South West
Adult Critical Care Escalation Framework v4.5

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NHS England NHS Improvement

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Working Group	NHSE/I System Transformation Lead, South West Critical Care Network Manager and Nurse Lead, EPRR Leads		
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Author	Donna Bowen (System Transformation Lead – Adult Critical Care, Major Trauma and Burns) and Working Group Members	**Version issue date**	22/12/2021

Document management

Revision history

Version	Date	Summary of changes
1.0	Oct 2020	• Working group established to refresh framework update
1.1	19th Oct	• Cover sheet for document version control, CRITCON Levels and Region Contacts added
1.2	20th Oct	• Roles and Responsibilities and reference to ROC in place of ICC, membership agenda and activating a planned response in escalation
1.3	27th Oct	• Revision following huddle members feedback; terminology and language; Region – South West, sub region - Severn, Peninsula and Wessex and Network is SW CritCare ODN. • CRITCON staffing ratios referred in RAG as consideration, recommended numbers met or not met in line with current guidance (DRAFT) • University Hospital Dorset – Poole' and 'University Hospital Dorset – Bournemouth referred to separately • 5.1 Retrieve leadership representative deputy Dave Ashton-Cleary confirmed • Appendix 2 Region members SWASFT rep Phil Coburn confirmed • Appendix 3 'Capacity Transfer' replaces 'non-clinical transfer'
1.4	29th Oct	• Working Group member edits and decisions to expand framework to include in-region mutual aid response
1.5	30th Oct	• Allocation of Equipment SOP and process • Region Contacts roles and responsibilities clarified • Activation Response Team (ART) SOP – escalation triggered • In-region Mutual Aid Initial Response Group (IRG) SOP and process
1.6	3rd Nov	• Updated Activation Response Team (ART) SOP – 3rd coordinator role identified • inclusion of in-region mutual aid TOR and Agenda – embedded • addition of National ACC Wave 2 Surge Plan Summary – National Context; Appendix 10 • COVID-19 Pandemic CRITCON Levels - updated – becomes Appendix 4
1.7	6th Nov	• Adult Critical Care Huddle Agenda update – Appendix 10

		• Surge Definitions and sub regional baseline Core Beds, Green Surge and Amber Surge (maximum capacity) now defined • JESIP Decision Support Model added Appendix 8 • Revised Appendix 1 to incorporate Regional Operational Centre (ROC)
1.8	10th Nov	• Revision Triggers • Correction on green Surge beds available for Dorset • Retrieve SOP added including referral contacts
1.9	12th Nov	• Nightingale Activation and use page 6; section 3.3 • Revision Triggers and inclusion of CV-19 50% occupancy page 7 (Response to physical capacity) • Surge Escalation levels updated page 10 • Appendix 1 update to reflect Regional Operational Centre (ROC) Page 10 Amber Surge stand up response
2	16th Nov	• Revision triggers and descriptors; < or > 100% core capacity and >75% Green Surge reached; Surge escalation levels updated page 10 • Triggers - Core Capacity table included page 7 • Assumptions page 6, 3.3 Nightingales – updated narrative • CRITCON added to Surge escalation levels page 10 • Renal Replacement Therapy (RRT) – Regional Huddle Contacts updated page 19 • Appendix 1 updated to reflect trigger descriptors page 15
2.1	26th Nov	• Northern Devon Healthcare NHS Trust Core bed baseline number adjustment • SWASFT contact updated; Trust Incident Manager (TIM) which is a designated 24/7 escalation response, contact as part of Activation Response Team (ART) region contacts updated
2.2	12th Jan 2021	• Physical Critical Care Capacity Numbers Core Baseline, Green Surge and Maximum Amber Surge updated in line with Provider Trust Chief Executive and Chief Operating Officers declarations and agreements • Appendix 1 Escalation Flow Diagram update • Appendix 6 Capacity Management Principles v1.3 guiding on Intra-Regional and Inter-Regional Mutual Aid describing partner responsibilities and due diligence
2.3	3rd March	• Response to Physical Capacity expanded to include 175% threshold and CRITCON 4 / Maximum capacity reached – Page 9 • Page 11 additional notes includes percentages L3 from baseline • Surge Escalation levels expanded Page 13 to include Maximum Capacity reached / CRITCON 4 Emergency Triage • Appendix 1 Flow document update • Appendix 3 (page 19) Inclusion of intel gathering from closed communities into SOP • Appendix 6 Capacity Management Principles version update v1.5 • Appendix 6 National Critical Care Capacity Repatriation Principles updated v3.1 • Appendix 11 (page 32) SWCCN De – Escalation and Restoration guiding principles included
2.4	3rd June	• Revision to CCG contacts Appendix 2 ART SOP (removed Claire Thompson replaced by Matt Thomas, added Carmen Chadwick-Cox – Somerset CCG) • Appendix 2 ART SOP – added deputy Retrieve contact Dave Ashton-Cleary • Appendix 5 (page 21) STL support contacts Claire Kennedy added re Paeds/SIC

		• Appendix 5 (page 22) re Nightingale removed contacts Claire Thompson and Siobhan Healey • Appendix 5 (page 23) CCG removed Debbie Rigby – replaced by Carmen Chadwick-Cox Somerset CCG • Appendix 12 (page 33) Nightingale Mark Cooke in place of Claire Thompson now removed • Related documents page 4 - OPEL, on-call Action cards, sub-regional escalation frameworks/Severn – owners updated
2.5	8th Sept	• Principles of Capacity Transfers Appendix 12 (page 33) guiding in 'business as usual' situations • Adult Critical Care Huddle Agenda now becomes Appendix 13 (page 34) membership is temporarily expanded effective 18th August 2021 to include Neonatology and Paediatric Intensive Care to support operational pressures in collaboration with all partners
3.0	18th Oct	• Change to email address for the Regional Coordination Centre (ROC) and inclusion of NHSE/I on-call contacts and Urgent and Emergency Care, Pages 19 (Appendix 2) and 23 (Appendix 5)
4.0	26th Oct	• Remove reference to Nightingale capacity and routes of escalation • Introduce Business as Usual escalation SOP Appendix 2 Page 19 • Peninsula CCG contact update Appendix 3 and 6 • Triggers Page 8 and 10 and Surge Escalation Levels Page 13 revised to include new Business as Usual SOP • Updates to Sections 5, 6 ,7 ,8 guiding in and out of hours process • Provider proforma SBARD to guide situation report for in or out of hours escalation Appendix 15 • Directory of Critical Care Networks and Contacts Appendix 16
4.1	Dec	• Appendix 1 update re new in and out of hours BAU process
4.2	8th Dec	• EPRR review and edits including new contents page
4.3	13th Dec	• Incident Levels included, new Section 9 • Adult Critical Care Surge Plan Guidance Appendix 17 • Appendix 5 updated CRITCON including staff declarations
4.4	14th Dec	• Revision BAU SOP to include steps to protect elective P1 P2 surgery
4.5	15th Dec	• Actions at CRITCON 1-2 p13 Surge Escalation Levels, p15 5.2 out of hours response • Adjustment to Northern Devon Green Surge Beds and revision of totals p12

