CR10/02

Minutes of the CREST meeting, held on Thursday 7 November 2002, at 2.00pm in Conference Room C3.18, Castle Buildings.

Present:	Dr D Stewart (Chairman) Dr M Briscoe Professor R Davidson Dr K Fitzpatrick Mrs F Hodkinson Mrs J Holmes Dr G Mock Mr M O'Hare Mrs E Qua Dr C Russell Dr M Smith Dr J Stone Dr T Trinick Mrs M Waddell Mr G Hannan } Secretariat Miss A Lowry }
Apologies:	Mr G Humphreys Dr A McKnight Dr A Montgomery
In attendance:	Mr F Bradley (for Item 5) Mrs K Fleck } (for Item 6) Dr P McClements } Dr J Trinder (for Item 4)

1. Introduction and apologies

[redacted]

2 Minutes of the previous meeting

[redacted]

3. **Matters arising**

(i) **Microbiology Services**

[redacted]

(ii) **Epilepsy Services**

[redacted]

(iii) **Use of Cortico-steroids in the Treatment of Asthma**

[redacted]

(iv) Waiting Lists

[redacted]

4. **Provision and Appropriate Use of Intensive and High Dependency Care**

[redacted]

5. **Best Practice – Best Care**

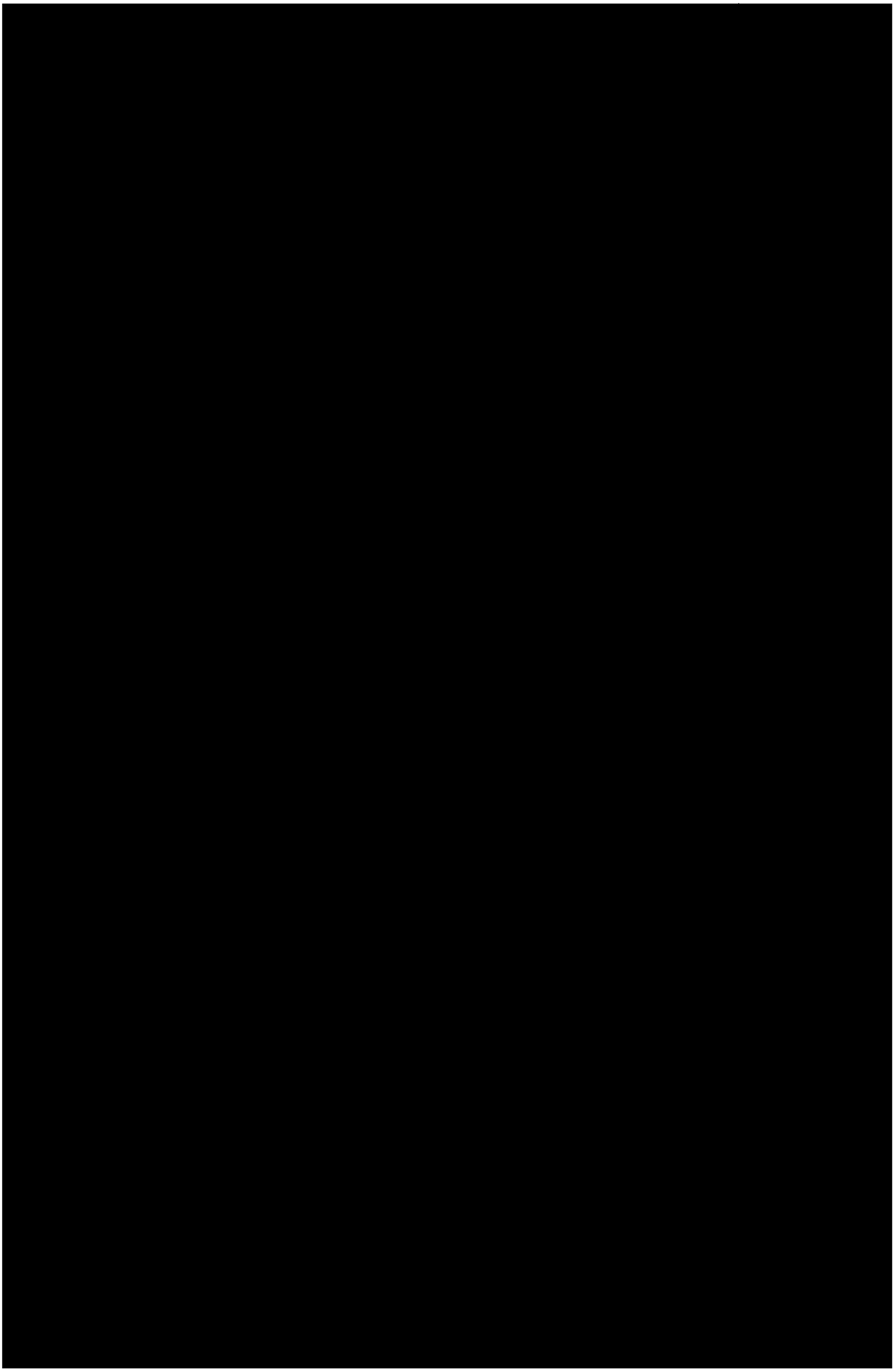
Mr Bradley reported that as of 6 November 2002, Ministerial approval had been received to proceed with the implementation of Best Practice - Best Care. He reported that it was mandatory to consult on the Bill passed by Parliament which would be disseminated to interested parties on 18 November 2002. This would be a fast track 8 week consultation period which would close by Mid-January 2003 and would be the only opportunity to influence the clauses within the Bill. It was hoped this would become primary legislation by May 2003, with full legislative powers from June 2003.

