South East
Critical Care Network

Annual Report 2018/19

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A number of reviews, surveys and data reports are listed in the annual report; full details of which can be requested (with appropriate authorisation) from caroline.wilson2@nhs.net

The website version of the report contains no unit identifiers in the data graphs.

1. Summary

Caroline Wilson
SECCN Network Manager/Lead Nurse
National Adult Critical Care Data Sub Group - National Network Managers representative

2018/19 has been a busy and productive year with continued collaboration on a range of important projects both within the network and with neighbouring networks and through the instigation of two new professional interest groups to further stretch the network reach and ambition.

The SECCN groups established this year are for Pharmacy and Clinical Psychology and it is with great pleasure that we welcome members from across the spectrum of professional groups committed to developing and improving critical care practice. The transfer and rehabilitation groups have continued to meet and have progressed on important work to ensure the safe transfer of the critically ill and the development of comprehensive rehabilitation throughout the patients' pathway of care.

Concerns expressed by staff about workforce have been heeded by SECCN; a survey to look at nurses' satisfaction was undertaken and the very interesting results will be discussed at nurse lead forums this year; and a medical workforce engagement event facilitated by the Faculty of Intensive Care Medicine is to be organised in 2019/20 in partnership with the Kent, Surrey and Sussex Deanery.

Despite significant changes in the regional configuration of NHS England and NHS Improvement the profile of Critical Care remains high and SECCN has continued to work as part of an NHS South wide Improving Value Scheme on a variety of projects; leading on a comprehensive review of regional demand and capacity and on an very exciting project to promote early mobilisation of critical care patients. The recommendations of the demand and capacity report and a sister costing report will influence the direction of work in the coming months and units will be kept fully informed.

SECCN has also worked with neighbouring networks to develop and test a very comprehensive gap analysis tool for the recently published Adult Critical Care (ACC) Service Specification. The process for network assurance visits has been reviewed and as well as adding in an element of peer review it has been agreed to use the gap analysis tool to structure visits during 2019/20.

Repeating the words of last year's report, the SECCN data report for 2018/19 is a reminder of the challenges critical care units commonly face, none more so that the delayed discharge of patients to the ward and the associated impact on other performance metrics such as night time discharge. Despite this, outcome, as measured by standardised mortality ratio, remains generally very good and units are congratulated on this achievement.

Network successes for the year includes continued adoption of the STricT transfer course, a mapping of service delivery in all aspects of the rehabilitation pathway, the initiation of projects to look at night time discharge and ventilator associated pneumonia and, once again, the hosting of a very well evaluated critical care network conference.

The administrative arm of the network is very small and all the good work has been dependent on the support and participation from units within South East, thank you to everyone who has engaged with and supported SECCN throughout the year.

Caroline Wilson

Dr Mike Carraretto

SEC CCN Network Medical Lead
and Chair of National Critical Care Medical Leads Group

We have had a busy and rewarding year working with our colleagues across all of the intensive care units in the region. The working groups have continued to be productive and engaging; through these we have ensured a continued progression of the delivery of critical care across the network. It remains a real testament to participation of staff from every ICU across Kent, Surrey and Sussex that we all continue to improve through this strong collaboration.

Our close working with the other two networks in the south and with NHS England specialised commissioners has resulted in highly valuable representation and advice, meaning the critical care service we deliver is better understood and supported by specialised commissioners. We continue to work with South West and South Central and our commissioners in delivering on a range of projects which are aimed at ensuring quality of care as well as cost effectiveness.

Our network is represented by us at the national level through the network managers and medical leads groups. In particular the medical leads have worked to produce an important memorandum of understanding regarding immediate access to life preserving treatment at a specialist centre without being delayed by lack of a critical care bed at that centre. This guidance has been endorsed by the ICS and published on their website along with advice on repatriation of patients from overseas, also produced by the work of the national medical leads.

Through my role as chair of the national medical leads for the critical care networks I am able to now represent the networks at both the Intensive Care Society's Standards and Guidelines Committee and the Faculty of Intensive Care's Professional Affairs and Safety Committee. These two important groups for our profession are committed to working with us more closely in the future, taking into consideration our experience and opinion to enable us to assist you all with implementation of guidance from the ICS or FICM in your units.

I have been re-appointed to the Clinical Reference Group for Adult Critical Care this year after a period of absence and will be working closely with them to ensure that there is good communication with the recent approval and imminent release of the National Service Specification for Adult Critical Care D05, ensuring its appropriate implementation, and supporting the units in their service delivery and development in conjunction with network oversight and oversight from the CRG.

For me one of the best parts of this job, working for our network, remains the network visits and meeting you all. We share the learning from all the great work you do and excellent services you deliver and also assist you in developing and delivering improvements for your own critical care units. There has been a continuation in service development in many key areas over the last year. All of this in turn helps to inform us and enable us to represent critical care accurately at the regional and national level, therefore thanks to all of you.

Michael Carraretto.

2. Stakeholders and Governance

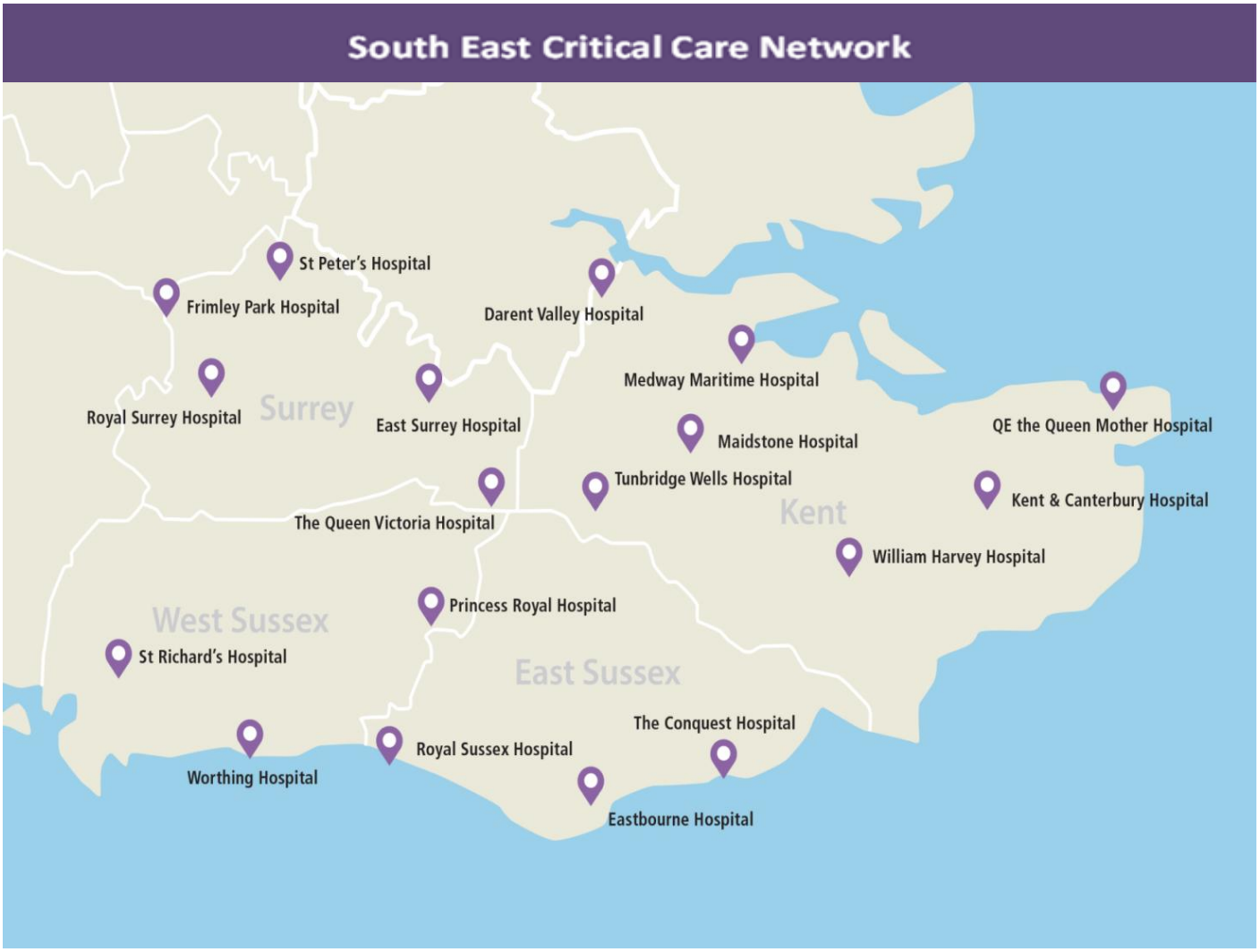
Medway NHS Foundation Trust became host to the South East Coast Operational Delivery Network (ODN) for Critical Care & Neonatal in October 2013. They are responsible for employing the ODN team and supporting their roles. Oversight and governance arrangements for the South East Critical Care and Neonatal Networks have been provided in partnership with NHS South Specialised Commissioning. The realignment of NHS England and NHS Improvement into South East and South West regions will impact on the governance framework and it is anticipated that future arrangements will be confirmed in 2019/20.

