Value for Money Framework North West London Critical Care Network www.londonccn.nhs.uk

Clinical Networks must demonstrate clear benefits and provide value for money in terms of economy, efficiency and effectiveness. This is particularly true within the current health economy. This Value for Money Framework was designed by Sue Shepherd following the review of Clinical Networks within the East Midlands Region, and is designed for completion by Clinical Networks to enable clear identification of where the Networks add value.

This Framework is designed with section headings (as a guide) to enable Networks to specify areas/items of work that are under implementation or have been successfully completed within each section to demonstrates the added value of the work being undertaken by the Network.
When completing each section, networks are advised to expand on their answers to articulate where and how the network systems and processes make improvements in care possible; particularly development and implementation of improvement to equity and quality across the pathway of care that is only possible in the context of the Network (see attached guidance notes).

The Framework outlines the added value of the **North West London Critical Care Network** for the period 2015-16. Returned to NHS England, London 26 August 2015

Value for Money Framework			
Network:	**North West London Critical Care Network 2015-16**	Name of person completing form:	Angela Walsh & Network Strategy Group & CCGs
Funding provided to the NWLCC Network by NHS England from top sliced CQUIN since 2014-15 is £149K **(Network formerly used a *local membership* model - provider and commissioner funding- up until 2013)**		**Funding of £149,000 per annum from NHS England. The Network is hosted by NWL CCGs.** This document has been competed to demonstrate *value for money* for this top sliced CQUIN spend of £149,000 per annum.	
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Identify issues in terms of the section headings and type in the added value for patients, carers, clinicians, providers, commissioners etc. as relevant into each box							
Identified Benefit	**What is the added value for:**						
	Patient/Carer?	**Clinicians?**	**Providers?**	**Local Commissioners?**	**Specialised Commissioners?**	**Financial/Resource?**	**Other?**
Quality/Service Improvement:							
1. **Critical care survivors rehabilitation**- integration with primary care ***risk stratification by GPs*** and care planning in community *Network work programme 8 & 10*	Goal: networked, equitable development and application of shared pathways of post-critical care rehab care across 7 acute Trusts and multiple primary care providers. Patients' needs following ICU recognised and shared in a timely and informed way. Reduction in "lost information" with GPs having better understanding for the critical care episode and its impact	Critical care and GPs have direct communication within NWL via shared IT discharge letter links Primary care clinicians have access to critical care expertise in MDG fora Critical care clinicians secure better understanding and relationship with services in primary	Meets critical care service specification requirements ; Boosts IT linkage between providers and GPs in NWL; may support reduced DTOCs; Reduced variation, standardisation and streamlining of critical care patient discharge documentation	Right treatment for the patient in the right location Expertise taken to patient rather than patient taken to hospital With supported management in primary care keeping patients as well as possible for as long as possible Reducing requirement for access to secondary care services		Goal is reduced long term disease burden for this patient group, including return to work in appropriate cases. Potential for significant reduction in primary care demand, access to secondary care, and social care requirement. Highly cost effective	Across NWL 2M population with pilot for borough population. Development work undertake collectively between and on behalf of multiple providers and with shared provider + commissioner mandate across NWL – would be very difficult or

	Patient care planned by GP once home; access to *primary care-based earlier intervention* for on-going post critical care issues requiring clinical support Support from care navigators; may prevent readmission to hospital	care locally				delivery through working with integrated care clinical infrastructure (not duplicating or reinventing) Forward planning with care planning and MDG process for risk stratified patients Standardised notifications increase clinical time available for patient care	impossible to achieve on individual site basis without network.
	This supports NICE 83 rehabilitation after critical care in an integrated structure and as a networked approach provides consistency and more equitable approach						
2. **Joint working with providers and commissioners and contracting teams in North West London** *Network work programme 11,12*	1. Checks in place that national critical care standards are being enforced with CCGs 2. Support mechanisms in place to ensure national standards are understood and delivered	1. Support mechanisms in place to assist with interpretation and application of national standards	1. Helps provider on a corporate level ensure standards are met 2. Supports provider with benchmarking to enable areas for improvement at local level 3. Helps provider identify and address areas of non-compliance and mitigate risk	1. Expert advice for CCG commissioner on national requirements 2. Supports CCG clinical and non-clinical commissioner in working with provider on understanding clinical and corporate governance 3. Capable of working in partnership as critical friend to both commissioner and provider 4. Potential source of specialised	See added value for CCG commissioner. This is supplemented by the network's expertise to work across CCG and specialised commissioning	1. Expert advice to guide and advise technical and analytical teams working within CCGs and providers alike 2. Critical friend to enable partners to identify and assess financial risk and possible causes 3. Advisory role in selecting suitable tools and priorities to investigate queries	1. Capable resource able to present complex information in a way that is suitable for multiple end users

