

Critical Care Peer Review Action Plan CTM July 2021

Cwm Taf University Health Board's (CTUHB) general critical care services were peer reviewed on **September 27th 2019**. This is a report of that review. The review **did not cover the Princess of Wales unit** as that was reviewed a year ago whilst it was part of the then, Abertawe Bro Morgannwg ULHB.

Please complete as directed below. Please only insert one name under "Individual accountable" even if many people need to undertake the action – the individual accountable is the person who is responsible for ensuring that everyone carries out their allocated actions by the agreed date and for reporting progress to the LHB's Critical Care Delivery Group quarterly.

Under date for completion – please state the date by which the actions identified will be undertaken – ongoing is not a date. If the objective has been achieved, please say so.

Leadership/Strategic Planning/Governance

Serious concern 1: The perception of the critical care team and the panel of a lack of senior management engagement and response to concerns.

Other than a 20-minute attendance at the plenary session, no management representatives were present on the day of the visit. CTUHB is the final Health Board to be peer reviewed in this, the first round of reviews of all critical care services in Wales and the first where there was so little managerial representation during the visit. There was no Executive in attendance at the feedback session – again, this is the first time this has happened in any Health Board. At all other Health Boards, Directorate Managers have been present throughout the visit and Executive Directors have attended the feedback session to hear the initial impressions of the Peer Review team.

There appears to be little link between the operational issues identified by clinicians and the Health Board strategic vision for care of critically ill patients, particularly in the Integrated Medium Term Plan (IMTP). The recent re-organisation makes it an ideal time to review the provision of critical care services throughout the new UHB and agree a strategic vision and clear plans.

There is a lack of consistency and clear structure of the documentation for policies and plans. There is what seems to be a lack of rigour in plans, with no clear comparison against agreed standards and a consistent lack of achievable and time-specific objectives.

The repeated rescheduling of the visit and the late submission of evidence suggests that the Health Board expects managerial and administrative tasks to be picked up by senior clinicians, who are already extremely stretched.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|--|------------------------|---------------------|---|
| All | See above | Appointment of a dedicated Clinical Director and Operational manager for the Critical Care Service for the UHB | Medical Director | 2022 | Ongoing - CSG Clinical Leads appointed. Operational management provided from within the Surgical and Anaesthetics CSG. Provision of dedicated management support to be agreed during development of the Clinical Service Strategy (due 2022). |
| All | See above | Review the provision of critical care services throughout the new UHB and agree a strategic vision and clear plans, which is represented in IMTP | Medical Director | 2022 | <ul style="list-style-type: none"> - Ongoing - work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) - ILG teams engaged locally with monthly meetings and quarterly Delivery plan meetings including representatives from national Critically Ill Implementation Group - Oversight with AMD for Quality and Clinical Effectiveness on behalf of MD - Critical Care will continue to be highlighted as a priority within CTMs IMTP |

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| POW | The majority of these issues raised in the Peer Review are historical now based upon the system in place when PoW was part of ABM. | No action required | N/A | N/A | The new management structure has placed a management team much closer to the acute setting in the Bridgend locality (Bridgend ILG director team – BILG). Due to the closer nature of this management director group local issues are dealt with much quicker and local responses are developed. |
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Serious concern 2: Nurse Training: There is no Practice Nurse Educator on either site and <50% of registered nurses have recognised academic critical care course. This has significant implications for nurse training and means that Cwm Taf LHB has no input into the important nurse training developments currently being agreed by the All-Wales Critical Care Education nurses group and Higher Education institutions in Wales. It almost certainly contributes to the recruitment problems, with the knock-on effect of high agency nurse usage.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--|--|------------------------|---------------------|--|
| RGH | Recruitment to Nurse Practice Educator commenced | Appointment of a Practice Nurse Educator | Andrew Hermon | Sep-21 | Post has now been approved until the end of the financial year, recruitment commenced |
| PCH | Recruitment accompanied by an ongoing training package to retain our staff. | Active training with recruitment | Gill Owen | Mar-22 | Ongoing - staff being appointed on a phased approach to allow training and embedding within the department |
| PCH | There is currently an SBAR and funding for a Practice Nurse Educator for Prince Charles Hospital – we are hoping to appoint in the New Year. | Appointment of a Practice Nurse Educator | Gill Owen | Completed | Appointed a Practice Educator w/c 21st June 2021 |

Serious concern 3: Consultant rotas are not sustainable in RGH- 1:6 is very vulnerable to collapse with no clear plans to address.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|--|------------------------|---------------------|--|
| RGH | <p>The current model means that 4 Consultants are covering the 1:8 rota – this is unsustainable. Once the new recruit starts this will become 5 (it should be noted that 2 posts were advertised but only one suitable applicant). It is hoped that this will increase to 6 with a further appointment later in 2021.</p> <p>The remaining 2 on call slots will then remain vacant until the 2 Consultants close to retirement are replaced – meaning that 25% of all on calls will need to be covered on a locum basis. Waiting for them to retire will leave further gaps on the day rota pending recruitment. Earlier recruitment would provide cover for the on call gaps and provide succession planning, but would require funding.</p> | Further recruitment - Earlier recruitment would provide cover for the on call gaps and provide succession planning, but would require funding. | Piroska Toth-Tarsoly | 2022 | Ongoing - Under-resourced for staffing has been the significant concern by the clinical Critical Care team. This needs to be addressed urgently. COVID-19 pandemic has starkly highlighted this need. Work ongoing with Finance and Deputy Clinical Service Group Manager to determine funding establishment, current vacancies and gaps in rota. Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |

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| POW | <p>1:7 Consultant rota - From 2022 there will be 5 substantive consultants and one locum working a 1:8 rota. This is not compliant with GPICS standard and is, by definition, unsustainable. 2 substantive consultants plan to retire with the next 3 years.</p> <p>The locum consultant is hesitant to become substantive due to uncertainty with Critical Care services in the HB and may leave the service.</p> <p>There is increased consultant resident hours (14 hours every 24 hour period) compared to other sites in the HB. This is due to weaker junior tiers and lack of a specific middle grade tier unlike other sites. Due to this increased workload it is felt that falling to 4-5 consultants in total would be unsustainable and unsafe and would therefore represent service collapse. There is a very real risk this will happen in the medium term.</p> | Consultant posts to be advertised, however there are no known applicants for these and so limited confidence of being able to recruit. | Joseph Riddell | 2022 | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |
| PCH | <p>1:8 Consultant rota - Consultant rota filled but with one gap on the on call rota due to Consultant only working days. Ideally, however, the on calls that are currently covered by Anaesthetists would be delivered by ITU Consultants. It is not possible to recruit to these posts, however, as there are no vacant day sessions.</p> | Nil currently - plan for recruitment in the event of loss of staff (due to retirement/covid/other) | David Jones | N/A | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |

Serious Concern 4 (a) : Lack of Allied Health Professionals (AHPs).

PHYSIOTHERAPY – GPICS2 (National standards) specifies 0.25WTE physiotherapists per Level 3 bed. Both units have 6 Level 3 beds and therefore each unit requires a minimum of 6.75 WTE physiotherapists across all 3 sites. PCH has 1 Level 2 bed on the main ITU whilst RGH has 4 Level 2 beds located on a separate 4 bedded High Dependency Unit. Physiotherapy support for Level 2 patients is unspecified in GPICS2, but potentially the demand for rehabilitation for this patient group is as time intensive (if not more so) than for a Level 3 bed.

- PCH has - 0.5 WTE physiotherapy cover instead of the 1.625 WTE they require when one includes cover for the HDU bed.
- RGH also has – 0.5 WTE physiotherapy cover rather than the minimum cover of 2 WTE to cover the 6 level 3 beds and 4 HDU beds.
- Neither unit is undertaking 7 day working as per GPICS recommendations therefore patients admitted on a Friday will not see a physiotherapist until Monday unless the duty doctor requests On Call physio, which would be only be for urgent respiratory physiotherapy.
- The current physio staffing levels mean that providing 45 minutes rehab per patient 5 days per week, as per NICE Clinical guideline 83, is not achievable. Consequently participation in Multi-disciplinary team (MDT) activity is being adversely impacted at
- Clinical level i.e. rehabilitation, ward rounds and Follow Up clinics and
- Service delivery and development level i.e. participation in the Critical Care Delivery Group and Morbidity & Mortality meetings

The extent of MDT involvement was not evident in notes from MDT meetings provided; e.g. no references to weaning / rehab plans being in place. The AHPs spoken to during the visit concurred with this and advised that they had already expressed disappointment at the choice of cases selected as not being a true reflection of MDT rehabilitation. However, several selected cases appeared to have been long stay, complex rehabilitation patients and references to weaning / rehab plans should have been reflected in these MDT minutes.

The use of the Myrrdin patient administration system does not accurately reflect intra-disciplinary activity i.e. it does not record if more than one therapist of the same discipline is working simultaneously with a patient as is often the case in complex rehab and therefore activity is at risk of being under-reported, thus potentially hampering any bids for increased staffing.

The peer review team noted low attendance at the Peer Review Plenary Session by Allied Health Professionals. The clinical team in the Health Board did not seem to be clear on which members of staff from which staff groups should be attending the Peer Review Plenary Session (meetings) which concurred with overhearing on the afternoon of the Review a leading member of the Cwm Taf asking who should be attending the session. This called into question how truly inclusive of the wider MDT CTUHB Critical Care currently is. The invitation did not appear to have been extended to AHPs as widely as it could have been. Profession-specific clinical skills training for physiotherapists was noted by the review team as being very poor.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--------------------------------------|---|------------------------|---------------------|--|
| RGH | 0.5 WTE; recommended 2.5 WTE minimum | Business case to be developed to include this | ILG Lead | Sep-21 | There is a funding deficit rather than a problem with recruitment. If funding was available these posts could be recruited to. Business case being developed to include all AHPs (to be completed Sept 2021) - Pharmacy, Physio and Dietetics would be key roles required in RGH. A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| PCH | 0.5 WTE; recommended 2.0 WTE minimum | Business case to be developed to include this | ILG Lead | Oct-21 | PCH obtained 1 bed uplift funding for extra bed, this is 0.25WTE increase in PCH funding but not yet appointed to. Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |

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| POW | 1.2 WTE; recommended 2.25 WTE minimum | Business case to be developed to include this | ILG Lead | Oct-21 | Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
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Serious concern 4 (b): Lack of Allied Health Professionals (AHPs).