Approval History / Reviewers

This document has been developed in partnership and reviewed by the following:

Reviewer name	Title/responsibility	Date	Version
Critical Care Huddle – membership group	Senior Leadership and Sub Regional Teams	21st Oct	1.2
Jacquie Kemp Adult Critical Care National Programme of Care (Commissioning)	National POC Senior Manager	3rd Nov	1.6
SW CCN Board	Network Board Members	5th Nov	1.6
Working Group Members	Authors	3/03/21	2.3

		15/12/21	4.5
Critical Care Huddle – membership group (escalation triggers and learning from recent wave)	Senior Leadership and Sub Regional Teams	4th June 15/12/21	2.4 4.5

Approved by

This document is approved by the following:

Name	Status	Title	Date	Version
ODN (Operational Delivery Networks) Critical Care Board South West	Critical Care Huddle review and approval	Clinical Directors / Board Members	5th November 2020	1.6
SCOG (Specialised Commissioning Operational Group) South West	TO BE INFORMED (APPROVAL NOT REQUIRED)	Senior Leadership Team	Nov 2020	2
Regional Operational Centre (ROC) South West	TO BE INFORMED (APPROVAL NOT REQUIRED)	Senior Leadership Team	Nov 2020	2

Related documents

Title	Owner	Location
OPEL (Operational Pressure Escalation Levels) Framework	UEC	NHS England NHS Improvement
COVID-19 Pandemic CRITCON (surge levels)	Adult Critical Care - ODN	NHS England NHS Improvement
On-call Team Regional Action cards (NHSE/I)	EPRR	NHS England NHS Improvement
Service Specification Critical Care – D05	National NHS England	NHS England NHS Improvement
Workforce Readiness Assessment	Graham Brant and Hayley Peters	Adult Critical Care Network – South West
DRAFT Framework for Organising the Acute Sector Workforce to meet the Phase 3 COVID-19	Ramani Moonesinghe	NHS England NHS Improvement
Sub-regional escalation frameworks	Matt Thomas Penny Harris / Sam Waddy Kujan Paramanantham / Martin Schuster-Bruce	Severn Peninsula Wessex
Joint Decision Model (JDM) (JESIP guiding principles)	EPRR	NHS England NHS Improvement
Adult Critical Care Transfer SOP Capacity Management Principles	Scott Grier	Retrieve

Document control

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Contents

NHSE/I South West Adult Critical Care Escalation Framework

1. Purpose

1.1. This document describes the South West process for coordination of Critical Care escalation at the regional level in the event that existing network escalation pathways are exhausted.

1.2. Operational escalation systems and protocols vary considerably from one local health economy to another. Noting that flexibility at local level is necessary, this document provides an overarching escalation framework for the South West Region to bring consistency to local approaches, improve management of network escalation, encourage wider cooperation, and make regional and national oversight more effective and less burdensome.

1.3. The framework recognises that the capacity and facilities of each partner unit is unique, and that some variation of the model will be required, for example in relation to case-mix or size of unit. The following guidance is a 24/7 response.

2. Business as Usual Escalation Processes

2.1. Principles of subsidiarity are paramount; all decision making should be held as local as possible within the acute trust and sub regions with appropriate escalation made to the Regional Team as required.

2.2. South West Critical Care Network business as usual mutual aid processes between provider critical care units will continue to meet demand for services for the local population.

- Where a network hub or plan exists then capacity will be managed via this agreed route;
- In hours the South West Critical Care Network (CCN) Coordinator will support escalation across units; refer to SOP as per Appendix 2
- Out of hours Units contact each other via established WhatsApp groups and can request support from the Regional on-call team when required.
- It is accepted that for the Critical Care network as other networks (Cardiac, Burns etc) the use of Operational Pressure Escalation Levels (OPEL) is not appropriate and the use of Core (baseline beds), Green Surge and Amber Surge (maximum capacity) will be used throughout this document.
- Retrieve Adult Critical Care transfer service is in operation from 2nd November 2020. Refer to Retrieve SOP as per Appendix 8
- Regular Sitrep and Directory of Services (DOS) information is provided at a regional and national level for critical care. This provides oversight on availability of all adult critical care beds and identifies CRITCON (surge) levels across the system ICUs. These are used to prevent an

individual provider reaching CRITCON level 4 (maximum capacity reached and no ability to admit) without the network, region or system being aware and therefore able to take action to ameliorate this, please refer to Appendix 3.

3. Assumptions:

3.1. For the purposes of an escalation response the South West CCN is expanded to include 4 hospitals in the Wessex CCN (Salisbury NHS FT, University Hospital Dorset NHS FT – Poole, University Hospital Dorset NHS FT – Bournemouth, Dorset County NHS FT).

3.2. Critical Care escalation will initially expand within three sub region footprints- Severn, Peninsula and Wessex following BAU processes.

3.3. Regional escalation processes support locally developed surge plans.

3.4. When one sub region escalates to Amber surge all the sub regions should move to Amber Surge Capacity.

4. Plan Activation

4.1 Each trust has an initial “core baseline” capacity with an ability to surge within the unit (Green Surge beds) and a total capacity (Amber Surge beds) which includes capacity outside of the unit.

4.2 When support is required from beyond the network, NHSE/I South West Regional Operational Centre (ROC) may take control of the management of surge and determine use of facilities and resources to meet the needs as a whole system / Regional response, based on advice from the South West Critical Care Network.

4.3 Once the trigger points are reached all units within the sub-regions are guided to activate their escalation policies to help manage the increased demand and mutual aid response.

4.4 NHSE/I South West will co-ordinate the response following ‘green surge’ reaching >75% capacity in one or more sub-regions / and or as per clinical recommendation to activate an escalation response.

TRIGGERS – Response to Physical capacity

Core Capacity / CRITCON 0

TRIGGER	ACTION	Other to note
Less than 100% capacity of core beds and / or <50% core beds occupied by CV19 patients	No action required by the Regional team	Business as usual

Core to Green Surge / CRITCON 1-2

TRIGGER	ACTION	Other to note
One unit within a sub region has reached 100% of their Core capacity and / or 50% core beds occupied by CV19 patients and / or on clinical recommendation should escalate.	No action required by the Regional team See Appendix 2 for BAU In and Out of Hours Response	Mutual Aid Response within a sub-region will be ongoing via South West Critical Care Network (WhatsApp Group and Sub-regional mutual aid meetings)

Green Surge to Amber Surge (Maximum Capacity) / CRITCON 3-4

TRIGGER	ACTION	Other to note
One or more units has reached >100% of their Core capacity and / or >50% core beds occupied by CV19 patients and / or on clinical recommendation	Regional response; refer to Appendix 1, 2 and 3. • Mutual aid response ongoing through SW Critical Care Network • ***In hours*** Activation Response Team (ART) stood up to support mutual aid response, • ***out of hours*** NHSE on-call • Critical Care Huddle informed	Coordination by EPRR and Regional Operational Centre (ROC) sight of neighbouring regions available capacity.
One or more sub regions have reached 100% of their green surge capacity and / or >50% core and green surge beds occupied by CV19 patients and / or on clinical recommendation	All units within subregions move to Amber Surge capacity	Coordination by EPRR and Regional Operational Centre (ROC) sight of neighbouring regions available capacity.

