East of England Adult Critical Care Operational Delivery Network

Annual Report 2022-2023

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Foreword

Welcome to the East of England Adult Critical Care Operational Delivery Network Report 2022/2023.

There is so much to be proud of again this year and I cannot believe that a year has passed, and it is time for the network to complete the annual report. Our adult critical care services across the East of England encountered challenges associated with capacity and workforce. The network continues to witness and observe a true collaborative approach regional wide to ensure that our valuable capacity is utilised efficiently and effectively. The Regional Adult Critical Care Transfer Service had its one year birthday milestone and has played again a huge role in supporting adult critical care with its expertise.

It is with immense pleasure that I can introduce our latest annual report for 2022-2023 which provides a flavour of the work carried out over the last year. Integrated Care Systems (ICS) are the new health system structures in England that were introduced as of July 2022. ICSs are partnerships between the NHS, local authorities and other partners such as charities who work together to plan and deliver joined up health and care services. Each ICS has an integrated care board (ICB) which is responsible for developing a plan in collaboration with all relevant stakeholders for meeting the health needs of the population. The network this last year has been continuing to develop its relationships and links with the six ICSs in the East of England to ensure that each organisation is aware of our challenges within the services as well as good news stories. Table 1 provides an overview of the ICSs and the populations that they cover in the East of England.

The Network continues its work with NHS England (East) in relation to the governance and reporting requirements of network business as well as the capacity reviews and capacity planning. We have been able to work closely with the National Team in relation to Capacity Modelling and understanding our short fall in capacity numbers and how investment in capacity might look in the region. It has been important to ensure that critical care service leads are kept informed and involved regarding these discussions.

The core network team remains small with Dr Mark Blunt heading up as our Clinical Director, Karen Cotton as our Innovation and Lead Nurse, Isabelle Delain who leads on our regional wide education programme with some support from both Felicity Chapman and Sarah Entwistle and Mandy Baker who coordinates us all and supports all admin across the network. I would like to extend a big thank you to those team members for all their hard work this year.

Melanie Wright *– Director, East of England Adult Critical Care Operational Delivery Network*

Over the last 3 years there has been a sea change in the inter-service working across the hospitals of the region. This was a necessity over the pandemic, but it is notable and of great value that the relationships developed have continued over the last year. As we go forward in what is likely to be an increasingly challenging environment, part of the important role of the network is to provide a platform for mutual support and assistance and to encourage and support this process.

The last year has been quite different from the preceding two, with the receding face of the Covid pandemic being replaced by the very real challenge of recovery. Many of our units have seen significant personnel changes, and there are several very significant workforce issues across all staff groups and apparent in most hospitals. In general, nursing and medical recruitment is an increasing challenge, and perhaps more importantly retention of staff continues to be a great concern. We continue to highlight these issues at a national level, both within the critical care hierarchy and the NHSE workforce planning.

We have had the great pleasure to visit all the hospitals in the region this year to undertake the latest round of peer reviews which has allowed us to discuss the innovative work taking place in many hospitals and to identify the specific challenges that each unit faces. There has been an opportunity in most of these to bring a representative of the local ICS to the unit, many of whom have only

limited previous exposure to the issues and needs of critical care, and hopefully this has improved their knowledge as commissioners going forward. The peer review process is one of critical friend, differing from the inspection processes of other organisations. This has helped ensure that they continue to be conducted in a supportive and open manner, whilst the network continues to maintain its objective of focussing minds on the provision of equitable, safe high-quality critical care across the totality of the region.

Finally, it is important to recognise the development of an outstanding critical care course by colleagues within the network. The collaborative working that has ensured the success of this is exemplary and the massive amount of work undertaken by Karen, Isabel, Melanie and others throughout the region is clear. This innovation is unique in the UK and is a fantastic demonstration of our success as a group of professionals across multiple sites within one region.

***Mark Blunt** – Clinical Director, East of England Adult Critical Care Operational Delivery Network*

For the Critical Care network annual report for 2022-23, it is encouraging not to be commenting on the pandemic, although it has certainly left a legacy for critical care services and nursing in particular. Whilst the workforce suffered both physically and mentally there are positive actions being taken with initiatives that will help in retaining our nurses and safeguarding our patients for the future. I expanded on certain priorities last year and these have not changed with workforce, well-being and education remaining the top 3. The difference this year has been that the focus has been on building on what we have learned, improving the recovery and retention of staff and stabilising the education. New workforce roles are becoming better established with improved support to integrate them safely into practice. National support for nursing establishments, skill-mix and a career pathway has lifted the profile of staff retention and well-being. It is also reassuring that NHSE continue to recognise and support the training needs of critical care nurses, this has been demonstrated by the further funding for the step 1 training and the critical care award with the announcement that the blended-learning framework has been extended from 2 to 4 years.

***Karen Cotton** – Innovation and Nursing Lead, East of England Adult Critical Care Operational Delivery Network*

Background

The Adult Critical Care Network covers the six counties within the East of England with a population of approximately 7 million, 6 Integrated Care Systems, and 20 adult critical care units with a total bed base of 348 (Table 2). This bed base has remained static over the last year. All tertiary speciality services are represented within the network; Neurosciences incorporating the 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 11.0% of the population.

Integrated Care System	Population
Mid and South Essex	1,256,523
Suffolk and North East Essex	1,048,423
Norfolk and Waveney	1,086,462
Bedfordshire, Luton and Milton Keynes	1,070,212
Hertfordshire and West Essex	1,612,064
Cambridgeshire and Peterborough	1,008,472

***Table 1:** Populations of each Integrated Care Systems (ICSs) in the East of England (data taken from The Health Foundation)*

Hospital	All Beds	Level 3	Level 2
Mid and South Essex ICS			
Southend	**17**	**9**	**8**
Basildon General	**18**	**14**	**4**
Basildon CTC	**14**	**10**	**4**
Broomfield	**18**	**10**	**8**
Suffolk and North East Essex ICS			
Colchester	**15**	**7**	**8**
Ipswich	**14**	**6**	**8**
West Suffolk	**9**	**6**	**3**
Norfolk and Waveney ICS			
James Paget	**12**	**6**	**6**
Norfolk and Norwich	**28**	**14**	**14**
Queen Elizabeth	**13**	**5**	**8**
Bedfordshire, Luton and Milton Keynes ICS			
Milton Keynes	**10**	**4**	**6**
Luton and Dunstable	**12**	**6**	**6**
Bedford	**10**	**6**	**4**

Hospital	All Beds	Level 3	Level 2
Hertfordshire and West Essex ICS			
Lister	**18**	**12**	**6**
Watford	**18**	**10**	**8**
The Princess Alexandra	**10**	**5**	**5**
Cambridge and Peterborough ICS			
Hinchingbrooke	**6**	**4**	**2**
Peterborough	**16**	**8**	**8**
CUH JVF	**31**	**20**	**11**
CUH NCCU	**23**	**17**	**6**
Royal Papworth	**36**	**36**	**0**
TOTAL	**348**	**215**	**133**

Table 2: *East of England Adult Critical Care Capacity (as of March 2023)*

NB: NCCU planned refurbishment October 2023 for 14 months, should not affect capacity.
CUH 1st September 2023 reopen to normal baseline of 59 critical care beds.

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. This has been clearly demonstrated post pandemic with the network taking on a key leadership and coordination role.

The overall aim of the East of England Adult Critical Care Operational Delivery Network is to

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

Over this last year the network has continued to support NHS organisations with adult critical care capacity in the East of England and supported the requirements for critical care repatriations to either critical care or ward level. Table 3 (see page 7) shows annual admissions of critical care services in the East of England.

Hospital:	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
MSE									
Basildon ICU	619	628	607	600	526	651	736	581	754
Basildon CTC	----	1166	1190	1201	1081	1130	1017	831	923
Broomfield	663	726	987	995	946	942	875	676	723
Southend	426	483	488	499	556	765	848	759	742
ESNEFT									
Colchester	545	612	682	671	677	625	586	593	539
Ipswich	881	979	880	821	755	801	862	684	754
West Suffolk	510	534	496	632	621	626	610	473	451
James Paget	668	589	618	677	628	624	634	557	573
Norfolk & Norwich	1676	1630	1592	1804	1981	1969	1875	1616	1763
Queen Elizabeth KL	901	871	827	782	740	813	709	528	515
Luton & Dunstable	1288	1252	1205	1404	1435	1385	1402	914	837
Bedford	546	549	510	516	495	484	504	430	412
Lister	855	884	929	1037	1090	1244	1049	1100	1075
Watford	934	927	814	947	898	985	1073	810	757
Princess Alexandra	703	626	643	714	768	621	728	605	543
NWA									
Hinchingbrooke	563	599	560	570	475	387	376	397	420
Peterborough	790	713	830	778	799	684	712	661	609
CUH									
NCCU	----	----	1000	993	1002	1012	1108	1078	1099
JVF	----	----	874	924	1029	1018	1022	1604	1536
RRU	----	----	----	520	507	485	487	0	0
Royal Papworth	2559	2817	2785	2787	2716	2667	2386	2006	2248
Total	**15,127**	**16,585**	**18,517**	**19,872**	**19,662**	**19,918**	**18,526**	**16,903**	**17,273**

Table 3: *Annual Admissions by each Unit (Data obtained from monthly submissions to the network)*

Regional Adult Critical Care Capacity

The East of England has one of the lowest number of critical care beds for the size of the population relative to the rest of the UK (Table 4). As the population in the East of England continues to grow and age along with advances in medical technology the demand for critical care is increasing. The investment in critical care services has been largely static in recent years and has not kept pace with the growth in demand for services.

While pressure on critical care beds across the region is a problem in general, pressure on beds in the tertiary centres for specialist treatment is of particular concern as by definition they are offering services that are not offered at other hospitals and this impacts on the flow of patients across the region. There are also often delays in tertiary services specialities repatriating patients back to their local hospital both at ward and critical care level.

Over the last couple of years capacity requirements has been dominated by the Covid-19 pandemic and demonstrated the challenge of scalable flexibility in critical care provision to accommodate peaks in demand. During the peak of the pandemic the East of England provided a total of 521 critical care beds in extremely challenging circumstances. Whilst this year we have not required this capacity it does demonstrate the scale of demand in extremis. Expansion of bed capacity at Level 1 and 2 will provide flexibility within our overall capacity to manage future demand.

Discussions nationally have highlighted the unmet needs of critically ill patients overall and it is widely accepted provision on average across the East of England is below where it needs to be. The Network was able to support coordination of a presentation to regional colleagues by the National Adult Critical Care Team on the population and demographic modelling. This interesting work continues to inform the strategy and discussions with the local ICSs regarding capacity increases.

