NHS

North of England

Escalation Guidance for Local Critical Care Capacity Pressures

This policy is not to be used for sudden 'Rapid/Major Incident response' events

Prepared by the Cheshire & Mersey, Greater Manchester and Lancashire & South Cumbria Adult Critical Care Operational Delivery Networks on behalf of NHS North of England (NW region)

Date	May 2018. This supersedes previous versions
Status	FINAL
Changes	A Baldwin
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Owner	NHS England (NW)
Review date	May 2020

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Introduction

The following escalation plan is intended to guide Acute Providers, NHS England Area Teams and Emergency Preparedness, Resilience & Response Leads (EPRR) on the expected actions required when critical care capacity (Level 3 Intensive Care beds) within a Network is experiencing exceptional demands and when local mutual aid may not be available. This policy is intended to assist **local escalation** only, and will be superseded by the North West Escalation plan (*NHS North West Major Contingencies: Guidance for Critical Care Escalation 2018*) in light of any declared major incident or clinical event, where wider coordination and escalation is required.

State 0: Bed state - Green
Beds available, no evidence of excessive demand on critical care servcies within the locality
OPEL 1: Bed state - Green/Amber
Increase in demand for L3 capacity with some units escalating beds across the Network and possible increases in capacity transfers
OPEL 2: Bed state - Amber/Red
Evidence of significant increase in demand for critical care beds(L3) across a Network with internal escalation in places and mutual aid provided through capacity transfers.
OPEL 3: Bed state - Red
Inadequate capacity to meet the Networks demand with wide scale internal escalations and no local mutual aid available
OPEL 4: Bed state - Red +
Wide spread Trust escalation and no clear indication of imminent availability in capacity

De-Escalation

- There is a recognition of the need for organisations to return to normal function as soon as possible to enable everyday Trust activity
- The local Network will provide intelligence & advice on the pressures within the system and support local decision making on de-escalation strategies
- De-escalation should not impact negatively on the ability to provide mutual aid across the Network in the event there is continued localised pressures
- It is important that local identification and discussions on the ability to de-escalate is directed between Trust Directors & NHS England Area Teams.

Local Escalation Triggers for NW Networks			
Capacity stage	**Cheshire & Mersey**	**Greater Manchester**	**Lancs & South Cumbria**
NORMAL	**> 11**	**> 8**	**> 7**
OPEL 1	**10 - 6**	**7 - 5**	**6 - 4**
OPEL 2	**5 -3**	**4 - 3**	**3 - 2**
OPEL 3	**2 - 0**	**2 - 0**	**1 - 0**
OPEL 4	**0**	**0**	**0**

CRITICAL CARE **LOCAL** ESCALATION CAPACITY PRESSURES

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ESCALATION STAGES AND ACTIONS

N.B. Stakeholder actions will be initiated based on a combination of local intelligence, capacity and clinical judgements

