East of England Adult Critical Care Operational Delivery Network

Annual Report 2024 – 2025

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Foreword

Welcome to the East of England Adult Critical Care Operational Delivery Network Annual Report 2024/25. Firstly, I would like to extend thanks to all the clinical and support staff and stakeholders who have worked tirelessly to support all adult critical care services in our region. Your dedication, support and contributions ensure that we continue to deliver first class services and exceptional care to our patients. In addition, a big thank you to the core network team for all their ongoing support to myself and to the wider adult critical care community.

Throughout this year, our focus has been on ensuring quality care through rigorous peer reviews of all units, this round of peer reviews, like other years, were conducted with an Integrated Care System (ICS) representative or specialised commissioner. The reviews focussed on the standards contained within the Adult Critical Care Service Specification (D05), repeat of the Safety Attitudes Questionnaire and a deep dive into the provision of pharmacy services within critical care. This was a very interesting exercise, highlighting workforce challenges across critical care and innovative practice relating to quality services.

For the upcoming year, 2025/26, we have two large projects to coordinate and implement. These will be the procurement exercise for the regional continuation of the post-registration award in critical care nursing at level 6 and level 7, and secondly, the region-wide Network Analytics project, in conjunction with Mela. Both projects provide exciting opportunities and support collaborative working.

Melanie Wright – East of England Adult Critical Care Network Director

This has been another busy year for the East of England Adult Critical Care Operational Delivery Network. It was a great pleasure to complete peer reviews at all the units as it gave us all a chance to talk in detail about the issues that are affecting critical care in the front line at each of the units. It also allowed us to see some of the innovative work that is going on across the region. It is however clear that this has been a difficult year for most with significant financial limitations across the board. The capacity improvements that we hoped would occur as a result of the recognition of the shortfall during the pandemic have not materialised and at the moment the focus is more on avoiding reductions in capacity rather than looking to increase capacity and overall care quality. It is clear from our discussions with colleagues in other networks that this is certainly not just a regional issue but is one that is being faced across the country. The Network continues to work with trusts and ICSs to identify where the shortages are having the most significant impact and try to ensure that improvements can occur to ensure that units are able to provide the quality of care that their patients need without the need for inappropriate delays to admission or transfers to alternative facilities.

Benchmarking has always been seen as a fundamental role of critical care networks and collection and analysis of data is a core activity, however over the years this has been limited by the lack of availability of that data. Some of the function is undertaken by ICNARC and the use of this national benchmark has been important for all networks in assuring the quality of care in each region. The ICNARC process is based on the need for the highest quality data to

ensure accuracy of information and the importance of this should not be undermined, however the process has always suffered from the scale of the national programme, and the delay created by the checking processes that support this information standard. From a regional point of view this means that when the regional reports from ICNARC arrive they are often up to 12 months from the last admission, and it is also nearly impossible to investigate specific issues in detail if these are not part of the reporting process. The opportunity to use this data as it is flowing to ICNARC to provide Network-wide data analytics that can be queried in detail is very exciting and this is an important project for the coming year.

Dr Mark Blunt - East of England Adult Critical Care Network Clinical Director

I have completed my first year as lead nurse and have been overwhelmed by the support, enthusiasm and resilience of the critical care staff from across the region.

During 2024 we have seen continued stress on the system, with workforce pressures remaining as a major issue in many units. The publication of the United Kingdom Critical Care Nursing Alliance (UKCCNA) Workforce Optimisation Plan 2024-27 has offered us direction for the future of critical care nursing. Introducing a framework that recognises the skills and knowledge that critical care nurses gain during their careers and offering guidance on staffing levels required to maintain standards in critical care. As an adjunct to this, the network produced a toolkit for unit lead nurses offering practical solutions for the issues of recruitment and retention.

2024 saw the continued development of Network groups, to improve our regional communication and collaboration. We are in the process of developing a regional benchmarking/ quality improvement group – which will begin with work on pressure ulcer prevention by the tissue viability group. The multi-disciplinary rehabilitation forum has been re-established and is looking forward to working together on regional projects. With the anticipated publication of National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) study 'Rehabilitation following critical illness' and the plans for the inclusion of rehabilitation in the next round of peer reviews, there will be much for the group to focus on.

The Martha's rule pilot process began in April 2024. Most of the units in the region have participated in this first phase and have made good progress. The Network team remains in close contact with NHS Innovation East and the regional Outreach teams to support whenever needed.

Nurse education continues to be both a concern and a priority. With the completion of NHSE's blended learning contract, the network's education team are working on strategies to continue the provision of the current courses in a cost-effective way as possible.

2025 will see us move into a phase of increased financial insecurity. It is important we work together to maintain the high standards we aspire to. I hope recent publications such as the 'Intensive care environmental recipe book' will help us save money and resources with a positive impact for ourselves, our patients and the environment.

I look forward to our continued collaboration in 2025.

Sarah Entwistle – East of England Adult Critical Care Network Lead Nurse

Our Region

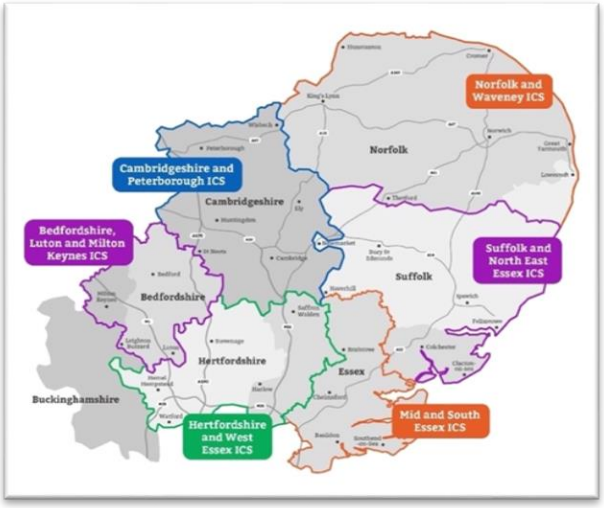

Figure 1 – *Map of region showing Integrated Care Systems and hospital sites*

The Network supports 14 acute trusts, which totals 21 adult critical care units in 19 hospitals. The region has a population of approximately 7 million, with 6 integrated care systems. All tertiary speciality services are represented within the network; Neurosciences incorporating Major Trauma Centre beds; Cardiothoracic services and Burns critical care. There are also extensive transplant services and Extracorporeal Membrane Oxygenation (ECMO) beds. The Network covers approximately 14.7% of England and 11% of the popula tion.

Unit	Total Beds	Level 2	Level 3	
Southend	17	7	10	
Basildon General - ICU	18	8	10	
Basildon Cardiothoracic ITU	14	6	8	
Broomfield	18	8	10	
Colchester	16	8	8	
Ipswich	14	8	8	14 Level 3 Equivalent
West Suffolk	9	3	6	
James Paget	12	6	6	
Norfolk & Norwich	28	14	14	
Queen Elizabeth	13	8	5	
Milton Keynes	10	6	4	
Luton & Dunstable	12	6	6	
Bedford	10	4	6	
Lister	18	6	12	
Watford	19	9	10	
Princess Alexandra	10	5	5	
Hinchingbrooke	6	2	4	5 Level 3 Equivalent
Peterborough	14	6	8	5 Level 3 Equivalent
Addenbrookes JVF	32	12	20	
Addenbrookes NCCU	27	6	21	
Royal Papworth	**36**	**0**	**36**	
TOTALS	**353**	**138**	**217**	

Table 1 – *Bed capacity for each individual unit confirmed January 2025*

Annual admissions to adult critical care units

Hospital:	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
MSE Basildon ICU Basildon CTC Broomfield Southend	619 ---- 663 426	628 1166 726 483	607 1190 987 488	600 120 995 499	526 1081 946 556	651 1130 942 765	736 1017 875 848	581 831 676 759	754 923 723 742	792 1017 822 696	711 791 1002 784
ESNEFT Colchester Ipswich	545 881	612 979	682 880	671 821	677 755	625 801	586 862	593 684	539 754	570 729	616 761
West Suffolk	510	534	496	632	621	626	610	473	451	444	418
James Paget	668	589	618	677	628	624	634	557	573	619	669
Norfolk & Norwich	1676	1630	1592	1804	1981	1969	1875	1616	1763	1772	1742
Queen Elizabeth King's Lynn	901	871	827	782	740	813	709	528	515	685	628
Milton Keynes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	413	385
Luton & Dunstable	1288	1252	1205	1404	1435	1385	1402	914	837	816	746
Bedford	546	549	510	516	495	484	504	430	412	380	358
Lister	855	884	929	1037	1090	1244	1049	1100	1075	1002	975
Watford	934	927	814	947	898	985	1073	810	757	881	913
Princess Alexandra	703	626	643	714	768	621	728	605	543	546	583
NWA Hinchingbrooke Peterborough	563 790	599 713	560 830	570 778	475 799	387 684	376 712	397 661	420 609	394 671	389 764
CUH NCCU JVF RRU	---- ---- ----	---- ---- ----	1000 874 ----	993 924 520	1002 1029 507	1012 1018 485	1108 1022 487	1078 1604 0	1099 1536 0	998 1534 0	983 1674 0
Royal Papworth	2559	2817	2785	2787	2716	2667	2386	2006	2248	2235	2369
Total	**15,127**	**16,585**	**18,517**	**19,872**	**19,662**	**19,918**	**18,526**	**16,903**	**17,273**	**18,016**	**18,261**

Table 2 – *Annual Admissions by each Unit (Monthly QI data submissions to the Network)*

Our Objectives

The Network continues to foster information sharing and facilitates cross-organisational co-operation and collaboration, addressing difficult decisions and supporting problem-solving particularly where this involves multiple agencies. The overall aim of the East of England Adult Critical Care Operational Delivery Network is to

- improve patient experience and outcomes,
- reduce unwarranted variation,
- ensure effective equity of access, equitable care and timely admission and discharge to and from adult critical care services,
- take a whole system collaborative provision approach to ensure delivery of safe and effective services across patient pathways, adding value for all its stakeholders.

Governance and Structure

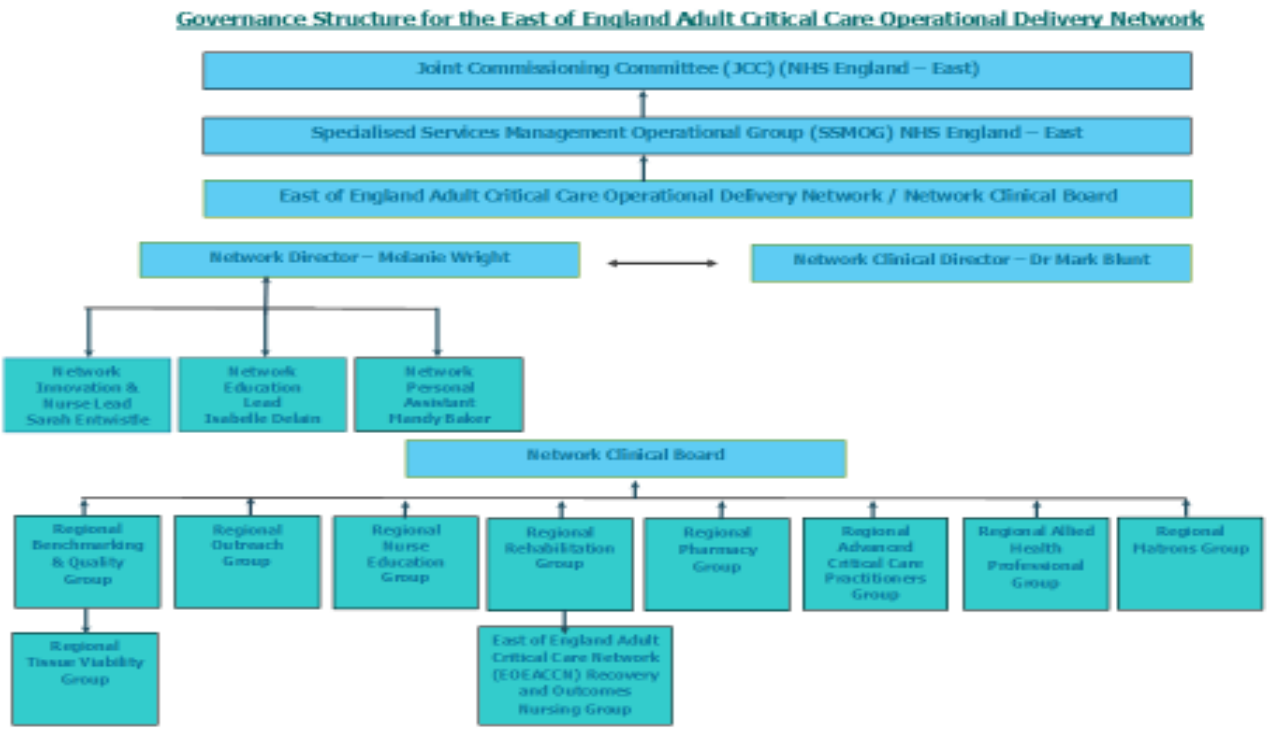

Figure 2 – *governance structure for East of England adult critical care operational delivery network*

The Network aims to support all our units to deliver a critical care service in line with national standards and to understand the factors that impact on delivery.