Region/ICS	Bed Stocktake 2023	Beds used by residents	Beds per 100k Popn, flat	Need index DeprivationEthnicity + EL Casemix	Beds per 100k Popn Need Adj	Beds Needed Gap to 10 (Population Level)	Total Beds Required	New Beds per 100k Need Adj Popn	Popn Beds required in in-area Hospitals	Beds provided to out-of-area patients	Provider level beds required	Total Additional Beds Needed (Provider Level)
Y61 - East of England	346	425	8.13	0.97	8.36	85	510	10.02	304	129	433	87
21 - Bedfordshire, Luton & Milton Keynes	35	59	7.97	0.91	8.78	8	67	10.00	34	4	38	3
22 - Hertfordshire & West Essex	46	106	9.08	0.90	10.11		-106	10.11	42	13	55	9
23 - Suffolk & North East Essex	34	56	7.01	1.03	6.80	26	83	10.00	42	4	45	11
24 - Norfolk & Waveney	51	64	7.58	1.15	6.61	33	97	10.00	66	7	73	22
41 - Cambridgeshire & Peterborough	112	53	7.48	0.86	8.68	8	62	10.00	53	91	144	32
42 - Mid & South Essex	68	86	9.00	0.99	9.04	9	95	10.00	68	11	79	11
Y56 - London	927	654	9.67	0.87	11.05	1	685	11.05	544	449	1008	81
Y58 - South West	311	344	7.45	0.98	7.60	109	453	10.00	267	113	409	98
Y59 - South East	429	533	7.45	0.94	7.94	145	679	10.11	427	119	550	131
Y60 - Midlands	563	605	7.10	1.04	5.36	277	881	10.00	504	241	845	282
Y62 - North West	561	564	9.96	1.11	8.96	73	638	10.13	565	62	627	66
Y63 - North East & Yorkshire	609	591	8.48	1.09	7.78	109	750	10.00	698	83	782	173
Y63 - North East & Yorkshire	609	591	8.48	1.09	7.78	109	750	10.00	698	83	782	173
Grand Total	**3746**	**3746**	**8.28**	**1.00**	**8.28**	**859**	**4605**	**10.18**	**3409**	**1196**	**4563**	**917**

Table 4: *National provision of critical care beds by population with weighting by deprivation, ethnicity and casemix.Gap analysis based on 10 beds per 100K weighted population (data from Critical Care National team)*

NCDR Portal

This platform is of benefit to all Adult Critical Care users and the Network strongly advises that all staff register to this portal. This provides a view of capacity across the region as well as the other regions within the country. There is a wealth of data on daily workforce numbers and this platform also holds the information obtained from the annual stocktakes.

If you are not registered and wish to do so, you will be asked to name an Approver, please identify **melanie.wright5@nhs.net** who will approve an account for you.

A link is provided below for you to register, this link will provide you with an overview of the platform.
https://ncdr.ardengemcsu.nhs.uk/

Peer Reviews

The Network concluded all 20 peer reviews last year between May – December 2022.
Each review was carried out by the small network team providing consistency with representation from the unit's local Clinical Commissioning Group /ICS (two reviews that did not have ICS representation due to last minute sickness).

The focus of this round of reviews (4th round) was to evaluate the adult critical care service against the standards contained within the Adult Critical Care Service Specification (D05). The review is intended to support critical care to identify the areas where the service does not fully meet the

specific standards and where further improvement and investment is required. In addition to the D05 assessment, units also completed a self-assessment against the Guidelines for the Provision of Intensive Care Services (GPICS). Both assessments can be used by organisations to provide valuable information on the provision and state of adult critical care services and support identification of good practice, future improvement areas and priority areas for action. In addition, the Network has included the Safety Attitude and Psychological Safety Survey. Each critical care service has developed an action plan to progress the areas which have been identified as partially met or unmet. For 2023/24 the Network will be meeting with all units to discuss progress relating to each action plan. The network would like to thank all critical care services for carrying out all the work associated with the peer reviews, particularly the self-assessments. In addition, the network peer review team was welcomed by all concerned and supportive of the process.
Figures 1-9 show regional compliance (20 units) against the standards contained within the Adult Critical Care Service Specification (D05).