				expertise to support working at SRG and urgent care network level.			
3. Benchmarking good practice *Network work programme 1, 9*	Ensuring continuous service improvement and equity of care to patients across entire Network, through on-going review and sharing of best practice, e.g. in: - critical care transfers - care of deteriorating patients including sepsis and AKI - Rehabilitation post critical care.	Networking and support to clinicians via transfer data-sharing, Quality Measures, regular joint clinical forum board with data review, shared service development initiatives (e.g. deteriorating patient work stream), annual conference	Common standards of care and practice in inter-site transfers and service development within sites, with best practice sharing and training/culture change programmes	Access to transfer data and quality measures, providing detailed visibility (with expert, neutral, interpretation and discussion when required) of provider clinical activity. Frequency of access to data (can act swiftly if trend/change arises)		Substantial data collection and analysis, free to member organisations, provided by Network activity and through clinician participation at point of care, via a model developed by and for clinical users.	
4. Care of deteriorating patients implementation group NEWS, AKI, Sepsis *Network work programme 9*	Reducing risk of harm or failure to rescue.	Sharing of challenges and learning ; sharing workload linked to development and roll out; Shared management and expertise; leverage of " critical mass" within the organisation; Common training for staff rotating	Reduces need for or expedites critical care admission where appropriate Sepsis CQUIN AKI CQUIN Consistent approach and common training for responders including those clinical staff who rotate across North West London	Recognising sick patients more quickly with targeted interventions may reduce LOS, and cost of admission to ICU Slipstreaming Sepsis and AKI CQUINs		Delivered on cost-neutral basis through networked, shared learning and development with existing hospital teams with funded Network time efficiently used to co-ordinate significant contributions by a wide range of clinicians in their existing professional development time. reduce emergency admission to ICU for preventable harm minimise ICU LOS	

					for those patients who do need admission (*at £1200 per bed day*)	
	Supports NICE CG 50 , AKI, Sepsis and duty of care					
5. Incident audit and targeted strategy for reduction and solutions Network work programme 6	Safety; prevention & reduction in harm or risk of harm; better information; Learning from incidents, pattern recognition across organisations, sharing and preserving knowledge of incidents (Networked organisational memory).	Safety; prevention and reduction in avoidable harm or risk of harm; learning across and from multiple sites, events and incidents	Information for business cases and data benchmarked with neighbours Facilitates communication between and across providers for resolution of cause (e.g. acute, LAS, community) as a networked network of care approach. Also feeds into local training with staff	Information regarding flow Early warning of trend, or a shift due to reorganisation	CNST subscriptions NHS LA payments equipment damage reduction	
	Economy of scale and effort to deliver for a geography					
6. Responding to patient, user, carer, relatives feedback *Network work programme 8*	Patient, user, relatives feedback can be acted upon/ across multiple sites; patient representative has access to board and senior staff	Clinical staff can bring initiatives for testing with former patients Work up via MDG including former patients	Greater access to service user views from a hard to reach group	Services influenced by user/carer feedback	Utilising existing feedback/solutions through networked learning and approach Patient representation fully integrated into Network structure and events - more effective than, and without the administrative costs of, a standalone patient group	
	Network and Network programme and events gives patients, former patients, relatives' access to senior decision makers in multiple organisations					
7. Critical care service specification analysis and standards implementation with commissioners and	Equity of access and consistency in expected standard of care wherever patient treated Care meets national /London	Leverage for clinicians to deliver standards of care in line with professional bodies' best practice;	Supports service delivery	Identification, support and validation for locally-led action to mitigate outliers and reduce variation. Discrimination e between acute areas	Cost-free benefits of strategic and commissioning experience in existing senior	

working with contracting teams *Network work programme 18*	standards	Opportunities for clinicians and commissioners joint working Clinical and contracting alignment		and critical care areas.	staff – saves costs of obtaining external expert advice; detailed sector wide knowledge at NWL network level CCMDS HRG payments for critical care linked to designated services with agreed standards to be delivered Reduction in variation	
8. QM1 Consultant cover audit quarterly *Network work programme 18*	Audits and assures 7 day consultant supervision and care of patients. Quarterly reporting frequency provides detailed granularity (e.g. impact of staffing changes) not available through ICNARC.	Senior: Use to support rota discussions and local business case delivery Junior – ensures senior cover is transparent	Demonstrates adherence with agreed standards and consistency thereof ; non-compliance can trigger action	Demonstrates adherence with agreed standards and consistency thereof ; non-compliance can trigger action	CCMDS HRG payments **pricing** for critical care are based on senior decision making and staff accessibility and cover – this helps demonstrate the VFM regarding availability of Senior decision making Local knowledge and timeliness of reporting with opportunities for early & rapid intervention when/if problem arises	Senior level gate-keeping for a very expensive service and limited resource