We do this through peer review visits, regular gap analysis reviews and network meetings including our quarterly Clinical Board.

Critical Care is not without risk however, solid engagement with clinicians at all sites provides collaborative opportunities for the sharing of best practices. Our aim is to 'ensure every patient requiring critical care receives exceptional, safe and effective high-quality care.' This is achieved through robust quality assurance processes and collaborative working across all stakeholders in the East of England

Nurse Education

Specialist Critical Care Award

Post-registration education for Critical Care Nurses continues to be one of the main foci for the Network as units strive to fulfil the standards of 50% of their nursing staff with a post-registration critical care qualification/award in line with Guidelines for the Provision of Intensive Care Services (GPICS) and Faculty of Intensive Care Medicine (FICM) standards. The Network has key personnel identified to lead on the Step 1 Programme and the Critical Care Course.

The 2023/2024 cohort of the Adult Critical Care Course, led and delivered by the Network with the support and accreditation of the University of East Anglia (UEA), completed their studies in July 2024, with ratification of results at the exam board in October 2024. Whilst there are some outstanding results related to exceptional circumstances and extensions, overall, the outcome has been positive with a 99% Pass rate for Module 1 and a 96% Pass rate for Module 2. This means that 96% students have passed both Modules so far. There were four 'break in studies' and one withdrawal from the course out of a total of 126 students. Withdrawals and break in studies decisions were based on themes such as personal circumstances, and new posts outside of critical care.

The numbers of places on the course were increased on successive academic years since the course's first delivery in 2019, where 54 students were registered. This was increased to 100 students for the October 2020 and the September 2021 intakes. And in response to the growing needs of the units in the region, there were 130 in 2022/2023, and 126 in the 2023/2024 cohort. The 2024/2025 cohort currently has 134 students, to account for the shortfall from 2023/2024. Many challenges arise from supporting the learning of such a large cohort. However, the Network continues to evaluate students' experience and respond to feedback, striving to make timely changes to promote success for all students which in turn will have an impact on patient care, safety, experience and outcomes. Higher intakes have positively benefitted the number of staff with the course per unit, as in January 2022, there were seven units which fell below 35%, and in January 2025 this had reduced to two units under 35%.

The current 2024/2025 cohort is studying on our second delivery of the adapted Modules which continue to adopt a Blended Learning approach. Teaching and learning occur through completion of activities either online – synchronously or asynchronously – or face-to-face in classrooms. The ratio of online to face-to-face classes ranges from 70:30 to 90:10. The East of England Adult Critical Care Network Course is now in its sixth year running. The

modules were adapted with the lessons learnt from sharing educational practices within the Blended Learning Programmes Community of Interest. The titles of the Modules changed from Management of the Critically Ill Adult to Care of the Critically Ill Adult (Module 1), which focuses on clinical systems-based competence and Professional Issues in Critical Care (Module 2), which highlights the importance of teamwork, rehabilitation, end-of-life care, leadership and professionalism. In the redesign of the Module, the quality improvement proposal assignment was moved to Module 2 to better support its potential implementation on local units. We have received good feedback from both cohorts of students, who have undertaken the newly adapted modules. Module 1 is now more clinically based, and Module 2 focuses on professional issues and leading within Critical Care. Students have highlighted in their feedback the advantages of online learning: financial implications, less travel, more family friendly and getting opportunity to hear from experts. A minority of learners would still prefer a complete face to face delivery of the course.

The aims of blended learning programmes have been identified by NHS England as:

• To create innovative, accessible programmes using the latest digital and other technologies.

• To attract greater numbers and a more diverse student population.

• To create a significantly different education offer that will support the growth of a qualitatively different, expert and professional workforce suited to the demands of healthcare now and in the future.

• To facilitate the growth of digitally capable learners.

The Network was successful in securing funding from NHSE and became a provider of the Quality Framework for Blended Learning Critical Care Education in November 2021. The Network team continues to collaborate with the National NHSE Blended Learning Team working to achieve the aims mentioned in the above section.

Further discussion with NHSE has led to an extension of the original 2-year contract for an additional 2 years, which allows the Network to offer 130 places per cohort for Adult Critical Care nurses working in units across the region without a fee to individual Trusts. This applies to cohorts 2024/2025 and 2025/2026. Our current model of teaching relies on each unit participating in the course delivery and the Network would like to take this opportunity to thank the Clinical Education and Practice Development teams from all units in the East of England for their continued support, ensuring that students receive the most up-to-date information from experts in practice and guiding them to apply theory into practice.

Funding from the NHSE Blended Learning Contract will cease in October 2025, with the last cohort on the Contract being cohort 2025/2026. Notification of potential cost for course starting in September 2026 has been communicated to each Trust Director of Nursing (DON), Trust education leads, and unit leads.

The Network recognises the need to also support the development of the Clinical Educators not only for them to contribute to the Critical Care Course but also to support improvements in teaching and learning in practice. In the last year, the Network has been able to provide funding:

- For 20 Educators to complete a 2-day course on high-fidelity simulation based learning experience, allowing them to develop their skills in designing and facilitating Simulation during study days and within their own workplace.
- For Educators to complete a Postgraduate Certificate in Education in Healthcare. Most units in the region now have one or more educators who hold this qualification, this is an impressive achievement.

We have also delivered a face-to-face away day for Network Educators, for the second year, with the collaboration of the University of East Anglia, to provide support in marking academic work, enabling Educators to apply the theory they have learnt through their Postgraduate Certificate in Education in Healthcare. It is expected that this will become an annual event.

Shiny Mind

In April 2024 critical care Health Care Support Workers (HCSWs) were invited to attend the 'Power to Shine' course run by Shiny Mind. This was the second of two 4 online courses the network commissioned with additional funding it had received. The course focused on psychosocial and wellbeing aspects of work including self-development and empowerment. The course received positive feedback, and Shiny Mind produced a feedback video which was presented to the Matron's group at their face-to-face meeting.

Step 1 Programme

On 1st April 2022, the Network launched its online step 1 competency programme. The programme content, which was designed by Felicity Chapman and Sarah Entwistle, in collaboration with UEA, is accessed using UEA's Blackboard Training and Development site. The programme aims to provide band 5 nurses across the network with critical care foundation knowledge and prepare them for undertaking the 60 credit Care of the Critically Ill Adult Course. The programme has been funded by NHSE as a blended learning programme. It consists of 40 hours asynchronous online learning, with two days face-to-face training provided by the learner's workplace. The funding pays for the access to the online content and provides each unit with £197 per student when enrolled on the course, which helps towards the cost of providing the face-to-face training. Learner knowledge is assessed at a local level using CC3N's Step 1 competency book as well as through online quizzes within each block of learning. All three elements are required to complete the programme. The course allows students to study flexibly and aims to be a reliable way to provide education at a time when staffing issues frequently disrupt study days. It is anticipated that by reducing the amount of face-face-training they provide, Educators will be able to spend more clinical time with junior staff. Since January 2022 (including our pilot cohort), we have enrolled 750 learners on the course, with the next cohort due to start in April 2025. Our target is to enrol 1100 learners in total by October 2025. There has been positive feedback about the content from students and feedback will continue to be reviewed every six months. Educators are sent reports to allow them to monitor the progress of their students. Updates have been made to the course, including the addition of end of block quizzes for the students to complete, and a new platform, to match that used by the specialist critical care course. A new section has also been added to the programme on the topics of appraisal of literature and development of critical writing skills to support learners in preparing for undertaking further studies such as the Critical Care Modules. This is even more relevant as a significant proportion of our learners in the region have not previously studied in the UK. The course content is reviewed annually, and in line with the impending release of the updated Step 1 competency book.

Peer reviews – Commissioning standards: what we have learnt

The Critical Care Network has conducted another round of peer review in 2024. This review encompassed all hospitals within the network, excluding Milton Keynes, which is part of the Thames and Wessex Network despite being within the region. Prior to each review, units were required to complete a self-assessment against the commissioning standards (D05) and provide access to the safety attitudes questionnaire (SAQ). These tools have been utilized in the previous two peer reviews; additionally, this year, an extensive pharmacy assessment was mandated.

Each review involved participation from the local critical care team, comprising medical, nursing, pharmacy, and other multidisciplinary team (MDT) members, along with representatives from the pharmacy hospital leadership, the network team, a network pharmacy representative, and a representative from the local Integrated Care System (ICS). During the review, there was an opportunity to discuss and critically evaluate various components of the self-assessments, culminating in a final agreed statement of compliance.

This report examines D05 compliance across the region and compares the findings from 2024 with those from 2022. A comprehensive discussion of the pharmacy element results is included elsewhere in this report. The SAQ was thoroughly analysed in the previous report and will not be revisited at this time.

Standards 1.1 to 1.5

ADMISSIONS

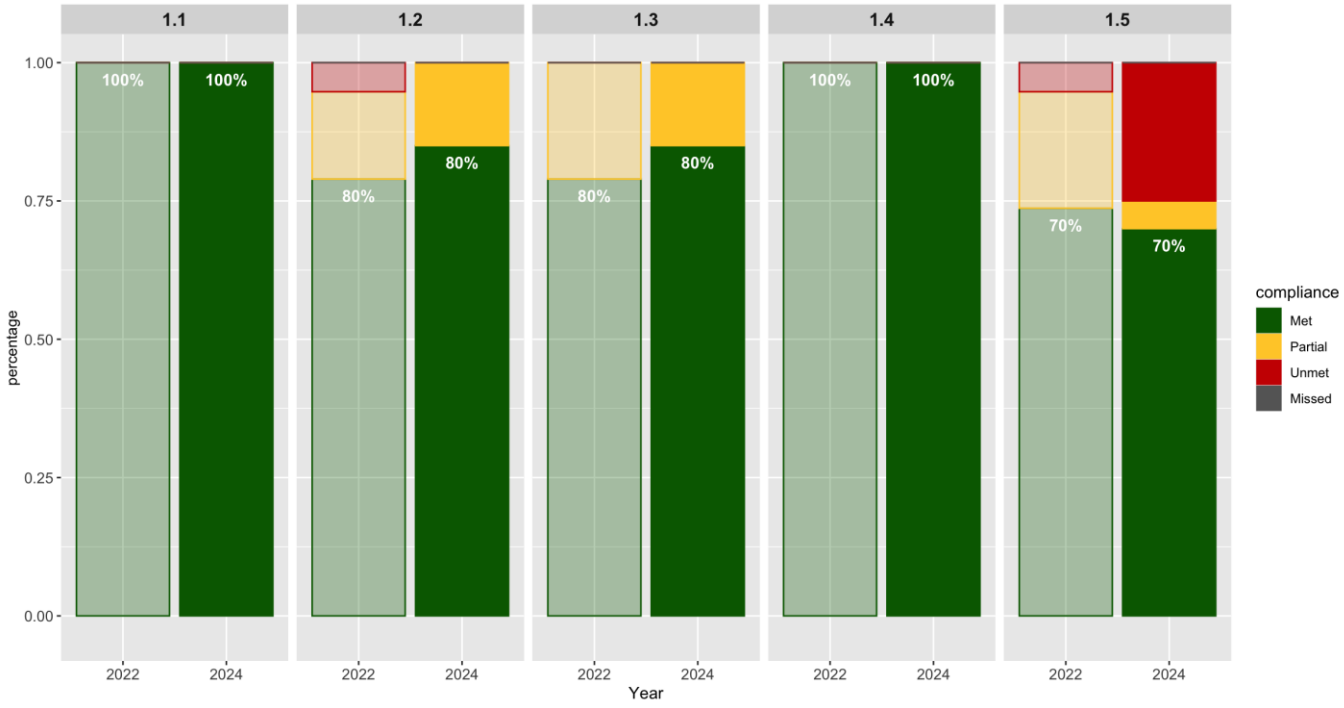

Figure 3 – *Corrected assessment against D05 for standards 1.1 to 1.5 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in Table 3)*

