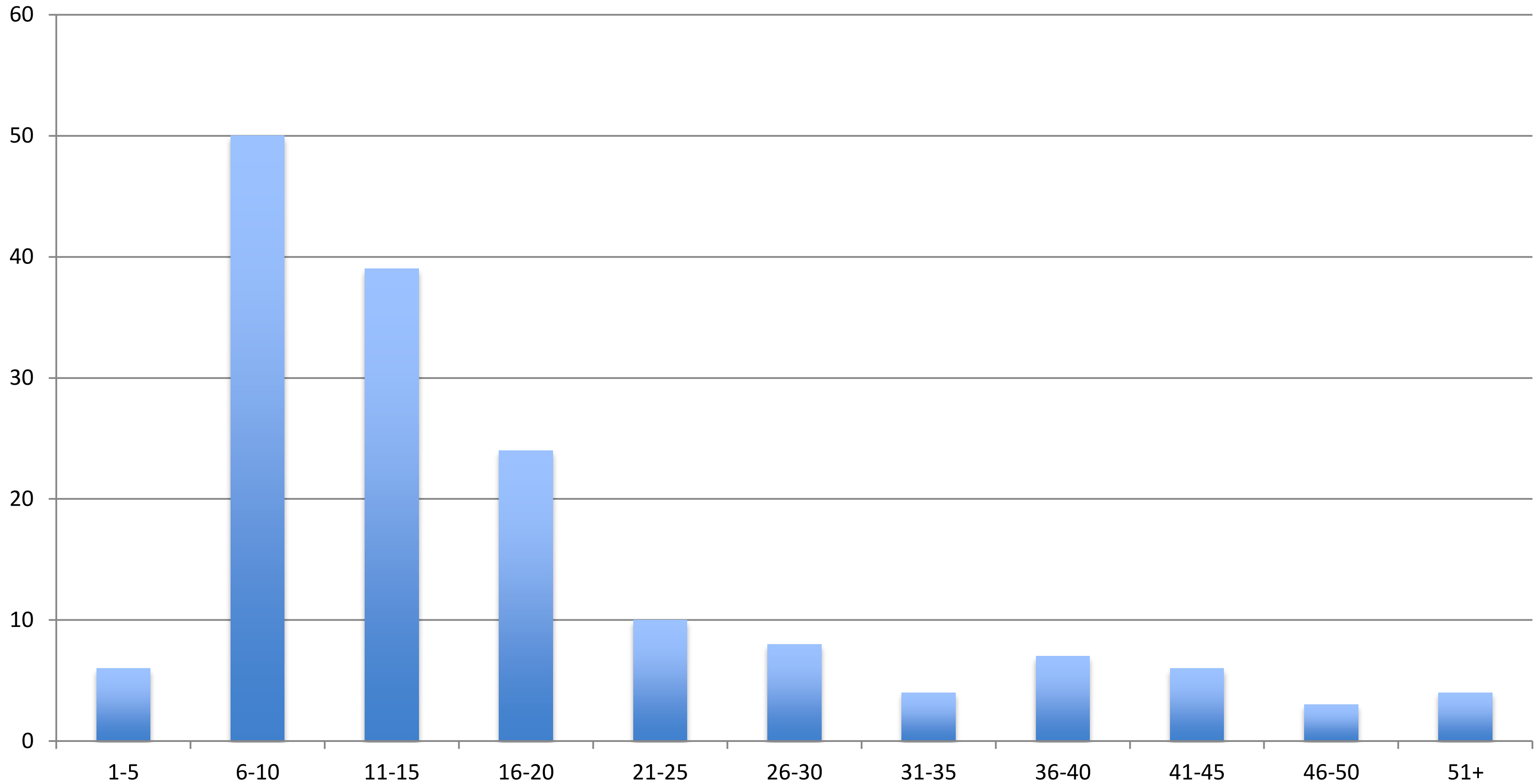
2.OPERATIONAL

3.EQUIPMENT

4. DATA COLLECTION

SHIT CREEK
PADDLE STORES

UK Adult Critical Care 2012 (FICM)