9. QM2 Proportion of nurses with a post-qualification, university-accredited critical care course audit quarterly *Network work programme 18*	Ensures adequate training levels for staff in a complex high tech environment where patients have life threatening dependency	-motivating -staff development -succession planning -increases expertise	• Benchmarking and visible reporting across organisations • Reduction in variation of purchased/provided care • Rapid intervention possible if standard falls • Evidence-based and locally agreed setting of target ensures 'just right' (and not excessive) staffing and training levels.		CCMDS HRGs and payments **pricing** based on competency and skills available consistently this helps demonstrate the VFM regarding availability of skills of nursing support available and being paid for by commissioners Local knowledge and timeliness of reporting with opportunities for early & rapid intervention when/if problem arises Clinically-consulted and locally set target ensures safe trained cover while avoiding 'luxury provision' (QM score plateaus at 70%, no added incentive to train above nationally evidenced levels).	Drives purchasing of education Surge capability protection
10. QM3 Clinical governance activity audit *Network work programme 18*	Quarterly reporting and assurance of adequate clinical governance activity per site, patient safety and learning from events to prevent recurrence	Demonstrable compliance (or not) with good practice processes	Benchmarked confidence indicator	Promotes and benchmarks provider governance processes		

11. QM4 Implementation of a " care of deteriorating patient" track and trigger system outside ICU audit *Network work programme 18*	Reduction in potential harm early recognition of and response to deterioration	Consistent documentation for acute medical staff on rotation to multiple sites in NWL Opportunities to feedback, adjust improve responses Can influence national mandated guidance using a networked evidence base Lever for clinicians to create change in their organisation	demonstrable evidence of standardised approach Identified outliers	NICE 50 roll out progress and compliance utilise in trust/commissioner quality/ harm reduction discussions	Prevents inappropriate admission to ICU for patients that will not benefit (and at a cost of £1200+ per bed day) Identifies early DNAR (do not actively resuscitate) patients which helps prevent futile resuscitation attempts on a patient or inadvertent admission to higher levels of care (at a cost of £1200+ per bed day)	Resuscitation Council ILS (immediate life support) guidance 2010
12. QM5 Documented Consultant involvement in ICU admission gate-keeping audit *Network work programme 18*	7 day, consultant-delivered decision-making for patient admission to critical care and treatment plans.	Identifies variation in documentation, supports evidencing of senior decision-making.	Identifies variation and improves organisational documentation	Ensures appropriate, documented ICU admission decision-making and effective use of resources.	Prevents inappropriate admission to ICU for patients that will not benefit (and at a cost of £1200+ per bed day)	Prevention of futile admissions
13. QM6 Compliance with ventilator-associated pneumonia prevention bundle audit *Network work programme 1*	Evidence based care showing risk reduction in acquiring pneumonia as a patient in ICU ditto reduced LOS	Doing patients no harm and being able to demonstrate this to others	-Improves capacity, flow, and availability of resource -demonstrates compliance with evidence based "safer" care - example of quality and can be reported via joint quality groups		Reduction in treatment and drug costs from using evidence based care bundle on all eligible patients	Patient safety
14. QM7 Compliance with central venous catheter infection prevention bundle *Network work programme 18*	Evidence based intervention that reduces the risk to the patient of a central blood borne infection	Doing patients no harm and being able to demonstrate this to others	Improves capacity, flow, and availability of resource -demonstrates compliance with evidence based "safer" care - example of quality and can be reported via joint quality groups		Reduction in treatment and drug costs from using evidence based care bundle Prevention of HA	Patient safety

					infection	
15. QM8 Unplanned extubation rate audit *Network work programme 18*	Patient risk reduction	Benchmarked patient safety measure	Risk identification; targets measures to reduce risk	Benchmarks patient safety and risk of avoidable extra resource utilisation (accidental extubation requiring re-intubation increases LOS).		
16. QM9 Patient or carer satisfaction survey return rate audit *Network work programme 18*	Critical care-specific feedback to guide on-going practice		Measure of appropriate engagement with end users			
17. QM12 Late night discharges from ICU audit quarterly *Network work programme 18*	Late night discharges are disturbing for patients and increase risk.	Provides data on patient flow and unit practice, benchmarked against peers	Essential component of critical care capacity planning	Benchmarks patient safety and risk of avoidable extra resource utilisation (late night discharges increase risk to patient safety and increase risk of readmission). Measure allows quarterly monitoring including during hospital bed pressures	Collection and analysis of data essential for capacity and flow, free to member organisations.	
18. QM13 Unplanned ICU readmissions quarterly audit *Network work programme 18*	Unplanned ICU readmission is an indicator of patient risk. The measure facilitates corrective action for future patients	Provides data on patient flow and unit practice, benchmarked against peers	Identifies patient risk and potential unit stress indicator.	Benchmarks patient safety and risk of avoidable extra resource utilisation (late night discharges increase risk to patient safety and increase risk of readmission). Measure allows quarterly monitoring.	Collection and analysis of data essential for capacity and flow, free to member organisations.	
Capacity:						
19. QM10 ICU 'capacity shortfall' (non-clinical transfers, cancelled electives, refused specialist referrals) audit quarterly *Network work programme 6*	Patient avoids delay in access to level of care Patient avoids an intervention with known risk	Staff benefit from time saved in not moving patients	Provides inter-organisational benchmarking for equity of access and appropriate commissioning of capacity Provides data and information for strategic/tactical decision making More ambulance time freed up for front line calls rather than critical or immediate calls for hospital transfers		Reduction in ambulance utilisation for inter hospital transfers, thus freeing up frontline asset	
20. Critical Care Reviews – clinical capacity safety and configuration – for commissioners and Trust	Assures (for the patient as well as staff and organisations) that capacity and configuration meet patient needs: *bed at the right hospital with right standard of care and response available*	Capacity in right place Fewer patient moves	Underpins efficient delivery of service Business case development	Confidence in provider services Action plans and results Resolution of disparities Alignment of designation of services,	Optimising utilisation of resource Reduction in wastage	