South East Critical Care Network (SECCN) works with NHS providers of critical care, NHSE regional teams and Clinical Commissioning Groups to deliver programmes of work with agreed annual priorities. Throughout 2018/19 SECCN has worked closely with fellow networks in the NHS England (South) region and with colleagues in Specialised Commissioning to continue a programme of improvement for Critical Care. This collaboration will carry forward into 2019/20 as part of a combined South East and South West Improving Value Scheme.

The South East Critical Care Network team consists of

- Caroline Wilson – Deputy Network Manager/Lead Nurse
- Dr Mike Carraretto – Network Medical Lead
- Sue Overton – Network Administrator (shared with Neonatal ODN)

SECCN serves the counties of Kent & Medway, Surrey and Sussex. The population served is approximately 4,420,000 over 3,545 square miles.



SECCN consists of the following Critical Care Units from 12 Acute Hospital Trusts.

Ashford and St Peter's Hospital NHSFT	St Peters Hospital Critical Care	15 beds – level 3 & 2 13 beds commissioned
Brighton and Sussex University Hospitals NHST	Royal Sussex County Hospital Critical Care – including neurosurgery	31 beds – level 3 & 2
Brighton and Sussex University Hospitals NHST	Royal Sussex County Hospital Cardiac Intensive Care Unit	8 beds – level 3 & 2
Brighton and Sussex University Hospitals NHST	Princess Royal Hospital Critical Care	12 – level 3 & 2 8 beds open
Darent Valley NHST	Darent Valley Hospital Critical Care	10 beds – level 3 & 2
East Kent University Hospitals NHS FT	Kent & Canterbury Hospital Critical Care	10 beds – level 3 & 2 6 beds commissioned
East Kent University Hospitals NHS FT	Queen Elizabeth the Queen Mother Hospital Critical Care	9 beds level 3 & 2
East Kent University Hospitals NHS FT	William Harvey Hospital Critical Care	13 beds – level 3 & 2
East Sussex Healthcare NHST	Conquest Hospital Critical Care	11 beds – level 3 & 2
East Sussex Healthcare NHST	Eastbourne Hospital Critical Care	8 beds – level 3 & 2
Frimley Park NHSFT	Frimley Park Hospital Critical Care	12 beds – level 3 & 2
Maidstone and Tunbridge Wells NHST	Tunbridge Wells Hospital Critical Care	9 beds – level 3 & 2
Maidstone and Tunbridge Wells NHST	Maidstone Hospital Critical Care Unit	9 beds – level 3 & 2
Medway NHSFT	Medway Hospital Intensive Care Unit	9 beds – level 3
Medway NHSFT	Medway Hospital Medical High Dependency Unit	6 beds – level 2
Medway NHSFT	Medway Hospital Surgical High Dependency unit	10 beds – level 2
Queen Victoria NHSFT	Queen Victoria Hospital / dedicated burns beds – affiliated with Burns Network	5 beds – level 3 & 2
Queen Victoria NHS FT	Queen Victoria Hospital/ General Critical Care beds	2 beds – level 3 & 2
Royal Surrey County NHSFT	Royal Surrey County Hospital Critical Care	28 beds – level 3 & 2 20 beds commissioned
Surrey and Sussex Healthcare NHST	East Surrey Hospital Critical Care	16 beds – level 3 & 2
Western Sussex NHSFT	St Richards Hospital Critical Care	10 beds - level 3 & 2
Western Sussex NHSFT	Worthing Hospital Critical Care	12 beds - level 3 & 2

The SECCN clinical and governance forum is held twice a year. Here the annual work programme and key quality outcome data are presented and discussed with agreed actions. Additional specialist and sub group meetings are convened throughout the year. SECCN has active engagement from medical, nurse and allied health professional critical care leads from all critical care units in Kent, Surrey and Sussex, fostered through an ongoing programme of unit assurance visits. SECCN regularly attends national critical care managers, medical and nurse leads groups. Furthermore Mike Carraretto contributes to the national overview and priorities in his role as Chairman of the National Critical Care Medical Leads Group with associated membership of the critical care Joint Standards Committee, as does Caroline Wilson in her role representing the national managers at the National Audit Critical Care Data Group of the Clinical Reference Group for Adult Critical Care.

3. NHS England (South) Adult Critical Care (ACC) - Improving Value Scheme

SECCN continues to work closely with neighbouring networks and Specialised Commissioning South to develop and deliver the ACC Improving Value Scheme. The vision of the scheme is to achieve a high quality, safe, effective and sustainable critical care service providing patients with timely and equitable access to an appropriate environment and clinically appropriate length of stay. The work during 2018/19 has focussed on a number of key areas. All the work streams are ongoing and will continue into 2019/20:

- Demand and Capacity Review
  The need to quantify and qualify the capacity needed for efficiency and equity of access to ACC is unequivocal. In an attempt to better understand demand and capacity a review template was developed and sent to all regional Trusts in July 2018 with a request for completion from NHS England (South) by all units that attract a critical care tariff. The review asked for a combination of quantitative and qualitative information and, whilst the limitations of the review were acknowledged, it did serve to illustrate and clarify many very important issues. A demand and capacity report and comprehensive data appendix were produced and circulated to providers and commissioners.

Demand is complex and can roughly be divided into what we know and record, what we know and either don't record or record inconsistently and what we don't know. Even in the former category, admission number, levels of acuity and organ support, length of stay etc. are dependent on emergency and surgical pathways, alternative care areas and, of course, patient flow. The report and the unit submissions from which the report is compiled will be used to encourage conversation and collaboration between providers and commissioners about how best to manage precious and costly ACC resources. Recommendations listed in the report will determine the direction of this work stream throughout 2019/20.

- Costing Review
  A costing review tool was circulated in tandem with the demand and capacity review. Units were requested to list the cost of selected operational measures under the headings: clinical support services; consumables; staffing; unit characteristics. In general this review proved more difficult; the number and quality of returns was disappointing and demonstrated anomalies and inconsistencies which resulted in some unusual and unexplained results. Nonetheless, the review did serve to highlight the complexity of comparing critical care unit costs and informed a number of recommendations to be followed up in the coming year.