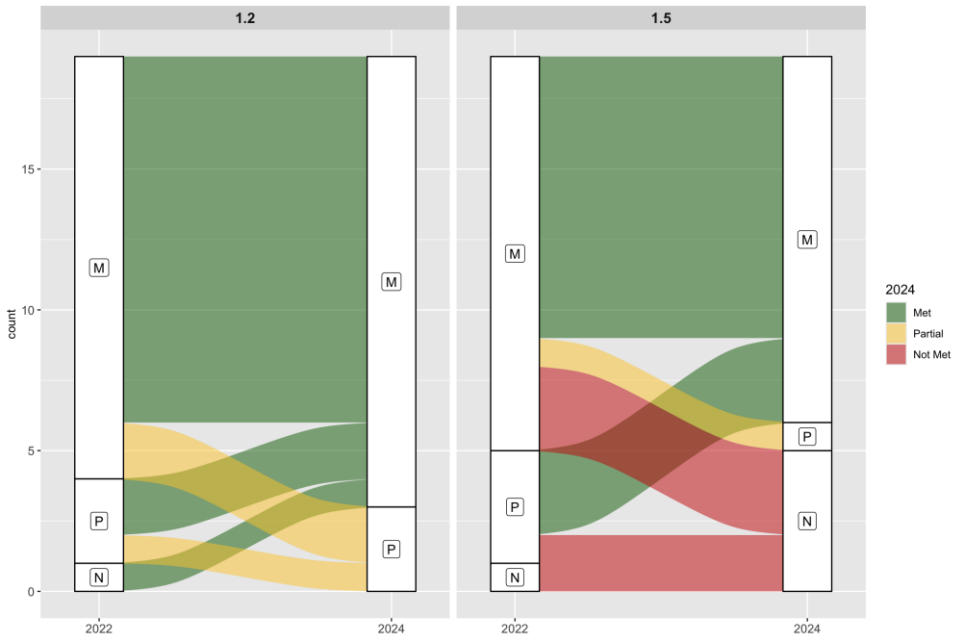

Figure 4 – *Alluvial plot showing change in status of individual units standard alignment (standards 1.2 – timely admission and 1.5 – avoidance of capacity transfers)*

Standard	Short description
1.1	Management of deteriorating patient (NICE 50)
1.2	Timely admission within 4 hours
1.3	Avoid unnecessary elective surgical postponement
1.4	Consultant led decision to admit
1.5	Avoidance of interhospital capacity transfers

Table 3 – *Standards 1.1 to 1.5 with short descriptions*

These relate to admission and the picture is little changed overall though it is notable that a small number of units (3) have difficulty with timely admissions (1.2) and the planning and admission of elective surgery (1.3). In both these cases whilst the proportion is similar half the hospitals involved have changed over the 2 years.

There has been a further increase in hospitals undertaking transfers of patients due to capacity constraints (now the case in 25% of units). It is notable that this has increased since the pandemic and this is likely to be partly due to experience and comfort in the process and the availability of a properly trained and resourced transfer team. It rightly continues to be considered a last resort but there are definite benefits for patients being transferred from a unit that is unable to provide adequate staffing to manage them with the actual transfer being managed in the safest way possible. Even so there continues to be a potential negative impact on patients due to the need for a new team to manage the patient without the benefit of the insights gained over their stay to that point (excepting what can be gleaned from the notes) and particularly the change of supporting speciality. This may be particularly relevant in surgical cases and is mitigated where the transfer takes place between hospitals that are within one organisation (indeed there may be actual benefit if the specialist team are based at the destination hospital). The network continues to press trusts and ICSs not to see transfer as appropriate and to ensure adequate capacity to avoid this, unless it is part of an internal trust strategy in trusts with multiple sites and has been clearly planned for with the risks and benefits appropriately evaluated.

Standards 2.1 to 2.6

MEDICAL STAFFING

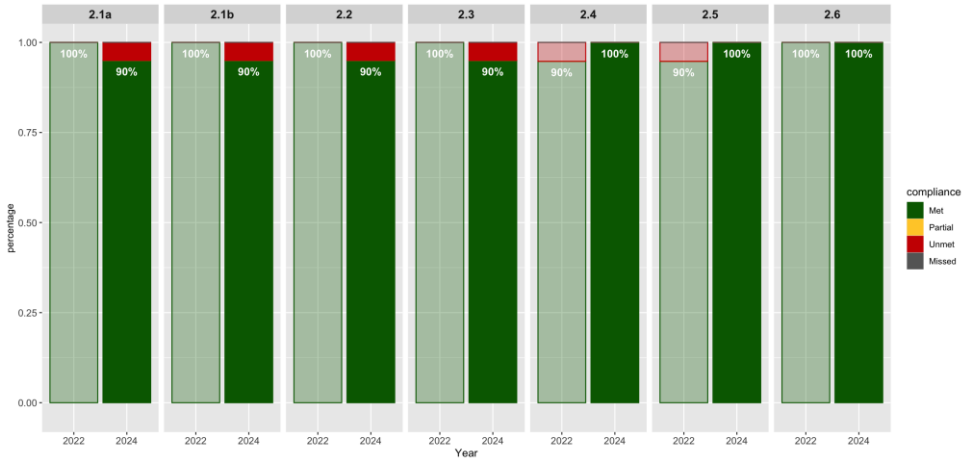

Figure 5 – *Corrected assessment against D05 for standards 2.1a to 2.6 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in Table 4)*

Standard	Short description
2.1a	Clinical Director and Matron
2.1b	Engagement with ACC ODN
2.2	Care led by ICM consultant
2.3	Consultants free of other commitments when covering ICU
2.4	ICM consultant available 24/7
2.5	Admission plan discussed with ICM consultant
2.6	All admissions seen by consultant within 12 hours

Table 4 – *Standards 2.1 to 2.16 with short descriptions*

These standards continue to be well met, with a small fall due to one unit struggling to appoint a new medical lead, though this has subsequently been resolved.

Standards 2.7A TO 2.7H

PHARMACY SERVICES

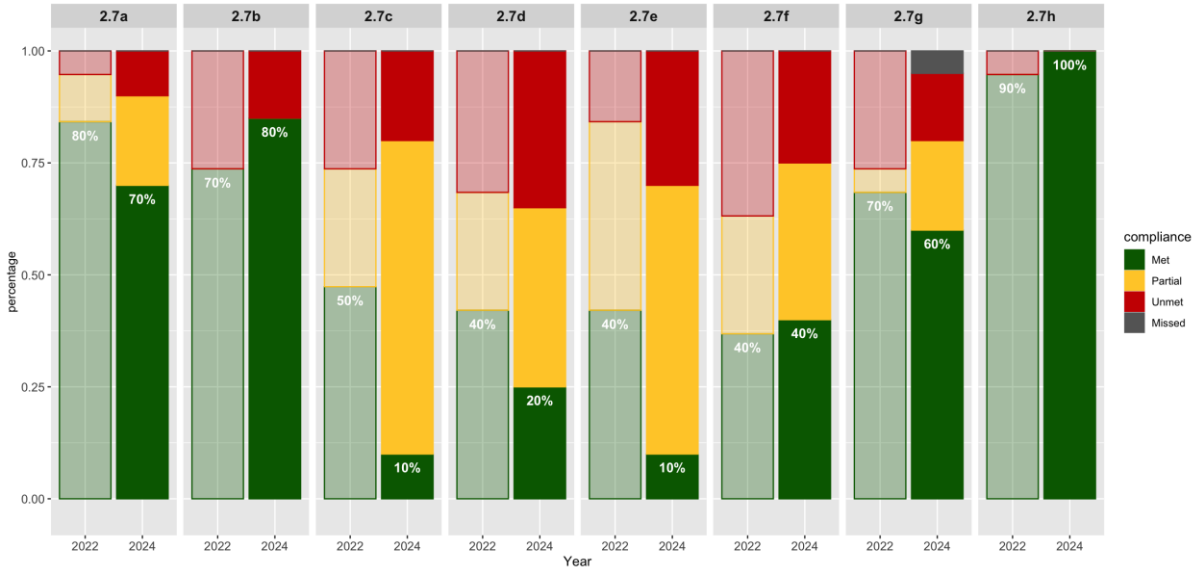

Figure 6 – *Corrected assessment against D05 for standards 2.1a to 2.6 showing percentage of units fully meeting, partially meeting and failing to meet the standards*

These pharmacy related standards are discussed further elsewhere.

Standards 2.8 to 2.8.1E

MULTIDISCIPLINARY TEAM PRESENCE

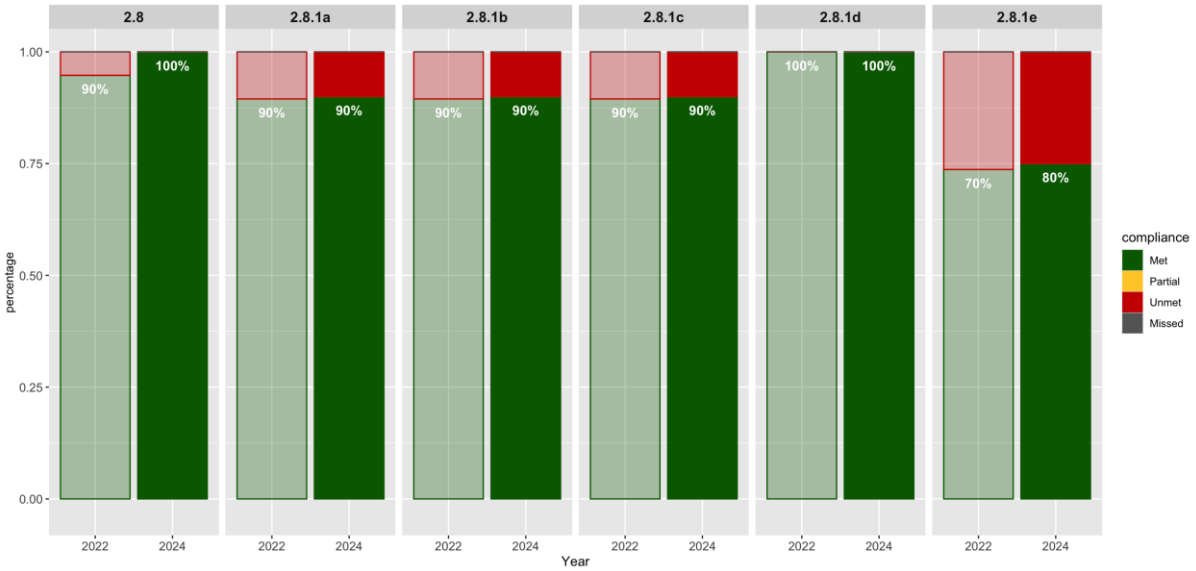

Figure 7 – *Corrected assessment against D05 for standards 2.8 to 2.8.1e showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 5)*

Standard	Short description
2.8	ICM Consultants
2.8.1a	microbiology
2.8.1b	pharmacy
2.8.1c	dietetics
2.8.1d	physiotherapy
2.8.1e	speech and language

Table 5 – *Standards 2.8 to 2.8.1e with short descriptions*

The daily availability of the whole breadth of the multidisciplinary team (MDT) saw continuing difficulties in a small number of units. Again, the overall number is unchanged though in each case one unit has improved and a different unit deteriorated. SALT availability is poor in a quarter of units, again with approximately half of this in units that met the standard in 2022 and half of those failing in 2022 now reporting access to this service.