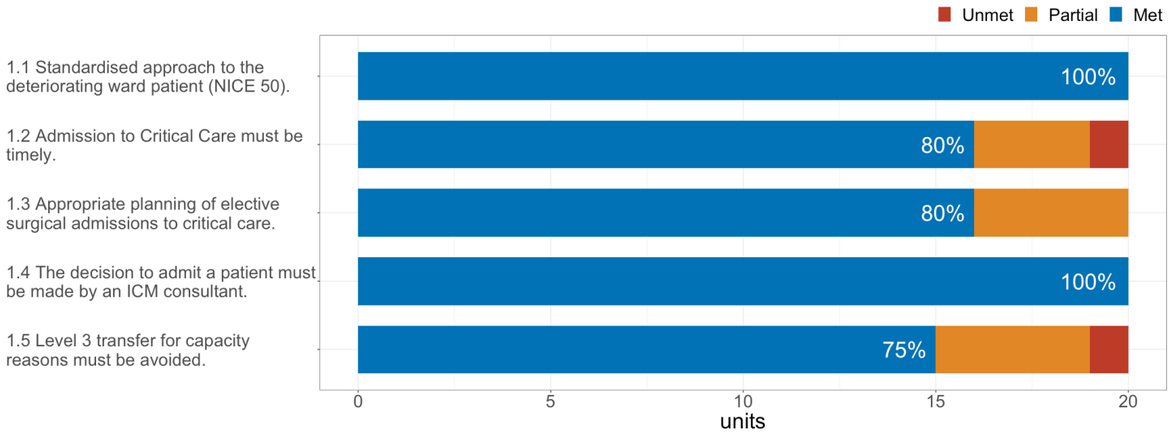


Figure 1: *Responses to D05 questionnaire – Admissions*

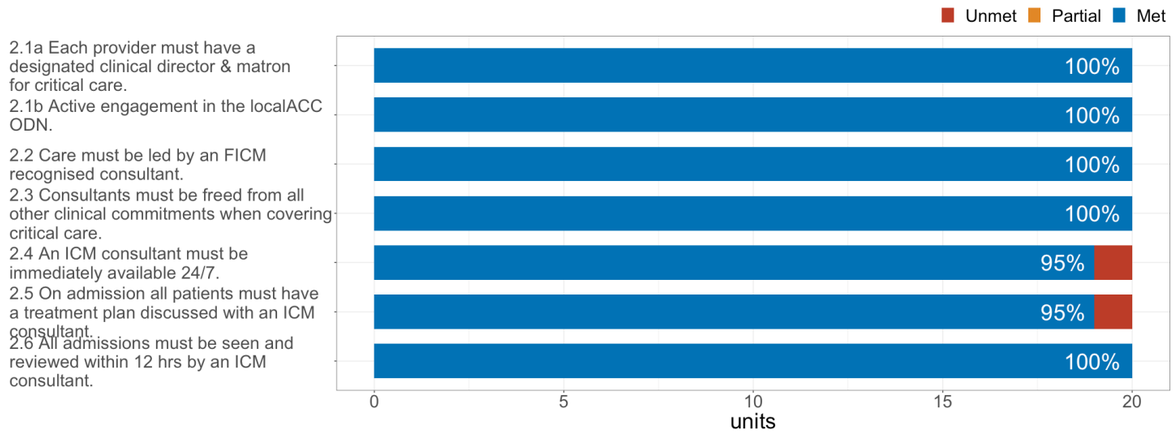


Figure 2: *Responses to D05 questionnaire – Medical Staffing*

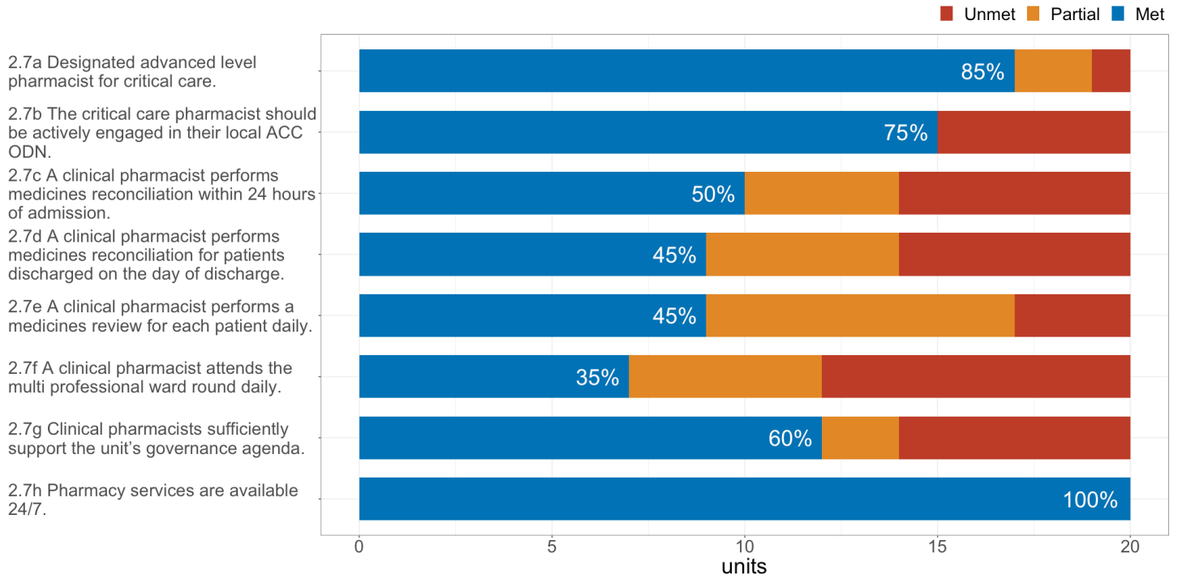


Figure 3: *Responses to D05 questionnaire – Pharmacy Staffing*

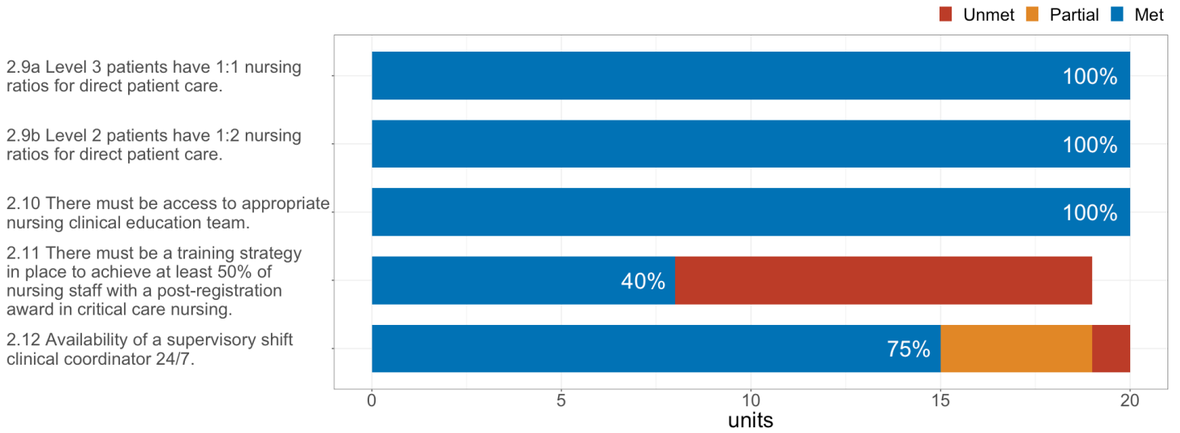


Figure 4: *Responses to D05 questionnaire – Nursing Staffing*

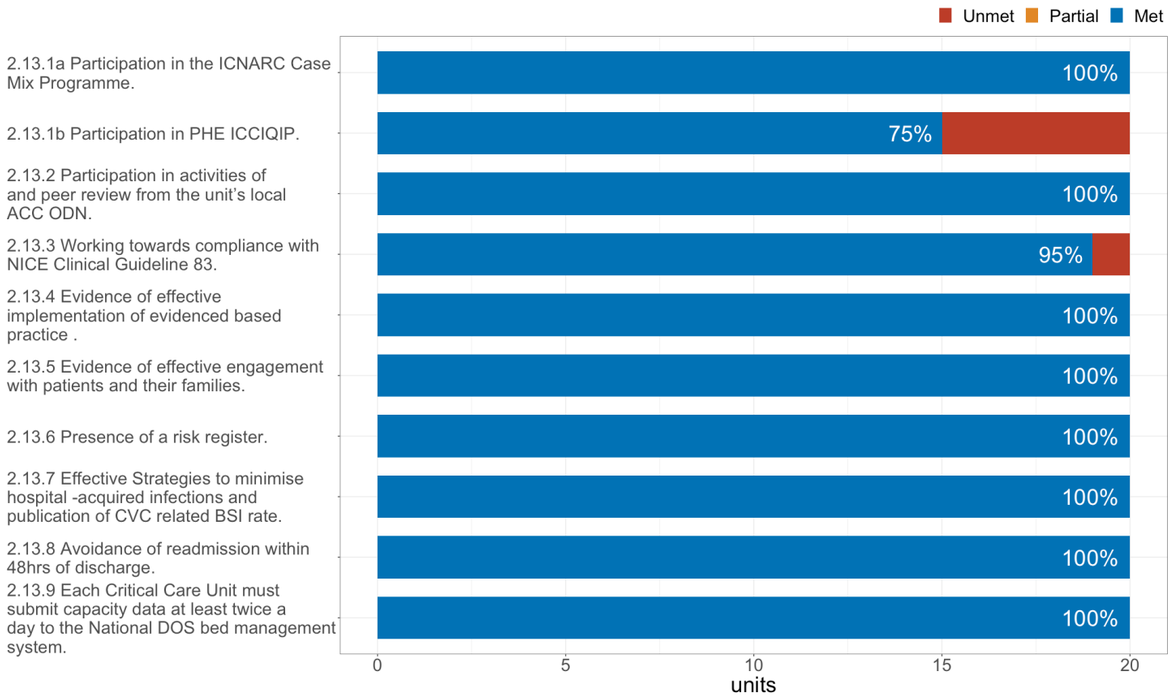


Figure 5: *Responses to D05 questionnaire – Participation in national audit programmes*

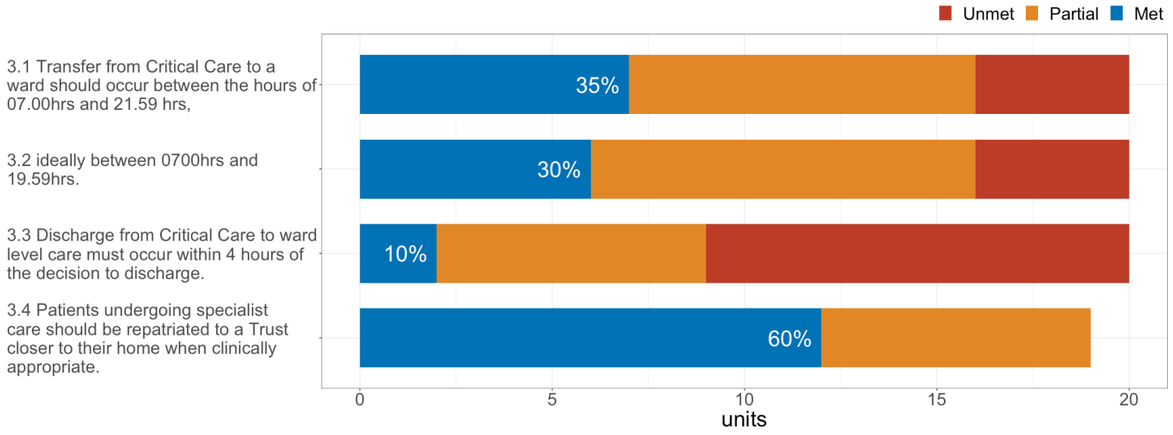


Figure 6: *Responses to D05 questionnaire – Discharge*

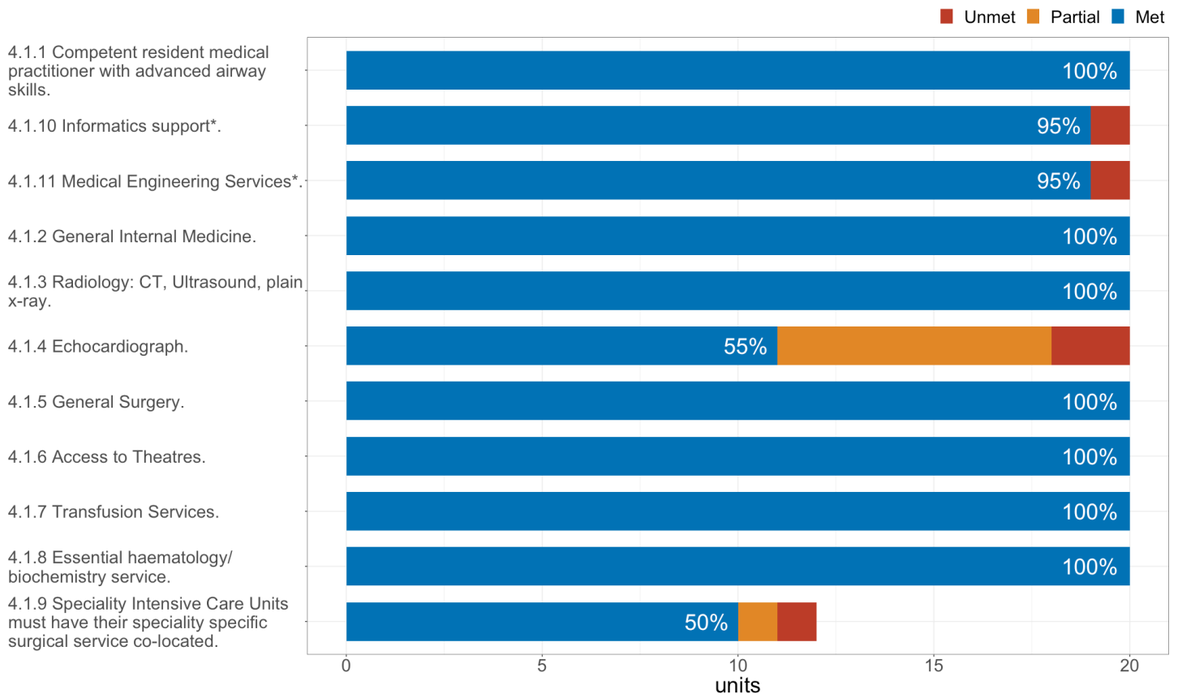


Figure 7: *Responses to D05 questionnaire – Immediate onsite service availability*

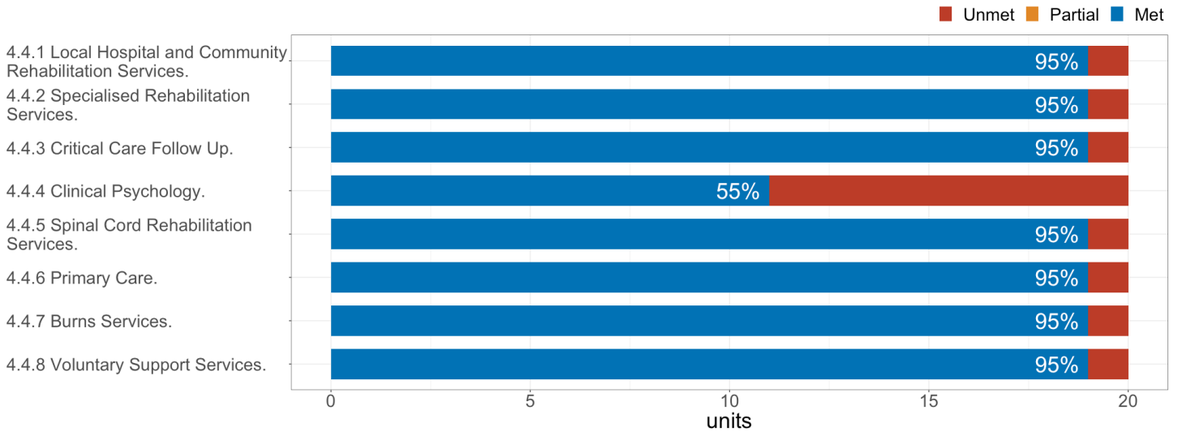


Figure 8: *Responses to D05 questionnaire – follow up and post discharge service availability*