- Rehabilitation
  A regional rehabilitation co-ordinator has been appointed for the NHS South East Region (this includes the east section of Thames Valley critical care network as well as SECCN) to review pathways of referral for ongoing rehabilitation; rehabilitation in this sense referring to all patients who need rehabilitation or placement in an NHS or non NHS location. The initial focus of the role will be on pathways into and out of spinal units and this should have a knock on effect to SECCN hospitals. The role will broaden in time to cover the placement and rehabilitation of patients of all specialties awaiting ongoing transfer of care for rehabilitation needs.

- Standardised Mobilisation Project (SMP)
  Building on exciting work on early mobilisation at University Hospitals Southampton the SMP project aims to facilitate timely mobilisation in ACC across the region. Initial work in 2018/19 has focused on developing an audit tool and data spreadsheet to assess current mobilisation practice and a benchmarking tool for rehabilitation staff resource. Both tools are to be piloted in April/May 2019 with the objective of wider roll out thereafter. Next steps for 2019/20 include agreement of the SMP pathway and an educational programme to encourage adoption where resource permits. A repeat audit will follow to demonstrate the impact of SMP on metrics including time to mobilisation and length of stay.

- Cancelled Elective Surgery due to lack of post-operative ACC bed
  During 2018/19 the initial phase of this work stream has focused on well performing units in South West to better understand their approach and potentially replicate practice elsewhere.

- Clinical Commissioning Group (CCG) and Sustainability and Transformation Partnership(STP) Engagement
  The aim of this work stream is for integrated collaborative commissioning of ACC with a designated lead commissioner for each ACC unit. An initial challenge has been to enable data sharing between CCGs and specialised Commissioning and this is progressing at a preliminary site in SECCN.

- Delayed discharge and discharge at night
  Data clearly shows that delayed discharge remains a thorny problem for ACC despite attempts to raise the profile of discharge delay for some time. In an attempt to better understand its impact three SECCN units have offered to look more closely at night time discharge and the links between untimely discharge and discharge delay. An early audit in 2018/19 served to identify gaps in data and a more detailed audit is to be completed in 2019/20.

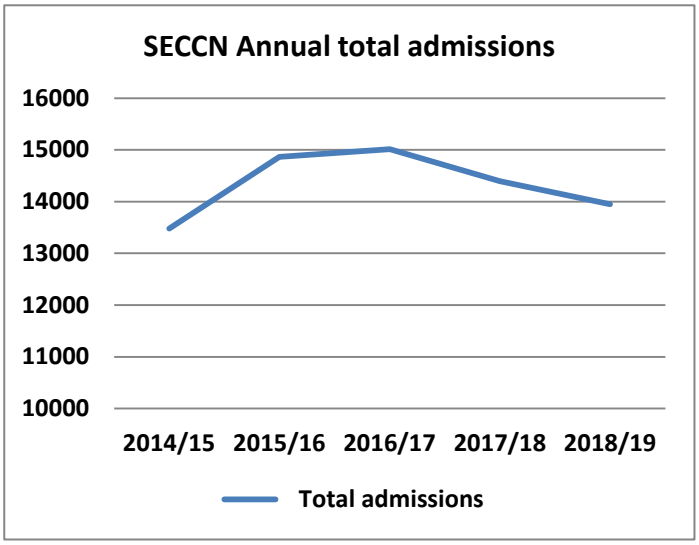
4. 2018/19 Data Report

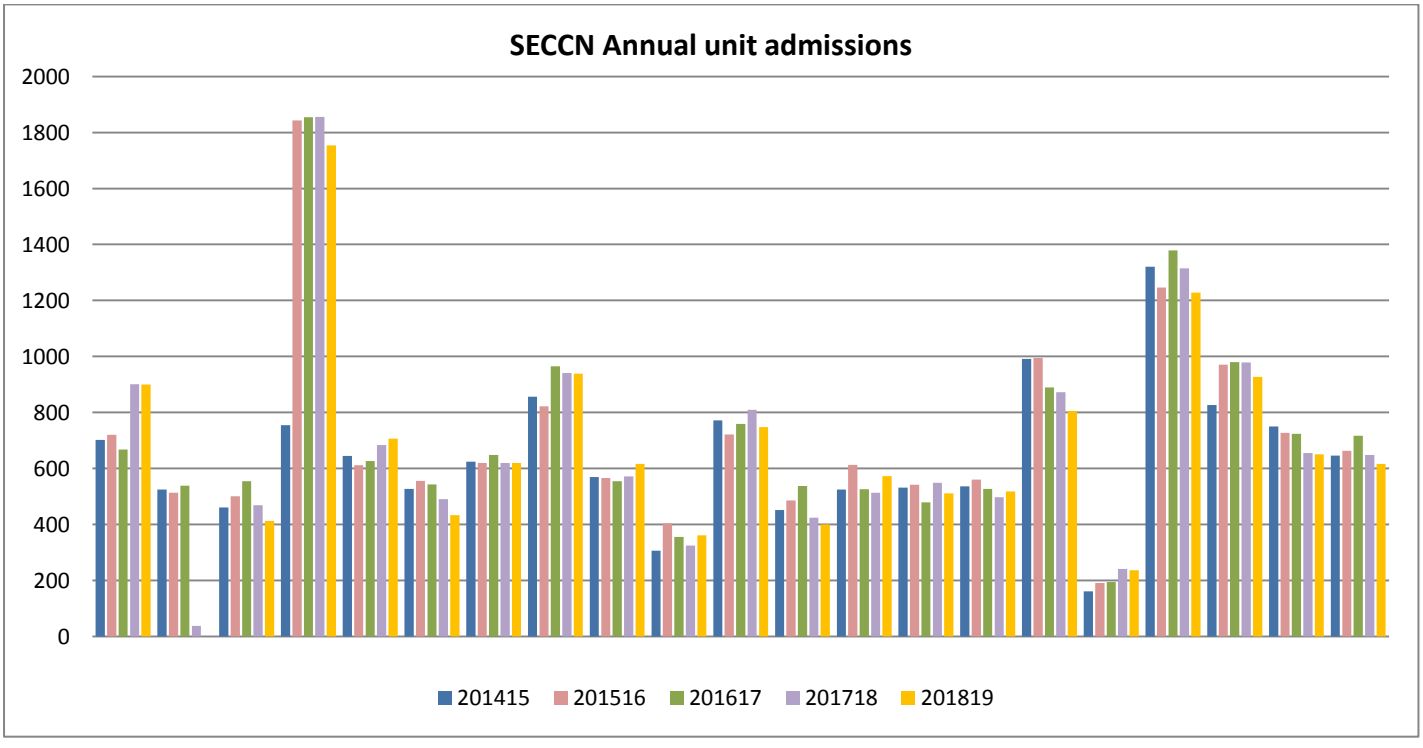
An annual network report is produced by the Intensive Care National Audit and Research Centre (ICNARC) following a robust validation process (due to which the 2018/19 report is not yet available). Data prior to 2018/19 is taken from ICNARC data. The 2018/19 data presented is taken from network data unless indicated otherwise. Network data is submitted monthly via a dedicated template from unit data software. Each unit is sent a monthly summary of specific data metrics which are collated in a combined quarterly network report. This permits timely analysis of data but precludes full data validation. Queen Victoria Hospital (QVH) does not currently submit to ICNARC so all data for QVH is taken from network data. The Cardiac Intensive Care Unit at the Royal Sussex County Hospital submits data to the National Cardiac Benchmarking Collaborative – this data is not presented in the report. The graphs in this report are minimised for ease of presentation; more detail can be found in the network quarterly reports.