Standard 2.9 to 2.12

NURSING

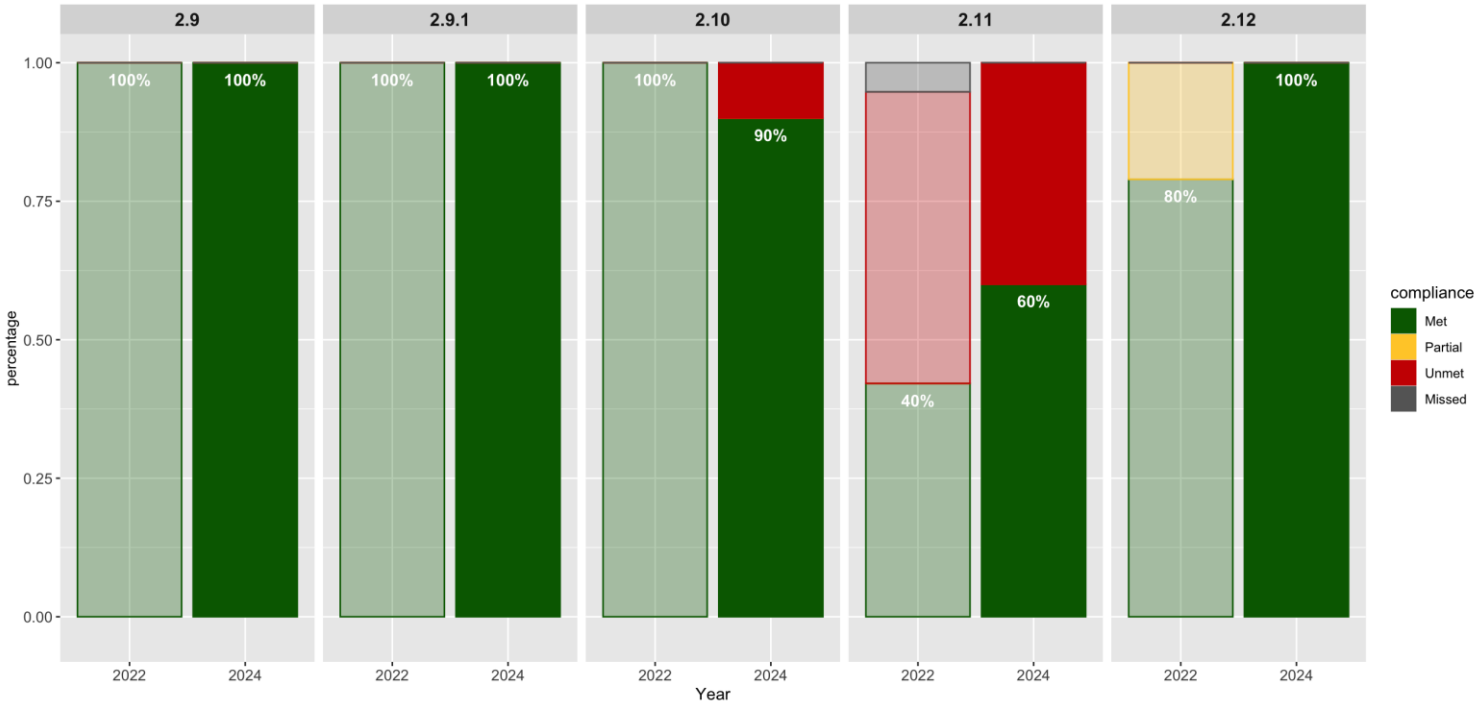

Figure 8 – *Corrected assessment against D05 for standards 2.9 to 2.12 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 6)*

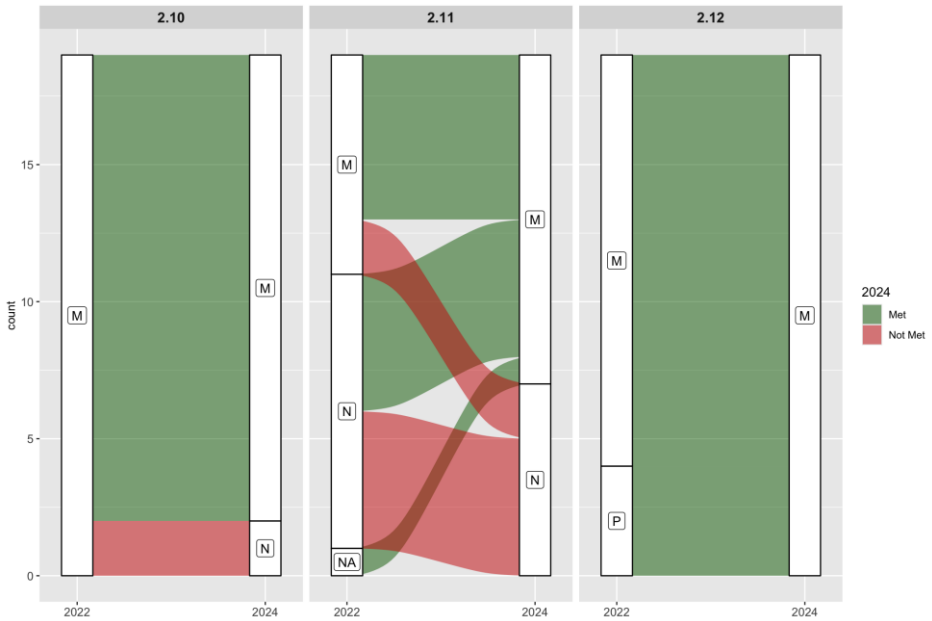

Figure 9 – *Alluvial plots showing change in status of individual units standard alignment (standards 2.10 – clinical educator, 2.11 – course completion and 2.12 – presence of shift coordinator)*

Standard	Short description
2.9	Level 3 patients receive 1:1 nursing
2.9.1	Level 2 patients receive 1:2 nursing
2.10	Adequate clinical educator time available
2.11	50% of nursing staff with critical care course
2.12	All shifts have supervisory shift coordinator

Table 6 – *Standards 2.9 to 2.12 with short descriptions*

All units continue to report that they meet the requirements for adequate staffing, though in one case this is frequently by reducing bed capacity. In all cases when the submissions in the directory of services (DoS) are reviewed there are frequent shortages against the commissioned capacity though shortages against admitted

patient numbers are rare throughout. Two of the larger units newly reported inadequacy in availability of nurse educators. There has been a significant increase in units achieving the requirement for 50% of staff to have completed the critical care course (now 60% compared to 42% in 2022). Whilst not part of D05, review of stocktake data suggests that there continues to be marked shortfall in higher banding for these staff, and several units reported more than 10 nurses still working at band 5 following successful completion of the course and a number of these continuing at this band for 5 years or more. All units now have shift coordinators present for at least 98% of shifts.

Standards 2.13

AUDIT/NATIONAL DATA COLLECTION PARTICIPATION

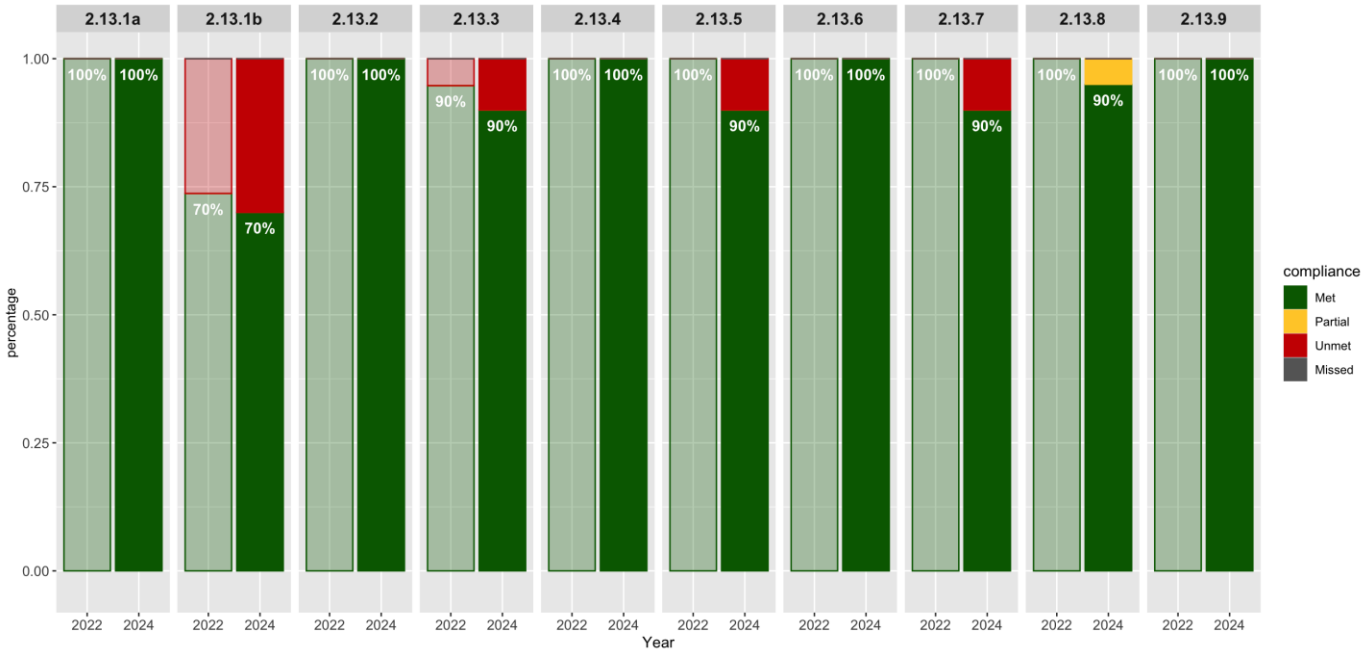

***Figure 10** – Corrected assessment against D05 for standards 2.13 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 7 below)*

Standard	Short description		Standard	Short description
2.13.1a	Unit participates in ICNARC		**2.13.5**	Evidence of effective engagement with families
2.13.1b	Unit participates in ICCIQIP (national vascular line infection audit)		**2.13.6**	Effective use of a risk register
2.14.2	Unit participates in ODN peer review process		**2.13.7**	Strategies to minimise catheter related blood stream infections
2.13.3	Unit is working towards NICE CG83 and QS158		**2.13.8**	Avoidance of readmission within 48 h
2.13.4	Evidence of implementation of evidence based practice		**2.13.9**	Twice daily submission to DoS

***Table 7** – Standards 2.13 with short descriptions*

All units continue to supply ICNARC data, though there has been difficulty with this in one unit over the intervening period between the peer reviews which is now resolved. Units are less convinced of the value of the ICCIQIP programme with increasing feelings that the return is not worth the amount of work required. It is not clear that this will continue to be part of the commissioning standards going forward.

Standards 3.1 to 3.4

DISCHARGES

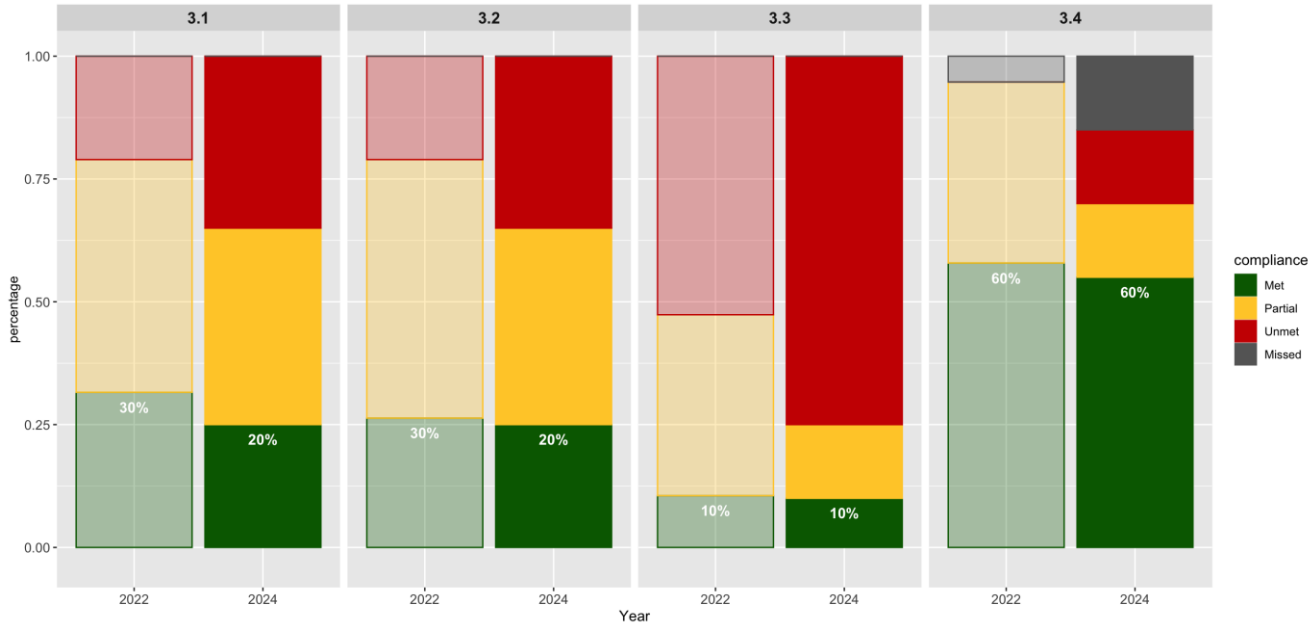

Figure 11 – *Corrected assessment against D05 for standards 3.1 to 3.4 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 8 below)*