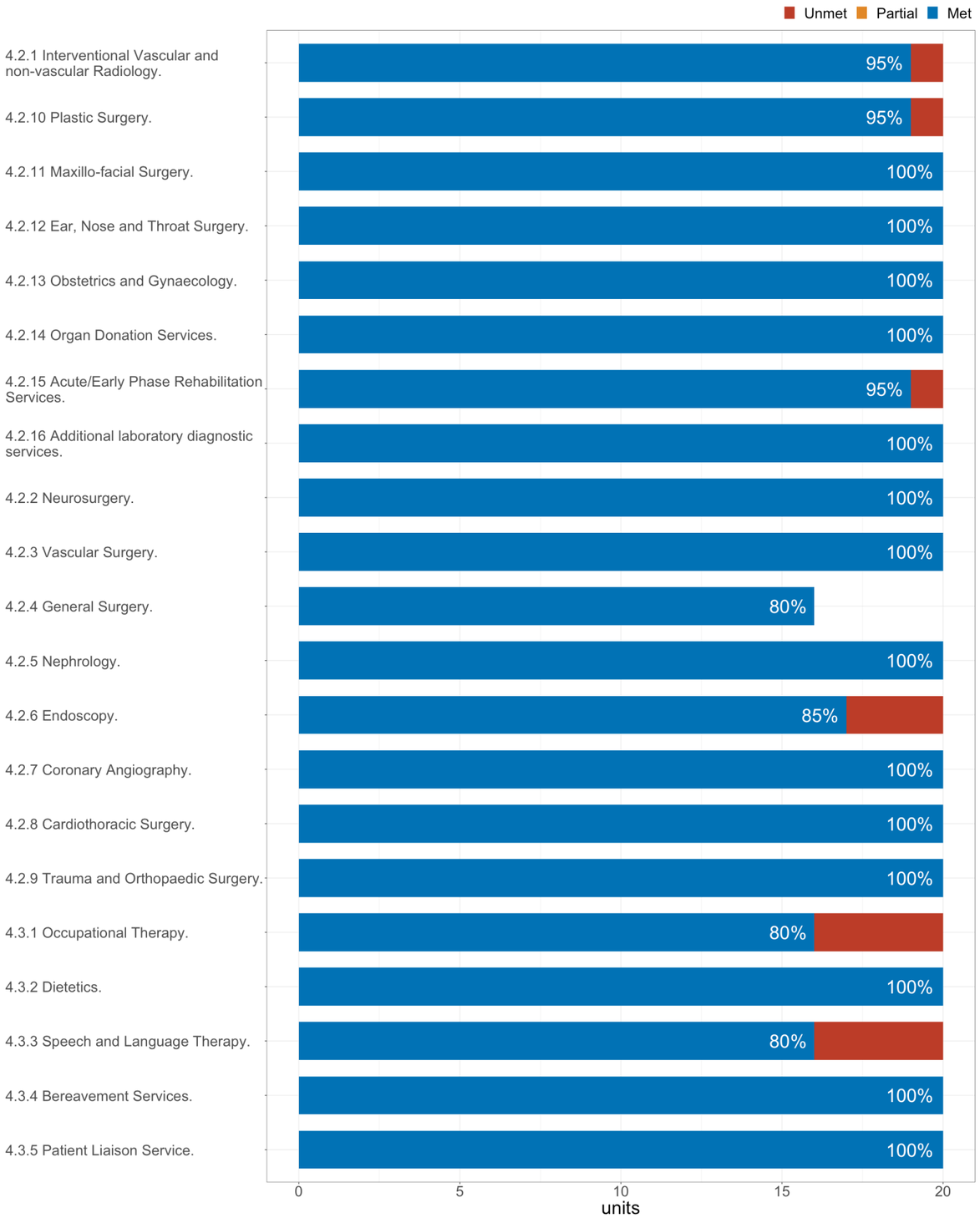


Figure 9: *Responses to D05 questionnaire – Available on or off site service availability*

Regional Nursing

It has become valuable for the network nursing groups to be able to operate using a hybrid model of face-to-face meetings and Microsoft Teams meetings. It has also been pleasing to see the enthusiasm of staff in travelling again and meeting each other face-to-face, with most hospitals being well-represented at both the Outreach and Education groups.

The Outreach lead group have new and changing priorities and are currently benchmarking themselves against the newly published Critical Care Outreach Practitioner Framework **https://www.norf.org.uk/CCOP-National-Competencies-and-Career-Framework**, which allows self-assessment against a career pathway with an associated suite of competencies, commencing with Enhanced Competencies and proceeding through Advanced Competencies to Consultant Competencies. A sharing event is being planned for all Outreach Nurses for 5th July 2023, with an interesting programme developing around the framework, academic pathways, updated national dataset, the Outreach role in rehabilitation and tracheostomy ward rounds.

Workforce

It is only now we are really experiencing the full effects of the legacy of the pandemic on the workforce, especially nursing. Those who were intending to move on, put their plans on hold, those intending to retire, put their plans on hold and now in addition to those plans proceeding, we have the addition of those who have now decided to retire and NOT return and those who have decided to move on because of the effects of the pandemic. Thankfully, it does appear that some of those who helped during the pandemic have chosen to take permanent employment, and the whole episode has attracted some nurses to the speciality which includes some newly qualified nurses. Although historically critical care has preferred not to give newly qualified nurses their first nursing employment, this has become one of the ways of boosting the workforce, investing in their training, with higher levels of support and increased supernumerary time. One thing that has been learned from the pandemic is that there is not a pool of speciality trained nurses to draw on and therefore we must look at other ways to 'grow our own' skilled workforce. We also need to address the exodus of nurses that is continuing, but taking heed of the results and recommendations of the retention survey that was carried out by the Critical Care National Networks Nursing Leads (CC3N) group Summer 2022.

CC3N Retention Survey Results

1 in 2 (49%) nurses are expecting to leave their current adult critical care unit in the next 3 years

Top 5 Contributing Factors in the decision to leave

1 - Lack of recognition through pay awards (46%)
2 - Working on other wards (45%)
3 - Lack of recognition from management (37%)
4 - Stressful and traumatic work experiences (33%)
5 - High workload (32%)

Top 5 contributing factors of workplace stress for critical care nurses

1	**Staff Shortages**
2	**Working on other wards *** **Combination of being asked to work on another ward outside of ICU and being asked to work on another ICU ward.*
3	**Stressful and traumatic work experiences**
4	**Workload**
5	**Work-life balance**

CC3N Retention Survey Recommendations (in brief)

- Minimising and thorough risk assessment of critical care nursing staff moves to other wards and departments.
- Need for a National Critical Care Nurse Staffing Establishment and clearly defined National Critical Care Nurse Ratios.
- Recognition of Critical Care Nursing as a speciality and remuneration/pay in accordance with skills, knowledge, and experience of critical care nurses with a defined career pathway.
- Need for Flexible staffing arrangements / rotas.
- Staff Mental Health and Wellbeing must be made a priority.
- Units should have a comprehensive plan to provide a working environment and core conditions which meet National ACC Workforce Wellbeing Best Practice Frameworks, policies.

Response from Network

As a result of the CC3N retention survey, peer review discussions and a request from a meeting of the critical care educators, a letter has been sent to inform the Trust Chief Nurses and Heads of Education of several points that may be affecting nursing recruitment and particularly retention within their critical care units. It is a possibility that this is information they are unaware of. The letter gave the following information:

- The amount of supernumerary practice time and study time that is required to train a critical care nurse; this needs to be ring-fenced to complete the training in a timely manner to enable the service to deliver high quality, safe and effective care to all patients.
- The pandemic has increased previous turnover of staff; therefore, the workforce is very junior.
- The redeployment of staff to the wards is having a negative effect on training and moral.
- The training is costly and therefore, retention is key and a cost saving.
- The skill-mix across the region is variable and should be equalised, allowing reward for extensive training.
- The CC3N retention survey was an accompanying document as well as two current position statements, firstly from the Faculty of Intensive Care Medicine and the Intensive Care Society and a further statement from the UK Critical Care Nursing Alliance.

Nursing Associates (NA) Project

The Health Education England (HEE) funded pilot project for the introduction of Nursing Associates into critical care units is progressing well. HEE host bi-monthly meetings to support the 5 Trusts signed up to the project. The funding has been utilised in different ways by different Trusts, whether it be to introduce a fixed term educator to support trainees or to fund posts for trainee NAs or to employ registered NAs. Currently there are 5 registered NAs and 11 trainee NAs in the region across the 5 Trusts, although some are still recruiting. The University of East Anglia are in the process of writing an evaluation for publication.

Advanced Critical Care Practitioner (ACCP) Update

The September 2022 and January 2023 intakes for the ACCP training was incentivised by a national funding offer which was additional to the previous year's regional offer and amounted to £133,505 per student over a 3-year timeframe. This allows for all the required backfill for staff in training and allowed 2 new Trusts to appoint new trainees and 5 Trusts to expand their ACCP workforce. Table 6 shows the current position for the regions ACCP workforce. The national funding offer has also allowed for the appointments of 2 TDP leads, 1 day a week each to ensure teaching opportunities are available, students are supported through their studies and clinical training and to ensure a consistency in training throughout the region.

This year's offer has decreased, but it still an excellent opportunity. The offer is for full tuition fees for 3 years to master's degree level at £6000 a year plus (subject to confirmation of funding) £10000 per year for 3 years. Total of £48000 per trainee. All applications must be discussed and agreed via the organisation's Advanced Clinical Practitioner (ACP) lead who will then include within the demand scoping survey.

Number of ACCPs currently with positions in East of England Critical Care units	10
Number of ACCPs currently in training in EoE units from the 2021/22 training year and prior to the HEE 2022/23 funding offer	6
Number of ACCPs commenced training under the HEE 2022/23 full funding offer	14

Table 5: *ACCP posts within East of England critical care units*

Well-being

The network continues to work with the Mental Health Network and the regional well-being hubs. The group has developed to invite well-being leads from each Critical Care unit and the embedded psychology staff from those Trusts who have been able to secure a service for their patients, relatives, and staff. This has been a useful forum for the psychology staff to meet each other and share initiatives and concerns.

It sadly seems a time of instability, with certain unknowns about how the well-being hubs will be funded in the future, although they will be functional for at least the next 6 months.

The results of the CC3N retention survey show the need for staff support remains vital, so at a time when the future of the well-being hubs is unknown it is disappointing to hear that many Trusts are still finding it impossible to implement their own embedded psychology services and with 2 Trusts losing very successful services at the end of fixed term contracts. The well-being group conducted a survey (Table 6).

What psychology input is present on your unit?		
Answers	**Number of Trusts**	**Comments**
Fully funded embedded Psychology service for patients/relatives/staff	2	The two largest network Trusts with multiple units and over 50 beds each have a cross-section of psychological staff and work as a team.
Fixed term post for Psychology service for patients/relatives/staff	3	All three of these Trusts have two sites each, the funding has been renewed for year 2023/24 at one Trust and the future for the other two are currently unknown.
Business case in progress for full psychology service – Please give position	6	Two business cases are currently active as part of a critical care expansion. Four business cases have all been declined, some more than once.
Non-funded Trust Psychologist, who fits it in their role (goodwill)	2	One Trust has no business case submitted and the other has had business case rejected.
Psychology services have been lost	2	Two Trusts who had previously had fixed term services for patients/relatives/staff have not been able to renew contracts.
What would benefit your staff the most?		
There were two overwhelming responses to this: • The embedded psychology services would be beneficial to all. • The Professional Nurse Advocate (PNA) initiative needs expanding with allocated time for PNAs to deliver restorative supervision and for staff to attend sessions. In addition: • A mix of reflective sessions, webinars, debriefing, educational workshops were delivered by some Trusts on team days or on request. • Rest facilities were generally thought to be adequate, but a couple of Trusts have poor facilities. • Other thoughts were a need to feel valued, reduction in work-related stress, adequate staffing and adequate time and a space to carry out reflective-restorative supervision sessions.		