Number of admissions

2018/19 Q 1/2/3 ICNARC data where available – Q4 network data
2013/14 – 2016/17 – ICNARC data where available

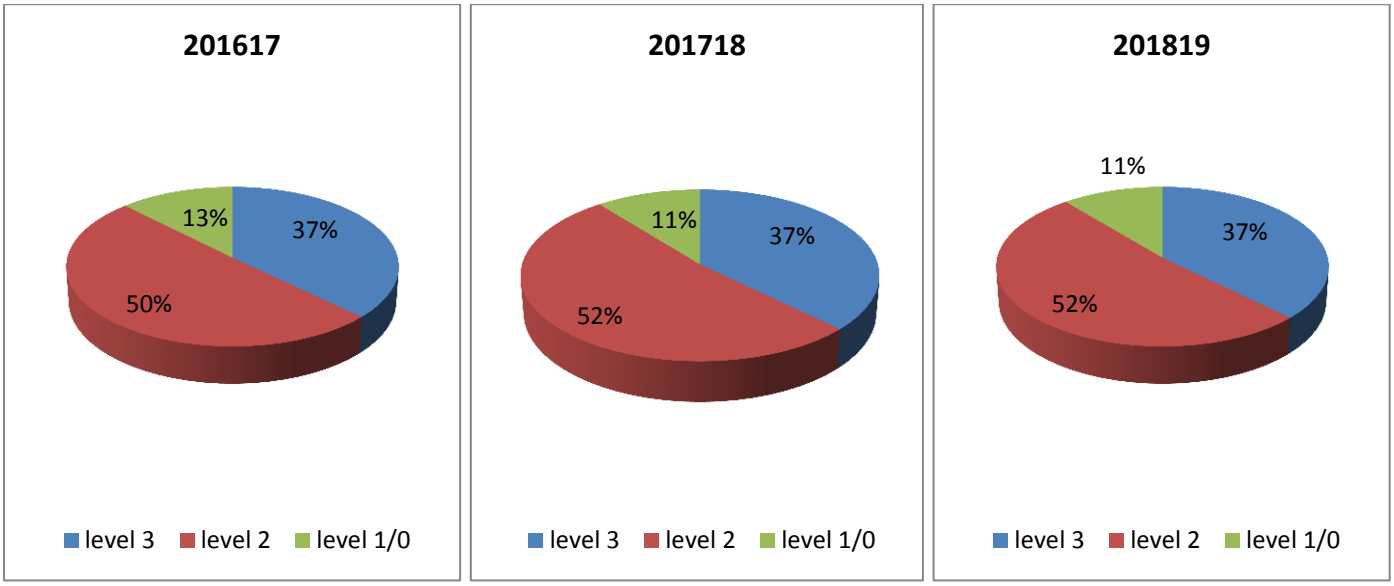
As with the data presented in the 2017/18 report, the trend over the past five years is difficult to interpret due to changes in configuration of critical care services. The transfer of neurosurgical services from Hurstwood Park to Royal Sussex County Hospital in 2015 is associated with an increase in admissions for the latter. The merger of the intensive care unit (ICU) and medical high dependency (MHDU) unit at St Peter's hospital in 2017 is associated with a drop in combined admissions as some patients would have previously been counted for both an ICU admission and step down to MHDU. It is not possible to say whether the slight fall in total SECCN admission for 2018/19 is part of an ongoing trend or not.

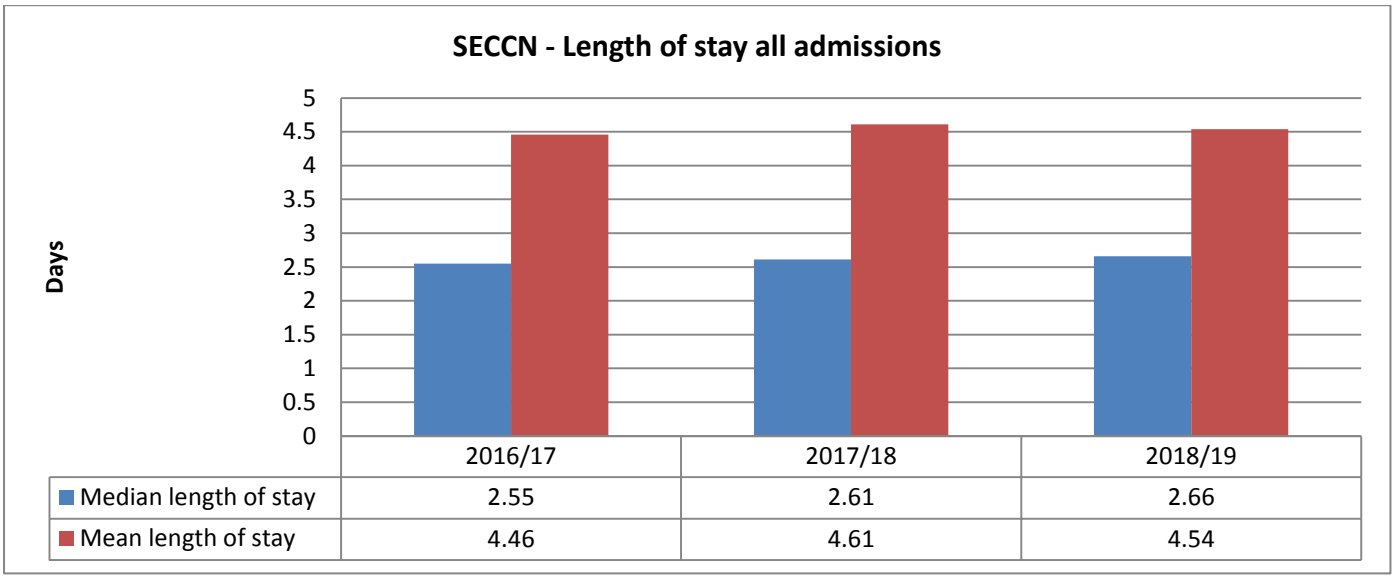




Activity - levels of care, organ support and length of stay

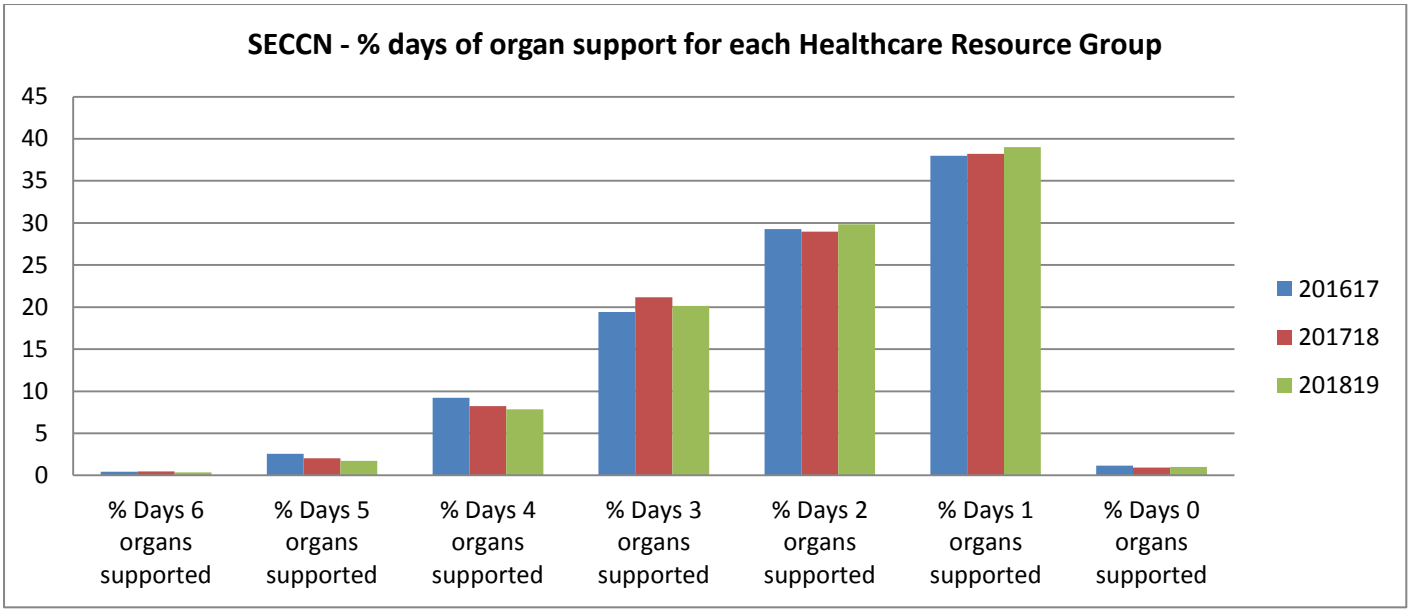
During the past three years, where there is data available, the total levels of care bed days for SECCN and the average length of stay in critcal care have remained very constant.
All levesl of care and length of stay data taken from the network report.