CMH NPH Ealing *Network work programme 12*				and demand for care with commissioned resource	Local network subject matter expert(s) plus clinical time for review, at 5-10 days per review would be approx. £7000-£10, 000 per review – this cost is included in the Network local membership model and met by the Network normal running costs	
21. Winter/pressure surge planning *Network work programme 6*	patient experiences safe care in the right place in timely way	Optimal patient flow within their service areas Can escalate via Network and obtain additional expertise and help in immediate situation	Additional clinically focussed support for patients in a system of care Reduces variation in access due to seasonal pressure	Intelligence and subject matter expertise on optimising flow available to Spec Comm, CCGs & Performance teams Greater understanding of capability and trigger points via Network dashboard Operational intervention opportunity in a practical way to support individual and cohorts of patients System planning and response for mutual aid	Using Network resource, active network planning and system management at a micro level of individual patients can impact on the £ bottom line. E.G ensuring specialist patients move from ICU/HDU to definitive care elsewhere with minimal delay (saving £1200 per bed day saved) Evidence can be £100k of bed day activity in 2 weeks so preventing delays and moving patients can have big impact.	Good network spot audit data and early escalation can and does improve patient flow and influences bed capacity at receiving sites
22. Winter/pressure surge response *Network work programme 7*	Early escalation and triangulation of patient delay in access - from wherever in the system the patient with critical care needs arises					

Research/Education/Training:					
23. Training and development of knowledge and skills in critical care transfers *Network work programme 2*	Reduction in harm by ensuring consistent networked standards and clinician knowledge in transfer of critically ill patients. Also ensures interoperability (*for patient benefit*) by training in shared language/terminology and knowledge between sites, between professional disciplines, and with LAS Patient safety any patient being transferred is escorted by staff aware of the specific challenges associated with transferring critically ill patients and having skills to prepare and deal with eventualities	Up skilling staff to deal with critical care transfers Confidence and support for clinical staff Sharing and benchmarking best practice Reduced variation in training across all sites in NWL, creating a passport for these skills	Reduction in training requirement Provision of appropriately trained staff Improved care for patients being transferred Alignment with London standards and ICS 2013 Breaks down barriers across organisations Local training sessions supported by standardised education package reducing variation in all areas where critically ill patients may be transferred	London Standards Confidence for the Quality and safety agendas Reduction of incidents Rapid early warning of unexpected shift so action can be taken Links also to CCGs' dashboard	400 staff per year trained by the Network. The Commercial cost of a transfer course *would b*e £150 per person = **£**60,000 . Trusts do not have this money available in their training budgets. Clinicians give of their time to support this network training: Cost of faculty if commercial or outside provider, 4 trainers at a cost of £300/day/trainer (total £1200/day). We provide 10 courses per year, the total commercial value of the trainers would be £12,000 per year (we get this for free) Avoiding individual invoicing for each of the 400 staff or by proxy the organisations saves £30 per invoice (x 400) opportunity cost to NHS avoided of approx. £12,000 Online access to Network films on www.londonccn.nhs.uk saving hours of training time away from the unit and department - making patient safety more accessible Local training sessions supported by standardised products across NWL savings therefore £60,000 (400 staff trained) £12,000 (faculty costs saved) £12,000 (opportunity cost of invoices) (£84,000 of commercial value *currently met within network arrangements and our membership model)* We get free loans of equipment for training from companies due to Network reputation and name

24. Network educational event - winter *Network work programme 16*	Highly visible opportunity to influence clinical and organisational practice across multiple sites	Developmental opportunity for multi-disciplinary staff from each site Peer support CPD Revalidation	To influence clinical and organisational practice across multiple sites	Network events include commissioner/contracting input and attendance Builds relationships Sharing clinical /contracting/commissioning perspectives	Moderate commercial cost would be £150 per delegate (for 100 delegates) to attend this level of conference £150 per speaker (E.G 6 speakers) as honorarium Total cost/value of the event = £15,900 *Network delivers this for approx. £5k and gets sponsorship to do so in order to make it cost neutral.*
25. Physician, emergency medicine, critical care trainee rotations targeted education and NWL system knowledge (NEWS, sepsis, GIM day for trainees) *Network work programme 9*	Patient safety and prevention and reduction in risk of harm	Network-wide and multi-professional benefits in shared learning and clinical skills – providing clinician feedback	Organisational benefit from having system wide training (clinicians move on to next site with skills from previous site and with network knowledge of system not just the organisation they work in)	NICE CG 50 Sepsis and AKI bundle and CQUIN	64 trainee physicians at General (internal) medicine training day half a day delivered by network linking organisational and clinical issues within a system of care £3,200 for training (at commercial value of £50 per half day per delegate) delivered cost-neutral by Network as part of membership model 7 Speakers £75 per half day =£525 value (delivered by Network members for free as part of membership model)
26. Network Transfer Faculty Event – summer *Network work programme 5*	Safer care in the right place at the right time	Development of tools and resources relevant to issues and problems arising in NWL Professional development and CPD Talent management and identification in network	Development of tools and resources relevant to issues and problems arising in NWL Supporting operational pathways for adult patients from wards, HDUs and ICUs Supports unlimited access to transfer training (on line) Supports critical	Evidence based practice for professional and national standards Supports patient safety agenda in sector Addresses patient safety issues tactically cross system in NWL - all providers, all sites reduction in variation Early warning of unexpected strategic change impact Optimising ambulance utilisation	20 experienced clinicians provide expert advice on training and work pathways: this would cost £300/day per attendee 20 attendees Total = <u>£6,000</u> <u>(saving</u> <u>)</u> Network clinicians provide this time freely for the benefit of patients in NWL and due to their commitment to transfer safety