Table 6: *Results of survey undertaken by well-being group*

It was noted that the larger Trusts have services that include various roles such as psychologist, assistant psychologist, therapists and advanced nurse practitioners in psychological therapies. This combination of different roles seems to work well to cover all aspects of patient, relative and staff care. Clearly not all the smaller Trusts could operate in this way, but with so many business cases being turned down, joining Trusts, facilitated by the ICBs would be a sensible solution as a degree of psychology services forms part of the commissioning service specification document.

The regional Professional Nurse Advocate (PNA) Lead has now returned to post showing a commitment by NHS England to promote the PNA strategy. The Critical Care PNA infrequently meet due to lack of dedicated time for the role, this needs to be addressed to allow further support for each other, and to share learning and practice. There is also a national Critical Care PNA group that have recently held a very successful conference.

The Intensive Care Society 'Thriving at work' toolkit has been completed by 4 Trusts, and in light of the nursing retention survey results, the aim would be to encourage further participation and work in the future on improvements that we can make as a network.

Education

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 GPICS and FICM standards. The Network Education team has welcomed 2 additional members: Sarah Entwistle and Felicity Chapman, who are leading on the Step 1 Programme and are also involved in the running of the Critical Care Course.

The 2021/2022 cohort of the Critical Care Course, led and delivered by the Network with the support and accreditation of the University of East Anglia, completed their studies in October 2022. Whilst there are some outstanding results related to extenuating circumstances and extensions, overall, the outcome has been very positive with 100% Pass for Module 1 and 86% Pass at first attempt for Module 2. This means that 86 % students have passed both Modules so far (final % Pass to be confirmed in May 2023 after resubmission results for Module 2 are published). There were 5 withdrawals from the course out of a total of 106 students. 5 students also decided to take a break in studies and join the course again in the next academic year. Withdrawals and break in studies decisions were based on themes such as personal circumstances, new posts outside of critical care and relocation abroad.

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, 130 students are currently studying on the 2022/2023 cohort. 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.

The current 2022/2023 cohort is studying on the Modules adopting 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. 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. However, online learning may still be met with some resistance by some and not fully suit all types of learners, associating this approach with face-to-face classroom teaching and using a variety of digital technologies to address students' learning needs can have many benefits, as highlighted by HEE in their document published in February 2023 – Delivering HEE commissioned blended learning programmes – Provider guidance.

The aims of blended learning programmes have been identified by HEE 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 by HEE through becoming a provider of the Quality Framework for Blended Learning Critical Care Education in November 2021. The Network team continues to collaborate with the HEE Blended Learning Team working to achieve the aims mentioned in the above section. In March 2023, Isabelle Delain presented on the use of face-to-face high-fidelity simulation to enhance knowledge gained from online learning sessions at the National HEE Blended Learning Event in London. This was a good opportunity to share what was learnt from running a blended learning course with HEE and other course providers. Further discussion with HEE has led to an extension of the original 2-year contract for an additional 2 years, which will allow the Network to offer 130 places per cohort for Critical Care nurses working in units across the

region free of charge. This will apply to cohorts 2024/2025 and 2025/2026 (with cohort 2023/2024 already within the current/original HEE contract). 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.

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 12 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.

The Critical Care Course is now in its fourth year running. Many lessons have been learnt over the past 3 years and exploration and discussion of the feedback provided by students, Educators, Module Leads and other stakeholders have led us to carry out a full review of the Modules. This has resulted in the redesign of the Modules. The aim is to start delivering the 2 new Modules for the next cohort from September 2023. The content of the Modules will largely be unchanged. However, the order and pace of delivery, and the types of assessments have been reconsidered to continue improving student experience. The titles of the Modules will change from Management of the Critically Ill Adult to Assessment and Management of the Critically Ill Adult (Modules 1 and 2).

On April 1st 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 5s across the network with critical care foundation knowledge and prepare them for undertaking the 60 credit Management of the Critically Ill Adult Course.

The programme has been funded by HEE as a blended learning programme. It consists of 40 hours asynchronous online learning, with 2 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 they enrol on the course 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. All three elements are required to complete the course.

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.

During the first year we have enrolled over 450 students on the course, with another 50 set to start in April. There has been positive feedback about the content from students and feedback will continue be reviewed every 6 months. Educators are sent reports bi-monthly to allow them to monitor the progress of their students. Updates have already been made to the course, including the additional of end of block quizzes for the students to complete. It is our intention to review course content annually.

Network governance and reporting

The original governance structure and reporting was to a Board of Board with an acute hospital trust Chief Executive Officer having the role of Chair. With the advent of new networks this became unstainable and NHS England – East took the decision to stand down the Board in early 2022. A temporary revised governance structure was implemented with the Network currently reporting through to the Joint Commissioning Committee. This includes the production and agreement of an annual work plan and an annual report, within year monitoring of progress with attendance at review meetings and development of reports.

This next year will see ICBs developing arrangements for networks to be commissioned collaboratively by NHS England and NHS Improvement and the ICBs they serve. This will support a single system of consistent, sound governance and accountability arrangements that will enable ICBs to manage clinical networks, align networks with system priorities and leverage the maximum benefit for pathways and patients. So, movement of specialised services will take place and be delegated to ICBs in the future. It is important to not forget that specialised commissioning is only a small proportion of the work that adult critical care fulfils.

The network continues with the clinical board and alternates now between face to face and online meetings. The representation from the adult critical care community at these meetings is impressive and the team recognises the support and contribution that all have made and continue to do daily. We have a highly active and supportive lead from specialised commissioning NHS England - East, as well as a regional adult critical care senior leader who remains incredibly supportive and committed to adult critical care and the work that the network carries out.

During 2023/24 Specialised Commissioners remain the commissioner of the network, and this coming year it is anticipated that there will be a move to joint commissioning with the ICSs. It is also expected that the network will work with Specialised Commissioning to review the current governance arrangements as the movement of specialised services will be delegated to ICBs in 2024/25.

Finance

At Month 10 adult critical care reported position was 26k favourable variance against agreed funding. The extra HEE funding has been received and spending is in progress according to plan.

Safety attitudes and psychological safety – analysis of returns from peer reviews

Introduction

The delivery of high-quality critical care involves trained staff working as a team in well-led organisations that value their staff and prioritise patient safety. Safety culture is broadly defined as a 'a global phenomenon and encompasses the norms, values, and basic assumptions of an entire organisation'. Organisations with a positive safety culture have communication based on mutual trust, a shared perception of the importance of safety, confidence in the effectiveness of preventative measures and support for the workforce. Safety climate may be seen as the staff's perception of safety in relation to management support, supervision, risk taking, safety policies and practices, trust and openness.

More recently there has been increasing interest in psychological safety which is a similar concept concerning staff perception of whether it is safe to take interpersonal risks at work such as voicing concerns, asking questions and giving feedback. Both of these concepts were developed in industry but have been increasingly used within a healthcare setting. During the 2022 round of peer reviews the network again asked staff in each of the hospitals to undertake the Safety Attitudes Questionnaire (SAQ). This is a validated series of questions aimed at increasing understanding of the safety climate of the units. It was a repeat of the similar survey undertaken in the last round of peer reviews in 2019. This gave the opportunity for greater staff involvement in the peer review process and additionally gave staff an opportunity to provide anonymised free-text feedback which has proved to be of significant value to the review process and the leadership teams. In 2022 the network also added a series of questions to assess psychological safety. These were derived from the question set developed by Amy Edmondson for use in general work environments.

Whilst the hospital grouped data (and its comparison with the information available from other units) was used within individual peer reviews it was felt that there would be value in exploring the safety climate across the region, and particularly if this had changed with the impact of the pandemic between the two series of peer reviews. Secondary analysis looked at the use of an extra question set to evaluate psychological safety and whether this provided added value to the original questions.

Methods

Data collection was done online using the JISC survey tool. Individual hospital links were created to manage data collection for each peer review, and these were coalesced into a single database, with hospital identifiers and free-text entries removed. Scores for the individual domains was created using the recommendations from the Centre of Healthcare Quality and Safety who developed and provide free licence to use the questionnaire. The scores range from 0 to 100 for each domain.

Information about the use and publication of the anonymised data was provided to participants. Demographic data concerning role and length of time in critical care was collected (though not mandated), and this was used to group responses for analysis.

Demographic data was collected for role (nursing; medical; AHP; support) and critical care experience (short: >3 years; medium: 3-10 years; long: <10 years).

Analysis was performed using R with comparisons undertaken with Mann-Whitney U test with Holm-Bonferroni correction for multiple testing. Because of the risk of alpha error due to multiple groups of tests statistical significance was accepted at the 0.01 level rather than 0.05.

Data from 2022 for SAQ was then assessed for correlation with the 10 individual questions within the psychological safety survey (spearman rank correlation). Whilst all outcomes were statistically significant this relates to the very high number of data-pairs. Of more interest is the value of the Spearman coefficient. A value of >0.5 suggests a reasonable degree of correlation. This work was undertaken to try to understand better the individual questions within Dr Edmondson's question set and their relation to the SAQ.