STAGE	HOSPITAL	NETWORK	NHS ENGLAND
0	• Normal hospital activity. • Critical Care units to complete DoS bed data in a timely manner • Bed status reports available to critical care units via NHS DoS • Minimal delayed discharges	The local critical care network will monitor bed numbers and capacity (non- clinical) transfers through NHS DoS	• Normal surveillance strategies • Bed status information available to AT Director of Operations & Head of EPRR via NHS DoS **(for information only)**
1	**<u>Consider</u> activation of local escalation policies that includes:** • No delayed discharges in L3 beds • Use of escalation beds e.g. theatre recovery • Additional comments should be placed on DoS regarding local pressures being experienced in units e.g. staffing for beds	The Network will monitor the number available bed stock on DoS to ensure delayed discharges are expedited from critical care units	• All agencies review Business continuity plans • Bed status information available to AT Director of Operations & Head of EPRR via NHS DoS • **<u>Local</u>** area team Director of Op & Head of EPRR to consider need for local teleconference
2	**Activation of local escalation policies that should include those actions as above and:** • Potential conversion of general critical care beds from L2 to L3 • Identify suitable L2 capacity area • Assess need for temporary suspension/cancellation of non-life threatening adult non-oncology surgery which may require critical care support • Assess mutual aid available within locality	• Advise to activate local hospital escalation policies where appropriate • Monitoring of pressure on neighbouring networks	• **<u>Local</u>** Area Team Director of Operations & Head of EPRR to consider briefing on-call Strategic Commander to take over Command & Control
	ACTIVATION OF STRATEGIC SUPPORT FROM NHS ENGLAND AREA TEAM AND/OR NHS ENGLAND REGIONAL TEAM FROM THIS STAGE ONWARDS		
3	• Internal capacity maximised to avoid capacity transfers • Identification of additional beds to support increased L3 activity • Suspend elective major adult oncology & cardiac surgery • Review the need to suspend all elective surgery with the exception of minor day cases • MTCs must prioritise their tertiary workload ahead of any elective activity	• Continuing collaboration between all three NW Networks, Area Team EPRR Lead and Providers to identify local issues and remedial actions • NW team aware via DoS that Critical Care capacity is under strain • Trusts to be made aware of strain on system	• Initiate daily teleconference calls with Trust Emergency Planning Leads • On-call Commanders to take stock of the situation • Consider early activation of C & C processes • Briefing NHS England **<u>Regional</u>** team
4	**No clear indication of imminent availability in L3 critical care capacity** • Widespread activation of trust escalation policies • Widespread mutual aid for both critical care and MTCs	• Consider activation of NW Major Contingencies Guidance for Critical Care escalation • Consider wider Network engagement /escalation	• Activation of Command & Control processes • Daily conferences and SITREPs

Appendix 1

Additional monitoring information requirements during escalation

The information required daily by 09.30, as a minimum, as follows:

1. Number of level 3 patients and any patients ventilated outside critical care
2. Number of level 2 patients
3. Number of beds closed due to level 3 escalation
4. Number of beds closed due to staffing problems
5. Number of expected level 3 patients stepping down to level 2, and level 2 to level 1/0 in next 24 hours
6. Number of delayed discharges from critical care
7. Number of cancelled electives in last 24 hours?
8. Number of critical care transfers out of the trust within the previous 24 hours (and if any, where to)
9. Any additional blocks in the system impeding flow?
10. Any patients awaiting repatriation for overseas or from within the UK?
11. Any further escalation measures taken or planned?
12. Additional information that may be relevant to inform capacity management processes

Applies to Cheshire & Mersey only

Cheshire & Mersey Adult Critical Care Operational Delivery Network (2013)
Guidelines for the use of Specialist Critical Care beds in Liverpool Heart & Chest hospital and the Walton Centre during escalation

Stages 0 and 1 - No action

Stage 2 - Preparation for possible declaration of Stage 3

Stage 3
As pages 2 & 3 above. For LHCH and The Walton Centre this entails cancellation of all elective non-life threatening cardiac and neuro-surgery likely to require critical care post-operatively. Anticipate significant numbers of transfers in from other critical care units (see below). Emergency workload to be retained.

Stage 4
All elective surgery will cease and all available beds used for capacity transfers (see below) from other providers.

Principles underlying the development of the Specialist Centre Patient Transfer Guideline and Log