			paediatric transfers not undertaken by CATS(children's acute transfer service)			
27. Mass on-line education and pathway verification/guidance/ open source for London and beyond *Network work programme 14*	Patient safety and prevention / reduction risk of harm Transparency of training material as open access.	Free access to education and reference material Greater access to pathway information and intelligence when pathways are failing patients	Reduction in staff time away from clinical duties Free clinical training for staff Unlimited access to training material	Confidence in adherence to standards National and internationally recognised best practice Number 1 on Google Part of NWL education pathways for Nurses and Drs	All material is open access and is freely available. By doing collaborative education and online material – economy of scale is achieved. Network on line products for this year at www.londonccn.nhs.uk ECMO video (national relevance) May 2015 Rehab after critical care network training video to support integrated care with GPs (in production) Care of the critically ill child for/during transfer (linked with CATS)(in storyboard) £12,000 met within Network Membership model NB Benchmarked commercial cost would be approx. £50K + for filming , plus add hire of venues and equipment used	
28. Network publications peer reviewed and published on innovations and impact for patients *Network work programme 17*	Constant drive toward innovation benefits patients by ensuring that NWL sites remain at the leading edge of change from the front and ensuring rapid uptake of new patient care initiatives (e.g. NEWS, AKI).	Publication and visible innovation encourages bottom-up involvement of frontline clinicians and further new ideas – e.g. the new intrahospital transfer tool was initiated and		Network transfer audit & training programme and quality measures are part of the NWL data and assurance technical review process, and have been presented at international conferences in Paris and Berlin, attracting peer interest including from Harvard. Potential clinical and health management journal publication (HS	Makes benefits more widely available to others – not having to reinvent (and helps avoids cost of reinventing)	

		designed by an NWL trainee.		+/- an ICM journal) Emergency nurse magazine (transfer training and relevance to ED moves)		
29. Transfer bag – modified Delphi study and system change implementation *Network work programme 3*	Standardisation of configuration for essential transfer equipment across NWL, reducing preparation time before intra-hospital or inter hospital transfer of critically ill or injured patients . Significant patient safety impact by ensuring staff familiarity and immediate, standardised availability of critical equipment. Design includes patient specific and individualised risk assessment and response	Contribution to large scale patient safety initiatives and impact on patient safety by standardised equipment across all sites in NWL, evidence based. All staff knowing where equipment is located in the event of need / emergency	Reduction in variation and standardisation of equipment and training for all staff including those on rotation in NWL Reduction in cost of wastage of equipment and drugs Reduction in staff time checking equipment (and freeing up time to care)	Network provided multi-disciplinary and cross site training with standardisation of workflow and equipment, improves efficiency of intra-hospital and inter-hospital transfers. Reduces checking time enabling better utilisation of staff time on escort away from department (in particular, these are often senior ED nursing staff, whose absence impacts ED flow). (Some EDs do 80 transfers a day so small time savings may have big impact)	Free to all staff following initial investment for development Licencing potential for other national and international organisations being explored – patent pending Product/package development to reduce inefficiencies and waste for member organisations. Cost-free as performed by existing Network mechanisms (?cf. commercial development costs?	International
30. Transfer App *Network work programme 4*	Patient safety Reduction of harm / risk Escorted by staff with excellent guidance and advice available	Free immediate access to clinical information Repository of useful information in the event of need Supports staff in the event of an emergency providing useful tips and emergency contact numbers and details	Instant access to relevant clinical information for staff without the investment in the IT by providers Access to all info	Free immediate access to useful current information (in the event of need in normal or unusual circumstances Elements can be used in staff induction or for training sessions for contracting and commissioning teams who want a better understanding of the critical care system	Free to all staff following initial investment for development App development phase 1 and phase 11 = £10k when commercially the app would be minimum of £30k to develop	London wide

