EUROPEAN CRITICAL CARE FOUNDATION

Making a difference when it's critical

Critical Care Day Roundtable

Introduction and overview of topics

Most EU citizens will suffer critical illness, need time-sensitive treatment or be faced with vital decisions for themselves or loved ones at some point in a lifetime.

But despite the availability of scientific evidence for best treatment and care, a host of non-medical factors influence clinical practice. They include organisational and administrative arrangements, cultural attitudes, economics, law, and politics. Doctors experience these influences in each and every interaction with patients and families, colleagues, hospital staff and healthcare authorities. Taken together, they shape the structures and processes of healthcare and they determine its quality and safety (Figure 1).

There is a growing awareness of the role of these structures and processes on patient outcomes. The European Commission recently appointed a panel of experts to to provide an opinion on a possible Future EU Agenda on Quality of Healthcare[i].

The Expert Panel identified five core dimensions of high quality care:

- Effectiveness (improves health outcomes)
- Safety (prevents avoidable harm related with care)
- Appropriateness (complies with current professional knowledge, meet standards)
- Person/patient-centredness (considers patients/people as key partners in the process of care)
- Efficiency and Equity (optimal use of available resources without differences, variations and disparities in the health achievements of individuals and groups)

The examples brought to the European Critical Care Foundation's first Critical Care Day reveal the factors driving the quality of care, and the way in which they are key to patient outcomes.

- From acute heart attacks to stroke, the importance of timely access to best practice treatment is reflected in hard data on mortality and morbidity. Adjustments to governance, organisation and the healthcare workforce can bring improvements.
- Sepsis accounts for around 30 per cent of the burden of critical care across Europe. Identifying at-risk patients combined with early recognition and management would save lives.
- Varying practices in paediatric intensive care lead inequities and inequalities in outcomes for critically ill children. European standards of care could start to address this.
- And vital decisions at or near the end of life – are there opportunities to better understand what is most important to our patients?

The Critical Care Day will explore these and other topics of importance for the critically ill. The roundtable will be innovative in highlighting the improvements that could be secured by promoting high quality care. It will be ground-breaking in bringing both hot topics and neglected issues to the attention of EU healthcare policymakers.

We invite you to join us in ***making a difference when it's critical.***

Meeting endorsements

Society of Paediatric and Neonatal Intensive Care

STENT FOR LIFE

Acute cardiovascular crises – acute myocardial infarction and acute coronary syndromes

William Wijns, Stent for Life Initiative Founder and Chairman of EuroPCR

For each 30 minute delay in treating an acute heart attack, the relative risk of 1 year mortality increases by 7.5%. The earliest possible reperfusion is also essential to reduce the risks of suffering further cardiovascular events and heart failure. Minimising these risks depends on timely access to best treatment (primary angioplasty). However despite long-term, ongoing efforts to overcome organisational barriers impeding access to primary angioplasty, implementation is still patchy and incomplete, averaging at 50 per cent of eligible patients across Europe, with wide variations still observed between the best and least well served EU Member States. Addressing this situation requires mobilising multiple partners in the organisation and delivery of care. The Patients' Rights Directive in Cross-border Healthcare provides an important framework for encouraging collaboration across national borders and regions.

EU policy areas and options for further activities or collaboration:

- Ongoing implementation of the Patients' Rights Directive in Cross-border Healthcare, in particular through the work of the Expert Panel on Effective Ways of Investing in Health
- Monitoring of opportunities in border regions to support cross-border projects and continued collaboration with Stent for Life Initiative

Acute neurological crises - Stroke

Boris Lubicz, Department of Diagnostic and Interventional Neuroradiology, Erasme University Hospital, Brussels

Mechanical thrombectomy for stroke patients with large vessel occlusion has shown very promising results in a number of recent studies. It is becoming the treatment of choice for eligible patients if received within a 6 hour timeframe. However this presents a major challenge – how can this therapy be made available to the vast numbers of patients in need? Barriers include a lack of appropriately trained and qualified interventionalists, and organisational changes needed to streamline current acute stroke management flow in order to save time and save brain. EU efforts must support the rapid uptake of this promising new therapy, given the heavy toll of stroke in human and financial terms.

EU policy areas and options for further activities or collaboration:

- Organisational barriers, multi-disciplinary collaboration, sharing best practices
- European Parliament Brain Awareness Week (March 2015)
- Integration in current Parliamentary initiatives in the area of stroke
- Research current stroke treatment provision across Europe or in selected countries, to map needs and and identify barriers

Meeting endorsements

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STENT FOR LIFE

Intensive care medicine
Jean-Louis Vincent, President, World Federation of Societies of Intensive and Critical Care Medicine

Although critical care medicine is now well established, the exact curriculum to become an intensivist is not yet well defined in Europe. Interestingly enough, we do not know what an intensive care unit is, as it is difficult to define it by the type of patients, the equipment available or the personnel required.