Occupational therapy (OT) – GPICS states that there should be access to OT 5 days per week and that they should be involved in the management of any complex functional, cognitive and psychosocial issues including delirium and Follow Up clinics. Neither unit has any formal arrangement for access to OT.

A physiotherapist on the RGH site has extended her scope of practice (trans-disciplinary) to include measuring up and ordering wheelchairs, including electric chairs. However, this extended role is specific for this member of staff and appears to be a locally agreed arrangement as opposed to an officially documented competency, which could be replicated for other staff. There is no reference to this staff deficit in any of the documents supplied to support Peer Review.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--|---|------------------------|---------------------|--|
| RGH | No access; recommended access 5 days/week, 2.3 WTE | Business case to be developed to include this | ILG Lead | Sep-21 | There is a funding deficit rather than a problem with recruitment. If funding was available these posts could be recruited to. Business case being developed to include all AHPs (to be completed Sept 2021) - Pharmacy, Physio and Dietetics would be key roles required in RGH. A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| PCH | 0.2wte in post; recommended 1.64 WTE | Business case to be developed to include this | ILG Lead | Oct-21 | PCH obtained 1 bed uplift funding for extra bed, hence 0.2 WTE OT now in post. Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| POW | No access; recommended 2.07 WTE | Business case to be developed to include this | ILG Lead | Oct-21 | Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |

Serious concern 4 (c): Lack of Allied Health Professionals (AHPs).

Speech and language therapy (SALT) – GPICS specifies 0.1 WTE SALT are required per level 3 bed, this equates to **2.7 WTE (inc POW)** for the beds in Cwm Taf. CTUHB has **2.1 WTE** = less than half the required amount. If you include the number of Level 2 beds over both sites currently, the potential hours required is 2.7 WTE.

The peer review team noted that the LHB has the only specialist Critical Care SALT in Wales, which is a positive for the Health Board. However, in her absence, there is no cover. This is of significance for RGH in particular, as it is the UHB appointed centre for Ear, Nose and Throat (ENT) and the tracheostomy service. This appears to have been recognised by the Critical Care Delivery Group (CCDG), as the minutes consistently refer to the need to employ more specialist staff to develop this service and the Clinical Specialist Physiotherapists appear to have developed an effective combined online / classroom training programme, which they deliver regularly. SALT access to appropriate profession-specific critical care related training is supported.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--|---|------------------------|---------------------|--|
| RGH | 0.3 WTE (shared with PCH); recommended 1.0 | recruitment | ILG Lead | Sep-21 | Ongoing; recruited 0.3 (post shared with PCH) in Oct 2020 - priority is to make post 1.0 wte for ICU across PCH and RGH sites. Business case being developed to include all AHPs (to be completed Sept 2021) - Pharmacy, Physio and Dietetics would be key roles required in RGH. A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| PCH | 0.3 WTE (shared with RGH); recommended 0.8 | Business case to be developed to include this | ILG Lead | Oct-21 | PCH obtained 1 bed uplift funding for extra bed, hence 0.1 WTE SLT increase and now in post (post shared with RGH) - priority is to make post 1.0 wte for ICU across RGH and PCH sites. Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| POW | None available; recommended 0.9 WTE | Business case to be developed to include this | ILG Lead | Oct-21 | Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |

Serious concern 4 (d): Lack of Allied Health Professionals (AHPs).

Dietetics – GPICS specifies 0.1WTE dietitians are required per Level 3 bed

• PCH has 0.6 WTE = 18.5 hrs worked over 5 days (potentially within GPICS recommendations).

• RGH has 0.5 WTE = 18.5 hrs worked over 2.5 days with cover outside these hours dependent on the availability and goodwill of colleagues which means patients can go 4+ days without dietetic intervention.

In RGH, dietetic access to appropriate profession-specific critical care related training is not particularly well supported (limited to 50% of course fee only) and is temporarily blocked due to staff shortages. However, training in PCH does not appear to be as difficult to access.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--|---|------------------------|---------------------|--|
| RGH | 0.5 WTE (over 2.5 days); recommended 1.0 WTE | Business case to be developed to include this | ILG Lead | Sep-21 | Business case being developed to include all AHPs (to be completed Sept 2021) - Pharmacy, Physio and Dietetics would be key roles required in RGH. A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| PCH | 0.6 WTE; recommended 0.8 | Business case to be developed to include this | ILG Lead | Oct-21 | PCH obtained 1 bed uplift funding for extra bed, hence 0.1 WTE Dietetics increase and now in post. Business case being developed to include all AHPs. A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |
| POW | 0.0 WTE; recommended 0.9 WTE | Business case to be developed to include this | ILG Lead | Oct-21 | Business case being developed to include all AHPs A unified approach is required across the UHB and in areas such as Dietetics and SLT where <1.0wte are required, posts could be appointed to cover across sites. |

Concern 1: Capacity and delayed transfers of care

In 2013, the Welsh Government launched its delivery plan for the critically ill: Together for Health – a delivery plan for the critically ill (2013). The plan accepts the Intensive Care Society's (ICS) recommendation that the optimal occupancy level for critical care units is about 70%. Intensive Care Society. Standards for intensive care units. London (1997) <http://www.ics.ac.uk/icmprof/downloads/ICSstandards4302.pdf> .