The split for levels of organ support *(taken from ICNARC data so 201819 Q1/2/3 only)*shows a similarly consistent picture but with a very subtle shift to fewer organs being supported. This data must, however, be treated with caution; Healthcare Resource Groups (HRG's) are determined by a continuum of organ support with patients allocated to the highest level of organ support received irrespective of how long for. The percentage for each HRG does not equate with total unit bed days activity. Daily organ support data would remedy this and is believed that it is to be added to a revised ICNARC dataset being trialled in 2019.

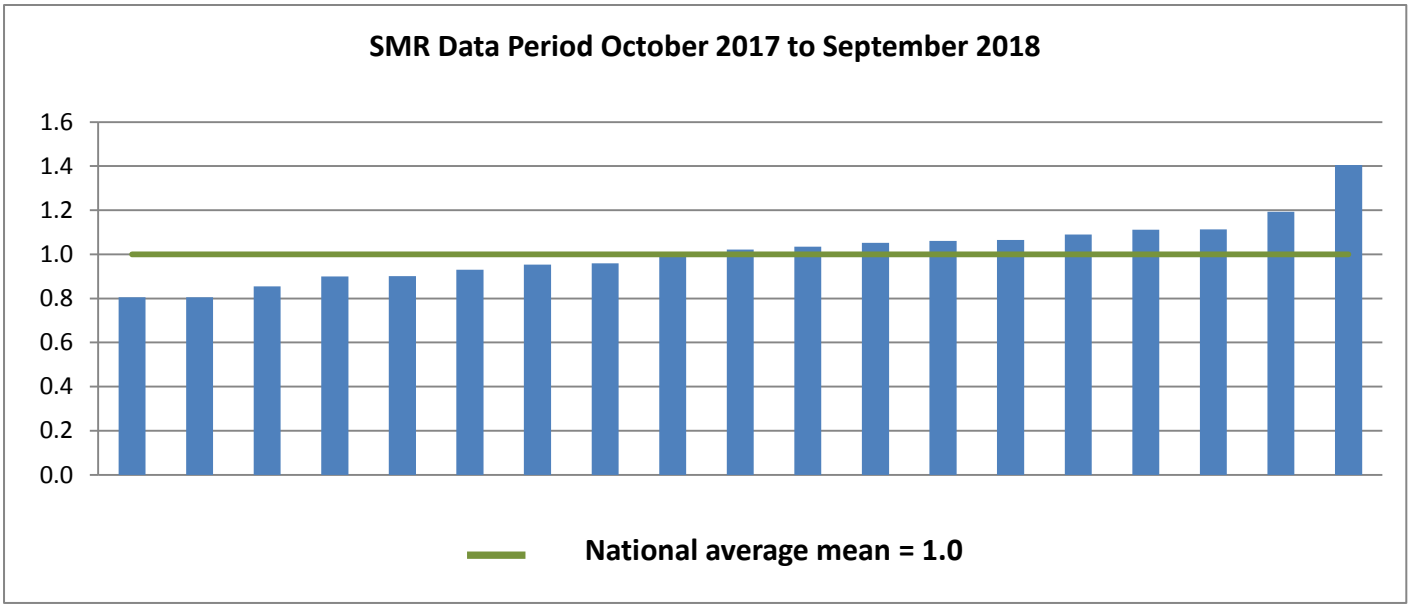
Anecdotally, units continue to report significant pressures, with minimal respite at traditionally quieter times of the year. That this conflicts with the data currently captured indicates more work is needed to better understand demand and activity and, as previously mentioned, will be a focus of the NHS South Improving Value Scheme.



Performamce metric – Risk adjusted acute hospital mortality

Data taken from latest available specialised service quality dashboard.Calculated using ICNARC score – please note this may vary from scores calculated using different severity of illness scores including those reported on Ward Watcher software which use the Apache 11 model.

The standard mortality ratio (SMR) is calculated by ICNARC and is derived from the ratio of observed to expected deaths using a severity of illness tool. The performance across SECCN is generally very good compared to the national mean. Just one unit sits outside 2 standard deviations from the mean; the reasons for this have been explored and it is hoped that more current data will reflect improvement in coding and reporting. To ensure accurate and consistent submission of data an ICNARC run SECCN data workshop has been organised for May 2019.

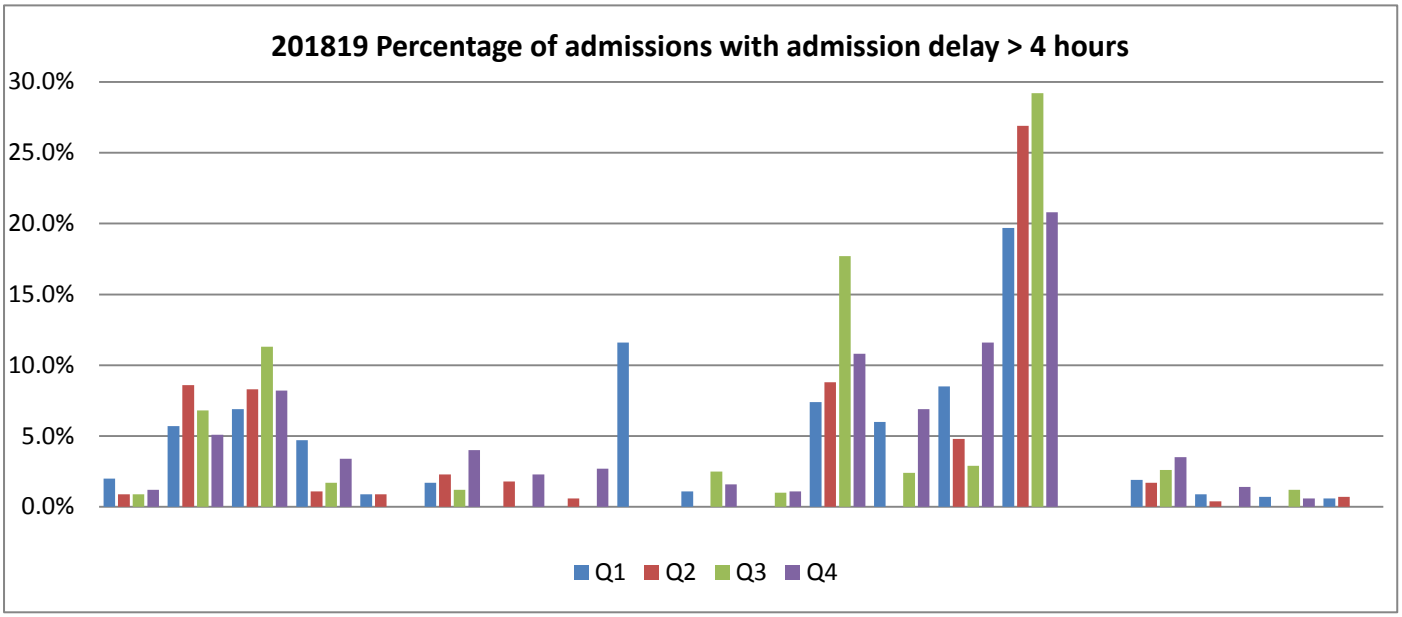


Efficiency metric - 2018/19 Delayed admission to critical care

Data taken from the network report.