TRIGGERS SUMMARISED – Response to Physical capacity

CORE BEDS
<100% capacity and / or <50% core beds occupied by CV19 patients

No action required by the Regional team

GREEN SURGE
One or more units at >100% of Core Capacity and / or >50% core beds occupied by CV19 patients / CRITCON 1-2 Low to Medium Surge

Mutual aid response and oversight via South West Critical Care Network
Business as Usual SOP Appendix 2
Region Response; coordination through Regional Operational Centre (ROC)

AMBER SURGE
One or more sub-regions at 100% of Green Surge Capacity and / or >50% Green surge beds occupied by CV19 patients / CRITCON 2-3 Medium to High Surge

In hours Activation Response Team (ART) stood up – Appendix 3 and 4
Out of hours NHSE/I on-call
Region Response; coordination through Regional Operational Centre (ROC)
GOLD Command
Incident Control Centre (ICC)
National single point of contact (SPOC)

MAXIMUM CAPACITY REACHED / CRITCON 4 Emergency Triage
All sub regions at >175% Core Capacity or Amber Surge Capacity in use

Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation). *This must **only** be implemented on National directive from NHSE/I and in accordance with National guidance*

Physical Critical Care Capacity by Sub Region

Each trust has an initial "core baseline"[1] capacity with an ability to surge within the unit (Green Surge beds) and a total capacity (Amber Surge beds) which includes capacity outside of the unit.

SEVERN Sub Region / Trusts	Core Beds Baseline	Green Surge Beds	Total Green Surge	Amber Surge Beds	Maximum Capacity	Additional Notes
Gloucester Royal Hospital and Cheltenham General Hospital NHS Trust	25	9	34	12	46	
Great Western Hospitals NHS Foundation Trust	12	4	16	14	30	
United Hospital Bristol and Weston NHS Foundation Trust	49	19	68	4	72	Includes Weston and CICU Bristol Heart Institute (Weston baseline 5, BRI baseline 20, CICU baseline 24)
North Bristol NHS Trust	46	9	55	31	86	
Royal United Hospitals Bath NHS Foundation Trust	13	7	20	19	39	
Yeovil District Hospital NHS Foundation Trust	10	0	10	9	19	
Musgrove Park Hospital – Somerset NHS Foundation Trust	14	4	18	6	24	
Sub Total	169	52	221	95	316	

[1] Due to local conditions it is accepted that on anyone day the core bed base could be +/- 20% and therefore clinical discussions both vertically and horizontally are recommended at an early stage.

PENINSULA Sub Region / Trusts	Core Beds Baseline	Green Surge Beds	Total Green Surge	Amber Surge Beds	Maximum Capacity	Additional Notes
Northern Devon healthcare NHS Trust	8	0	8	12	20	
Royal Devon and Exeter NHS Foundation Trust	13	10	23	38	61	2 ICU unfunded beds within Green Surge
Torbay and South Devon NHS Foundation Trust	10	3	13	33	46	
University Hospitals Plymouth NHS Trust	28	18	46	71	117	Surge beds include Cardiac Core beds / staffed
Royal Cornwall Hospital NHS Trust	15	15	30	32	62	
Sub Total	74	46	120	186	306	

WESSEX Sub Region / Trusts	Core Beds Baseline	Green Surge Beds	Total Green Surge	Amber Surge Beds	Maximum Capacity	Additional Notes
Dorset County Hospital NHS Foundation Trust	8	0	8	5	13	
University Hospital Dorset NHS Trust Bournemouth	11	3	14	15	29	
University Hospital Dorset NHS Trust Poole	11	3	14	18	32	
Salisbury NHS Foundation Trust	10	2	12	4	16	
Sub Total	40	8	48	42	90	

	Core Baseline Beds	Available Green Surge Beds	Total Green Surge Capacity	Total Amber Surge Beds	Maximum Capacity	Additional Notes
SOUTH WEST REGION TOTALS *(all Sub Regions)*	**283**	**106**	**389**	**323**	**712**	234 = L3 ICU equivalent beds 175% of Core Baseline L3 = 409 beds 200% of Core Baseline L3 = 468 beds 250% of Core Baseline L3 = 585 beds 300% of Core Baseline L3 = 702 beds

Surge Escalation Levels

Escalation Level	Description	Decision sits with	Action Required
CORE Capacity Available Trigger 100% capacity reached **CRITCON 0**	**<100% of Core Capacity** **<50% core occupied by CV19 patients** • Treatment currently available at sub regional level. • Number of beds that can be delivered with: • Equipment that is available within organisation including equipment that would not normally be considered e.g. anaesthetic machines, use of theatre space • Current Oxygen capacity within trust • If equipment shortages, there is still mutual aid available from surrounding organisations • Escalation to green surge starts when these criteria will not be met in next 72 hours • Staffing recommended levels met	Individual unit level accountability, decision sits with the Acute Provider Trust. Exec to Exec Inter-regional hospital decision and agreement	• No actions required by the Regional team <100% or CV19 50% respectively of core beds. • SWCCN will be informed of all actions being taken within each sub region. • De-escalation to CCGs / sub-regions to manage • Once 100% or CV19 50% respectively capacity is reached at sub regional level escalation to Green Surge required and discussion to take place with Adult Critical Care Huddle / Regional Operations Centre to consider Activation Response Team (ART) subject to CRITCON declared
Green Surge **CRITCON 1-2 Low to medium Surge**	**>100% Core capacity or Green Surge capacity in use** **>50% core occupied by CV19 patients** • Mutual aid ongoing • Treatment currently available but in limited supply • Capacity may soon be exceeded if demand increases further. • Decisions about treatment will be influenced by the need to prioritise. • Staffing recommended levels exceeded	Individual unit level accountability, decision sits with the Acute Provider Trust. Exec to Exec Inter-regional hospital decision and agreement. Regional Operational Centre (ROC) and GOLD Command	• Mutual Aid response, sub-region escalation to the South West Critical Care Network • Critical Care Huddle informed • Business as Usual SOP **Appendix 1 2 and 4** • Refer to **Appendix 13** Principles of Capacity Transfer • Completion of SBARD **Appendix 15** • Inform the Regional Operational Centre (ROC) • Evoke Joint Decision Model (JDM) referring to JESIP guiding principles **Appendix 9**

Amber Surge
 	
CRITCON 2-3
Medium to High Surge
	Amber Surge
	<175% Core Capacity – Green Surge capacity exceeded (393)
	• Treatment at capacity utilising all available overflow beds.
	• Demand exceeds supply of treatment. Prioritisation is essential.
	• No clear plans for equipment, oxygen capacity physical barriers to further expansion
	• Staffing recommended levels exceeded
		Regional Level - Regional Operational Centre (ROC) – GOLD Command
		