Both units are running at above 70% of capacity most of the times. This is resulting in a relatively high rate of non-clinical transfers from PCH unit. (ICNARC figures)

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|---------|---|--|------------------------|---------------------|--|
| RGH/PCH | See above | Strategic planning to increase capacity | Medical Director | 2022 | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |
| RGH | See above | Develop business case to address needs | ILG Lead | Sep-21 | Business case in progress to open up additional 2 L3 beds (to be completed Sept 2021) |
| RGH | See above | Implementation of PACU provision | ILG lead | Nov-21 | Work ongoing to establish a part-time PACU facility on green ward for high risk op patents utilising £140k recurrent funding. Staffing agreed and further work to be completed with plan to commence from 1st November 2021. |
| POW | This issue has been superseded by the COVID-19 pandemic response. Highlighted the need for when expanded capacity was needed. There is a new plan for PoW going forwards. | Surge requirements and planning document updated | Joseph Riddell | Completed | Plan in place - updated on an ongoing basis |

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| PCH | Currently on Ward 4 as part of COVID Response. Interim plan is to move back to "old ITU" and put in two extra cubicles instead of the two back beds/pharmacy etc. This will give 4 Cubicles and 6 open bed spaces. | Engaging with planning team to ensure future needs met | David Jones | 2022 | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |
| PCH | Currently on Ward 4 as part of COVID Response. Interim plan (stage 1) is to move back to "old ITU" and put in two extra cubicles instead of the two back beds/pharmacy etc. This will give 4 Cubicles and 6 open bed spaces. | Expand to 10 beds | David Jones | Dec-21 | Work ongoing |
| PCH | Long term plan (stage 2) (with Ground & First Floor project) is a brand new ITU - final plans being reviewed aim to account for future need | Provision of new ITU facility | David Jones | 2026 | To inform and be informed by work to develop Clinical Service Strategy |

Concern 2: Delayed transfer of care

Patients should be able to transfer back to a ward no later than four hours after being deemed ready for transfer. Anything longer than this is a delayed transfer of care. The Welsh Government target is that no more than 5% of transfers should be delayed over four hours as, keeping a patient in a critical care bed longer than they need be is deemed a poor use of a scarce resource and is a less than ideal environment for the patient.

Percentage of patients delayed over 8 hours

PCH – 3.5% = 4th best out of 15 units

RGH – 9.9% = 10th out of 15 units

Wales – 7.8%

Percentage of patients delayed over 24 hours

PCH – 1.6% = 2nd best out of 15 units

RGH – 7.6% = 13th out of 15 units

Wales – 5.2%

Percentage of patients discharged direct from ITU to home

PCH – 6.4% = 7th out of 15 units

RGH – 5.8% = 5th out of 15 units

Wales – 6.5%

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|---|------------------------|---------------------|--|
| All | See above | DTOC to be reduced to recommended level | ILG leads | 2022 | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |
| All | See above | Bed modelling work | Medical Director | 2022 | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |

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| RGH | See above | Proforma being developed to ensure the correct discharge details are forwarded to the bed managers to ensure correct information as to which team the discharged patient is allocated to | Andrew Hermon | Sep-21 | Problem will not be resolved but has been requested to inform data collection - to be reviewed after one month. |
| RGH | See above | Safety briefings to be introduced 3 times per day that will highlight DTOCs | Andrew Hermon | Oct-21 | Work ongoing |
| POW | 6th worst rate in UK and has been consistently for previous few years. Senior BILG team are aware of the issues and developing a strategy with bed capacity across the ILG. | Bed capacity strategy being developed across the ILG | ILG Lead | 2022 | Work being undertaken in line with development of Clinical Service Strategy (to be completed 2022) |
| POW | PoW reports this through Datix with feedback or actions received from senior management team | Feedback or actions received from senior management team | Sophie O'Donovan | Completed | DTOCs recorded on Datix routinely - PCH same (add) |
| All | See above | Look at collecting the same data across all 3 sites for consistency | Nursing Leads | Dec-21 | |

Concern 3: The Critical care delivery group minutes submitted in evidence show the meeting is poorly attended. There is no executive involvement, counter to the national guidelines for such groups, and it is only held every six months where in all other Health Boards they are held quarterly. It is difficult to identify which professions are represented, which could be easily rectified. The groups could be utilised to encourage better MDT representation and development going forward. Physiotherapists are invited to the Critical Care Delivery Group Meetings but are unable to attend due to understaffing and clinical pressures. This is reflected in the CCDG Minutes, where there is scant reference to addressing issues in physiotherapy despite the clear, ongoing understaffing.

The Group seems to discuss a number of agenda items year after year with little evidence of significant progress. ICNARC results have not been discussed in the group since 2016, even though these statistics are produced at least annually and are an important part of measuring the quality of care provided in a critical care unit.