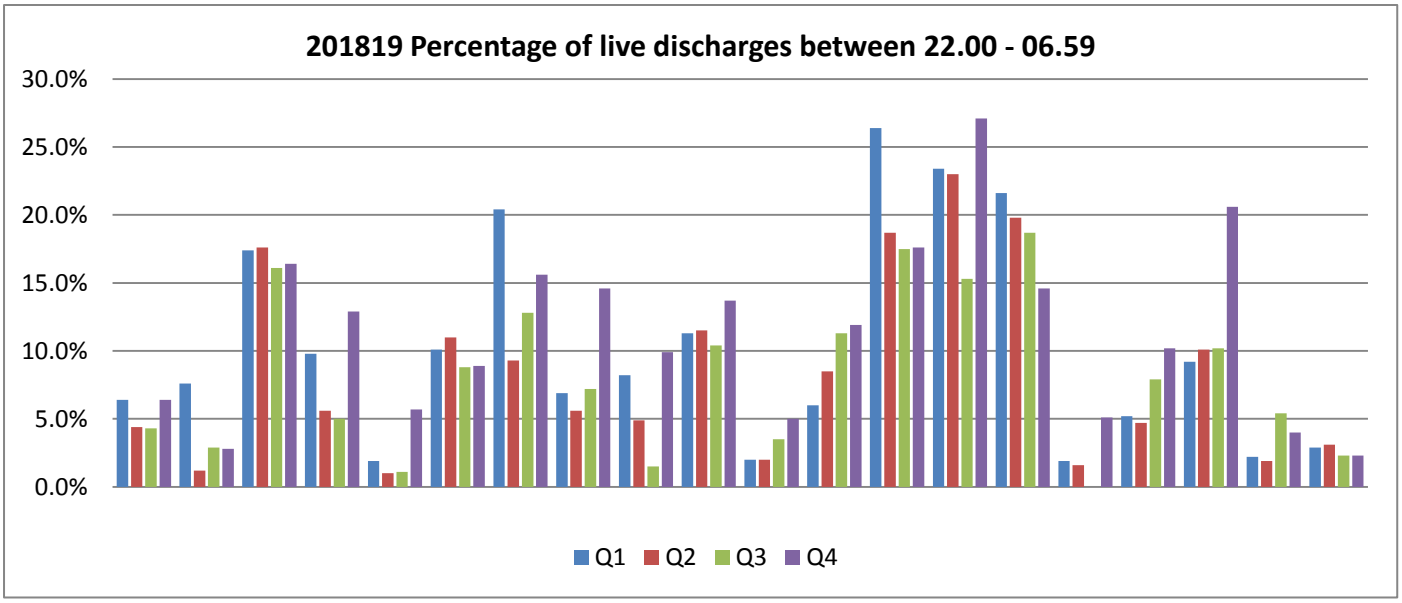
The target for SECCN and nationally is zero admission delays of over 4 hours. The data shows a similar picture to last year with a number of units struggling to achieve this. It is not known to what extent the variation between units is, in part, due to inconsistent reporting. Despite frequent discussion about admission delay at SECCN forums many

units admit to inconsistent documentation and capture of information. The time of decision to admit is to be included in the updated ICNARC dataset and it will be helpful in future to compare network and national information. In the interim, performance will be monitored and reviewed at network assurance visits. Feedback to date has identified a degree of acceptance of caring for patients in theatre recovery whilst critical care beds become available. The detriment to patients' experience and quality of care is hard to measure but both are likely to be compromised and the practice is not endorsed by SECCN.



Efficiency metric - 2018/19 Discharge from critical care between 22.00 & 07.00

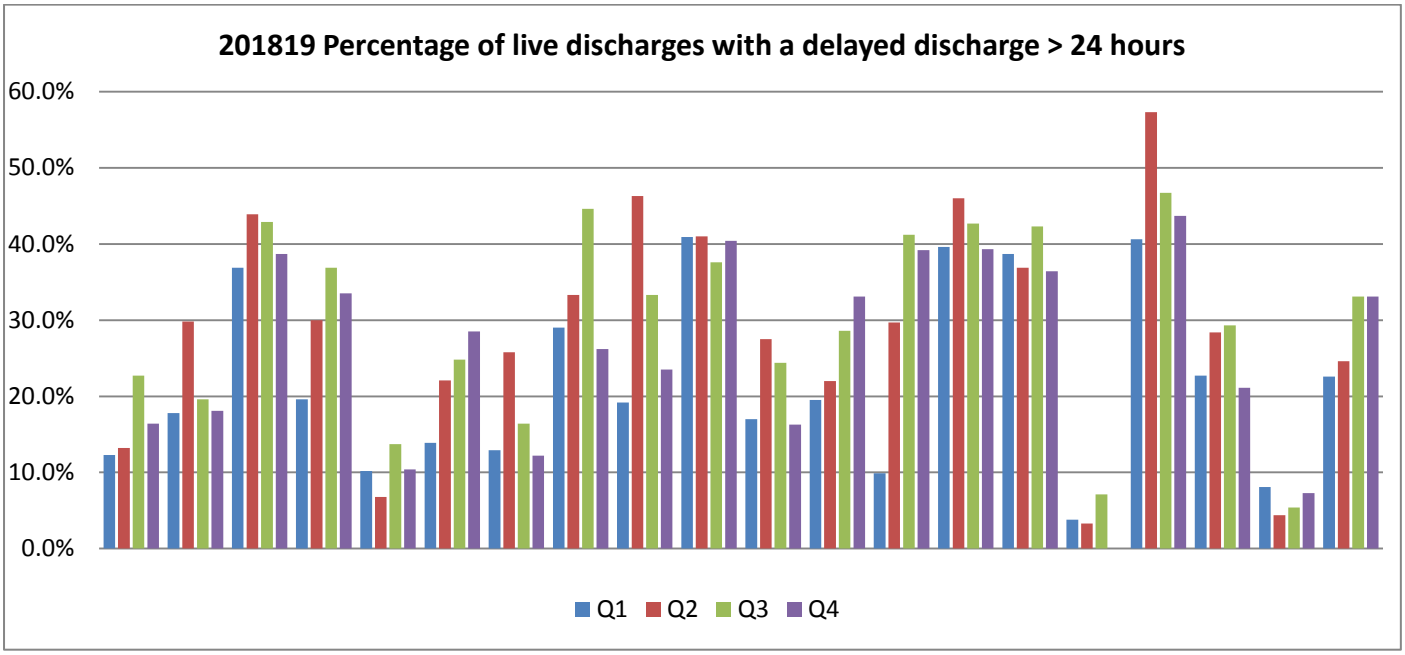
Data taken from the network report.