Sepsis accounts for some 30 per cent of the burden of critical care across Europe and is associated with high mortality. Early and effective management can save lives, but requires teaching and hospital organizations to improve early recognition and management. The US has just started (on Oct 1) a sepsis management program in their hospitals, which may not be optimal. New international criteria to better define the patients at risk will be presented early in October and should be implemented.

EU policy areas and options for further activities or collaboration:

- Better description of the criteria to define an intensive care unit
- Development of hospital-based programs for early identification and management of severe infections
- Integration with the Commission´s initiatives in the area of patient safety (EU Patient Safety and Quality of Care Expert Group) and follow-up of the Parliamentary Own-Initiative report entitled Safer Healthcare in Europe: Improving Patient Safety and Fighting Antimicrobial Resistance.
- To persuade the World Health Organization to include sepsis in the global burden of disease project and approve the designation of World Sepsis Day (WSD) as one of the World Health Days.

Paediatric intensive care - European Standards of Care for Children
Jean-Louis Vincent on behalf of Joe Brierley, Medical President of the European Society of Paediatric and Neonatal Intensive Care Medicine

Paediatric intensive care is a relatively new discipline, and is not widely recognised as a specialty in its own right, unlike adult and neonatal intensive care which have greater recognition in EU member states. Likewise, there are currently no European-wide standards of care for critically ill children, and PICU provision varies widely across Europe. Dr Brierley calls for the creation of a registry of European paediatric intensive care units in order to determine standards of care and performance, and to drive improvements for critically ill children. This is particularly needed in the area of end-of-life and palliative care, and would facilitate collaborative projects in large dataset research.

EU policy areas and options for further activities or collaboration:

- Cross-border collaboration, sharing best practices
- Identify elements of the 'European Standards of Care for Newborn Health' project, (initiated by the European Foundation for the Care of Newborn Infants) which could be replicated for children.
- Develop a plan of action leading to the creation of a European PICU registry

Meeting endorsements

Society of Paediatric and Neonatal Intensive Care

STENT FOR LIFE

End of Life care decision planning - The Conversation
Douglas Blackwood, ICU Fellow, Department of Anaesthetics, Barnet Hospital, London, UK

Dr Blackwood looks at how current systems are failing to respond to patients' wishes at end of life, and the importance of instigating earlier interventions to try and change this. He asks whether there is there a role for such discussions with the high risk surgical population as part of pre-operative work-up, and what the barriers to these efforts might be. Ultimately such conversations might enable medical practitioners to better provide the care patients desire at a time when they are most vulnerable.

EU policy areas and options for further activities of collaboration:

- Patient-centred care, sharing best practices
- Pain management, patient's rights
- Involvement in the European Patients' Rights and Cross-border Healthcare interest group organized by Active Citizenship

Anaesthesiology - Integrating critical care in the continuity of perioperative medicine. The point of view of the European Society of Anaesthesiology
Professor Dan Longrois, Chair of the National Anaesthesiologists Societies Committee (NASC) of the European Society of Anaesthesiology (ESA)

The main challenge for anaesthesiologists who, in the definition adopted by the ESA are in charge of anaesthesia, intensive care medicine, pain therapy, emergency and perioperative medicine, is to integrate all these activities both at the educational level and in routine clinical practice. The tools for integration are for the moment only partly operational, but they will be necessary, since in the last five years, several articles have demonstrated a convincing relationship between intra-anaesthetic events (e.g. arterial hypotension, heart rate values, blood loss) and postoperative complications. Other studies have shown that postoperative death is as high as 4 %, and that 70 % of deaths occur in patients that were never admitted to an intensive care unit (ICU).

Classically, risk stratification and "marking" of the patients for access to ICUs postoperatively, were based on pre-operative risk stratification.

The Guidelines published in 2014 in a collaboration between ESA and the European Society of Cardiology (ESC) recommend pre- and immediate post-operative risk stratification together with perioperative haemodynamic optimization in patients with cardiovascular diseases who would undergo non-cardiac surgery. This is in sharp contrast with the 2010 Guidelines on the same topic. The 2014 ESC/ESA Guidelines are clearly a challenge in the fact that the clinical pathways for patients with severe comorbidities that must undergo high/intermediate risk surgery must be redefined. In this context, the main challenges become, in addition to excellence in all previously cited domains of perioperative care, the continuity of care and prevention (as well as management) of access to ICU. Furthermore, delivery from the ICU back to the ward must be part of this continuity of perioperative medicine process.

In conclusion, ESA is reshaping its vision of continuity of care in perioperative medicine by integrating all domains of perioperative care that include but are not limited to intensive care medicine.