During the review, staff mentioned that a new group had been established to plan sustainable critical care services for the newly formed Cwm Taf Morgannwg UHB, but it was unclear how this would link with the Critical Care Delivery Group already in place.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|--|------------------------|---------------------|--|
| All | See above | Re-establish quarterly meetings with executive leadership representation and widespread stakeholder engagement including AHPs. | Neil Hawkes | Completed | Meeting held on 15/7/21 and attended by a wide range of staff groups and representation from the National Critically Ill Implementation Group |
| All | There are regular CC meetings within and across CTM by the CC leads | Meetings to be held monthly. | Neil Hawkes | Completed | Monthly meetings scheduled for the year in advance. Meetings include and are well attended by all staffing groups across Critical Care Services. |

Concern 4: Welsh Government Delivery Plan for the critically ill 2017-2020 – there was evidence from the minutes of the Critical Care Delivery Group (CCDG) to show that the group discusses elements of this, but the panel was not provided with a plan that clearly addresses each of the objectives in the WG plan.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|--|------------------------|---------------------|---|
| All | See above | Clear plans from UHB are needed as to how they envisage the Delivery of the Plan | Medical Director | Nov-21 | Ongoing , needs to be reviewed in view of the change to Quality Statement issued by WG. |

Concern 5: Nurses are frequently moved to wards to cover gaps in ward numbers, a practice that particularly affects the services in the ITU in Prince Charles hospital (PCH). This has been partially mitigated in RGH by implementing a policy of not putting the ITU nurses in charge of a ward, but having ITU staff support ward nurses in delivery of essential care tasks and leaving them free to return to ITU if occupancy on the unit changes during the shift.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|---|
| RGH | See above | Minimise re-deployment of staff to ward areas, this has been mitigated at RGH already with agreement that staff is released back to ITU if needed and nurses from ITU do not take care responsibilities of larger areas | Andrew Hermon | Sep-21 | Still an ongoing problem due to staff shortages - reiterated letter from WG CNO - will be pushed next week as impacts on patient safety |
| PCH | Unless an area of the hospital is in-extremis, and all alternative avenues have been explored, ITU nurses will no longer be redeployed to ward areas. This will only be with the agreement of the Senior Nurse for ITU and the Duty ITU Consultant. | No further action - process in place. | Gill Owen | Completed | Process includes discussion with Senior Nurse for ITU or Senior Nurse for Unscheduled Care and Lead Consultant before and redeployment made. Redeployment to last no more than 4 hours at a time so Nurse does not take charge of a dept. |
| PCH | Prince Charles Hospital now has the staffing required to run 24/7 Outreach, and this is due to go-live in early 2021. Operational pressures to run the unit during COVID-19 have meant the Outreach Nurses have been pulled back to the ITU. | 24/7 Outreach to be provided | Gill Owen | Oct-21 | Originally planned for September 2021 but due to long term sickness and secondments date has been pushed back to October 2021 - about to put another secondment to help that happen and prevent further delays |

Concern 6: Integrated Medium Term Plan

The IMTP does not mention critical care development in PCH or RGH despite the known shortfalls in service provision. There is a promise to develop a business case to refurbish and expand Princess of Wales ITU and develop a consultant workforce plan. A business plan is required for both sites, stating need for capacity and resources.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|---|------------------------|---------------------|--|
| All | See above | IMTP to clearly show future plans for Critical Care services including capacity and workforce planning. | Medical Director | 2022 | Ongoing - to be developed as part of the Clinical Services Strategy During an audit Sept-December 2019 mean capacity was 85-95%, current and proposed unit does not meet current and future needs for the care provision |
| RGH | see above | IMTP updated and issues identified by peer review are now part of the ILG IMTP | ILG Lead | Sep-21 | Business case in progress |

Concern 7: Psychology – GPICS specifies that there should be access to a psychologist to provide support to patients, family and staff. CTUHB have recently appointed a Clinical Psychologist who has yet to commence work. Apart from taking a lead role in the delivery of Follow Up clinics, it did not appear to be clear how the post will be utilised within the service on a day-to-day basis. That said, very few critical care units in Wales have a psychology service.

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| All | See above | UHB wide agreement to recruit 3 Band 8a posts (one for each ILG) which can provide cross cover across all 3 sites | ILG Leads | Mar-22 | Appointed 1 of 3 posts. Meeting scheduled for September 2021 to clarify service provision and to discuss and agree way forward to appoint to remaining 2 posts. |
| RGH | Clinical psychologist was not in post at the time of the Peer review. Now in post and has provided invaluable support for patients, families and staff alike. | Recruit Psychologist | ILG Lead | Completed | Clinical Psychologist now in post and has provided invaluable support for patients, families and staff alike. Service will need to be re-assessed following pandemic to see if current provision is satisfactory. |
| POW | There is now a follow up clinic with frequent patient reviews. However there is no psychologist provision to support this. | Recruit Psychologist | ILG Lead | Mar-22 | Funding agreed, no applicants on latest vacancy. Post advert being rewritten (potential developmental post to encourage applicants). |
| PCH | Limited provision | Recruit Psychologist | ILG Lead | Mar-22 | Funding agreed, no applicants on latest vacancy. Post advert being rewritten (potential developmental post to encourage applicants). |