		Reduces time away from unit and ambulance utilisation time providing access and egress details to all London CC Units			Licencing potential for other national and international organisations being explored	
Workforce:						
31. Critical Care Reviews – clinical capacity safety and configuration – for commissioners and Trust CMH NPH Ealing *Network work programme 12*	Assures (for the patient as well as staff and organisations) that capacity and configuration meet patient needs: *bed at the right hospital with right standard of care and response available*	Capacity in right place Fewer patient moves	Underpins efficient delivery of service Business case development Right staff to meet case-mix and demand	Confidence in provider services Action plans and results Resolution of disparities Alignment of designation of services, and demand for care with commissioned resource	Optimising utilisation of resource Reduction in wastage Local network subject matter expert(s) plus clinical time for review, at 5-7 days per review would be approx. £7, 000 per review – this cost is included in the network membership model and met by the Network	
32. Network educational & staff development event -winter *Network work programme 16*	Highly visible opportunity to influence clinical and organisational practice across multiple sites	Developmental opportunity for multi-disciplinary staff from each site Peer support CPD Revalidation	To influence clinical and organisational practice across multiple sites in a networked way	Network events include commissioner/contracting input and attendance Builds relationships Sharing clinical /contracting/commissioning perspectives	Moderate commercial cost would be £150 per delegate (for 100 delegates) to attend this level of conference £150 per speaker (E.G 6 speakers) as honorarium Total cost/value of the event = £15,900	

					Network delivers this for approx. £5K and gets sponsorship to do so in order to make it cost neutral.	
33. Modelling best practice relationships and behaviours including transparency and caring culture *Network work programme 1, 13,16, 17 and others*	Safer environment of care Patient experience improvement	Empowering staff by collective escalation and feedback, and through visibility of impact they can have on issues raised by staff Consistent /better decision making by clinicians closest to patient in need, in light of bigger picture and ability to influence	Assists provider to meet contractual and commissioning requirements Assists Commissioners and contracting teams to deliver contractual and commissioning requirements		Better informed decisions made closer to patient - evidence shows this reduces costs to NHS	Transparency and local ownership of problems and solutions
34. Collaborative knowledge-sharing - sum of outputs being more than the parts *Network work programme 15*	Reduction in variation of care Patient information - (shared learning from an incident can be spread – e.g. patient leaflet and resource)	Slip streaming on effort for delivery of results Clinical model advice Data analysis and comparison Peer support troubleshooting issues	Performance improvement	Performance improvement		
35. Support with complex and unusual situations or patients *Network work programme 6,13,15*	e.g. Repatriation from abroad Support to patient and family /GP trying to repatriate critically ill or injured UK patients from abroad Navigation to the right site and bed Expertise in referral and liaison	Supports receiving clinician Promotes "good behaviour" in challenging situations Early comms with clinical teams	Some external liaison Trouble shooting on pathway difficulties Leverage with other networks elsewhere in the country for onward moves (e.g. patients via Heathrow)	Support to individual GPs on their patient repats from abroad Reduced LOS - E.G pending specialist onward access Early warning of V expensive patients – potentially with longer term care needs	LOS savings for "hand- off " situations	

Organisational:						
36. QM11 Length of stay in ICU (median) audit quarterly *Network work programme 18*	Benchmarking measure relevant to patient care; helps to assure equity of access and outcome	Allows clinicians to benchmark and assess process of care and service pressures (alongside readmission rate)	Provides LOS data for capacity assessment and monitoring of service changes and pressures (e.g. delayed discharge from ICU)	Provides LOS data for capacity assessment and monitoring of service changes and pressures (e.g. delayed discharge from ICU).	Right patient in the right bed; avoiding code 90 CCMDS issue in non-critical care areas due to access delays	
37. QM14 Standardised Mortality Ratio reported quarterly *Network work programme 18*	Benchmarks patient outcome and assures equity of care	Enables clinicians to benchmark and assess own practice in real-time quarterly timescale; early recognition of trends.	Allows inter-organisational reporting and benchmarking on a quarterly frequency in real-time (not available with ICNARC)	Enables real-time visibility of acute Trust outcomes on quarterly timescale for discussion at CCG /Trust CQG etc.		
38. Individual patient reviews for CCGs/Trusts/service *Network work programme 12*	Review of care that may benefit other patients	Review of care that may lead to endorsement or change of practice	'Honest broker' function in facilitating or performing peer review of patient care at provider or CCG request, ensuring clinical expertise, with appropriate and fair insight.	V long LOS patient review for CCG/s demonstrate • appropriateness of pathway being followed for indiv patient • value for money on care (or not)	Network cost approx. £2000 met within normal business e.g. no charge to Network members – external cost £10k – £30K depending on type of review	
39. *Inter* Hospital transfer documentation, and transfer audit across North West London organisations *Network work programme 1*	Accurate record of patient journey and an intervention Reduced risk of transfer related incidents to patients Prevention of harm Learning from every patient journey captured	Evidence of patient preparation Legal record of an intervention Supports patient management during transfer Protocolises and guides best practice Can help prevent incidents "Safe" reporting tool	Identification of incidents that can be addressed to reduce potential for harm to other patients Identifies data including staff utilisation, risk areas within trust Information for informing their PTS contracting Benchmarking with others Capacity (rationale for move)	Reduces variation in transfer practice across NWL Supports quality and safety agenda, failure to rescue and harm avoidance Data available at site specific level to support SAHF discussions and business plans Aggregated intelligence from all sites including EDs, critical care, HDU, ward escalation, renal ; and some paediatric transfers/time critical transfers unable to wait for CATs.	Reduce delay in transfer Optimises use of critical and immediate categories by Trusts releasing more ambulance time for CAT A calls Reduces journey time (reduced delays for crew)	Common documentation across the entire sector so common training, common standard, common audit and shared No change when trainees move organisations within NWL