Results

1647 completed questionnaires were submitted (753 in 2019; 894 in 2022).

	number		teamwork			safety climate			job satisfaction		
	2019	2022	2019	2022	*sig*	2019	2022	*sig*	2019	2022	*sig*
Role											
Nurse	509	636	83.3	83.3		85.7	82.1		85.0	75.0	****
Doctor	112	121	91.7	91.7		92.9	89.3		90.0	85.0	
AHP	43	55	83.3	83.3		82.1	75.0		90.0	80.0	
Support	64	51	87.5	66.7	**	85.7	71.4	**	95.0	80.0	**
Experience											
short	219	248	87.5	83.3		85.7	82.1		90.0	85.0	
medium	262	317	83.3	79.2		82.1	78.6	**	85.0	70.0	****
long	257	316	87.5	83.3		91.1	85.7		87.5	80.0	
All	**753**	**894**	87.5	83.3	**	85.7	82.1	****	85.0	80.0	****

	stress recognition			unit management			hospital management			working conditions		
	2019	2022	*sig*	2019	2022	*sig*	2019	2022	*sig*	2019	2022	*sig*
Role												
Nurse	75.0	75.0		75.0	70.0		55.0	50.0	***	75.0	62.5	****
Doctor	75.0	75.0		85.0	80.0		50.0	50.0		78.1	68.8	
AHP	68.8	75.0		85.0	75.0		65.0	55.0		75.0	68.8	
Support	62.5	75.0		80.0	65.0		60.0	50.0		75.0	56.3	****
Experience												
short	75.0	75.0		80.0	75.0		65.0	55.0		75.0	68.8	**
medium	75.0	75.0		75.0	65.0	***	50.0	45.0	**	75.0	62.5	****
long	68.8	75.0		85.0	77.5		55.0	50.0		75.0	68.8	***
All	75.0	75.0		80.0	75.0	****	55.0	50.0	****	75.0	62.5	****

Table 7: *Median score for each of seven domains of the SAQ in the two peer review sets separated by role and experience. sig: statistical significance at ** p<0.01; *** p<0.001; **** p<0.0001.*

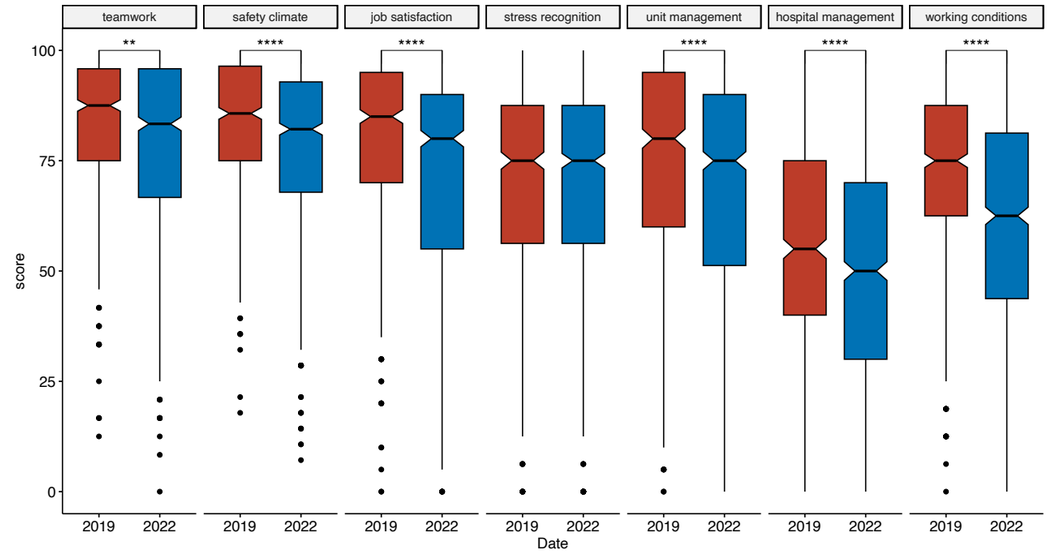


Figure 10: *Box & whisker plot comparing scores for all staff in each of the seven domains. Statistical significance of difference between the year groups - * p<0.05; ** p<0.01; *** p<0.001; **** p<0.0001*

For all staff scores fell significantly in all domains except stress recognition, most noticeably in job satisfaction and working conditions.

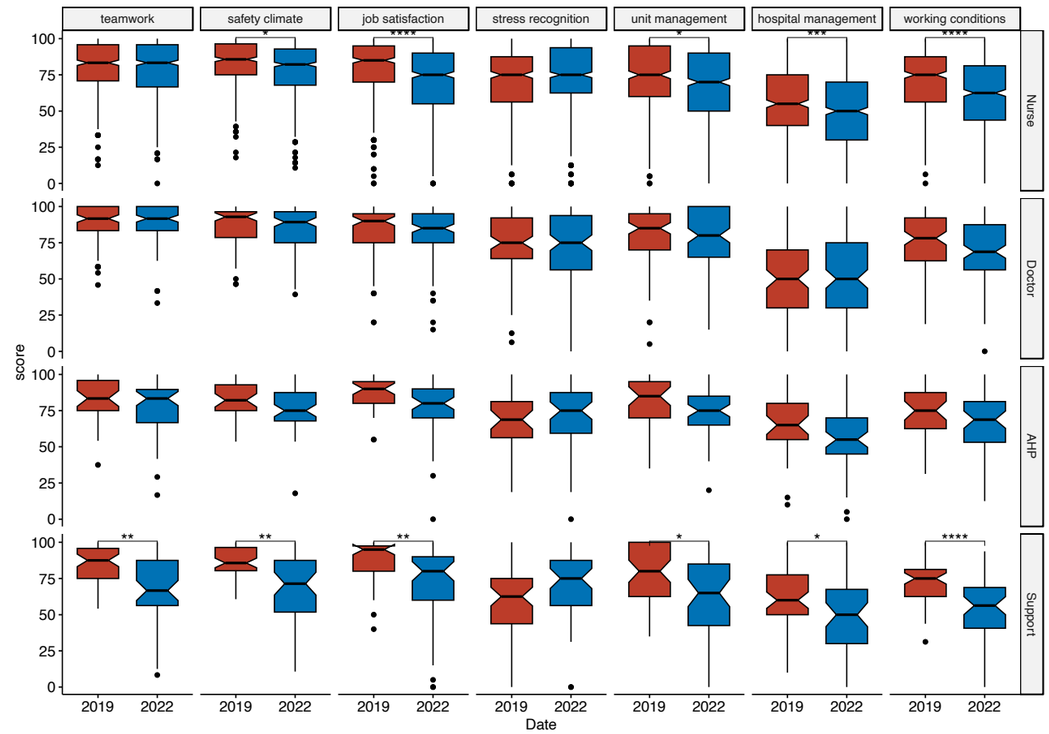


Figure 11: *Box & whisker plot comparing scores for staff separated by role in each of the seven domains Statistical significance of difference between the year groups - * p<0.05; ** p<0.01; *** p<0.001; **** p<0.0001*

Within the staffing groups these changes in job satisfaction hospital management and working conditions were significant in nursing staff and support staff, but whilst similar falls occurred in medical and AHP staff these did not reach significance.

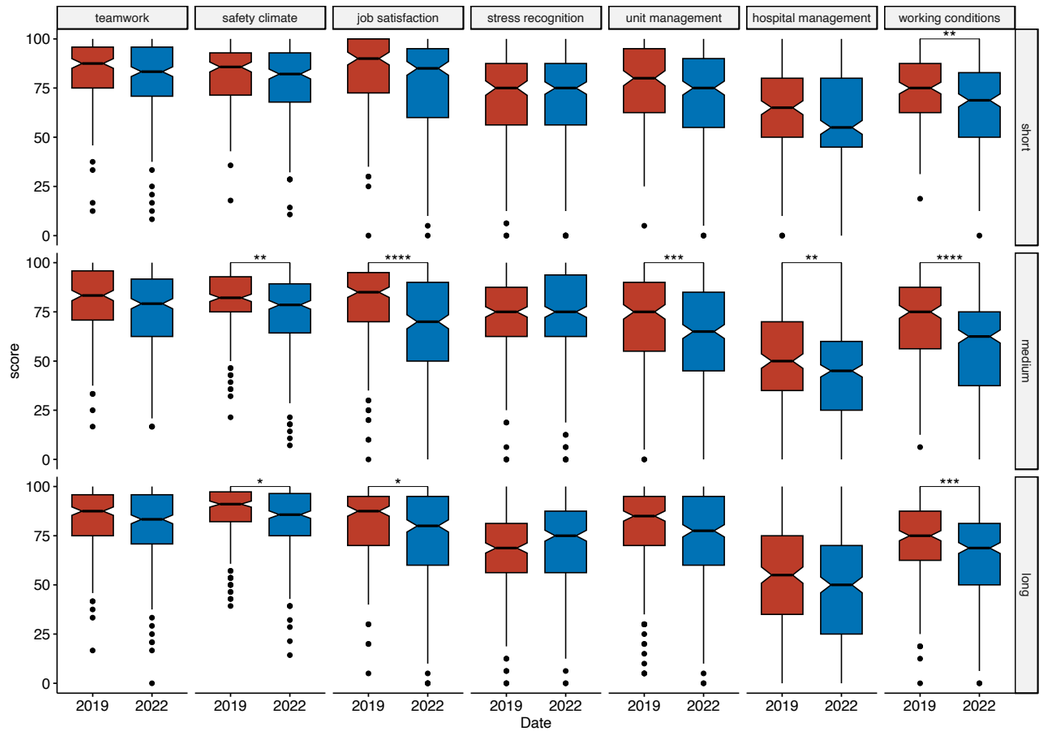


Figure 12: *Box & whisker plot comparing scores for staff separated by time working in critical care in each of the seven domains.*
(short: >3 years; medium: 3-10 years; long: <10 years).
*Statistical significance of difference between the year groups - * p<0.05; ** p<0.01; *** p<0.001; **** p<0.0001*

The fall in job satisfaction and working condition scales were also most profound in staff with 3-10 year's critical care experience, but this group also saw falls in perception of unit and hospital management and safety culture.

Psychological safety

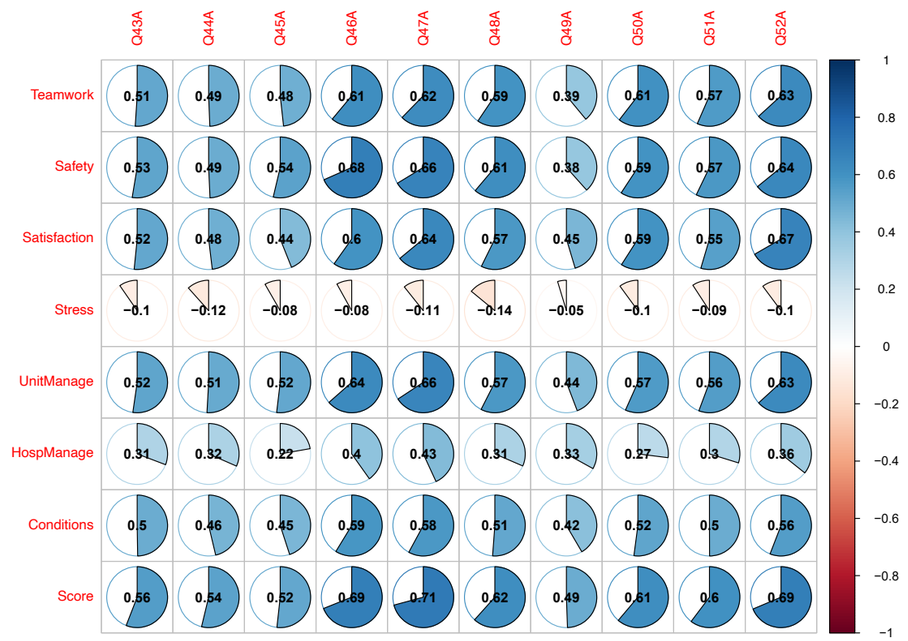


Figure 13: *Spearman correlation coefficients comparing the 7 domains and overall score from the SAQ with the 10 questions within the psychological safety set.*
Visual display of correlation matrix. Note: The blue circles filled clockwise in the figure indicate positive correlation, while the red circles filled counter clockwise indicate negative correlation. The larger the filling colour area, the darker the colour is, and the stronger the correlation is. Detail of questions Q43 to Q52 are shown below (Table 9)

Q43a	On this team, I understand what is expected of me.
Q44a	We value outcomes more than outputs or inputs, and nobody needs to 'look busy'.
Q45a	If I make a mistake on this team, it is never held against me.
Q46a	When something goes wrong, we work as a team to find the systematic cause.
Q47a	All members of this team feel able to bring up problems and tough issues.
Q48a	Members of this team never reject others for being different and nobody is left out.
Q49a	It is safe for me to take a risk on this team.
Q50a	It is easy for me to ask other members of this team for help.
Q51a	Nobody on this team would deliberately act in a way that undermines my efforts.
Q52a	Working with members of this team, my unique skills and talents are valued and utilised.