Concern 8: Pharmacy – Both units have a critical care pharmacist Mon to Friday and an on call service at weekends – 10 hours per week in PCH (recommended level is 22.5 hours per week). The number of hours not known for RGH. No pharmacists were present on either unit throughout visit, so it was not possible to explore pharmacy cover in any detail. – find RGH GPICS

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|--|
| RGH | 0.2WTE, vacant, not sustainable; 0.5WTE recommended | Increase dedicated ITU Pharmacy provision to 22.5 hours a week. | ILG Lead | Sep-21 | Business case being developed as key posts |
| PCH | 0.75 WTE recommended | Business case to be developed to include this | ILG Lead | Oct-21 | Business case being developed as key posts |
| POW | 0.65 WTE recommended | Business case to be developed to include this | ILG Lead | Oct-21 | Business case being developed as key posts |

Concern 9: Multi-disciplinary team meetings - whilst there are multidisciplinary meeting where individual cases are discussed, there is no record of attendance and AHPs find it difficult to attend.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|--|------------------------|---------------------|---|
| RGH | See above | Ensure attendance record is kept of weekly meetings | Piroska Toth-Tarsoly | Completed | Completed |
| RGH | See above | Provide time for MDT members to attend MDT meetings by improving service provision | ILG Lead | 2022 | AHP still no time recognition to attend due mainly to insufficient capacity / provision. Business case being developed to increase AHPs (to be completed Sept 2021) |

Concern 10: Mandatory training compliance– 2019 - fire = 47.5%, Basic Life Support/Advanced Life Support and ILS 45.8%, Pressure Area prevention = 40% Infection control = 23.7%

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|--|------------------------|---------------------|---|
| RGH | Once nurse practice educator appointed it is expected that the senior nurse will work alongside them to format comprehensive training plan. | Improve mandatory training compliance of staff | Andrew Hermon | Sep-21 | Post is now advertised and post expected to be filled by September 2021 |
| | | Training Needs Analysis | | Completed | TNA completed. PND commences in post end of August 2021. |

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|-----|---|---|-----------|-----------|---|
| PCH | The Senior Nurse for ITU, alongside the Nurse Practice Educator, is identifying and working through the deficits in mandatory training. Prince Charles being in a much worse position than that of Royal Glamorgan. | Ensure all staff have attended ALS with successful completion | Gill Owen | Feb-22 | Lack of available spaces for ALS training proved problematic. 50% of staff have now completed training and spaces are now booked for all remaining staff (to be completed by February 2022) |
| | | Implementation of MDT training within the department with a focus n emergency drills being carried out at least monthly | | Completed | 6 weekly rolling programme for MDT training now in place - to be managed by PND. |

Concern 11: Major incident/surge planning -

The Welsh Government mandates that in the event of a major incident or sustained surge, every critical care unit must be able to temporarily double their level 3 capacity.

The LHB Escalation policy does not say how it will double its level 3 capacity. A further undated, untitled plan was submitted which did set out how level 3 capacity could be doubled if necessary.

There is no major incident policy for ITU.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|--|------------------------|---------------------|---|
| All | See above | Major incident plan to be reviewed - This work has been completed which allowed the critical care bed capacity to be increased significantly during the pandemic | ILG Leads | Completed | Complete but under continual review |
| PCH | DJ has written an escalation card for Critical Care in Merthyr and Cynon that is now included in the SMOC Cards | Ensure escalation care is included in SMOC card | David Jones | Completed | Complete but under continual review |
| PCH | The escalation plan has been completed and submitted to the General manager | Ensure all staff are aware of the unit escalation plan | David Jones | Completed | All senior nurses received, print out on unit and used. |
| RGH | Escalation plan updated | Ensure consultant body and senior nursing staff aware | Piroska Toth-Tarsoly | Completed | Completed |
| POW | Escalation cards up to date | Ensure all staff are aware of the unit escalation plan | Joseph Riddell | Completed | Complete but under continual review |

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Service Delivery

Serious concern 1: Agency Nursing in PCH is at a very high level.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--|---|------------------------|---------------------|--|
| PCH | There was no strategic plan for the recruitment or retention of nurses in Prince Charles Hospital. | This is now being addressed by the new ITU Senior Nurse Gill Owen, and there are adverts out for Band 5, Band 6 and Band 7 nurses. This will be accompanied by an ongoing training package to retain our staff. | Gill Owen | Mar-22 | Ongoing - staff being appointed on a phased approach to allow training and embedding within the department |

Serious concern 2: There was no Healthcare Standards Audit from Prince Charles Hospital

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|--|
| PCH | Health & Care standards are completed monthly | For an appropriate audit framework to be embedded into the unit - Gill Owen is meeting with the audit team to progress this work. | Gill Owen | Sep-21 | Healthcare standards being used. Training on 19th August to pilot and then roll out framework - will share with RGH and POW to roll out AmAT system - in interim have been monitoring manually until system up and running |

Concern 1: Environment - Units are somewhat cramped and not fit for purpose – particularly noticeable in PCH, where the lack of space may compromise confidentiality and patient dignity. The suitability of the bed behind the central nursing station in PCH should be reviewed