			Ambulance utilisation			
40. *Intra* hospital transfer audit *Network work programme 1*	Accurate record of patient journey and an intervention Reduced risk of transfer related incidents to patients Prevention of harm	Evidence of preparation Legal record of an intervention Supports patient management during transfer Role models best practice	Identification of incidents that can be addressed to reduce potential for harm to other patients Identifies data including staff utilisation, risk areas within trust	Reduces variation in transfer practice across NWL Supports quality and safety agenda, failure to rescue and harm avoidance	Early indications suggest scanner time usage could be optimised Equipment standardisation	Links to understanding some performance issues – e.g. if 80 transfers a day from ED – 20 mins each that's 20 hours of staff time OUT of the department – can audit staff time taken , type, pinch points for activity etc.
41. Expediting individual patient moves for definitive care between organisations *Network work programme 6*	Right care, right place Avoiding delay in getting to tertiary centre where required Avoiding set-backs in established treatment pathways for patients	Capacity for access for other patients reduction in time spent trying to organise patient moves – feeing up time for clinical care	Access to general ICUs impacted if problem with outflow of tertiary patients Also supports tertiary trust with egress from tertiary so their next tertiary patient can access definitive specialist care highlights system flow	Right care, right place, reducing "holding" bed days e.g. more efficient use of current resources and reduction in waste of funds used to keep patients in "holding pattern" awaiting access.	E.G renal, CT, trauma, access & ECMO and repat/step downs - any delay in access costs CCGs approx. £1200 + per bed day – previous spot audits demonstrated approx. £100k wasted days in 3 weeks across NWL for CCGs and more robust escalation has prevent such a recurrence	
42. **Business continuity and EPRR** ***Network work programme 6***	Patient safety – learning shared from events Supplies intact for patient interventions – e.g. consumables and hardware	• system wide learning from incidents/ surge/planning • winter planning across a system of critical care patient "flow" - annual checklist updated • "early warning pattern" recognition in respiratory and critical care • Mutual aid (hardware/consumables)from one site to another - move the kit not the patient • Equipment loan facilitation (move kit not patient)			Subject matter expert (SME)– value to system at national, regional, patch and for individual organisations - all included in network	Participation as SME to EPRR local, regional and national exercises

		• Short term closure support • Agile critical care inter-liaison across a geography and out to other areas • Rapid identification and spot audit of patient pathway failures for common escalation • Participation and workshop for EPRR annual London conference • Supporting the development of flexible resourcing plans for 'unusual' events – e.g. Ebola/MERS CoV • Contributing to the analysis of risk for existing and emerging conditions, where they impact on critical care • Pan London communication regarding issues that impact on critical care – such as NHS BT shortages etc.			model	
43. **Joint working primary and secondary care** ***Network work programme 10, 11,12***	Shared, patient-centred decision-making (strategic) and patient pathway facilitation (operational) across primary/secondary care boundaries	Facilitated discussion, knowledge-sharing and decision-making across organisational boundaries. Integration of primary care clinicians into Network events and critical care development programmes. Integration of community-based clinical expertise (e.g. palliative care) into acute hospital service improvement (e.g. end of life pathway in critical care).	Helps meet CQUIN on rehabilitation prescription Helps meet service specification requirements	Building on existing risk stratification of patients in primary care in NWL to better identify and thus provide rehabilitation for critical care survivors in North West London Supports integrated care delivery for the benefit of patients	Potential reduction of admissions - and costs associated Support of out of hospital strategy education of GPs , primary and secondary care clinicians using networked tools	Network acts as conduit to support cross over
44. System navigation for critically ill or injured patients within and across organisations *Network work programme 1, 6, 9, 10, 12, 17*	Improved care across complex pathways – both strategic service development/improvement (e.g. early recognition and escalation of deteriorating patients; improved care of AKI patients; protocolised escalation of severe acute respiratory failure patients to	Opportunity to collectively identify and address clinical issues which would be difficult for clinicians to tackle on individual site basis (e.g., delayed acceptance by tertiary care).	Improved patient flow and reduced delay in inter-organisation transfers of care. Standardised pathway development for the most critically ill patients.	Reduction of delays and inefficiencies (e.g. use of critical care beds for single-organ AKI patients) through networked identification of opportunities, strategic discussion, collaborative approach with commissioning	E.G renal, CT, trauma, access & ECMO and repat/step downs - any delay in access costs CCGs approx. £1200 + per bed day – Previous spot audits demonstrated	