The numbers of patients being moved to the ward at night is very similar to 201718 with a figure overall that is a cause for concern. Initial work to understand the factors that influence night time discharge suggested an association with delayed discharge to the ward but the data available did not permit detailed analysis. Three units in SECCN have undertaken to review data in more detail in a two month prospective audit and it is hoped that the information will provide more clarity and direction for further review.

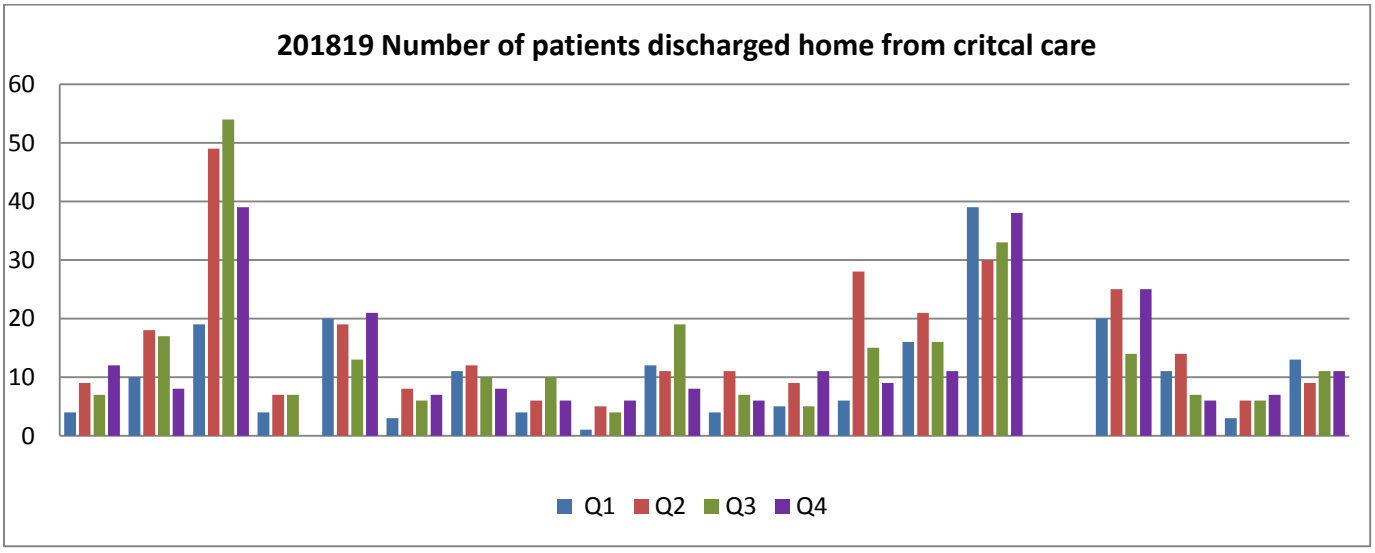
Efficiency metric - 2018/19 Delayed discharge from critical care

Data taken from the network report.



The figures shown in the graph above speak for themselves and show that despite repeated discussion with critical care clinicians about how best to tackle this problem the number of patients with a discharge delay remains troublingly high. This has major implications for critical care bed availability but, frustratingly, a direct association with other efficiency metrics such as delayed admission, cancelled elective surgery and the need to provide critical care in other care areas is very difficult to evidence. The need to do so is a recommendation of the NHS South demand and capacity report and will be part of future work. If an association with night time discharge is identified though the SECCN audit mentioned above it is the intention to widen the scope of the project to demonstrate the negative impact on patient experience and outcome that delayed discharge can have.

Efficiency metric - 2017/18 Number of patients discharged home



Unsurprising, given the evidence of discharge delay, many units have seen a continued increase in the number of patients discharged home from critical care. This mirrors a trend nationally and again, deeper understanding of the issues and its impact on patients and staff will form part of ongoing regional work.

All the efficiency metrics presented indicate continued pressure on critical care despite a small reduction in the numbers of patients being admitted. It is important to add a note of caution because any metric taken in isolation or without detailed analysis can be misleading and this report does not provide the level the analysis required to allow meaningful interpretation. Nonetheless, the implicit contradiction needs to be explored in more detail in the coming months. This dovetails with the NHS South work on demand and capacity and it is hoped that the combined regional effort will permit better understanding of the issues and identification of measures for sustainable improvement.

5. D05 ACC Service Specification[1]

In anticipation of the publication of D05, SECCN, in collaboration with South West and Thames Valley and Wessex Critical Care Networks, has developed and tested a gap analysis tool. The gap analysis covers all standards within D05 and will provide a comprehensive review of compliance in addition to the subset of issues that will be highlighted through Quality Surveillance Information System (QSIS) reporting. The tool has been developed to give clarity to definitions and compliance thresholds and has been circulated to critical care networks nationally for use as locally determined. The service specification and gap analysis tool have been shared with all units in SECCN. Ongoing review will be picked up as part of the NHS England (South) Improving Value Scheme.

6. Unit Assurance Visits

A programme of unit assurance visits was completed in 2018/19 with all Trusts visited during a twelve month period. The structure for the visits remained informal; actions and progress since the previous Trust visit were discussed along with specific challenges and achievements. The visits are fundamental to an appreciation of the issues that concern critical care staff and are an opportunity to offer advice and support and promote sharing of good practice and initiatives. Following discussion at a recent Governance and Clinical Forum it has been agreed to add an element of peer review to the visits in the forthcoming year, with clinical staff from a unit within SECCN attending along with the SECCN Medical Lead and Manager/ Lead Nurse. It has been agreed that the D05 gap analysis will serve to give structure to the discussion but the visit will remain informal. The discussion, findings and suggested actions for each visit is detailed in a SECCN visit report.

7. Nursing Workforce

It is widely reported that a shortage of critical care nurses is common nationally and internationally and that job satisfaction is a key factor associated with nursing retention and, conversely, turnover[2]. The significance of asking critical care nurses to work in other care areas within the hospital when wards are poorly staffed does not feature in the literature; however, discussion with critical care nurses throughout SECCN highlighted the negative impact on job satisfaction that this can have. In order to determine the level of impact this and other variables may have on the intention to continue, or not, in a critical care role, a short survey was developed and circulated to nurses throughout the network.

The survey was completed by 116 nurses and it was heartening to find that by far the majority of nurses like working in critical care and none stated that they actively dislike the environment. The comments demonstrate that critical care may be challenging and exhausting but it is also hugely rewarding. The concerns raised were in tune with those frequently cited in the literature; educational opportunity, fair reward for the skills of critical care nursing, safe staffing levels and opportunities for carer progression. All were cited as positive reasons for staying in critical care as well as reasons for leaving when perceived to be lacking.

However, the responses also suggest that a significant number of critical care nurses are leaving or considering leaving their role in critical care. The issue of primary concern is, undoubtedly, the frequent request for critical care

nurses to work in other care areas and the lack of support and confidence they have when asked to do so. It is not possible to state, definitively, that this has influenced nurses' decisions to leave or consider leaving critical care but a number of comments suggest that this is the case for a worrying number of nursing staff. The need to protect critical care nurses, to improve both retention and recruitment, make it imperative that the extent of anxiety and stress caused is heeded. The fundamental problem is inadequate ward staffing levels and the risk this poses to patient safety.

The survey has been shared with Network Nurse Leads nationally and is to be discussed at a forthcoming national nurse leads meeting.