- Critical care beds are a scarce and costly specialist resource. The sharing of critical care beds (the concept of mutual aid) across the Cheshire & Mersey Operational Delivery Network (and across the three NW networks when necessary) is a well-established and accepted principle as documented in the NW1, 2 and National3 Critical Care Contingency Plans.
- It is also accepted that elective surgery for non-life threatening conditions may be postponed to permit the admission of more clinically urgent cases to the critical care bed pool
- Many patients scheduled to undergo elective cardiothoracic or elective neurosurgery can be postponed safely to permit the use of normally cardiothoracic and neurosurgical critical care beds for appropriate other “general” more urgent patients.
- As part of mutual aid there is a longstanding agreement with Liverpool Heart & Chest Hospital and the Walton Centre that their elective surgery programmes would be postponed and that critically ill patients from elsewhere in the Network (and when necessary from elsewhere in the NW) would be imported into their critical care beds.
- Previous experience has indicated that this process has a number of barriers because it represents a different style of practice compared to normal circumstances where a small risk of transfer for the individual patient is considered to be acceptable towards the overall benefit of the population during the contingency period.
- The overriding ethical principle of “doing the greatest good for the greatest number” is consistent with the approach of accepting a generally considered low risk to transfer appropriate patients during periods of contingency.
- To assist in promoting the transfer of appropriate patients to Liverpool Heart & Chest Hospital and the Walton Centre it is proposed that during a contingency all critical care units should keep a log of patients who are clinically appropriate for transfer to the specialist centres.
- The log below has been developed following discussions between the Network’s senior critical care clinicians and clinical nurse managers including those from the specialist centres.
- The log applies to newly referred patients to critical care as well as established patients in critical care units, however where possible the admission of a patient to a critical care unit and the transfer out to a critical care bed in Liverpool Heart & Chest Hospital or the Walton Centre should be avoided in the first 24 hours.
- The log should be completed for each level 3 critical care patient once a day by the duty critical care consultant.
- During a contingency crisis all patients admitted to critical care and their families should be informed of the potential need to transfer to a critical care bed in a specialist centre.

The log is a data collection tool. When a transfer to a specialist centre is indicated the case must be discussed at consultant level which must include the identification of an appropriate parent team in the specialist centre (i.e. following existing critical care transfer protocol 4)

During the recovery period priority must be given to the repatriation of critical care patients back from the specialist centres to the referring units before returning to normal elective programmes

Appendix 2b

Cheshire & Mersey Critical Care Network

Applies to Cheshire & Mersey only

Specialist Centre Critical Care Contingency Transfer Log

Liverpool Heart & Chest Hospital

INCLUSION CRITERIA	EXCLUSION CRITERIA
• *Slow respiratory wean patients* • *Cardiovascular pathology* • *Respiratory failure due to underlying respiratory disease* • *Patients with sepsis who are unlikely to require surgery to address source of sepsis* • *Overdoses* • *Patients requiring renal replacement therapy*	• *Children* • *Trauma patients (with the exception of isolated cardiothoracic injury patterns)* • *Patients who may require the input of specialist teams not present on site (e.g. pancreatic surgery team, liver team, haematology team etc)*
IS THE PATIENT APPROPRIATE FOR TRANSFER TO LIVERPOOL HEART & CHEST HOSPITAL?	YES NO
COMMENTS	

THE WALTON CENTRE

INCLUSION CRITERIA	EXCLUSION CRITERIA
• *Primary neurology or neurosurgical pathology*	• *Children* • *Need for renal replacement therapy* • *Need for any non-neuro specialists input*
IS THE PATIENT APPROPRIATE FOR TRANSFER TO THE WALTON CENTRE?	YES NO
COMMENTS	

<u>Other factors that may need to be considered:</u>

- Age (young or old)
- Long term conditions (long term specialist care provided locally)
- Family circumstances
- Previous critical care transfer of that patient
- Specific infection control issues related to provision of critical care

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10th December 2013

Endorsed by CMCCN Clinical Group (2013, reviewed 2015 & 2017)

References

1. NHS England Management of surge and escalation in critical care services: Standard Operating Procedure for adult critical care (Nov 2013)
2. CMCCN Guidance for Intra-and Inter-Hospital Transfers (2009, last reviewed 2017)

References

Management of surge and escalation on critical care services: standard operating procedure for adult critical care (2013) NHS England

NHS England Emergency Preparedness resilience and Response framework (2015)

NHS NW Critical Care Contingency Plan (May 2018)

Operational Pressures escalation Framework (2016) NHS England

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