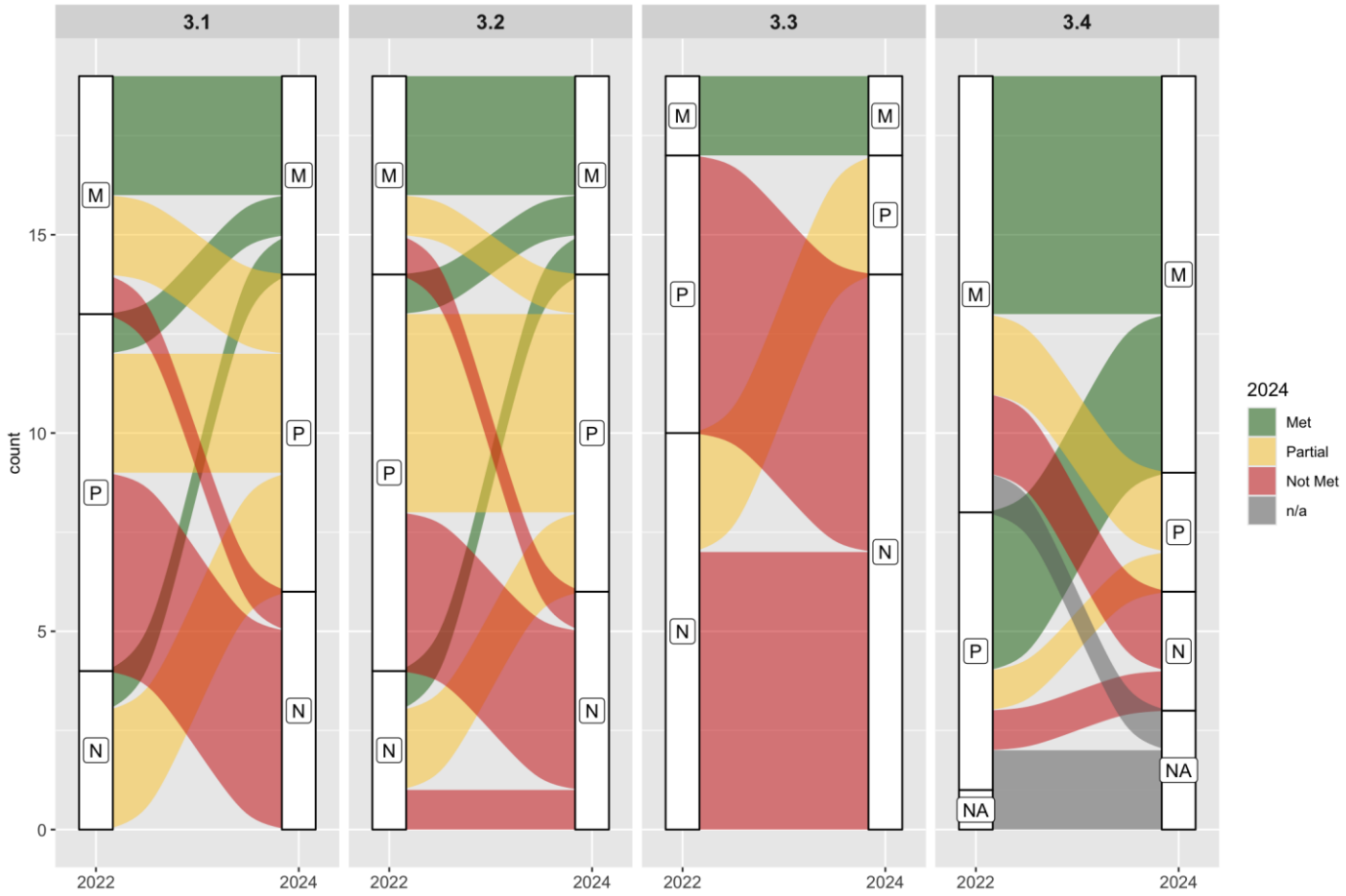

Figure 12 *– Alluvial plots showing change in status of individual units standard alignment (description in Table 8 below)*

Units continue to have significant difficulties with discharge delays, indeed the only 2 units able to discharge patients to ward level within 4 hours are the two cardiac units and is likely to relate to the high elective surgical populations in these units. Despite this a small number of units were able to avoid nocturnal discharges possibly due to capacity to retain these patients more often until the next morning and thus avoid a potentially unsafe discharge.

Standard	Short description
3.1	Discharge 0700 - 2159
3.2	Discharge 0700 - 1959
3.3	Discharge within 4 h
3.4	Repatriation within 48 h

Table 8 – *Standards 3.1 to 3.4 with short descriptions*

Standards 4.1

INTERDEPENDENCIES WITH OTHER SERVICES OR PROVIDERS (NORMALLY LOCAL)

Figure 13 – *Corrected assessment against D05 for standards 4.1 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 9 below)*

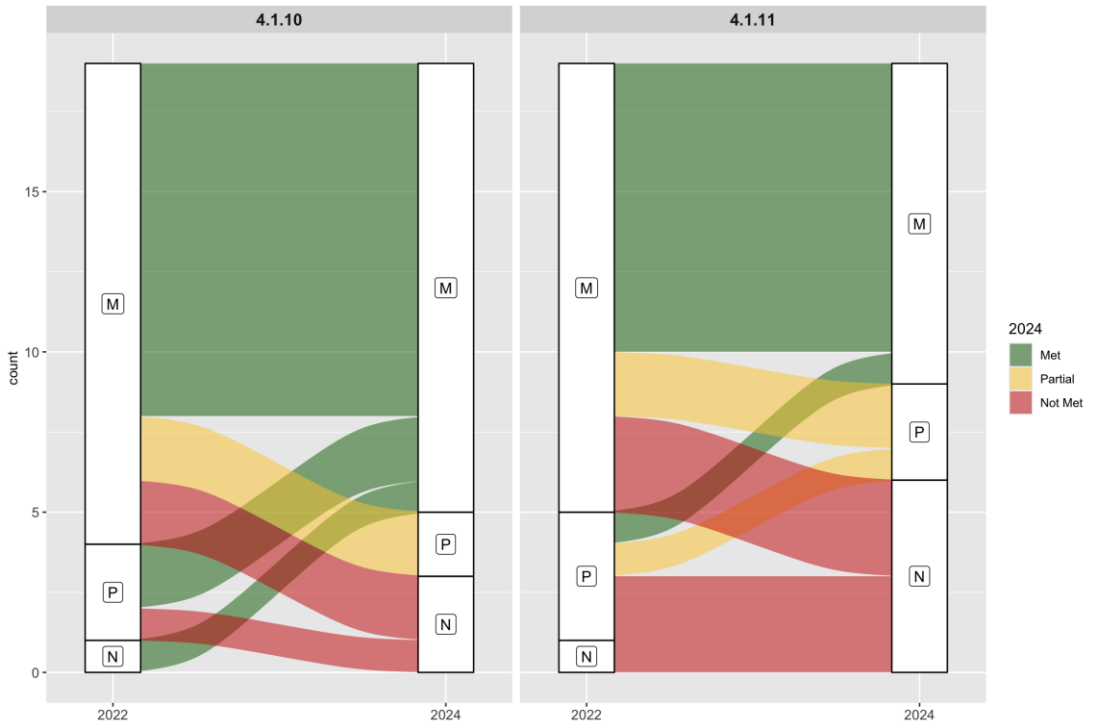

Figure 14 – *Alluvial plots showing change in status of individual units' standard alignment (standards 4.1.10 – informatics and 4.1.11 – medical engineering)*

Standard	Short description		Standard	Short description
4.1.1	Resident with airway skills		**4.1.7**	Transfusion
4.1.2	Internal medicine		**4.1.8**	Lab services
4.1.3	Radiology		**4.1.9**	Appropriate services for specialty units
4.1.4	Echocardiography		**4.1.10**	Informatics
4.1.5	General Surgery		**4.1.11**	Medical engineering
4.1.6	Theatres			

Table 9 – *Standards 4.1 with short descriptions*

The availability of supporting services locally is generally adequate though there continues to be lack of availability of formal ECHO services outside weekdays in most hospitals. It does appear that this standard is quite unrealistic due to limitations in cardiology services outside tertiary cardiac centres. FUSIC availability is increasing and is likely to prove adequate in most situations. There appears to be a fall in the availability of both informatics and medical engineering services across the region. The latter may not be inappropriate as it is possible that increasing complexity of critical care equipment may mean that local repair may be less possible, and it appears that in those situations where this is occurring there is adequate redundancy in equipment stock ensuring that the risk of a machine failure leading to loss of a time critical therapy. This can only be maintained if that extended stock is maintained to ensure it is immediately available with the associated increased cost. Of more concern as units and hospitals become increasingly computerised with expanded hospital wide EPR implementation it does seem that there are likely to be increasing need for informatics services and the impact of system failure outside weekday hours may be profound.

Standards 4.2

INTERDEPENDENCIES WITH OTHER SERVICES (NORMALLY DISTANT)

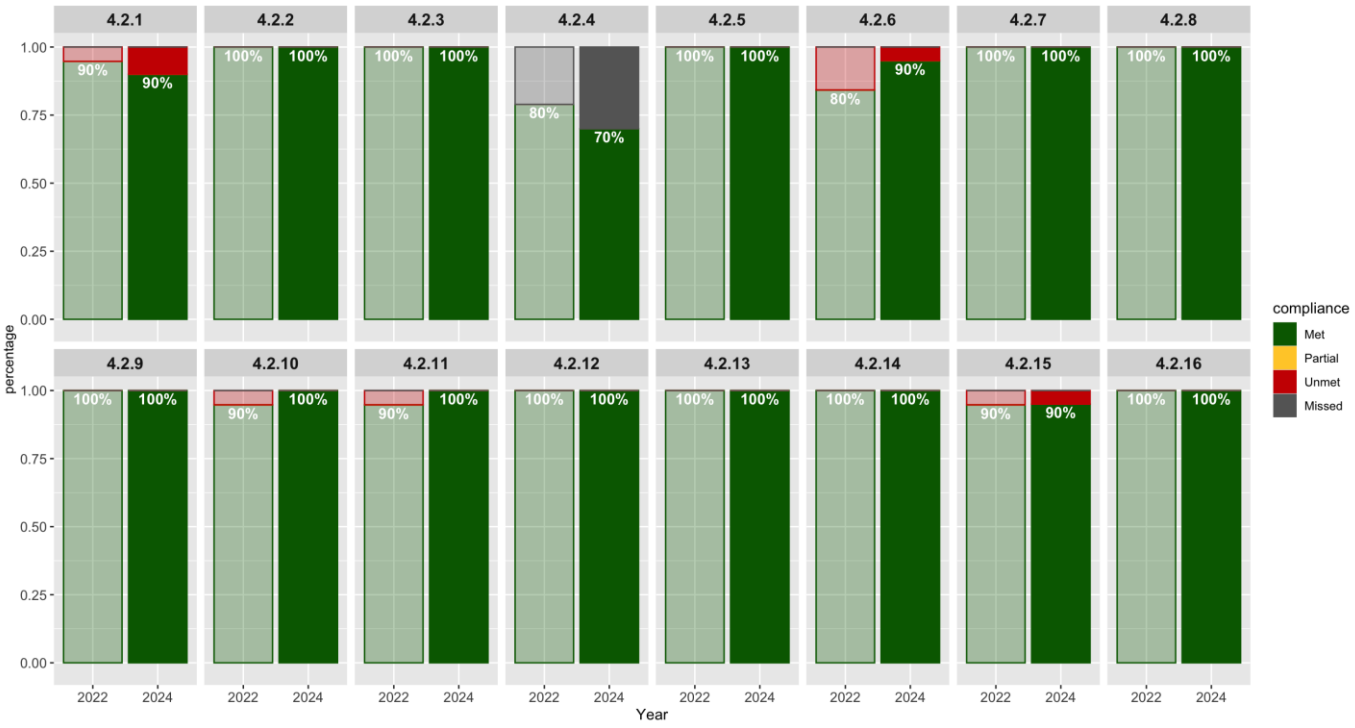

Figure 15 – *Corrected assessment against D05 for standards 4.2 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 10 below)*

Standard	Short description		Standard	Short description
4.2.1	Interventional radiology		**4.2.9**	T&O surgery
4.2.2	Neurosurgery		**4.2.10**	Plastic surgery
4.2.3	Vascular surgery		**4.2.11**	MaxFax surgery
4.2.4	General Surgery		**4.2.12**	ENT surgery
4.2.5	Nephrology		**4.2.13**	O&G
4.2.6	Endoscopy		**4.2.14**	Organ donation services
4.2.7	Coronary angiography		**4.2.15**	Acute rehab services
4.2.8	Cardiothoracic surgery		**4.2.16**	Additional lab services

Table 10 – *Standards 4.2 with short descriptions*

All units should have plans for accessing a range of the more complex specialist services either on site or elsewhere within 4 hours. These services are generally appropriately available though there is often administrative difficulty in actually meeting the 4-hour target due to the complexity of decision making beyond the hospital walls and then identifying appropriate capacity and undertaking the transfer. It is notable that we now only have one hospital that has not got access to timely endoscopy treatment of GI bleeding 24/7, though it is a concern that there has been no progress in this identified issue over the last 5 years.