UK Adult Critical Care 2012(FICM)

Number of Consultants in Unit

Number of consultants	Percentage
<6	14%
6-8	46%
9-11	21%
12+	19%

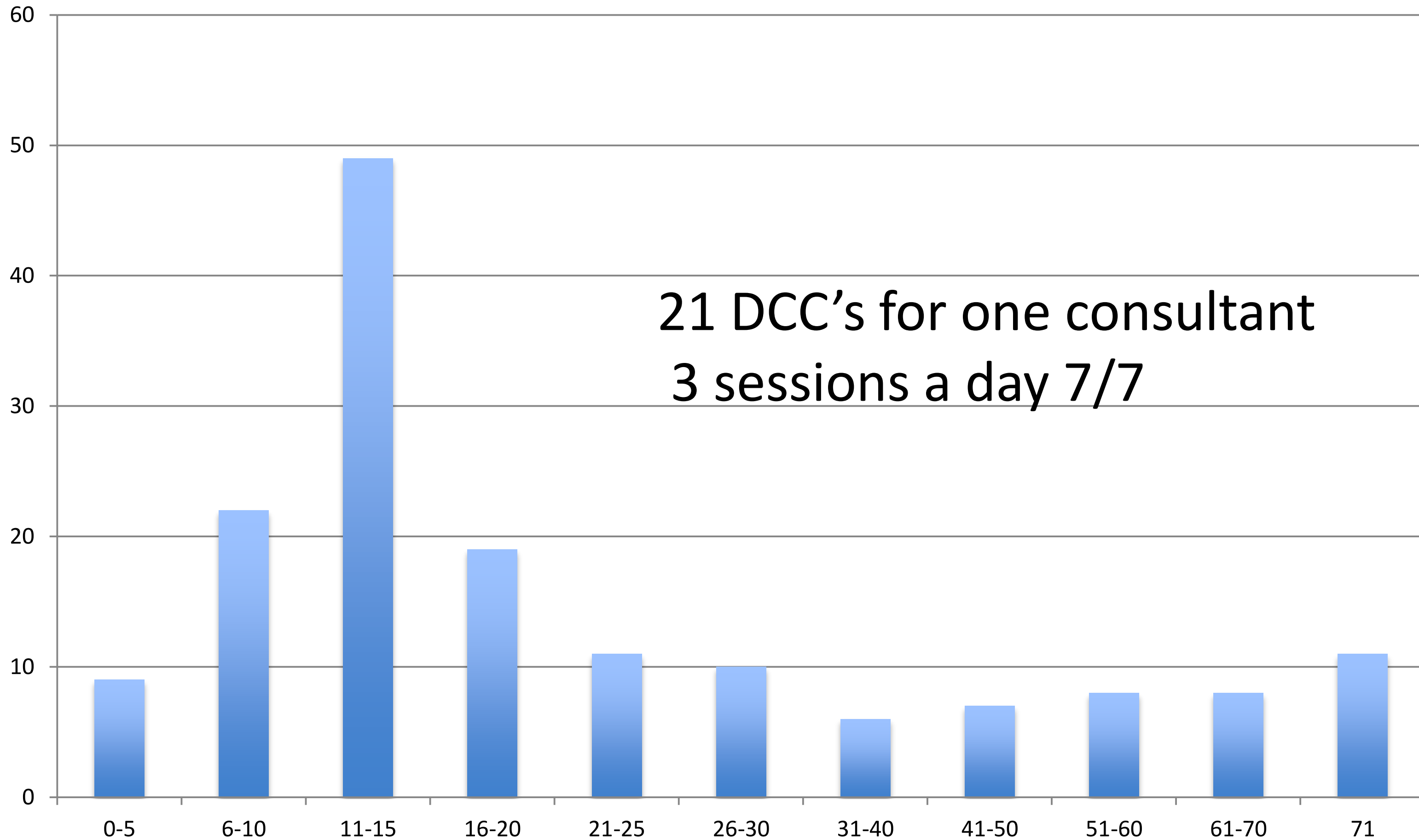
Core Standards for Intensive Care Units

1.1.1	**Care must be led by a Consultant in Intensive Care Medicine**	The Closed Unit model of intensive care has been shown to improve mortality and morbidity. A Consultant in Intensive Care Medicine is a Consultant who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine. A Consultant in Intensive Care Medicine will have Daytime Direct Clinical Care Programmed Activities in Intensive Care Medicine written into their job plan. These Programmed Activities will be exclusively in Intensive Care Medicine and the Consultant may not cover a second specialty at the same time.	Wilcox ME, Chong CKAY, Niven DJ et al. Crit Care Med. 2013, doi:10.1097/CCM.0b013e318292313a Baldock G, Foley P, Brett S.Intensive Care Med. 2001 May;27(5):865-72 Pronovost PJ, Angus DC, Dorman T, et al. JAMA. 2002;288(17):2151–2162. www.ficm.ac.uk/membership

Core Standards for Intensive Care Units

1.1.5	**A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and must undertake twice daily ward rounds**	The Consultant must see all patients under his/her care with trainee staff at least twice daily (including weekends and National holidays) and set a management plan, in the form of a structured bedside ward round. Consultant Intensivists must be available at all times to offer consultant level care to patients as necessary. Consultant Intensivists participating in a duty rota (including out of hours) must not be responsible for delivering other services, such as emergency medicine, acute general medicine and anaesthesia (including obstetric anaesthesia), while covering the critical care unit.	Paragraph 2, Schedule 12, National (English) Terms and Conditions of the Consultant Contract CICM. IC-01 (2011) Valentin A, Ferdinande P. Int Care Med. 2011; 37(10) Volume 37: 1575-1587 CICM. IC-01 (2011) AMoRC. The Benefits of Consultant Delivered Care. (2012) Barger LK, Ayas NT, Cade BE, et al. PLoS Med. 2006;3(12):e487