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|--|------------------------|---------------------|---------------------------------------|
| PCH | The ITU has moved since the Peer Review, and we are in a temporary home to deal with COVID-19 pending the completion of the Ground and First Floor Plan where ITU will have a brand new, 21 st Century facility. | Interim plan (stage 1) is to move back to “old ITU” and put in two extra cubicles instead of the two back beds/pharmacy etc. This will give 4 Cubicles and 6 open bed spaces | David Jones | Dec-21 | Work ongoing |

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|-----|---|--|----------------|------|--|
| PCH | Long term plan (stage 2) (with Ground & First Floor project) is a brand new ITU - final plans being reviewed aim to account for future need | Provision of new ITU facility | David Jones | 2026 | To inform and be informed by work to develop Clinical Service Strategy |
| POW | Update Dec 2020: Environment still does not meet GPICS/ ICS recommendations | Health Board agreement needed as to number of beds required on each site. This would require a complete rebuild of the department. | Joseph Riddell | 2022 | Initial discussions 3 years ago with Planning team (as part of ABMUHB). Development of Clinical Services strategy expected 2022. |

Concern 2: NICE Clinical Guideline (CG) 103 Delirium – Daily sedation holds not always done due to the lack of formal ward rounds and input on the importance of sedation holds. Nurses are directed on this by the medical staff and there appears no nurse-led directive on sedation holds. This results in the lack of compliance with some aspects of CG 103 i.e. undertaking sedation holds to assess delirium. The audit shows very poor compliance with CAMS assessments, with no action plan to address this.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|--|
| RGH | Currently not compliant with NICE guidance CG103 delirium | Improve compliance with daily nurse led sedation holds by nurse training in Delirium assessment (CAMS) and highlighting the importance of sedation breaks | Andrew Hermon | Completed | Training programme is a continual improvement and will be ongoing. |

Concern 3: NCEPOD guidance – “On the Right Trache” – Whilst there is clearly a lot of good work being done to improve the care of patients with tracheostomies and a lot of training has been undertaken in this area, unfortunately the LHB have not audited their compliance with the NCEPOD guideline “On the Right Trache”

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|-------------------------|------------------------|---------------------|--|
| All | See above | Carry out audit | Trache Lead | Completed | Completed on all sites; CTM Tracheostomy Steering Group established in June 2021 |

Concern 4: NICE CG 83/ Rehabilitation – Both units have audited compliance. Many of the standards are met. There is an action plan that addresses the unmet standards however, in the light of current physio staffing, providing 45 minutes rehab per patient x 5/7 as per NICE Clinical guideline 83 will not be achievable without an increase in hours.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|------------------|---|------------------------|---------------------|---|
| All | See above | To achieve rehab aims increase of ITU AHP provision is required (see above) | ILG Leads | 2022 | Increased ITU AHP provision is dependent on an increased AHP capacity across CTM which is currently not funded. Business cases are being developed to include all AHPs across all sites and a unified approach will be taken across the UHB to ensure that in areas where <1.0wte are required, posts could be appointed to cover across sites. |

Concern 5: National Emergency Laparotomy Audit (NELA) - NELA - This is a mixed result. The LHB is to be commended for the significant improvements that it has made in mortality rates for emergency laparotomies over the last 4 years. In 2016 (year 2) PCH had the 2nd worst mortality rates in Wales and RGH the 3rd. In the 2016 -2017 report RGH mortality rate is 8.3% compared to 10% national average.

In the year 3 report PCH was the only outlier hospital and had the highest mortality rate in Wales (19.7% compared to a National average of 11%). Since then mortality rates in PCH have almost halved (In 2016-2017 = 10.6% compared to a National average of 10%).

However, there is still a number of shortcomings in the service:

- Lack of Care of the Elderly input.
- Admission rates for those with a predicted >10% mortality into ITU need to be improved. This is undoubtedly a capacity issue.
- No dedicated emergency theatre
- No on-site endoscopy
- CT Scan reporting before surgery is poor
- The focus seems to be on achieving a good surgical outcome as opposed to a good discharge outcome. In November 2018 MDT decision making was raised but not elaborated upon and in March 2019, implementation of frailty scoring was raised. Rehab is core to optimising recovery and facilitating return to baseline and independent living for this frequently elderly cohort of patients.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|---|
| RGH | See above | Provision of Care of the elderly cover | ILG Lead | 2022 | Business case being developed (to be completed September 2021) |
| RGH | See above | Improve capacity to allow admission of high risk patients | Medical Director | Nov-21 | Business case to establish PACU capacity and increase Critical Care capacity is being developed - However, PACU is not suitable for EL patients |
| RGH | See above | Dedicated emergency theatre | CSG Lead | Completed | Completed |
| RGH | On call endoscopy service has been established, currently covering 12 hours every day | Plan for 24/7 service GI bleed on call consultant | Gastro Lead | Completed | In place for past 12 months |
| RGH | CT scan reporting has improved | ongoing | Sally Bolt | Completed | Radiology has asked for those taking longer than 1 hour to be recorded as an incident |
| RGH | See above | Improve discharge outcome of this patient population by improving Rehab provision (see concern 4) | ILG Leads | 2022 | Improved Rehab provision is dependent on an increased AHP capacity across CTM which is currently not funded. Business cases are being developed to include all AHPs across all sites and a unified approach will be taken across the UHB to ensure that in areas where <1.0wte are required, posts could be appointed to cover across sites. |
| POW | Admitting all emergency laparotomy patients whose risk of death was \geq 5% | Return to this standard of practice. | Joseph Riddell | 2022 | Until the pandemic this criteria was being met. Additional nursing and capacity issues have resulted in a decreased number of these admissions although the majority still come through. Although we have included a completion date of 2022, the ability to meet this standard is dependent on the end of the pandemic and therefore may change. |