		Regional Level with direct links to National SPOC single point of contact address england.spocskh@nhs.net
			• Once Green Surge Capacity reached all SWCCN sub-regions instructed to move to Amber Surge
			• Actions as per Green Surge
			• ***In hours*** – Activation Response Team **Appendix 3**
			• ***Out of Hours*** NHSE/I on call see **Appendix 2**
			• Coordination through the Regional Operational Centre (ROC)
			  ○ Regional GOLD Command
			  ○ Incident Control Centre (ICC)

Maximum Capacity
 	
CRITCON 4 Emergency Triage
	Maximum Capacity Reached
	>175% Core Capacity - Amber Surge Capacity in use
	• Demand exceeds supply of treatment. Prioritisation is essential.
	• No clear plans for equipment, oxygen capacity physical barriers to further expansion
	• Staffing recommended levels exceeded
	• Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation). *This must **only** be implemented on National directive from NHSE/I and in accordance with National guidance*
		Regional Level with direct links to National SPOC single point of contact address england.spocskh@nhs.net	• Actions as per Amber Surge
			• Coordination through the Regional Operational Centre (ROC)
			  ○ Regional GOLD Command
			  ○ Incident Control Centre (ICC)

5. In and out of hours process

5.1. In hours: (09:00-17:00 Monday – Friday)

- South West CCN Lead Nurse and Manager/Coordinator actively monitoring Unit capacity across the South West membership described in SOP as per Appendix 2

- Escalation of issues though business as usual processes including network hubs and between Units

- South West / Dorset / Salisbury CCN lead or nominated System ICC to notify NHSE/I South West Regional Operational Centre (ROC) when Green surge is at, or likely to exceed 75% capacity in the next 72 hours.

In Hours Escalation

- Once notified the NHSE/I South West Regional Operational Centre (ROC) Director convenes a call with the Critical Care Cell Director, SW CCN Coordinator, Critical Care Cell and Retrieve (Adult Critical Care transfer service) representatives to support the decision making around surge capacity, movement of patients and changes to specialised commissioned services that would impact or are impacted by the surge. NHSE/I Retrieve lead, CCG ICC representatives, representatives from the relevant network hubs and SWASFT as required on the call.

The Regional Operational Centre (ROC) will:

- Through a single point of contact ensure all systems are updated regularly
- Notify the NHSE/I Comms team to ensure appropriate comms are in place including Regional and National updates
- Monitor critical care capacity situation reports to ensure the right processes are in place to support the systems surge response.
- Ensure appropriate record keeping including capturing actions and decisions on Critical Care escalation calls

5.2. Out of Hours (17:00-08:59 and Monday to Friday, Saturday and Sunday)

- Out of hours NHSE/I South West will be alerted to Critical Care escalation issues through Regional on-call Manager; CRITCON 1-2 refer to BAU SOP Appendix 2, CRITON 3-4 / Level4 Incident refer to Appendix 3
- Regional on call manager:
  - Escalates to the Regional Director on-call
  - Notify the NHSE/I Comms on Call
  - Alerts the on-call Critical Care Cell members as per SOP Appendix 3

- Convenes a teleconference with all the above, relevant CCG on-call Director(s).

Critical Care Escalation teleconference

The teleconference to address critical care escalation will utilise a set agenda to support coordination of the response See Appendix 2 and 3, based on the Joint Decision Model (JDM) referring to the Joint Emergency Service Interoperability Principles (JESIP) Appendix 9.

6. Role of the Critical Care Network in hours:

6.1. The Critical Care network will support the Regional Operational Centre (ROC) in decision making in the delivery of Critical Care services and any services that impact on critical care demand

6.2. The SW Critical Care Network will help co-ordinate the development of aid strategies to sub-regions based on the daily sitrep, geography, transport, capacity and resource status of the region.

6.3. The surge plan will include specific trigger points for reverting to local provision – refer to sub-regional escalation plans and de-escalation guiding principles as per Appendix 12 Restoration Planning.

6.4. The role of the CCN in relation to the huddle and Regional Operational Centre (ROC) is to provide expert clinical advice, recommendations and guidance to ensure all critical care units in the region are aware of the escalation status and help co-ordinate plans to ensure all systems are preparing to support through mutual aid response or prepare for their own surge.

7. Potential Outcomes of escalation

7.1. Regional decision to move resources (mutual aid) across the SW Critical Care Network - be that moving patients, equipment or staff.

7.2. Identify options to change standard service flows or configurations.

7.3. Implementation of changes would be in discussion with the relevant system Incident Control Centre (ICC) and providers albeit the final decision will be made through the Regional Operational Centre (ROC).

7.4. Development of an action plan to ensure support within local system and a plan for returning to core bed base at the earliest opportunity will be coordinated by the South West Critical Care Network and via Critical Care Huddle as appropriate.

7.5. In extremis when CRITCON 3-4 is declared, members of the Activation Response Team (ART) as per Appendix 3 and 4 may be stood up in. In hours refer to Business as Usual SOP as per Appendix 2 and SBARD Appendix 15.

8. System Monitoring

8.1. To manage the system, demand on all units will be monitored using the nationally defined SITREP report and specialised commissioning DOS report collated by the Critical Care Network. It will be monitored daily through a dashboard produced by the analytical cell.

8.2. In the event of surge planning being implemented, monitoring of the impact of the changes and support to de-escalate will be facilitated through the Regional Operational Centre (ROC); who will liaise with local sub regions and the Critical Care huddle.

8.3. The daily critical care situation report will increase frequency (2-4 hourly or as required) to provide data to inform the regional planning of required actions, such as moving resources (staff / equipment), re-designation of units with the cooperation of the system as a response.