UK Critical Care 2012 (FICM)



UK Critical Care 2012 (ICNARC)

Average Number of ward rounds per day

Number	Monday to Friday	Weekends
1	23%	51%
2	54%	44%
3	19%	4%
4	4%	0%

UK Critical Care 2012 (ICNARC)

Percentage of Consultants
on call
dedicated ICU only
72%

Core Standards for Intensive Care Units

1.1.2	**Consultant work patterns should deliver continuity of care**	Analysis of UK Intensive Care Medicine Consultants, demonstrate that the majority work blocks of days at a time. This is to be commended for maintaining continuity of care. 5 day blocks of day shifts on ICU have been shown to reduce burn-out in intensivists and maintain the same patient outcomes as 7 day blocks. A minority of units still have different Consultants covering for 24-hour blocks throughout the week.	Ali NA, Hammersley J, Hoffman SP, et al. Am J Respir Crit Care Med. 2011 Oct 1;184(7):803-8 FICM Workforce Advisory Group

UK Critical Care 2012 (ICNARC)

Pattern of Consultant Work

Consecutive Days	Percentage
1	20%
2-5	61%
6-7	19%

Core Standards for Intensive Care Units

1.1.3	**In general, the Consultant/ Patient ratio should not exceed a range between 1:8 – 1:15 and the ICU resident/Patient ratio should not exceed 1:8**	The best current evidence is a Consultant/ patient ratio in excess of 1:14 is deleterious to patient care and Consultant well being. However the actual ratio needs to be determined by the following factors: • Case Mix • Patient Turnover • Ratios of Trainees • Experience of Trainees • Telemedicine • Surge Capacity	Valentin A, Ferdinande P. Int Care Med. 2011; 37(10) Volume 37: 1575-1587 Ward NS,Afessa B, Kleinpell R. CCM. 2013; 41(2): 638–645 CICM. IC-01 (2011) Landrigan CP, Rothschild JM, Cronin JW, et al. N Engl J Med (2004) 351:1838–1848

Nursing Standards

The following nurse to patient ratios are adhered to
Level 3 patients have 1:1 nursing ratios for direct patient care
Level 2 patients have 1:2 nursing ratios for direct patient care

A minimum of 50% of nursing staff must have a post-registration award in critical care nursing (moving to 70% over time).