Table 8: *Individual questions within the psychological safety set. Question number is shown in Figure n3 above.*

Looking at the psychological safety data we can see that there is strong correlation between the overall score for SAQ and Q46 (when something goes wrong we work as a team to find a systematic cause), Q47 (all members of this team feel able to bring up problems and tough issues) and Q52 (working with members of this team, my unique skills and talents are valued and utilised). These questions in the psychological safety set also had closest correlation with individual domains of the SAQ (Q46 – safety culture, unit management; Q47 – safety culture, job satisfaction, unit management; Q52 – safety culture, job satisfaction). There is little correlation between stress recognition and any of the questions within the psychological safety set.

Discussion

Whilst it is not possible to assess survey response rate overall, we can compare the number in nursing roles in 2022 (636) with the headcount in the national critical care stocktake for the same period (1922). This suggests that the survey response rate was approximately 33%, which is somewhat disappointing but suggestive of difficulties ensuring that all staff had received the request and potential overload with similar processes within the NHS and individual trusts. The low response rate may lead to bias.

SAQ

Overall, we observed lowest scores in the perceptions of hospital management domain in both 2022 and 2019. This is in keeping with many other published SAQ data and is likely to represent the wider overall role of that team. Teamwork and safety climate are scored higher in both years by medical and nursing staff compared both to other domains and other staff groups.

We observed a decrease in safety climate most notably in working conditions and job satisfaction predominantly in nurses and support staff (HCA) with 3-10 years' experience. At least in nursing terms these maybe the staff who bore the biggest clinical load and were expected to work beyond their training by undertaking more extensive clinical roles and supervise reservist staff. It should be noted that within the job satisfaction domain the question 'morale… is high' and within working conditions the question 'the levels of staffing… are sufficient…' both had strong impact on the overall scores in those domains.

Psychological safety

We also looked at the newer question set on psychological safety to see if this has value. It is reassuring that there is good correlation in most questions with the components of the SAQ. This is certainly suggestive of significant overlap in applicability (though also that there is potential for duplication). It is of note that the question with the weakest correlation overall is 'it is safe for me to take a risk on this team'. This question was discussed at many of the peer review meetings, and it was felt that there was some confusion about the question – the objective of the question is interpersonal risk (speaking out, raising concerns, etc) rather than clinical risk but that this is not clearly stated and may have impacted on the responses.

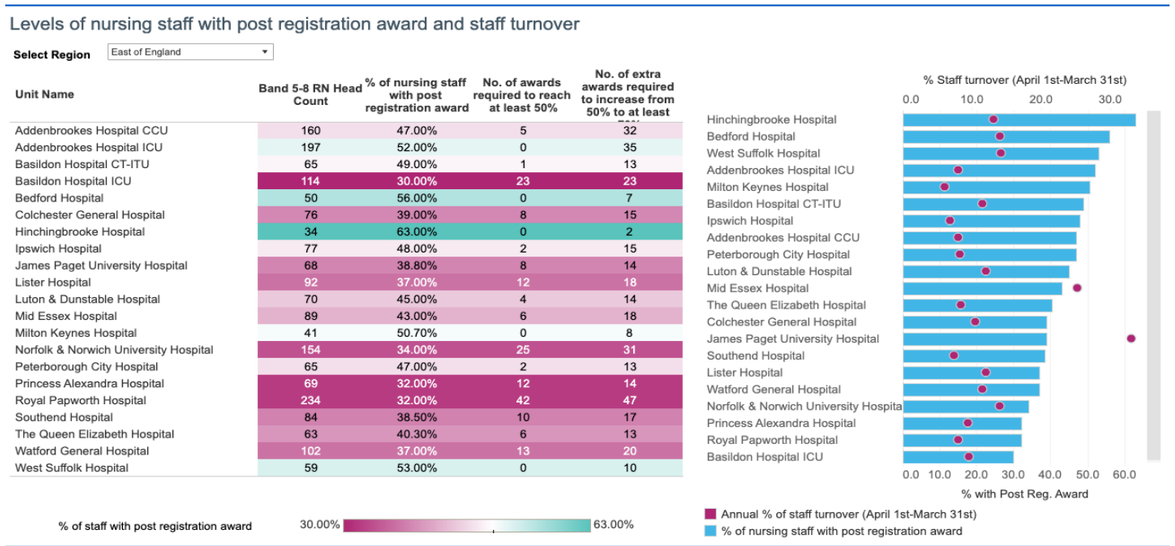
Overall, we continue to see a benefit from the use of the SAQ within the peer review process, and it is clear that the changes seen are influenced by similar pressures that has caused the concerns seen in the CC3N retention survey shown on page 18. The use of the psychological safety question set on this round of peer reviews has perhaps had less benefit and does appear to have significant overlap with the SAQ. In the interests of restricting the burden of the questionnaire it may therefore be appropriate to remove this in future peer reviews.

Adult Critical Care National Stocktake

A second stocktake was carried out this year to build upon the first stocktake data in 2021. The re-run this year supports understanding how capacity and the constitution of services has evolved and to support planning at network, system, regional and national level.

The stocktake collected information from all adult critical care units in the East of England with the network supporting, co-ordinating and validating all returns prior to final submission. The data was collected on bed capacity (both funded and unfunded) within each unit, types of units eg general, neuro. Expansion and surge capacity within each unit. The staff survey component included nursing and support staff, outreach and vacancy and sickness rates against these posts. The third and final component being a medical workforce survey.

The outputs from this national stocktake has been a Network Regional Report, further national and regional breakdowns can be found on the NCDR platform and include national and regional capacity within adult critical care and Level 3 surge capacity to help inform future model and capacity requirements both during business as usual and for winter pressures, planning and times of surge. There is also comprehensive information relating to workforce numbers and skill mix which demonstrates variation across the patch as well as nationally. The network continues to raise these differences and supporting innovation and change. A third adult critical care national stocktake will be taken forward into 2023/2024 workplan.



Unit Name	Band 5-8 RN Head Count	% of nursing staff with post registration award	No. of awards required to reach at least 50%	No. of extra awards required to increase from 50% to at least
Addenbrookes Hospital CCU	160	47.00%	5	32
Addenbrookes Hospital ICU	197	52.00%	0	35
Basildon Hospital CT-ITU	65	49.00%	1	13
Basildon Hospital ICU	114	30.00%	23	23
Bedford Hospital	50	56.00%	0	7
Colchester General Hospital	76	39.00%	8	15
Hinchingbrooke Hospital	34	63.00%	0	2
Ipswich Hospital	77	48.00%	2	15
James Paget University Hospital	68	38.80%	8	14
Lister Hospital	92	37.00%	12	18
Luton & Dunstable Hospital	70	45.00%	4	14
Mid Essex Hospital	89	43.00%	6	18
Milton Keynes Hospital	41	50.70%	0	8
Norfolk & Norwich University Hospital	154	34.00%	25	31
Peterborough City Hospital	65	47.00%	2	13
Princess Alexandra Hospital	69	32.00%	12	14
Royal Papworth Hospital	234	32.00%	42	47
Southend Hospital	84	38.50%	10	17
The Queen Elizabeth Hospital	63	40.30%	6	13
Watford General Hospital	102	37.00%	13	20
West Suffolk Hospital	59	53.00%	0	10

Table 9: *Percentage of staff holding a post registration award in critical care nursing (National Standard: Minimum attainment 50%)*