In addition, five workshops would be held during January and February 2003 on clinical governance aimed at how to develop structures and guidelines and the development of a support team.

A Trawl had been issued for the Grade 7 post, but it could be some time before someone was appointed to take the initiative forward. In the meantime Mr Bradley said he would head the Steering Group to draft the covering letter for the workshops and the Health and Social Care Governance circular to be issued by 18 November 2002.

6. **Diabetes Care**

[redacted]



[redacted]

7. Effective Decision Making Using the Theory of Constraints

[redacted]

8. Wound Management Educational Resource Pack

[redacted]

9. Getting Evidence into Practice/Guideline Development and Implementation

Professor Davidson referred to the presentation given at the previous meeting by Mr Matt Murray. He said a report had been completed, summarising the work undertaken and this would be submitted for inclusion in a high impact Medical Journal. A submission had been made to R&D Unit for funding and if this was successful it was intended to analyse the impact of the CREST DAG Use of Lipid Lowering Drugs, retrospectively.

10. Varicose Veins

[redacted]

11. Control of Pain in Patients with Cancer

[redacted]

12. Obesity

[redacted]

13. Prevention of Hyponatraemia in the Adult Patient

Dr Russell referred to the final draft Hyponatraemia guidelines. The sub-group had conducted 2 short meetings and most of the drafting and editing had been agreed and completed by e-mail. The group had discovered that fluid balance management was not a straightforward topic and they needed to make the guidelines easily understood, to be followed by junior doctors and nurses on the ward. The production of the guidelines had highlighted that junior doctors and nurses were not rained in pharmacology and fluid balance and these issues needed to be brought to the attention of the Universities. Dr Russell said he would forward the document to selected Renal Physicians, GPs and Nurses for final scrutiny. A half-day awareness raising conference to launch the guidelines would also be considered.

Action: Dr Russell

14. Home Enteral Tube Feeding

[redacted]

[redacted]

15. Psychological Management of Trauma

[redacted]

16. Evaluation of Equipment

[redacted]

17. Drug Advisory Group

[redacted]

[redacted]

18. Any other business

(i) Communicable Disease Control

[redacted]

19. Date of Next Meeting

The next meeting of CREST was arranged for Thursday 6 February 2003, at 2.00pm in Conference Room C3.18, Castle Buildings.

CREST AND CRITICAL CARE

Reasons for ongoing attention

- 1993 and 1998 CREST Reports.

- High dependency care not established
- Problems with access
- ICNARC

- Expensive resource (and increasingly so):

- Ongoing increasing demand.

  - elderly population
  - changing public and professional expectations
  - "rule of rescue" or "benefit of the doubt"
  - facilitates new treatments, which are dependent upon it
  - ward staff deskilled/hard-pressed.

- Potential for inappropriate use.

  - patient selection (controversial)
  - delayed discharge
  - failure to limit/withdraw aggressive treatment

- Developing Better Services 2002.

  - Focus on Acute Care
  - Patient-centred
  - Networks to address needs of populations

Foundation for Consensus of Expert GP in Comprehensive Critical Care – a review of adult critical care services

Work by:

- Audit Commission.
- London Health Economics Consortium.
- University of Birmingham.
- Institute of Modelling for Healthcare (University of Southampton).
- Medical Economics and Research Centre, Sheffield.
- Intensive Care National Working Group on Costing.

Comprehensive Critical Care

Overview

- Not just a new name – a new approach based upon severity of illness.
- Arrangements and standards need not be set up for individual specialties; set universally-applicable standards of care.
- Patients allocated care on basis of need rather than according to designation of the bed in which they happen to lie.
- 4 main themes of planning and delivery:
  - integration
  - networks
  - workforce development

- data collecting culture promoting an evidence base – will facilitate move from reactive to proactive service

These themes need to be addressed both nationally and within and between Trusts.