EU policy areas and options for further activities or collaboration:

- Integrated care

Autopsy - Decline of consented autopsies and implications for critical care
Angus Turnbull, Medical Student (6th Year), Imperial College London

Hospital/consented autopsy rates have been on the decline throughout Europe for the past 50 years and are currently on the brink of extinction throughout much of Europe. The main reasons for the decline are misconceptions surrounding the value of autopsy in modern medicine and difficulties in obtaining consent. Despite modern technologies, misdiagnosis rates remain alarmingly high, and autopsy still provides an ideal learning platform. Mr Turnbull proposes simple measures to increase rates, clarify of consent processes, and increase healthcare and lay education surrounding autopsy. Additionally, a pan-European autopsy database could provide much data for clinical audit, clinico-pathological correlation and accurate epidemiology into comorbidities and causes of death. Autopsy remains a key tool in ensuring patient safety and quality of care. Its decline must be reversed.

EU policy areas and options for further activities or collaboration:

- Patient Safety and Quality of Care
- Training and education of healthcare professionals
- Possible topic for a workshop with Science and Technology Options Assessment Committee of the European Parliament
- Follow-up of the clinical trial regulation

Figure 1:

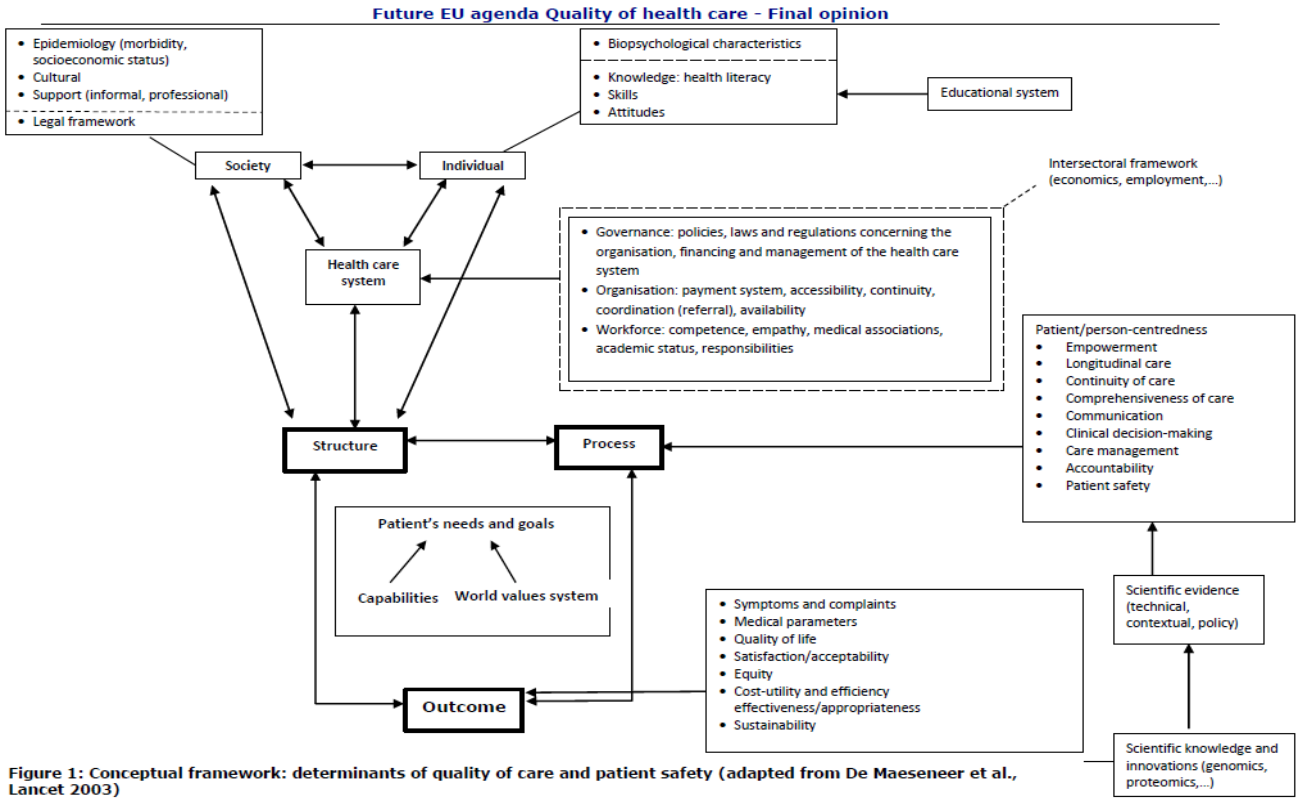

Figure 1: Conceptual framework: determinants of quality of care and patient safety (adapted from De Maeseneer et al., Lancet 2003)

References

[i] Expert Panel on effective ways of investing in Health (EXPH), Final report on Future EU Agenda on quality of health care with a special emphasis on patient safety, 9 October 2014