Standards 4.3

DAYTIME SUPPORTING PROFESSIONS

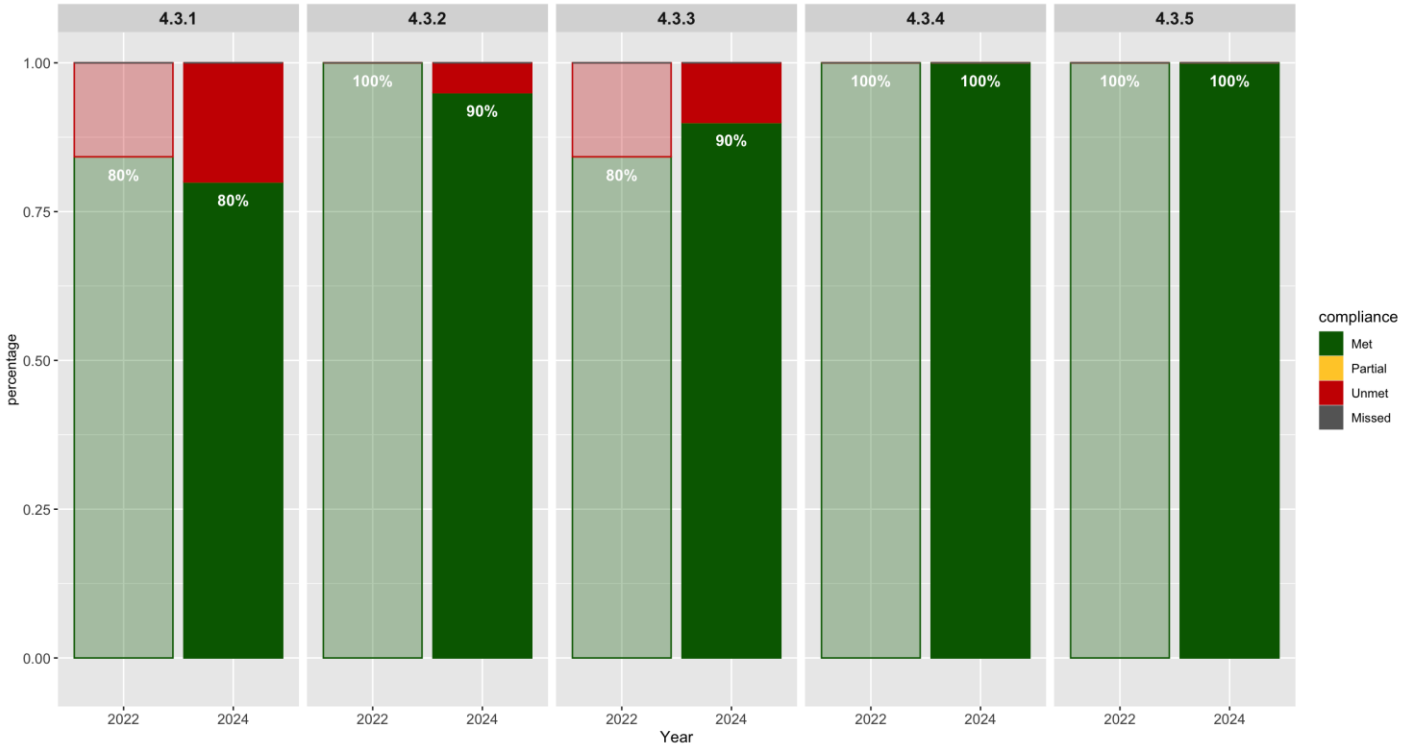

Figure 16 – *Corrected assessment against D05 for standards 4.3 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 11 below)*

Both Occupational Health (4.3.1) and Speech and Language services (4.3.3) continue to have gaps in availability though most units are able to access these intermittently.

Standard	Short description
4.3.1	Occupational therapy
4.3.2	Dietetics
4.3.3	speech and language
4.3.4	Bereavement services
4.3.5	Patient liaison service

Table 11 – *Standards 4.3 with short descriptions*

Standards 4.4

RELATED SERVICES

In general, related and follow up services are mostly accessible by all units; however, it is notable that there is now no follow up facility (an integral part of NICE CG83 and QS158) in 4 units. Given the increasing central drive to improve rehabilitation services after critical care this decline is a concern, and it is not clear that it will recover soon. Many units decry the decline of access to psychology services, either for the patients or the staff. It was a very positive outcome of the pandemic that these services became available almost universally, but it is very disappointing to see the decline and again concerns expressed that this is seen outside the present cost envelope of critical care.

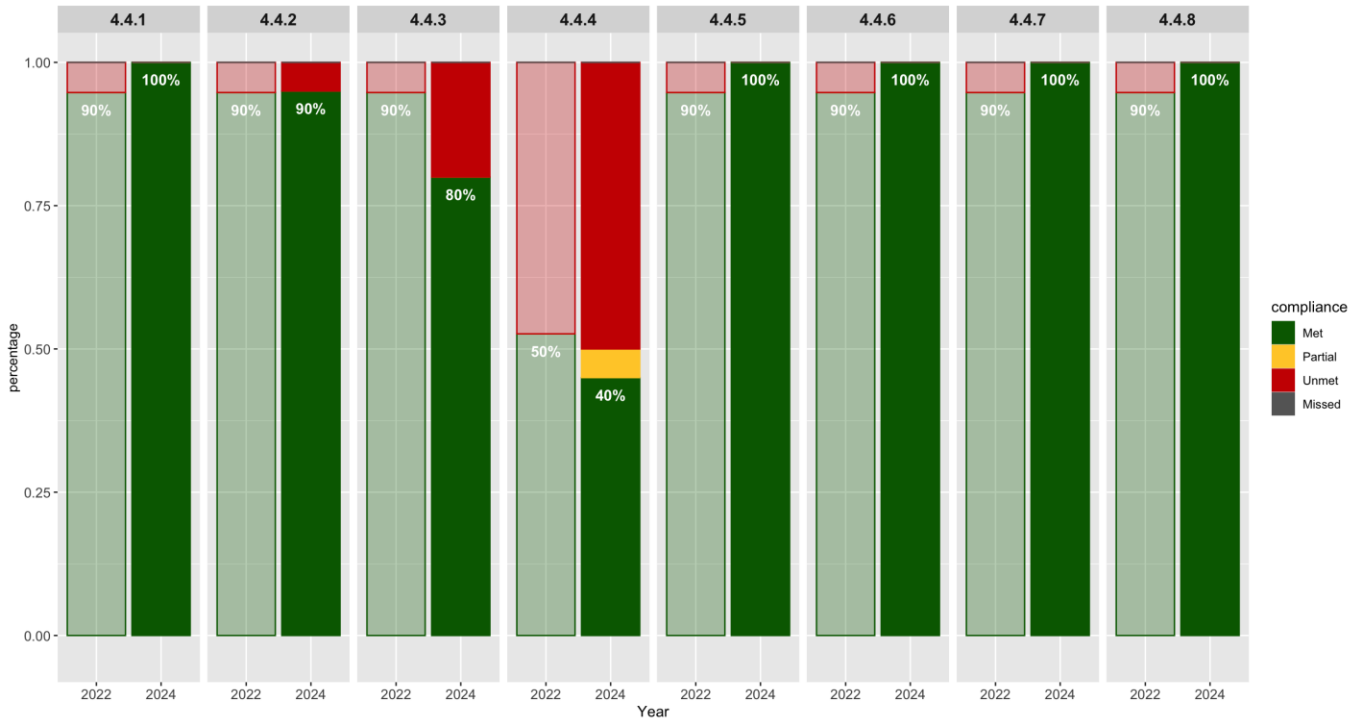

Figure 17 – *Corrected assessment against D05 for standards 4.4 showing percentage of units fully meeting, partially meeting and failing to meet the standards (description in table 12 below)*

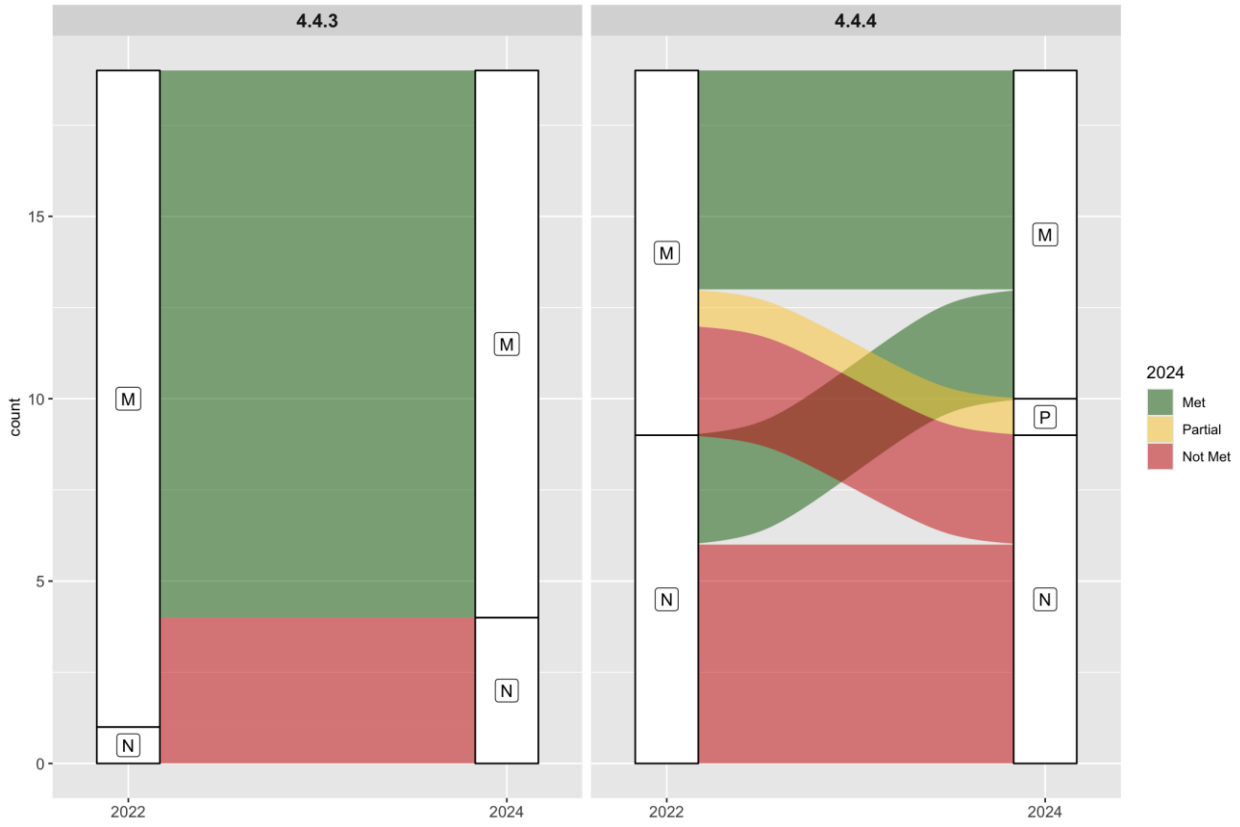

Figure 18 – *Alluvial plots showing change in status of individual units' standard alignment (standards 4.4.3 – follow up services and 4.4.4 – clinical psychology)*

Standard	Short description		Standard	Short description
4.4.1	Local community rehab services		**4.4.5**	Spinal cord rehab services
4.4.2	Specialised rehab services		**4.4.6**	Primary care
4.4.3	Critical care follow up		**4.4.7**	Burns services
4.4.4	Clinical Psychology		**4.4.8**	Voluntary support services

***Table 12** – Standards 4.4 with short descriptions*

Conclusions on alignment to commissioning standards during latest round of peer reviews

It is clear from the discussions around the region that there are significant pressures on critical care services at present (as there are on all services) due to the financial position within the country. Overall, the small capacity improvements seen over the last few years due to the needs of the pandemic are being removed with increasing difficulties associated with this.