Comprehensive Critical Care

Regional Issues

- The service is supposed to provide appropriate care for the sickest patients being looked after by the NHS.

  - should be patient centred
  - should address needs of local population
  - should be of a uniform standard throughout NHS

  "The proposals … will affect the delivery of acute care as a whole".

- No individual Trust can be expected to meet every peak in demand

  - not just a question of more beds
  - networks – common standards and protocols
  - dedicated Transport Service

- Human Resources – recruitment and retention

  - nursing
  - medical: CCST, IBTICM, Regional Advisor. CC requirements beyond ICM not yet quantified
  - therapy
  - technical
  - admin/support

Comprehensive Critical Care

Individual hospital issues

- Recognition that patients don't usually become critically ill instantaneously
  - continuum of severity of illness
  - many patients "at risk" are at ward level
- Timely assessment and treatment on ward can:
  - avert ICU/HDU admission
  - identify patients not suitable early
  - reduce the frequency of cardiorespiratory arrests
  - facilitate timely admission (influences outcome)
- General wards frequently don't identify the at risk patients
  - staff numbers, skill mix, junior doctors hours, cross-cover
- When at risk patients are identified, response times too slow
  - hierarchical structure of medical staffing
  - once arrest occurs, prognosis often bleak
- Critically ill patients' main needs are common, regardless of the location/specialty
  - resuscitation (pre-arrest) takes priority over diagnosis
  - traditional boundaries/geography mustn't get in way
- Post-ICU discharge support and follow-up
  - integration with NIV/weaning centre

Organisation within Trusts

Integration

Hospital-wide approach with services extending beyond physical boundaries of ICU/HDU

- **Critical care part of a comprehensive acute care pathway**

  - integrates prehospital care
  - integrates primary and community care post-discharge

- Patient classified (on basis of need) as Level 0, 1, 2, or 3

- All critical care beds, including specialist, should work together to ensure flexible use

  - intensive care
  - high dependency
  - post-anaesthesia recovery
  - renal
  - cardiac
  - neuro

- Trust-wide Critical Care Delivery Group

  - includes key professions which use and deliver the service
  - designated Executive Director with lead responsibility
  - members act as champions for decisions made

Data collecting culture

- Information for Management, Clinical Governance, Audit and Research.
  Robust data plus appropriate analysis re:

- activity }
- casemix-adjusted outcome } evidence of high standard of clinical care.
- cost }

"Data collection and analysis must be recognised as … an essential part of the Trust's clinical governance and risk management programme"

- sufficient clerical and administrative support.

- IT implications.

  - Clinical Information Systems
  - electronic patient record

- Appropriate information will allow Critical Care to move from reactive to proactive.

Implications for Northern Ireland

- Informal network already exists by necessity

  - not managed
  - no bed bureau
  - ? common protocols/standards
  - no mechanism for transfer of Level 2 patients

- More critical care beds needed for Level 2 and 3 patients.

- NICCaTs largely (but not completely) implemented

  - no nurse
  - doesn't cover critically ill in all specialties

- Need to achieve an **integrated approach** with clinical governance implications

  - integrated at all levels: commissioners, providers, within and between hospitals

    - ➢ should be a core constituent of any plans for acute care

  - remove traditional obstacles to timely treatment

    - ➢ critical care delivery groups
    - ➢ ? CREST could fulfil local equivalent of All Wales CC development Group

  - **Outreach services**

    - ➢ Need to identify suitable model
    - ➢ ? Medical Emergency Team
    - ➢ Support for ward staff

  - **New educational approaches** eg ALERT, HD modules for all ward staff in acute hospitals
  - **Hospital-wide approach to audit of care of critically ill**

- **Can A&E Departments stand alone in this context?**

- **IT requirements for data collection and analysis.**

We are unlikely to succeed in "Delivering Better Services" unless we build structures which allow provision of seamless care to the sickest of our acutely ill patients, regardless of where they are.

DHSSPS

References

- Documented physiological deterioration prior to "unexpected" cardiac arrest in up to 85% of cases

  Schein et al. Chest 1990 ; 98 : 1388-92

  Franklin et al. Crit Care Med 1994 ; 22 : 244-247

- Medical Emergency Team and Education program reduces unexpected cardiac arrests

  Buist et al BMJ 2002; 324: 387-390

- Calculation of critical care needs by population.

  Lyons et al. Lancet 2000 ; 355 : 595-8.