8. Transfer

Frustratingly, whilst discussions have taken place between commissioners of transfers in Kent, Surrey and Sussex (KSS) and South East Coast Ambulance (SECAmb), clear guidance on the process for requesting some critical care transfers is not yet available. All emergency transfers are and will be covered in the emergency contract with SECAmb; however, some non-urgent critical care transfers are not universally included. SECCN has worked hard to push for communication and collaboration and it is undoubtedly true that all parties appreciate the problem and are actively involved in finding a solution. The SECCN transfer guidelines, withdrawn in 2017 due to ambiguity over the process of requesting an ambulance have been updated in anticipation of new contract arrangements but remain withdrawn pending agreement and finalisation of Inter-Facility Transfer policy for KSS.

It is anticipated that there will be a requirement for all Trusts to contact a private ambulance company for non-urgent transfers. This is not ideal but would provide well needed clarity. A number of transfer incidents reported to SECCN have involved time delays due to uncertainty over which ambulance provider should undertake the transfer. However, governance and liability for Trusts and private ambulance providers has not been formally agreed. Private ambulance providers in KSS have been asked to submit a provider information document detailing their capability for safe transfer of the critically ill and all documents received have been shared with critical care units.

Over recent years, including 2018/19, transfer incidents have been reported to SECCN at the discretion of units when there has been a perceived value in sharing for wider learning. The transfer group has agreed that SECCN should attempt to get a more comprehensive understanding of both transfer incidents and the number of transfers. To facilitate this three units will trial a triplicate copy transfer form with one copy to be sent to SECCN for audit purposes. It is anticipated that some changes will be made to the form following the trial but that the principle of submitting a copy for audit will be adopted. SECCN have contacted North London Critical Care Network to discuss the potential for adding SECCN contact details to an App developed to assist clinicians with the clinical decisions and practicalities of critical care transfer in an attempt to make the process as robust as possible.

SECCN has collaborated throughout 2018/19 with South London Critical Care Network to develop a business proposal for a dedicated critical care transfer service for South London and KSS. A significant amount of progress has been made with funding secured for the business case to be developed and widespread support from clinical and trust executives generated. The proposal in the first instance is to cover transfers of all critically ill patients between South London hospitals and all transfers into and out of South London from hospitals in KSS. This will not, therefore, include many of the problematic non-urgent transfers that tend to take place between hospitals locally; meaning that work to finalise the commissioning arrangements and sign of the SECCN transfer guidelines remains a network priority.

The Simulation Tricky Trips (STricT) transfer course, a fully simulation-based course, developed by St Peter's and Royal Surrey County Hospitals and commenced in East Sussex Hospitals in 2017/18 has been further rolled out in 2018/19 to Brighton and Sussex University Hospitals and East Kent Hospitals. All other Trusts run local transfer

courses with a simulation element that meet SECCN minimum standards for transfer training. SECCN has committed to take over administration of the STricT website to provide course details for all transfer courses in SECCN.

9. Rehabilitation

A summary of best practice in relation to rehabilitation has been produced and circulated following review of data captured as part of an analysis of strengths, weaknesses, opportunities and threats (SWOT) and service delivery updates at SECCN rehabilitation group meetings. As with previous years, the provision of rehabilitation continues to develop but a standard for assessing and comparing practice and gaps in service delivery is not available. Progression of this work into 2019/20 will concentrate on mapping out a SECCN best practice standard and the development of an associated gap analysis tool for units to use to demonstrate compliance and identify areas for improvement along with justification for the resource to support this.

SECCN continues to collect and report on three rehabilitation metrics. Perhaps not surprisingly compliance with the completion of a short clinical assessment within 24 hours of admission to critical care has fallen in some units and this may well reflect a change in the standard following the publication of National Institute of Clinical Excellence (NICE) Quality Standard 158[3], that now stipulates assessment within 4 days or prior to discharge (whichever is sooner). SECCN will work with software developers to amend data collection in line with current standards and re-evaluate performance once this has been done.

10. Pharmacy

The Critical Care Pharmacists from across SECCN met at an inaugural group meeting in January. The purpose and initial objectives of the group were discussed and it was agreed that SECCN would circulate a survey to review pharmacy services. Previously developed in Thames Valley and Wessex Critical Cate Network the survey enabled both comparisons across SECCN and with other units in NHS South East. Information was submitted from eight Critical Care Pharmacists in SECCN. The findings show that whilst all units have pharmacy cover just one of the eight units has pharmacy cover that meets the standard set in the Guidelines for the Provision of Intensive Care Services (GPICS)[4]. The range of compliance for the seven other units is 0.21% to 70% of that recommended. Two units do not have a dedicated Critical Care Pharmacist, in three units there is no pharmacy attendance at the daily multidisciplinary ward round and there is little provision for other activity such as meetings, education, governance, audit, research, protocols / guidance and drug libraries. These findings, though disappointing, are in line with those of TVWCCN.

A Whats App group has been set up for the group and has been used to date to float ideas and ask questions of fellow Critical Care Pharmacists. It is the intention to work as a group to share guidelines and protocols and, if appropriate, develop a portfolio of guidelines for use in SECCN. The group also hopes to collaborate further with TVWCCN to explore the possibility of developing a structured training programme for Critical Care Pharmacists.

11. Clinical Psychology

SECCN was extremely pleased to see the appointment of Clinical Psychologists to work in Critical Care in two SECCN Trusts, East Sussex Healthcare Trust (ESHT) and Royal Surrey County Hospital (RSCH). In addition, a counsellor has been appointed to work with critical care staff at Medway Hospital. The small group met with SECCN leads to discuss how best to foster collaboration and facilitate development of the role as well as encourage the appointment in other SECCN hospitals. The business cases developed at ESHT and RSCH have been shared on request within SECCN and more widely with other networks. It is believed that two SECCN Trusts are actively working on developing a local business case.

The initial focus for 2018/19 has been establishing the role in the provider sites and discussion at the group meeting showed that there is a consensus on the priorities of the role for patients, family and staff. Staff education has been a priority for SECCN for some time and psychological skills training has been delivered in previous years. In order to

better inform the direction of future SECCN skills training staff who attended previous courses were asked to evaluate the sustainability of the skills learned by completing a short survey.

The limitations of the survey were pronounced with just a very small number of replies and the potential for staff to have developed and sustained skills for assessing and managing psychological distress via other formal or informal training was not evaluated. Nonetheless, the impression is that the course was of value with some sustained benefit. Staff reported increased confidence, of varying degree, for all aspects of recognising and managing psychological distress. The degree to which post course support and supervision would have increased sustainability is unknowable, but, slippage of skills is inevitable unless support and supervision is knowledgeable and prolonged.

The options for future SECCN psychological educational support are to facilitate similar training in the future or consider a more comprehensive programme delivered to a larger cohort of staff from a given critical care unit. It is hard to prove or disprove the merit of either from the data to date and it is the intention to foster collaboration with the appointed Clinical Psychologists to explore how to reach out to staff from other Trusts in a useful and sustainable way.

12. Annual Critical Care Conference

The annual SECCN conference is a great success story. Held in June 2018 for the 5th consecutive year the conference attracted delegates from across Kent, Surrey and Sussex and speakers both from SECCN critical care units and further afield. Subjects included the role of Physiotherapy in Critical Care Outreach; muscle wasting; citrate anticoagulation for renal replacement therapy; patient and staff well-being; pancreatitis management; the ventilated spinal injured patient and the immediate aftermath of major incidents. The conference was awarded accreditation by the Royal College of Anaesthetists. Evaluation of the event was overwhelmingly positive and all suggestions for improvement have been heeded for the conference in June 2019. A big thank you goes to the sponsors of the event who ensured the event remained free to delegates.

13. Reference

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