	RBHH) and individual response to complex patients and situations (see below)	Networked knowledge-sharing and promotion of agreed pathways (e.g. ECMO referral)			approx. £100k wasted days in 3 weeks across NWL for CCGs and more robust escalation has prevent such a recurrence	
45. Repository of information and expertise organisational/system memory *Network work programme 17*	Repository of critical care information and significant expertise available locally (clinical and contracting and CCMDS expertise in one place)				Having subject matter expert available facilitates much greater granularity in understanding contracts/ services within contacting process and link to financial performance and pathways of care	
46. Support with complex and unusual situations or patients *Network work programme 6, 13, 15*	Ability to intervene and assist directly with complex patient situations on an individualised basis – e.g. patients 'stuck' due to barriers to transfer between organisations. Application of knowledge, contacts and networking to unblock pathways for direct patient benefit.	Resource and go-to contact for clinicians faced with situations where local provider knowledge and support is not enough to unlock complex pathway issues.	Support for provider organisations as well as clinicians	Support, easy access to specialist clinical expertise, and organisational familiarity. Example: facilitation of individual requests for repatriation of complex patients from out of London including UK and international Commissioners re-direct queries (to them) to the Network office	Expert advice from Network office to Embassies, consulates /missions regarding repatriations of NHS eligible patients	Network expert advice provided advice to clinical repatriation services
Data/Information:						
47. Critical Care Review - commissioning: SLAM data activity and patient flow assurance review *all NWL CCGs data for 2014-15* - Major Trust - all sites *Network work programme 12,17*	Right clinical and equipping resource in place for patients with organ support needs	Support more integrated critical care strategy for lead clinicians	'Honest broker' / expert knowledge input into data review and assurance Trust can act on findings	'Honest broker' / expert knowledge input into data review and assessment using discrete and joint TOR Commissioners can act on findings	15-18 days activity Subject matter expert approx. cost using network £10,000 (but provided free of charge) CC contract value assessed£25M – identified £4M for detailed review – now reviewing	

					detail	
48. ***Inter* Hospital transfer documentation and transfer audit across North West London organisations (patient moves in an ambulance)** *Network work programme 1*	Every patient journey counts and informs practice Safe transfer for patient	Legal record of intervention for a patient Evidence of risk management evidence of pre-transfer preparation standardised documentation regardless of ward, hospital or trust in NWL	Benchmarked evidence Feedback on incidents and equipment failures Cross organisational ambulance utilisation optimised capacity shortfall indicators Monthly (and sometimes more often) reporting at ward, hospital, trust and network level for governance and sharing and learning	Capacity indicators and patient flow National and London standards for transfers - evidence of care provided for L1, L2 & L3 patients for moves from all areas not just critical care Internally published " success" in use across all commissioned acute providers Data and intelligence pulled in for Commissioner dashboard in NWL re above	Fewer ambulance journeys Reduction in delay (more ambulance time on the road for cat A and Cat B calls) Reduction in variation Saved £4k for every Trust and site in NWL to use same documentation due to bulk purchase and agreed common approach – Total cost saving was £20K and is an on-going saving common audit reduces duplication and keeps audit close to clinical staff As per previous entries regarding transfers	Network model documentation and audit adopted elsewhere in the country also Scotland
49. ***Intra* hospital transfer form for NWL and transfer audit (patient moves within a hospital)** ***Network work programme 1***	Prompt and checklist tool ensures equity of patient care and safety across multiple organisations Audit tool ensures that every patient journey counts and informs practice Safe transfer for patient	Legal record of intervention for a patient Evidence of risk management evidence of pre-transfer preparation standardised documentation regardless of ward,	Benchmarked evidence including time taken for transfers by clinical staff (not usually recognised) Better planning for times transfers take place (maintain staff resource in key areas under pressure)	Aggregated intelligence from across a geography not previously captured - links to ED performance (staff time moving patients not captured elsewhere)	Potential better utilisation of interventional radiology resources Targeted reduction in CT scanner time occupied with ICU cases (LNWH	

		hospital or trust in NWL	Feedback on incidents and equipment failures Capacity shortfall indicators Monthly (and sometimes more often) reporting at ward, hospital, trust and network level for governance and sharing and learning		example in progress) Targeted resourcing (EG 80 transfers from ED per day with each transfer taking 20 mins) As per previous entries on transfers	
Other:						
50. System leverage – identifying and working with levers that effect a shift in behaviour or service *Network work programme 6,9,10,11,12,17*	Right time, right place, right care (for the patient)	Clinician connection & collaboration for issues/ideas Front line clinicians seize opportunities out with formal Trust commissioning /provider mechanisms	More learning or progress for less outlay Comparative intelligence	Clinician and clinician commissioner as well as contracting teams get • subject matter expertise and patient pathway intelligence • reduction in variation of experience for patients across a geography • collaboration with clinical teams relating to all critically ill or injured patients irrespective of location (hospital/ ICY/ED/ Ward/diagnostics)	Opportunistic savings within • systems (reduction in delays) • training for system service delivery – home-grown and delivered • Slipstreaming effort (do it once but lots benefit across the system)	Network acts as *the fulcrum* for leverage