Capacity transfers are becoming increasingly common, possibly due to better acceptance of these as appropriate care. Given the improvement in the quality of the transfer process (due to the instigation of a properly staffed, trained and resourced transfer service), and therefore a reduction in the risk associated with the transfer itself it is reasonable to consider capacity transfer rather than managing patients with substandard staffing within the initial facility.

It is positive to see a general improvement in the nursing position with all units now providing supernumerary supervisors and correct bedside nursing, as well as an improvement in the compliance with post graduate education requirements, despite a perception that there is a reduction in nursing experience. It is also important to note that many units are well below the national mean for skill mix, with significant shortages in band 6 and band 7 posts and several hospitals with staff unable to progress to band 6 for many years despite having successfully completed the post graduate qualification. This does tend to lead to loss of staff from critical care into other posts where a band 6 is available and must be seen as a failure of the system when an individual is lost to critical care having completed extensive further training which is a significant undertaking both for the staff member and the unit who need to backfill their work during the training.

Admission delays in general are minimised though some units do still have problems meeting the regional target of 1 hour.

There continue to be significant issues with critical care pharmacy services, and these are focused on in more detail elsewhere in this report.

The decline in medical engineering support is notable and the impact of this is not clear, though it is possible that it could lead to units having difficulty with equipment availability due to uncorrectable failures out of hours, and the need for redundancy in equipment is an important consideration where this service is being reduced. It is probably more concerning that units are reporting a reduction in informatics availability given that there is a continuing increase in the use of electronic systems, with unit and hospital EPRs likely to be universal now by the end of the decade. Again, understanding the risk and protection needed to manage this gap is an important matter for several units.

The fall in follow up availability is disappointing and along with the decline in availability of clinical psychology is very much at odds with the national pressure to improve rehabilitation following critical care. This important area will be the focus of the next round of peer reviews.

Peer Reviews Outcomes of Pharmacy Deep Dive

Medicines are the most common intervention in healthcare and are fundamental to the care of critically ill patients. Due to the acuity of illness, multi-organ failure, co-morbidities, polypharmacy, and prevalence of unlicensed/off-label prescribing, critically ill patients are vulnerable to medicines-related harm. Critical care pharmacists are an essential resource within the multidisciplinary team to manage these risks, ranging from the individual patient level to systems level. A significant body of evidence demonstrates benefits of critical care pharmacists to improve safety, optimise medicines use, reduce expenditure and reduce length of stay. These quality enhancements underpin the national workforce guidance for critical care pharmacists and commissioned critical care standards pertaining to pharmacy.

During the 2024 round of Critical Care Operational Delivery Network (ODN) peer reviews in the East of England, a deep dive review of all critical care pharmacy services was carried out. This aimed to assess the current picture to contextualise risks of not meeting D05 commissioned standards and Guidelines for the Provision of Intensive Care Service (GPICS) and benefits when achieved.

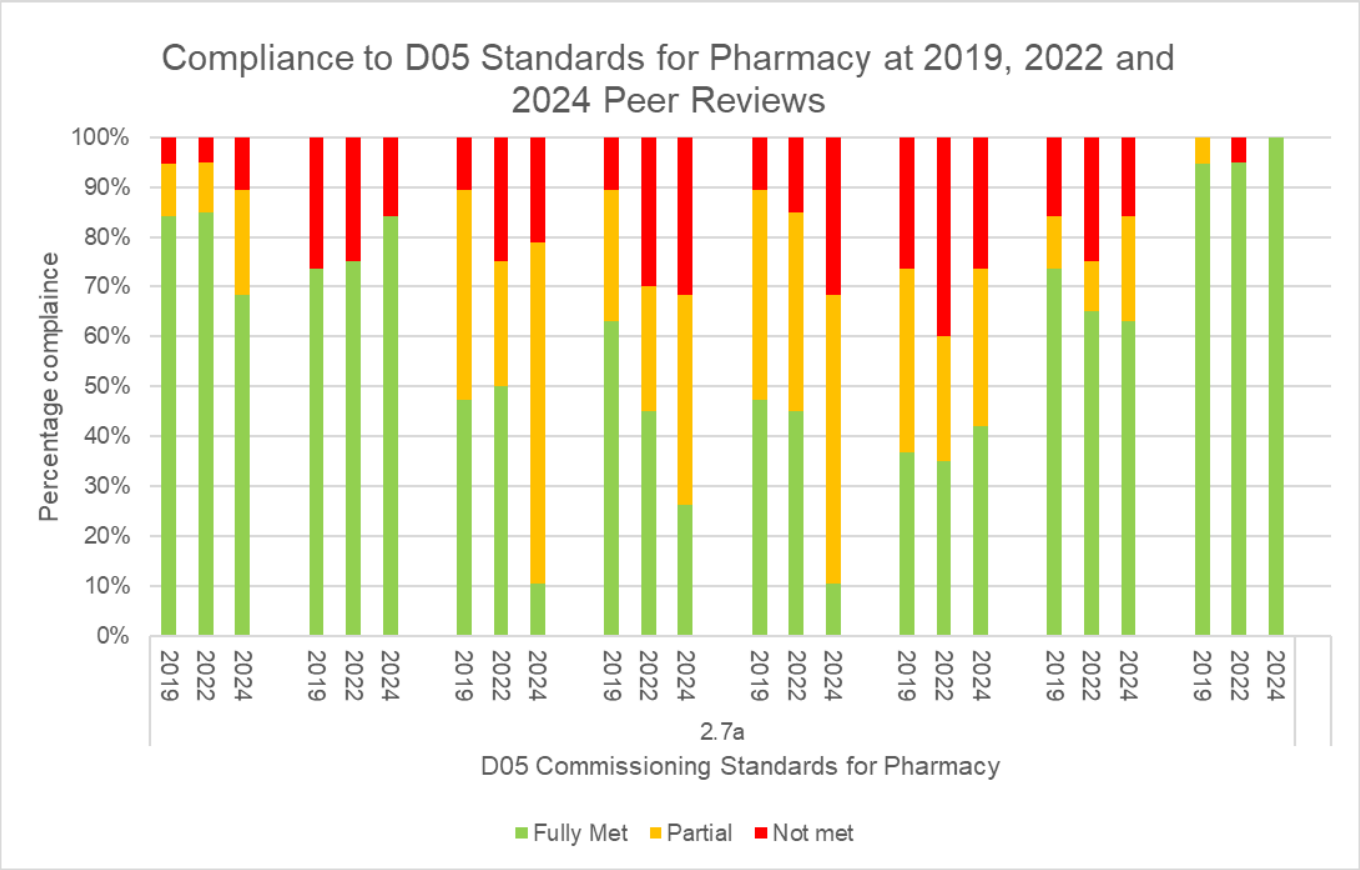

Figure 19 – *D05 Compliance results for pharmacy standards amalgamated from all EoE Critical Care units at 2019, 2022 and 2024 peer review rounds.*

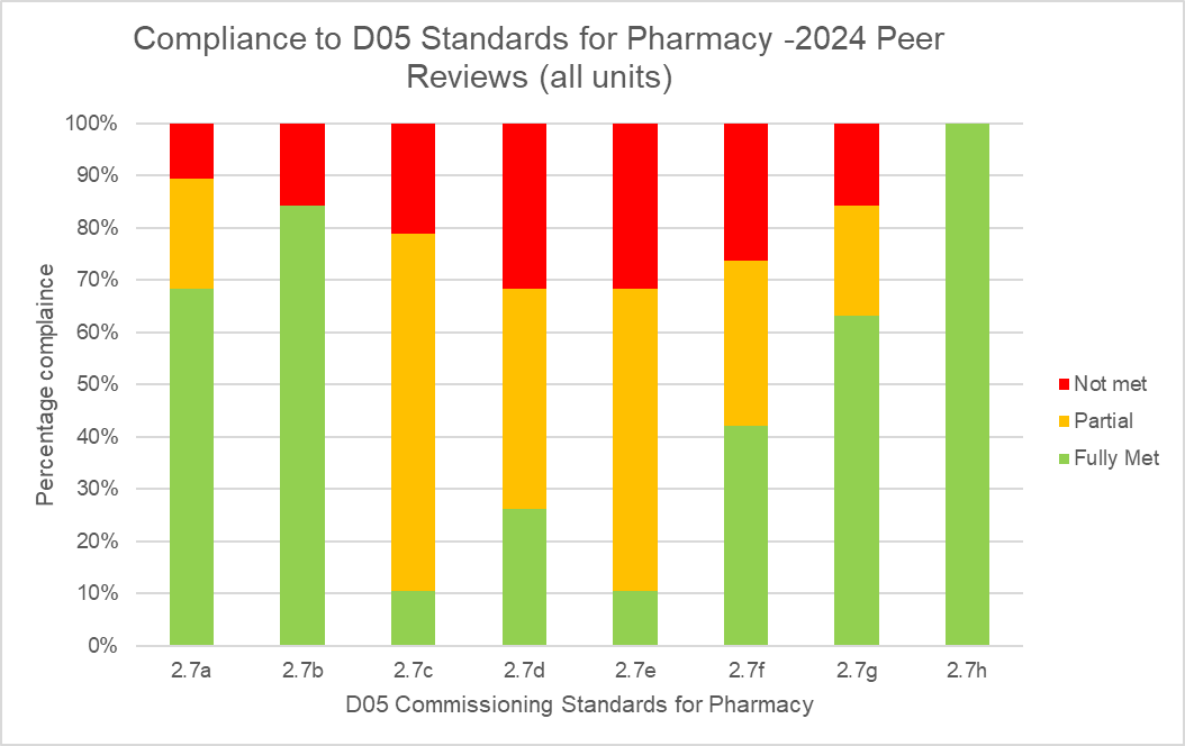

Figure 20 – *D05 Compliance results for pharmacy standards amalgamated from all EoE Critical Care Units 2024.*

Following peer visits, units developed and submitted action plans to address issues identified, including those relating to pharmacy. Action plans differed between units depending on specific local issues and structures but address some of the themes outlined here, including risk registers and business cases for staffing investment. Follow up meetings have now taken place, and all units have now updated their progress to the Network and the review team pharmacist. The network is keen to maintain momentum on this work following the high level of engagement secured from all Trusts and the productive conversations which took place. A comprehensive report has been shared with the regional chief pharmacist and presented at the Network clinical board meeting held in March 2025. The report has also been shared with the regional pharmacy community. Feedback has been sought from each critical care pharmacist that contributed to peer reviews on the process, support and actions. This data will be shared through the national critical care pharmacist Network leads group with the intention to develop the process for potential national context. In addition, critical care pharmacists across the EoE have been encouraged to complete the 2025 National Critical Care Pharmacy Workforce Evaluation. It is also intended that this report will be adapted and submitted for publication in a peer reviewed journal.

Recent developments in formalised critical care pharmacist career pathways and advance level credentialing offer a unique opportunity for career development. This may be perceived as an attractive option for those professionals in the early stages of their clinical pharmacy career with an interest in critical care.

We have identified some significant challenges in the EoE and should ensure that we work collaboratively with regional leads, commissioners and service leads locally to maintain a quality service level to our most vulnerable patient group and that this level is improved in line with national standards. The Network remains committed to supporting units to progress.

Network Sub-Groups

Regional Nurse Education Group

Chair: Lisa Enoch

The regional education group has met four times in the last year, with good representation from hospitals. There was a blended approach to meetings, with some online and face to face. The Terms of Reference for this group have been reviewed and updated. This group is very active in supporting the Network with the post-registration award in critical care nursing at level 6 and level 7, providing teaching and marking.

At each Education Group meeting, the Educators are asked to present any innovations in Education practice from their hospitals. The group have also discussed the renewed guidance around Nursing Associates in Critical Care, with the new emphasis being on ''assistant'' role. This generated good discussion around the role and has supported those units who have invested in the role.

Alongside the Step 1, 2, and 3 competencies, CC3N have a variety of other Critical Care focused competencies that are currently being reviewed, such as Trauma, Cardiac, Liver, Neuro, Step 4, Burns, and Maternal competencies. Some of the regional educators are involved with this national work.

Regional Advanced Critical Care Practitioners (ACCPs) Group

Chair: Will Thompson

There have been four quarterly regional meetings this year, 2 virtually and 2 face to face with excellent attendance. One took place at the first regional ACCP Symposium, kindly hosted by Anglia Ruskin University Chelmsford. The symposium allowed qualified and trainee ACCPs, Training Pathway Directors, Educational Supervisors and Unit Clinical Leads to network and attend talks that enabled the fulfilment of the 3 pillars of advanced practice research, education and leadership as clinical is covered by the day-to-day work on the units. The event received positive feedback, and additional symposiums are being considered for this year.