Concern 6: Health care standards

There were elements missing from the HealthCare standards audit submitted by RGH, but on speaking to the staff, they had been completed which the nurse on the panel viewed during the walk around. Healthcare Standards auditing need to be more robust on both sites. From the information provided there has been a decline in compliance from 2017 to 2018 in 5 of the themes. An action plan covering two years results was submitted, which does not instil confidence, one must question where was the action plan produced immediately after the first year?

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|---|
| RGH | See above | Improve compliance and documentation of Health Care standards audit | Andrew Hermon | Oct-21 | Healthcare standards being used. AmAT system will be rolled out in RGH following completion of pilot in PCH (commencing 19th August). |
| POW | Excellent Audit results | Action plans where standards are not being met. | Sophie O'Donovan | Mar-22 | To be continued; restructuring Band 7 management time and upskilling Band 6s to support this. Training being provided to Band 7 team in terms of action plan writing. Plans to take auditing digital. Working with senior nurses on the other sites and with clinical audit team to collate the appropriate information required for ITU. |
| PCH | Health & Care standards are completed monthly | For an appropriate audit framework to be embedded into the unit. | Gill Owen | Mar-22 | Gill Owen is meeting with the Clinical Audit team to progress this work. |

Concern 7: Use of agency nurses –both units occasionally have over 20% of nursing staff as agency staff.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|--|------------------------|---------------------|--|
| RGH | Establishment for 8 level 3 equivalent beds - no vacancies | No action required | Andrew Hermon | N/A | All vacancies filled - situation reviewed on an ongoing basis |
| POW | Establishment for 6 Level 3 equivalent beds and 1 Level 2 (PACU) Band 6 – x2 vacancies Band 5 –x 4.95 vacancies | No concerns regarding recruitment for nursing, all jobs are out to advert. | Sophie O'Donovan | Aug-21 | All posts in current establishment have been filled. SBAR paper submitted to increase establishment to support an additional 2 Level 3 beds (total 8 Level 3). 9 physical spaces on our template. High agency usage is only being seen in times of high acuity or increased surge capacity is open. |
| PCH | Establishment for 8 level 3 equivalent beds 8 x vacancies (currently being held) | Further round of recruitment | Gill Owen | Mar-22 | Ongoing - The service has successfully recruited 11 new nursing staff and is in the process of training these. Once they have developed the remaining posts will be recruited. There are no concerns in relation to ability to recruit to the establishment. |

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Outcomes

Concern 1: Patient/carer feedback – The LHB is not using the National survey to obtain feedback from carers on the quality of the service. This should be started immediately.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|--|---|------------------------|---------------------|---|
| RGH | Ongoing | Start using National Patient/Carer Survey | Andrew Hermon | Completed | Survey handed to visiting families |
| PCH | Currently in the process of establishing an online portal (Microsoft Forms with a QR Code) for patients and carers to give feedback. | Monthly reviews of patient / carer feedback | Gill Owen | Completed | Completely monthly as part of healthcare standards. Will form part of the AmAT system being rolled out from August 2021 |
| POW | Undertakes monthly review of the carers' survey and feeds back the results and subsequent actions in the carers' room on the unit. It has received excellent feedback from relatives in the National Carer Survey. | No further action required | Sophie O'Donovan | Completed | National standard framework |

Concern 2: ICNARC – since April 2017 RGH are reporting high levels for patients at low risk of mortality (see below). This is within 2 standard deviations and so may be due to the small numbers of patients needed to influence this figure. It is worth keeping an eye on.

April 2018 – Sept 2018 - Risk adjusted acute hospital mortality <20 risk = 1.44 = high but within 2 SD

April 2017-April 2018 - Risk adjusted acute hospital mortality <20 risk = 1.26 high but within 2sd

Unplanned readmissions within 48 hours are also high for RGH unit over this period.

| Site | Current position | Action to be undertaken | Individual accountable | Date for completion | Progress/status e.g complete/resolved |
|------|---|---|------------------------|---------------------|---------------------------------------|
| RGH | See above | Structured mortality review in place in the UHB for every death | BG | Completed | Completed but ongoing process |
| POW | A new ICNARC data entry clerk was employed and a programme started to improve the quality of data input. This resulted in mortality rates returning to within normal parameters by the next report i.e. the higher mortality figure was due to coding issues not poor care. | No further action required | N/A | N/A | |

| | | | | | |
|-----|---|---|------------------|--------|---|
| PCH | Data is collected and reported via the RGH site | To improve the quality of data on the PCH site - Gill Owen to email SD/GB requesting support to employ a data entry clerk for the site. | Gareth Blandford | Oct-21 | Data for PCH is currently entered on system in RGH. Business case submitted for data entry clerk for PCH - decision expected October 2021 |
|-----|---|---|------------------|--------|---|