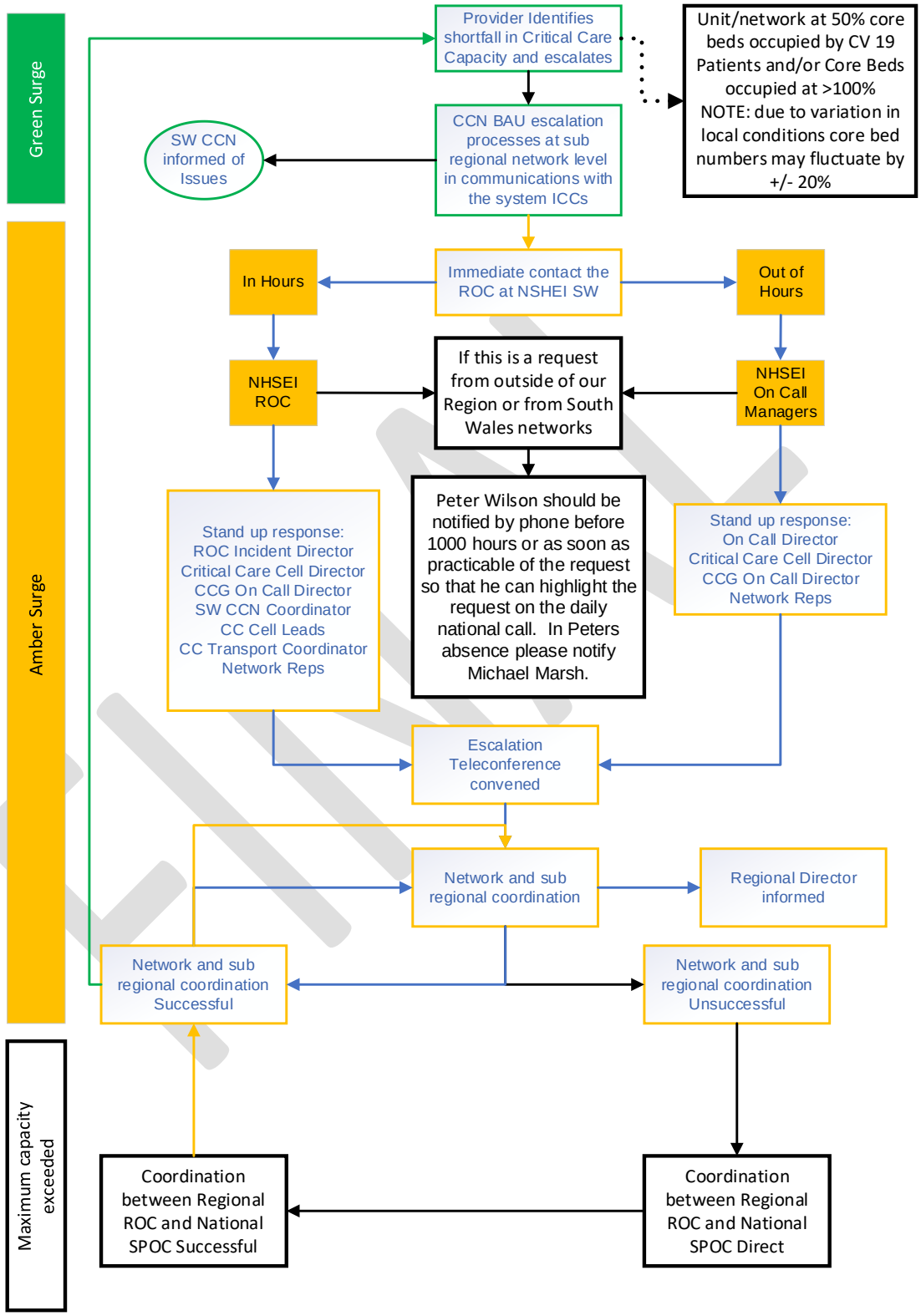
9. Incident Levels

As an event evolves it may be described in terms of its level as shown. For clarity these levels must be used by all organisations across the NHS when referring to incidents.

Level 2 An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.

Level 3 An incident that requires the response of a number of health organisations across geographical areas within an NHS England region.
NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

Appendix 1: Critical Care Escalation flow diagram



Appendix 2 – Business-as-Usual (BAU) escalation SOP CRITCON 0-2

IN HOURS

1. Contact SWCC Network Lead Nurse and Manager M.07920 767772 and notify escalating pressures i.e. Beyond capacity and trigger thresholds
2. Network Mutual Aid response via SWCCN clinical members WhatsApp group
3. Discussion with regional huddle members on status of sub-region and or regional level of escalation and response needed including;
    a. Physical capacity and any surge – ACC data dashboard update
    b. CRITCON including staff declaration
    c. Patient dependency
    d. Nursing ratios and whether in line with GPICs / BACCN
    e. Submission of ***SBARD Appendix 15*** to provide situational report
    f. Refer to Principles of Capacity Transfers ***Appendix 13***

OUT OF HOURS

4. NHSE/I On-call Manager notified of escalating pressures beyond capacity and trigger thresholds (SBARD ***Appendix 15*** provided by provider as part of escalation triggered to give situation report)

South West North On call: 0303 033 8833
(Bristol, North Somerset, South Gloucestershire (BNSSG) and Bath, Gloucestershire, Swindon and Wiltshire (BGSW)
South West South On call: 0303 033 5533
(Devon, Cornwall and Isles of Scilly (DCIOS) Dorset & Somerset)

5. Escalation triggered NHS/I Manager on-call notified, on-call manager alerts EPRR and Director on-call, coordination via the Regional Operational Centre (ROC)
6. Ensure elective surgery (other than P1 and P2) cancelled, acknowledging might be going outside recommended staffing ratios with all commissioned beds opened
7. Refer to standing Agenda as per Appendix 4, Invite Urgent and Emergency Care (UEC), SWASFT, Retrieve as required
8. ROC shift lead provides coordination of activities and invites a named loggist and minute taker to support decision response, strategic oversight of escalation.
9. ROC Coordinate Regional teleconference via MSTeams and stand up all members required;
    a. **IN HOURS** invites regional huddle members as required subject to need and ensures ICS incident room aware
    b. **OUT OF HOURS** invites system provider membership, provider lead clinician (if available), provider executive on-call, CCG director on-call for local sub-region or region ICS representative
10. Regional Operational Centre (ROC) coordinate and help guide on decisions and recommendations for action to support mutual aid response and de-escalation
11. **REFER TO APPENDIX 4 FOR TELECONFERENCE STANDING AGENDA**

Appendix 3 – Activation Response Team (ART) and SOP in extremis CRITCON 3-4 / Level4 Incident

1. Escalation triggered – Activation Response Team stood up
2. # denotes leads responsible for standing up core members of Activation Response Team
3. Lead Coordinators identified as 1, 2 and 3 – teleconference set up
4. SRO provides decision response, strategic oversight of escalation. Coordination of activities and actions supported by ART core members and EPRR (EPRR invite UEC if needed)
5. Coordinate Regional teleconference standing up members
6. invites regional huddle members as required subject to need
7. Regional Operational Centre (ROC) coordinate and help guide on decisions and recommendations for action to support mutual aid response and / or de-escalation
8. **REFER TO APPENDIX 4 FOR TELECONFERENCE STANDING AGENDA**

Role	Lead	Contact
SRO	# Steve Sylvester (ART) (IRG) Director	steve.sylvester@nhs.net
Critical Care Admin	# **3**. Chrissie Bugden (ART)	chrissie.bugden@nhs.net
Medical Director / SRO	# Peter Wilson (ART) (IRG)	peter.wilson23@nhs.net
Regional Operational Centre (ROC)	Dean Spencer – ROC Director (ART) deanspencer@nhs.net **South West North On call: 0303 033 8833 (BNSSG, BGSW)** **South West South On call: 0303 033 5533 (DCIOS, Dorset & Somerset)**	england.sw-roc21@nhs.net
EPRR	EPPR (ART) Neil Vine neil.vine@nhs.net Ian Phillips ian.phillips1@nhs.net	england.sw-eprr@nhs.net
Critical Care Network Clinical Leads	1. # Graham Brant (ART) (IRG) Lead Nurse and Manager # Andy Georgiou (ART (IRG) Clinical Director # Martin Schuster-Bruce (ART) Clinical Lead # Matt Thomas (ART) Deputy Clinical Director # Scott Grier (ART) Clinical Lead – Transfer (Retrieve)	Graham.brant@uhbw.nhs.uk Andrew.georgiou@nhs.net martin.schusterbruce@uhd.nhs.uk Matthew.Thomas@uhbw.nhs.uk scott.grier@nhs.net
ACC Thames Valley and Wessex	Kujan Paramanantham (ART)	kujan.paramanantham@nhs.net england.tv-w-criticalcarenetwork@nhs.net
System Transformation Lead	2. # Donna Bowen (Adult Critical Care and Major Trauma Region contact) (ART)	donna.bowen2@nhs.net
Sub Region	Mark Cooke – Strategy & Transformation Director (ART) Matt Thomas (ART) Severn Carmen Chadwick-Cox CCG (ART) Severn	mark.cooke1@nhs.net Matthew.Thomas@uhbw.nhs.uk carmen.chadwick-cox@nhs.net