Numbers of Advanced Critical Care Practitioners in the East of England (EoE)

Currently the EoE has 23 qualified ACCP with a further 17 in training with many expected to pass their second year ARCP in 25/26. There are 4 potential additional trainees posts coming in 25/26.

EoE ACCP Achievements

Graduates at University of Warwick have been highlighted for their excellence within the ACCP training programme: Eoin McNamee and Will Thompson are joint winners of the Best Professional Project of their intake, and Will Thompson won the Best Student Performance.

Multiple ACCPs are now undertaking FUSIC heart/lung. Ed Caetano at Colchester has been the first to complete the FUSIC Heart training and now is being supported by a mentor based at Broomfield to undertake FUSIC lung.

Across the region ACCPs have been supporting unit teaching, both nursing and medical. CUH have been supporting FY1/FY2 high fidelity and VR SIM teaching. With an upcoming multiprofessional simulation day being run. ACCPs have helped get involved with unit inductions as well as supporting unit teaching, and practical procedure support. These achievements are exemplary.

Quality Improvement

ACCPs have been actively involved in audits and QIPs within their trusts – possible aims to broaden these projects to regional projects. Most units have also engaged ACCPs in national research projects and audits with several of them

joining the research teams, including UK-ROX, SHORTER, MARCH ABBRUPT and SIGNET. Currently close engagement between ACCPs has led to QIPs in multiple trusts.

ACCP Victoria Jeffrey at West Suffolk Hospital led on a project assessing non-directed bronchial lavage leading to writing of protocols and clinical guidelines for the unit; they are currently collecting data on the project to report back.

ACCP Deepak Bagi at Luton and Dunstable Hospital had a poster accepted for presentation at the East Anglia Association of Anaesthetists Forum - which is a platform normally exclusive to anaesthetic trainees – however the group allowed the presentation on communication within critical care that highlighted the staff, their roles and their areas or expertise and interest. Better representing the various roles now seen in Critical Care. ACCP Sharon Sundersingh has been directly involved in supporting national audits and research within the unit.

ACCPs Charley Harris at Norfolk and Norwich Hospital has supported children visiting and aided developing SOPS and unit policy to support children in ICU. As well as frequently presenting to the hospital governance team and leading on changes in the unit. ACCP Serena Willmore has undertaken a post-op antibiotic prescribing audit which has led to improved antibiotic stewardship within the unit.

ACCPs on the Neuro Critical Care Unit in Addenbrookes Hospital have become a static workforce who now exclusively take samples for microbiology from external ventricular drains to help to standardise practice in a high-risk intervention. This has led to an increase in samples collected for ongoing research purposes and will be audited to assess the quality of the microbiology samples and the effects on patients in the coming year.

Training

Clinical Curriculum

The digital portfolio that was created by Will Thompson for trainee ACCPs to record their competencies and training documentation region wide has now been updated to the latest FICM ACCP curriculum and is now being used across the EoE, and has also been incorporated in other trusts across the UK such as London, Birmingham and Kent.

All current trainees will be expected to meet the Advanced Practice criteria to allow progression to Band 8a. They can register for FICM membership after finishing the PGDip and research module but must complete the full MSc to meet the AP criteria. This is in line with all other Trusts in the UK.

NHSE East ACCP team's platform set up by Ali Hopkins is now sharing resources and provides monthly teaching sessions for trainee ACCP's, with good support from all Regional LCL's and ES's. Enabling a standardisation of training across the EoE for all trainee ACCPs, as well as allowing qualified ACCPs to attend to ensure their knowledge is contemporary.

Access to Bridge for tACCPs is being explored with the advanced practice team as this will enable easier sharing of documents and teaching sessions and is currently a work in progress.

Finally, ongoing successful delivery of face-to-face training for all trainees takes place twice yearly.

Study Days

Addenbrookes Hospital ran a cross-trust study day based off the FICM optional service framework for diagnosing death for donation after circulatory death. This gave the baseline requirements for ACCPs in the region to undertake the OSF and support donation in their trusts; local policy and procedure is needed to ensure governance and is being developed within each trust.

Colchester Hospital ran an airway skills and drills day which was held at the beginning of December and was attended by trainee and qualified ACCP's. It supported the FICM Advanced

Airway Optional Skills framework and provided practical skills training and simulation exercises. The trainees had the opportunity to demonstrate practical airway skills including FONA, bronchoscopy and chest drain insertion. This has been regarded as useful by trainees and qualified regardless of how involved in direct airway management their current role.

Potential Projects

Qualified ACCP Spreadsheet

Building off the success of the trainee ACCP portfolio spreadsheet. There are plans between Will Thompson and the regional TPDs to develop a similar spreadsheet for qualified ACCPs, to enable a similar log of activity and keep evidence of competency easy to demonstrate. Not only will this support the individual, but potential standardisation could be used to support ACCPs moving between trusts in the region.

ACCP Information Communication

Given the political climate that ACCPs have found themselves in, there has been discussions within the group about producing a regional poster/coms leaflet detailing our role, how we can support our medical colleagues and the MDT and highlighting our clinical expertise, as well as our alignment with the advanced practice framework. The role is well understood within critical care – but this would aim to target the rotating doctors and new hire colleagues that are newly into critical care.

Allied Health Professional Group (AHP)

Chair: Samantha Petty

The last year has seen the launch of the national AHP Critical Care Capability Framework. Trusts are progressing at different rates regarding the use of this for job plans. We will be meeting to look at how each of our hospitals use this in April. This will allow us to try to look at all the different roles and AHP services across the region and how we apply this document.

The educational limb will be continuing with online presenters, and we will aim to continue and develop this over the coming year.

We have joined the nurses for the start of the rehab group and are just starting to look at what will fit within the two different groups as a lot of crossover.

Professional Nurse Advocate (PNA)

Co-Chairs: Sarah Williams and Sarah Entwistle

The Network PNA forum continues to meet quarterly online. With the reduction of contracted hours of the regional PNA leads, the group is now led by PNAs from the critical care network. As the PNA role grows, the group aims to offer support to critical care PNAs and an opportunity to collaborate and share ideas and ways of working. This year the group have shared a focused reflective session as well as information about PNA resources and QI. In 2025 the group is aiming to invite speakers from outside the region to the group, to draw in new ideas and experiences.

Pharmacy Group

Co-Chairs Laura Coslett and Joanne Wilkinson

It has been a busy and exciting year for the East of England Critical Care Pharmacy Network (CCPN). We continue to be an active and collaborative group focusing on strategic development of services, supporting learning, sharing practice, managing medicines shortages and disseminating information from a national level, including research opportunities.

Most notably this year, in line with previous workforce observations, data collection and the NHS England Adult Critical Care Pharmacy Workforce Strategy, we were supported by the network, to conduct a 'deep dive' review of all critical care pharmacy services in the region. This was incorporated into the network's formal peer review programme. The 'deep dive' aimed to assess regional critical care pharmacy services and staffing compared to national commissioning standards for England (D05) and the Guidelines for the Provision of Intensive Care Services (GPICS) standards. It was inspiring to hear during the reviews, at all Trusts, that the expertise and input of critical care pharmacists is recognised, highly valued and respected by the MDT. However, these reviews highlighted substantial deficits in the capacity of pharmacy services to critical care to deliver the commissioned standards. Staffing establishment was insufficient in most trusts across the East of England, with insufficient funded pharmacist time to deliver D05 or to meet GPICS. In many Trusts, vacancy gaps and recruitment compounded these challenges.

Findings have been escalated within Trusts and following presentation of the findings at the recent Network Clinical Board meeting, actions are being pursued at a regional level. The project, process and findings are also being shared at a national level. Improvements will take time, but the CCPN are keen to maintain momentum following the high level of engagement secured from all Trusts, to support the improvement required.

In line with the NHSE Adult Critical Care Pharmacy Workforce Strategy, training pathways have been established for the pharmacy workforce. The CCPN is supporting current delegates and those who have recently completed their Advanced Pharmacy Practice credentialing and those who have embarked on the Postgraduate Certificate qualification.

Outreach Group

Chair: Lisa Wood

The outreach group runs in-person meetings quarterly. This year there has been a strong focus on the implementation of Martha's rule. A speaker from NHS England presented to the group and there has been much discussion and collaboration to ensure the implementation is successful. In October 2024, the group held another successful sharing event. Topics covered included; sepsis, Martha's rule, the National Outreach Forum (NOrF) role in advancing practice, a service user review and using high flow oxygen in palliation. The day was rounded off with a 'good news's story. The next sharing event is planned for the 17th September 2025.

At the beginning of 2025 the network began collecting data from each hospital's outreach service. The data collected is based on the NOrF's minimum dataset higher level reporting. It is hoped it will allow units to monitor their workloads and benchmark against other units in the region. Currently it is too early to present findings, but we anticipate sharing information later this year.

Rehabilitation Group

Co-chairs: Tom Walker and Sarah Entwistle
Deputy Chair: Emily Clibbens

The rehabilitation group (multi-disciplinary) has reformed this year. It held its first meeting in February and there was attendance from most units in the region. The group will meet quarterly on Teams and is looking forward to working collaboratively to improve rehabilitation services across the region. The starting point will be to benchmark services offered by units within the region.

Recovery and Outcomes Nursing Group

Co-Chairs: Joy McAdam (CNS Team CUH) and Tamara Pendry

The former nursing rehab group has been renamed the Recovery and Outcomes group. It will continue as a subsidiary of the rehab group and will continue to meet in person twice yearly. This year the group has shared presentations on patient initiated follow up, patient experience groups, the role of Occupational Therapy in follow up, the role of rehabilitation assistants in ICU and an accredited complex rehabilitation course.

In October 2024 the Network was pleased to support the regional ICU recovery conference organised by the Clinical Nurse Specialist (CNS) team from Addenbrookes hospital. The conference 'To recovery and Beyond', included lectures and breakout groups; presenters included patients and relatives who had experienced critical care in the region. The conference was very highly rated by attendees. The network will support the team's 2025 conference which is planned for 19th September. We hope this day will be attended by professionals from across the region.

Matron/ Lead Nurse' Group

Chair: Sarah Entwistle
Co-Chair: Jane Olds

The Lead nurses' forum meets quarterly. The group meets mostly online, however, in 2024 one meeting was held face to face. The group is an opportunity to feedback national updates and for the lead nurses to discuss issues and share experiences. This year presentations have included the UKCCNA's Workforce Optimisation Plan 2024-27 and the EOE Nursing Workforce and Retention strategy, QI projects and benchmarking. Other topics discussed have been workforce, morale, incidents and sustainability.

Tissue Viability Group

Chair: Jane Olds

The tissue viability group is a small informal group established to benchmark and share ideas around reducing the incidence of pressure ulcers in our critical care units. Most recently the group has been working on setting regional standards that could form part of a regional education and benchmarking process.

Adult Critical Care Annual Census

The third annual national census has been delayed. It has been identified as a priority by the national Adult Critical Care Clinical Reference Group, and we are anticipating that this census will be completed in the summer of 2025. The format will remain the same as previous years with all data returns to be reviewed by the network prior to submission. All data will be shared widely via the NCDR portal where reports should be available. With the delay in the 2024 census, we are unable to provide a detailed analysis of each trust's adult critical care workforce. We anticipate providing this detailed information once the 2025 census data is collected and submitted.

Financial Overview

The financial performance of the Network for this reporting period has been closely monitored to ensure alignment with the established budget. The budget has been successfully achieved with no overspend, demonstrating effective financial management and cost –control practices. The network thanks the commitment and support from the network finance lead from Cambridge University Hospitals (Host Organisation).

Conclusion

This annual report details the many aspects of the network activities over the last year. The Adult Critical Care Network has had a successful year, marked by significant achievements, collaborative efforts, and continued commitment to providing exceptional care. Our collective efforts have enhanced patient outcomes, optimized resource utilization, and advanced the quality of care across all participating units.

As we look back on this year's progress, we celebrate the tireless work of our dedicated healthcare professionals and the strength of our partnerships. With the continued support from the critical care community and our stakeholders, we are well-positioned to meet the evolving challenges of the future.

Moving forward, we remain focused on innovation, continuous improvement, and the pursuit of excellence in critical care. Together, we will continue to build on the successes of this year and ensure that our network remains at the forefront of high-quality, patient-centered care. The Network team looks forward to working with all in 2025/26. Thank you all for your continuing support.

East of England Adult Critical Care Operational Delivery Network
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