Each Critical Care Unit must have a supernumerary clinical coordinator 24/7.

A Critical Care Unit must have a Clinical Educator, 1 WTE per per circa 75 staff.

All registered nursing staff supplied by Bank/Agency must be able to provide documentary evidence of their competence to practice within a critical care environment**.**

The number of non-established bank/agency nursing staff must not on average exceed 20% of a shift .

Admission to Critical Care

The provider must implement a standardised approach to the detection and response to deteriorating health on general wards with reference to NICE 50[13] .

Admission to Critical Care must be timely and meet the needs of the patient. Admission must be within 4 hours from the decision to admit (unscheduled admissions).

The provider should ensure appropriate planning of elective surgical admissions to critical care in order to avoid unnecessary postponement of surgery.

The decision to admit a patient to Critical Care must be made by a Consultant in Intensive Care Medicine.

The transfer of a level 3 patient for comparable critical care at another acute hospital (Non-Clinical Transfer) must be avoided.

Discharging Patients

Transfer from Critical Care to a ward between the hours of 07.00hrs and 21.59 hrs.

Discharge from Critical Care to ward level care must occur within 4 hours of the decision to discharge.

Transfer of a patient to a Trust , closer to their home, to continue their reablement following specialist critical care should occur within 48 hours of the decision to transfer.

Each patient must have an assessment of their rehabilitation needs within 24hrs of admission to Critical Care and all NICE 83[11] eligible patients must have a rehabilitation prescription on discharge from critical care. This must be updated throughout the rest of the patient's stay in hospital in accordance with NICE 83[11].(CQuinn)

Supported by Core Standards for Intensive Care Units

(ICS/FICM/CC3N/BACCN/RCN)

So far ….. Pragmatic approach

Adopted by CQC for ICU assessments

Aspirational Document

Not punitive….. should assist clinicians to drive improvement.

Dashboard

- Up Dated 3/12
- Rolling Year
- 6/12 out of date
- Public Domain
- ICNARC Generated

- Longtitudinal Data of Activity

Dashboard

- SMR (+ SMR Bands of low prediction of Mortality)
- Delayed Discharge beyond 24 hours (QIPP)
- Delayed Discharge beyond 4 hours
- Discharges between 2200 and 0700
- Non Clinical transfers
- Reintubation within 24 hours
- Readmission within 48 hours
- CVC infection rates
- Repatriation within 48 hours of request.
- Cancellation of Elective Surgery

"Our Network Structure"

Network Board

Medical Directors/Director Operations
Commissioners/CGG Representative
Networks Lead/Manager/Nurse
Patient Rep

“Our Network” :- The Future.

- Graham Brant Network Manager/Nurse
- Tim Gould Clinical Lead
- Data Analyst
- Secretarial Support

Funding

£80000 at Present

Network Activity
Clinical Effectiveness Committee

Mandated

Bed Status (National Website)

Emergency Resilience and Preparedness(Flu)

Repatriation Document

Visits

Dashboard Compliance

Derogation

Any Questions?

“Our Network” :- The Future.

Once admitted to Critical Care, care must be led by a Consultant in Intensive Care Medicine (as defined by the Faculty of Intensive Care Medicine). Medical staffing must conform to the standards described “ Core Standards for Intensive Care units”.

Each provider must have a designated Clinical Director/lead Consultant and matron for Critical Care.

Consultants must be freed from all other clinical commitments when covering Intensive Care and this must include other on-call duties.

A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and undertake twice daily ward rounds.

On admission to Critical Care all patients must have a treatment plan discussed with a Consultant in Intensive Care Medicine.

All admissions to Critical Care must be seen and reviewed within 12 hrs by a Consultant in Intensive Care Medicine.

Consultant led multi-disciplinary clinical ward rounds within Intensive Care must occur every day (including weekends and national holidays). The ward round must have attendance or daily input from nursing, microbiology, pharmacy, physiotherapy and dietetics.