	Darryn Allcorn CCG (ART) Peninsula	darryn.allcorn@nhs.net
Adult Critical Care Transfer **'Retrieve'**	Scott Grier (ART) Deputy – Dave Ashton-Cleary	scott.grier@nhs.net d.ashton-cleary@nhs.net

Appendix 4: Critical Care Escalation Agenda

Purpose:	1. Coordinate and manage Critical Care Escalation teleconference/MSTeams
Confirm Chair	1. Confirm Chair, Loggist and (if available) minute taker 2. Membership required – as per Business-as-Usual SOP Appendix 2 and in extremis as per Regional Contacts and SOP Appendix 3
Record meeting	1. Confirm attendance 2. Identify whether any additional members required (trusts/ CCG/ICS Retrieve (Adult Critical Care Transfer service lead) who will invite SWASFT if required
Strategic Objectives	1. Confirm objective of the meeting 2. Provide regional coordination of critical care resources across the South West to secure capacity, mutual aid response and mitigate patient harm **/ xxx** 3. To aid planning and resilience during escalation and support actions to de-escalate
Gather Information	1. Gather Information/Intelligence (including from closed communities) and review actions taken 2. Receive updates from Retrieve on capacity and demand to support transfers 3. Request SBARD completion as situational report from provider 4. Request update on METHANE report from SWASFT if required Is there any further information required? Major patient safety issues, concerns or risks, workforce or equipment issues and recommended course of action
Assess risk & develop working strategy	Agree a common understanding of risk • Discuss and confirm all participants understand the joint assessment of risks to support a common understanding of threats, hazards, likelihood and impact? Identify the key actions and response to mitigate • Agree responsibility and timescales for achieving objectives • Ensure the response is aligned to the objectives • Undertake a 'Horizon scan' to identify any potential/ emerging issues • Confirm whether there are any barriers to achieving the objectives (e.g. resource, logistics and time constraints) *If you must account for your decision, will you be able to say it was: Proportionate / Legitimate / Necessary / Ethical*
Consider Powers, Policies and procedures	Is there any legislation / process/ guidance that supports OR is a barrier to achieving the agreed actions?
Confirm Actions	1. Confirm actions and log each decision taken and by who 2. Clear leads and timelines for each action 3. Check with each organisation for anything additional to give rationale for the decision taken and any follow up response necessary to achieve the right outcome
Review	*(subsequent meeting:)* *Monitor impact of agreed actions* *Were the results as intended?* *Corrective actions required?*
Agree 'battle rhythm'	1. Agree timings for subsequent meetings 2. Membership 3. Frequency
Share action log	Circulate action log to the group and be clear on who is responsible, accountable and the timelines
Debrief	Consider a debrief; any learning outcomes and recommendations to address further iterations of the escalation framework and or ongoing risk management

Appendix 5 – CRITCON Levels

ACC CRITCON Levels

Please declare CRITCON level

DEFINITION	STATUS
Normal – *'Business as usual'*	
• Normal, able to meet all critical care needs, without impact on other services • Normal winter levels of non-clinical transfer and other overflow activity.	CRITCON 0
Low Surge – *'Bad winter'*	
• Usual funded critical care capacity full. Some non-clinical transfers	CRITCON 1
Medium Surge – *'Unprecedented'*	
• Usual funded critical care capacity full – overflow into quasi-critical care areas (theatre recovery, other acute care areas). High level of non-clinical transfers • Trusts beginning mutual aid	CRITCON 2
High Surge – *'Full stretch'*	
• Expansion into non-critical care areas (e.g. wards) and/or use of paediatric facilities for adult critical care. Trust operating at or near maximum physical capacity. • Maximum mutual aid between Trusts. Region wide geographical options appraisal for out of region mutual aid The prime imperative in CRITCON 3 is to prevent any single trust entering CRITCON 4	CRITCON 3
Triage – *'Emergency'*	
• Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation). • This must **only** be implemented on national directive from NHSE and in accordance with national guidance.	CRITCON 4

Staff Declaration: CRITCON 1,2 & 3 SHOULD BE FURTHER CATEGORISED A OR B	
• Adhering to BACCN / ICS staffing recommendations or unit norm	A
• Staffing below BACCN / ICS staffing recommendations or unit norm	B

Appendix 6 – Region Members Critical Care Huddle – in extremis CRITCON 3-4 / Level4 incident

TO NOTE
Activation Response Team (ART) Escalation Triggered (Appendix 3 and 4)
Initial Response Group (IRG) inter-region mutual aid (Appendix 7)

South West Region Contacts (HUDDLE)			
Role	**Lead**	**Responsibility**	**Contact**
SRO	Steve Sylvester (ART) (IRG) Director	Strategic decision response and oversight of escalation coordination	steve.sylvester@nhs.net
Medical Director	Peter Wilson (ART) (IRG) Medical Director	• NHSE/I decision response and oversight	peter.wilson23@nhs.net
Critical Care Network Clinical Leads **ACTIVATION RESPONSE TEAM (ART)**	Graham Brant (ART) (IRG) Lead Nurse and Manager Andrew Georgiou (ART) (IRG) Clinical Director Martin Schuster-Bruce (ART) Clinical Lead Matt Thomas (ART) Deputy Clinical Director Scott Grier (ART) Clinical Lead – Transfer 'retrieve'	• Activation response and standing up members as a result of escalation triggered. • Coordinate regional teleconference Guiding ROC on decisions and recommendations for action to support mutual aid response and support de-escalation	Graham.brant@uhbw.nhs.uk Andrew.georgiou@nhs.net martin.schusterbruce@uhd.nhs.uk Matthew.Thomas@uhbw.nhs.uk scott.grier@nhs.net
System Transformation Leads	Donna Bowen (Adult Critical Care and Major Trauma) (ART) Charlotte Ives and Claire Kennedy (Paed Critical Care and Surgery in Children)	NHSE/I Regional point of contact for Adult Critical Care supporting in hours coordination of activities. STL support contact	donna.bowen2@nhs.net charlotteives@nhs.net claire.kennedy10@nhs.net