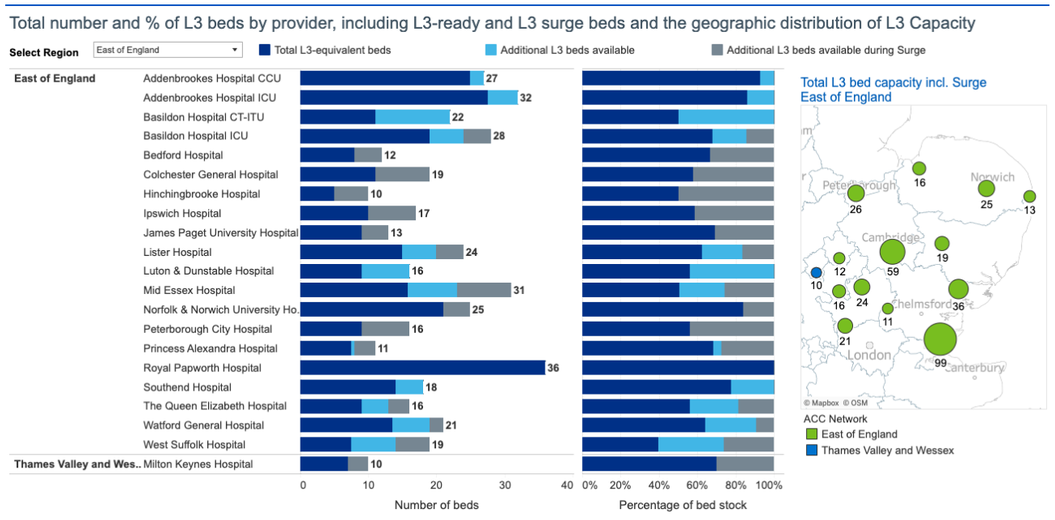


Table 10: *Number and percentage of Level 3 beds*

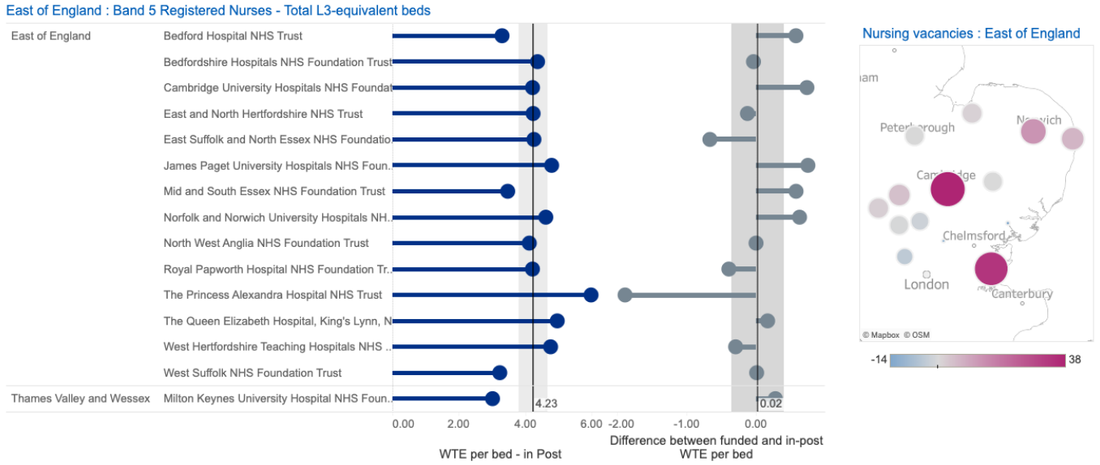


Table 11: *WTE band 5 nurses per level 3 equivalent bed*

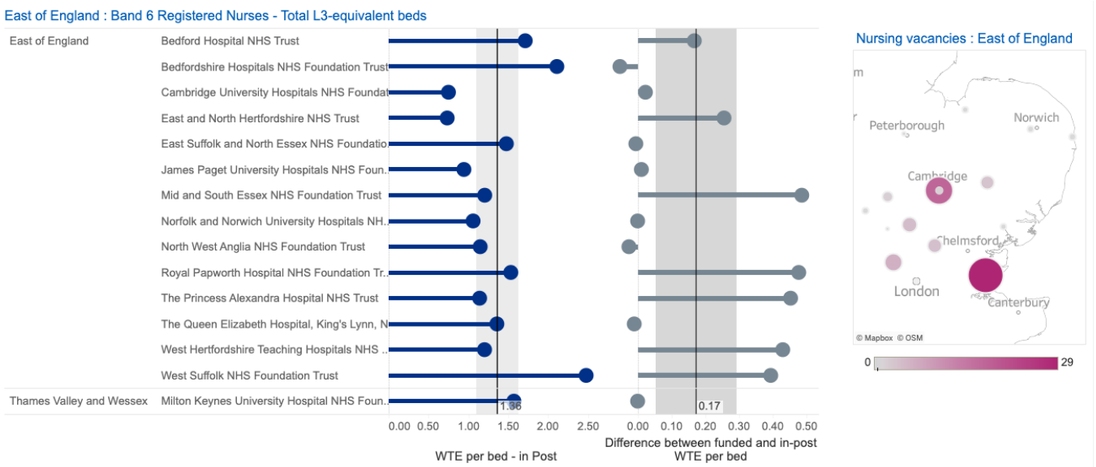


Table 12: *WTE band 6 nurses per level 3 equivalent bed*

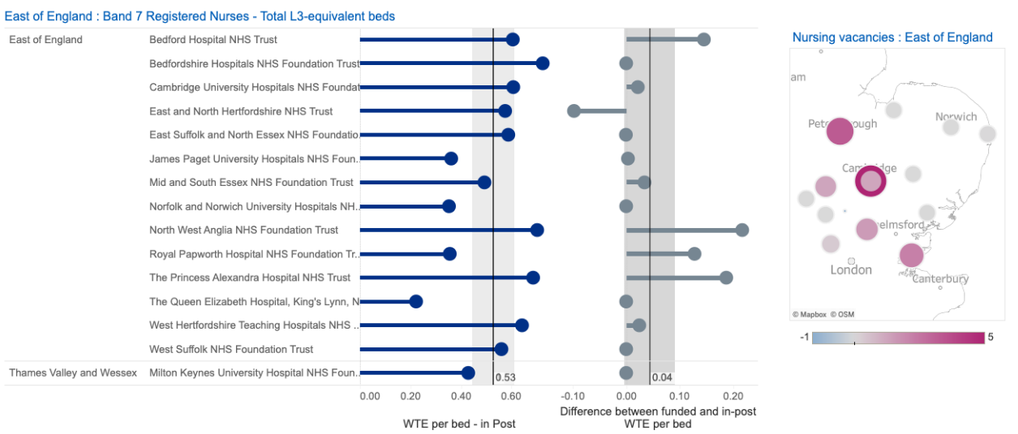


Table 13: *WTE band 7 nurses per level 3 equivalent bed*

Adult Critical Care Transfer Service

The Adult Critical Care Transfer Service (ACCTS) for the East of England launched in December 2021. Commissioned by NHS England, hosted by Cambridge University Hospitals NHS Foundation Trust and working in partnership with St John Ambulance (our interim Transport provider), ACCTS serves the East of England.

ACCTS provides a single point of contact for all adult critical care transfer referrals 24 hours a day, 365 days a year, via a dedicated 0333 number. All calls are managed by a Duty Consultant who triages, coordinates and can provide remote decision support if required. ACCTS operates two teams daily, the day team (08:00-20:00) and the afternoon team (12:00-22:00) from our base on the Cambridge Research Park.

Each transfer team consists of a Duty Consultant (who works within the region in Critical Care and/or Anaesthetics), Transfer Practitioner (all of whom are experienced Critical Care Nurses or ODP's) and a technician from St John Ambulance. We have dedicated Ambulances that are prepared with specialist critical care transfer equipment and drugs.

Our First Year

ACCTS has completed its first full year of service from December 2021 – December 2022.
In that first year we:

a. Completed **521** transfers. **283** of these were emergencies / escalations of care, **65** were capacity and **171** were repatriations. Over **100** out of region transfers.

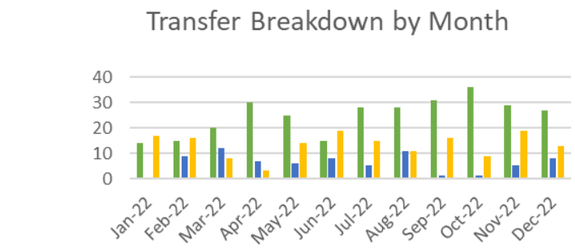
b. Moved into our new base on Cambridge Research Park.

East of England
Transfer
Adult Critical Care Transfer Service

c. Opened our new simulation suite for training and introduced a local education programme with an MDT approach.

d. Introduced a local induction process.

e. Launched a 24/7 ACCTS Consultant led phone line for all referrals.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Emergency	14	15	20	30	25	15	28	28	31	36	29	27
Capacity	0	9	12	7	6	8	5	11	1	1	5	8
Repatriation	17	16	8	3	14	19	15	11	16	9	19	13

Table 14: *Transfer by month and reason*

Table 15: *Transfer by speciality*

Service User Feedback

- Central to the development, implementation and future evolution of ACCTS is engagement with stakeholders, including clinical colleagues, Acute NHS Trusts and specialty networks whose patients require transfer.
- The ACCTS Leadership Team have put service user experience at the centre of its strategy for continual improvement and so feedback is sought from all who interact with the service, and this is reviewed and acted upon in an open and transparent manner at each Clinical Governance Committee.
- Feedback has been overwhelmingly positive, with the vast majority of those using the service indicating they are very satisfied with ACCTS.

Figure 14: *The overall experience of using ACCTS*

Conclusion

This annual report details the many aspects of the network activities over the last year. Overall, it has been both challenging and successful. The region continues to try to implement the identified shortfall of critical care services in a situation of profound financial restraint. The workforce issues within medical, nursing and pharmacy staff particularly provide an ongoing challenge to any expansion plans, and it is not at all clear how this can be resolved either regionally or nationally. We continue to encourage Trusts to promote staff retention strategies. Whilst the massive improvement in cross-site communication and working has impacted on the care delivered to our patients it is important to remember that this is there to assist local plans and resilience rather than replace it.

The educational arm of the network continues to go from strength to strength and this is seen nationally as a leading approach that has provided higher quality, more local ownership and cost efficiency, though the turnover of staff associated with the last few years has put significant pressure on this process to try to recover the national objective of 50% of staff with post-registration awards. In line with this the network continues to push Trusts and systems to recognise the increased utility of these qualified nurses with better grading (in line with many other areas within nursing). This is particularly important both to encourage course enrolment and staff retention following course completion.

We are immensely proud of and grateful for the work of all the staff associated with adult Critical Care because of their professionalism, dedication, and consistent desire to improve quality care. The Network team looks forward to working with all in 2023/24. Thank you all for your continuing support.

Priorities for 2023/2024

Continue progressing work on service provision and need

- Using the annual stocktake data review and validated capacity and enhanced perioperative care beds within the region.
- Continue working with NHSE East and ICSs regarding the strategy to increase critical care capacity.

Collaborate at Local, System and National Level

- Share best practice across all units.
- Continue with active engagement with all relevant stakeholders.
- Maintain close working with the East of England Adult Critical Care Transfer Service and support the implementation of a 24/7 service.
- Maintain attendance and participation at all relevant local, regional, and national meetings.

Effective pathways and Resources

- Review existing policies and procedures.
- Review and maintain website.
- Participate in investment and reinvestment priorities.
- Support rehabilitation needs and outcomes work and wellbeing strategies.
- Support winter planning and critical care surge planning.

Network Governance

- Participate in regional discussions regarding governance structure.
- Work with region to ensure ICS engagement.

Workforce and Wellbeing

- Support new ways of working for the benefit of patients and staff.
- Monitor development of new roles.
- Promote recruitment and retention.
- Continue with the Pharmacy and AHP meetings across the network.
- Identify gaps and take forward a strategy to reduce the variation and promote the need to have a skilled equitable workforce.
- Use the ICS 'Thriving at work' toolkit; make improvements in well-being.

Education & Education strategy

- Monitor percentage of staff holding the critical care qualification in specialism (QIS).
- Deliver QIS to 130 students per year across East of England.
- Change structure of existing course in response to feedback from students and educators with university partners.

Finance and Payment

- Understand and support the new payment proposals for Adult Critical Care.
- Monitor budget and HEE spending

Data and Reporting

- Develop plan for Network Data role.
- Continue daily review and validation of DOS and NCDR.
- Support development and implementation of the latest version of CRITCON.
- Develop and submit data reports.

East of England Adult Critical Care Operational Delivery Network
www.eoeccn.org