Critical Care Huddle	Chrissie Bugden (ART	Huddle - Admin support	chrissie.bugden@nhs.net
Deputy Director	Luke Culverwell	NHSE/I decision support and oversight	luke.culverwell@nhs.net
Head of Acute Transformation	Kat Young	Spec Comm Advice and Guidance ODNs	katharineyoung@nhs.net
Head of Acute Commissioning	Selena Riggs	Spec Comm Advice and Guidance Providers	sriggs@nhs.net
ROC Regional Operational Centre	Dean Spencer – ROC Director (ART) deanspencer@nhs.net	Escalation response and regional coordination **South West North On call: 0303 033 8833 (BNSSG, BGSW)** **South West South On call: 0303 033 5533 (DCIOS, Dorset & Somerset)**	england.sw-roc21@nhs.net
EPRR	EPPR (ART) Neil Vine neil.vine@nhs.net Ian Phillips ian.phillips1@nhs.net	Activation Response team - Emergency Preparedness Resilience and Response	england.sw-eprr@nhs.net
UEC	Kevin Johnson	Regional Head of Urgent and Emergency Care	kevin.johnson@nhs.net
Adult Critical Care Thames Valley and Wessex	Kujan Paramanantham (ART) Gillian Leaver - Deputy	Sub regional Network Lead Lead Nurse	kujan.paramanantham@nhs.net gillian.leaver@nhs.net
Strategy and Transformation	Mark Cooke – S&T Director (ART)	Responsible for determining use of resources and capacity across the South West	mark.cooke1@nhs.net
Adult Critical Care Transfer	Scott Grier (ART) Dave Ashton-Cleary (Deputy)	Retrieve – coordinate and prioritise Adult Critical Care transfers in and out of hours response www.retrieve.nhs.uk/refer	scott.grier@nhs.net d.ashton-cleary@nhs.net
SWASFT	Phil Cowburn *Escalation will be supported by first point of contact; Trust Incident Manager (TIM) which is 24/7 response 0300 303 4874*	Acute Care Medical Director / GOLD Command *SWASFT input determined by Retrieve clinical lead or deputy as required*	philip.cowburn@swast.nhs.uk

Pharmacy	Tracey Williams	Chief Pharmacist	tracey.williams10@nhs.net
Emergency Medicine Consultant and HEE Workforce	Lisa Munro-Davies	Workforce Advice and Guidance	Lisa.Munro-Davies@hee.nhs.uk
CCG	Darryn Allcorn (ART) Peninsula	CCG perspective - Advice and guidance SURGE BEDS	darryn.allcorn@nhs.net
CCG	Carmen Chadwick-Cox Severn (Somerset)	CCG perspective – Advice and guidance SURGE BEDS	carmen.chadwick-cox@nhs.net
CCG Clinical Lead	Amelia Randal	Ethical Framework – Advice and guidance	amelia.randle@nhs.net
Comms	Annie Tysom Head of Comms Connor Dicks	Escalation System communications cascade	annie.tysom@nhs.net connor.dicks1@nhs.net
Renal Replacement Therapy	Luke Culverwell Anna Masserick	Advice and Guidance Renal response and coordination – shortage supplies (PROCESS)	luke.culverwell@nhs.net anna.masserick@nhs.net
Analytics	Marcus Albano Graham Brown Adam Scull	Data requirements and monitoring of capacity, demand and activity	marcus.albano@nhs.net graham.brown12@nhs.net adam.scull@nhs.net

Appendix 7 – inter - region Mutual Aid

Process

1. Regional EPRR team leads alert national team for mutual aid request.
2. National team instigate meet with all regions to discuss and consider request.
3. Response from South West will be informed through conversations through sub regions and networks on ability to respond to request

Initial Response Group (IRG)

Steve Sylvester	SRO and Director
Sam Waddy	Clinical Director SW CCN
Graham Brant	Nurse Lead and Network Manager SW CCN
Peter Wilson	Medical Director
EPRR	Refer to Region Contacts (Appendix 6)
Sub Region	Refer to required sub region lead as per Region Contacts (Appendix 6)
Martin Wilkinson	Director of Planning and Performance

See below DRAFT V0.1 National process embedded, Panel and TOR.

Critical%20Care%20Capacity%20Panel_ToR

South West Region Critical Care Capacity Management Principles v1.5

SW Regional Critical Care Capacity Manag

National Critical Care Capacity Panel – Repatriation Principles v3.1 (pending approval)

CCCP repatriation principles_v3.1 draft.d

Appendix 8 – Adult Critical Care Transfer SOP 'Retrieve' v1.4

For critical care transfer, the Retrieve service operates a 24/7 single point of access telephone number **(0300 030 2222)** through which all calls are consultant triaged, coordinated and, if required, given decision-support.

The clinical service operates 09:00-21:00hrs, providing adult critical care transfer with consultant-led teams operating in Peninsula and Severn.

Regional colleagues can access the Duty Consultant via the above number.

Retrieve operates a ***Leadership Team on-call*** that can be accessed by the Duty Consultant if required.

Consultant in Intensive Care Medicine and Anaesthesia,
Southmead Hospital, Bristol
Lead Consultant, Retrieve
South West Critical Care Network Lead for Transfer

Referring to Retrieve v1.4 21102020.pdf

Appendix 9 – Joint Decision Model (JDM)

Joint Emergency Service Interoperability Principles (JESIP)

Joint Decision Model (JDM)

All Directors and Managers should use the Joint Decision Model (JDM) to help bring together the available information, reconcile objectives and make effective decisions together. Like most decision models, the JDM centres around three primary considerations:

Situation	Direction	Action
What is happening? What are the impacts? What are the risks? What might happen and what is being done about it?	What do you want/need to achieve in the first hour (the desired outcomes)? What are the aims and objectives of the emergency response? What overarching values and priorities will inform and guide this?	What do you need to do to resolve the situation and achieve your desired outcomes?

Along with a Directors and Managers personal experience and knowledge of any given situation, the JDM is designed to help Directors and Managers make effective decisions together.

Overarching Aim

The overarching aim or purpose for using the JDM is common to all those involved in managing a response - the words in the centre “Working Together – Saving Lives, Reducing Harm”. All Directors and Managers and responding staff should remind

themselves of the importance of this purpose when responding to a multi-agency/organisation incident and applying JESIP.

Gather information and intelligence

The first stage of the JDM helps Directors and Managers gather all known information - or situational awareness – about the ongoing situation. Directors and Managers should ask:

- What is happening?
- What are the impacts?
- What are the risks?
- What might happen?
- What is being done about it?

Shared Situational Awareness is achieved by sharing information and understanding between the involved organisations to build a stronger, multi-dimensional understanding of events, their implications, associated risks and potential outcomes.

Responders cannot assume other service/organisational personnel see things or say things in the same way, and a sustained effort is required to reach a common view and understanding of events, risks and their implications.

Assess risks & develop a working strategy

The second stage of the JDM prompts Directors and Managers to ensure they have reviewed and understood all risks so that appropriate control measures can be put in place. Understanding risk is central to the response. One of the major challenges in successful joint response is for responders to build and maintain a common understanding of the full range of risks, and the way that those risks may be increased or controlled by decisions made and actions taken by the responders.

Consider powers, policies and procedures

The third stage of the JDM aims to ensure Directors and Managers have considered the following when planning their joint response:

- What relevant laws, standard operating procedures and policies apply?
- How do these influence joint decisions?
- How do they constrain joint decisions?

In the context of a joint response, a common understanding of any relevant powers, policies, and procedures is essential in order that the activities of one service complement, and do not compromise, the approach of the other services. This may also include considering all capabilities services can provide to find the most appropriate for the incident.

Identify options and contingencies

The fourth step of the JDM reminds Directors and Managers to consider all potential options when planning the joint response. For every potential option or contingency should consider:

- Suitability
- Feasibility
- Acceptability

There will almost always be more than one option to achieve the desired end state, and it is good practice that a range of options are identified and rigorously evaluated.

Whatever option(s) is chosen, it is essential that responders are clear about what they are required to carry out. Where the option is time-critical, there should be clearly agreed procedures for communicating any decision to defer, abort or initiate a specific tactic.

Take action and review what happened?

The fifth step of the JDM is about reviewing what has taken place and, if required, re-evaluating and amending plans.

Building situational awareness, setting direction and evaluating options all lead to taking the actions that are judged to be the most effective and efficient in resolving the issue.

As the JDM is a continuous loop, it is essential that the results of agreed actions are fed back into the first box - Gather and share information and intelligence - which establishes shared situational awareness. This will, in turn, shape any revision to the direction and risk assessment, and the cycle continues.

The JDM can be used in any multi-agency/organisational response environment. It is designed to be used in fast moving, dynamic situations but can equally be applied to pre-planning activity or more slowly evolving situations.

The follow decision tree may be helpful in providing a basis for moving through the Decision tree.

Appendix 10 – Allocation of Equipment

South West Critical Care Network

SOP for Equipment requests

There is a limited national stockpile of ICU equipment consisting of:

- Blood Gas Analyser
- Bronchoscope
- Enteral Feed Pumps
- Humidifier
- Mechanical Ventilator – Anaesthetic
- Mechanical Ventilator - Emergency
- Mechanical Ventilator - ICU
- Mechanical Ventilator – Transport
- NIV (BiPaP)
- NIV (CPAP only)
- Oxygen Concentrators
- Oxygen Regulators
- Patient Monitors
- Suction Pumps
- Syringe Drivers
- Video Laryngoscope
- Volumetric Pumps

Process

1. Identify type of device / manufacturer / model and order of preference
2. Make contact with the South West Critical Care Network (SWCCN) and complete Annex A, return via **swccn@uhbw.nhs.uk**

   ANNEX A

   include in the subject heading: ***Critical Care Equipment Loan Application***
3. SWCCN will contact the Regional Operational Centre (ROC) to achieve the required equipment.

NOTE: The Regional Operational Centre (ROC) have access to foundry where the most up to date equipment list is stored. **england.sw-roc21@nhs.net**

- If devices are listed they can be requested and should be provided free of charge.
- If devices are listed and the request is urgent, they can be provided within 3 days, subject to out of hours delivery details being provided.
- The devices will be delivered to the respective Trust stores / Goods inwards department
  - The Network may be able to assist with identifying units in region who may be able to offer a short-term loan of same equipment or transfer of existing national loan equipment if not required locally.
  - If impossible to provide equipment at all, is this a patient care limiting problem?
    - i.e. does the unit require patients to be transferred out to provide ongoing ICU care?
  - Ensure alternatives have been considered (e.g. for ventilators consider use of anaesthetic machines).

Appendix 11 – Wave 2 Surge Plan Summary - National Context

For Internal Use Only - Strictly Not for Onward / External Circulation
NOT AGREED POLICY

Surge Plan:		Adult Critical Care (ACC)
National Leads:	Ramani Moonesinghe / Jane Eddleston (Clinical)	Jacquie Kemp (Commissioning)
Summary of Approach to Surge	• Severe COVID Response Cell providing national leadership and co-ordination of over-lapping critical care workstreams and associated interdependencies – provides national oversight of surge / expansion plans • Identification / introduction of new evidence based COVID treatments via multi-agency RAPID-19 group • Surge planning led at regional level, supported by national modelling, alongside requirement to maximise the protection of elective and other urgent care provision (EU Exit, winter pressures, seasonal flu and recovery) • Adult critical care transfer model and toolkit available (NHS Futures) enabling mutual aid as part of expansion plans • Linked capital investment programme to support ACC expansion • Pooled access to oxygen, equipment and consumables managed through national mechanism and NHSEI Cell • Linked ECMO and Renal Replacement Therapy in Critical Care Plans	
Priority Risks for Mitigation	• Access to equipment and consumables • Oxygen infrastructure roll out in progress, but noted additional challenges in winter • Trusts and region's ability for the ongoing maintenance of essential services • Some centres not affected in wave 1 may not be as prepared for surge demand	
Supporting Data	New aligned data platform being developed to rationalise reporting – testing planned in October. Provides national operational data for day-to-day management, escalation and mutual aid in development	
Inequalities Considerations	Wave 1 saw an increase in the percentage of admissions for BAME groups compared to usual winter viral pneumonia admissions (8.6% compared to 25.5%). 70% of admissions were male compared to 54% in historic viral pneumonia admissions.	
Mechanism for Escalation of Issues *(Where*	Point of contact: england.ncpt@nhs.net	

Local Resolution Not Possible)	Weekly call with regional critical care cell leads. National co-ordination and oversight provided by Severe COVID Response Cell	
ACTION CHECKLIST		
Providers:		
Graded surge plans are in place by individual providers and ICS / STP networks in order to enable a stepwise approach to reduction in non-emergency services in the event of a major surge, rather than a binary stop / start approach		√
Develop realistic plans for expansion of critical and enhanced care services given capital, revenue and, most critically, staffing constraints		√
Ensure there are robust plans for transfer and mutual aid and that smaller units have ongoing support to manage capacity and intensity of work (including use of telemedicine and other remote support services)		√
Providers to support staff training to be able to deliver enhanced and intensive care. This might be in the form of secondments; study leave or provision of courses. Access now available to a European training programme.		√
Ensure oxygen and estates provision are sufficiently robust to provide anticipated increase in capacity		√
Actively engage with patients to support establishment of further research		√
Networks:		
Ensure transfer of patients across the networks is happening in a timely and safe manner to assist individual centres with capacity management.		√
Provide daily oversight of activity, demand and capacity by ensuring national data requirements are met		√
Support mutual aid across providers as appropriate		√
Supra-Regional / Regions / ICSs:		
SR: Proactive discussion between neighbouring regions about conditions in which mutual aid between regions would be enacted		√
R: Facilitate mutual aid within and between regions given potential for geographical surge		√
R: Endorse and support the development of ACC transfer services		√
R: Working with ICSs manage equipment and consumable demand and allocation when shortages or crisis in supply occur.		√
ICS: Facilitate mutual aid within systems		√
ICS: Provide oversight of resource and ability to deliver critical care, proactively monitor activity and capacity and be first point of contact for facilitating mutual aid across the ICS.		√
ICS: Working with regions, manage equipment and consumable demand and allocation when shortages or crisis in supply occur.		√
National:		
Establish and run Severe COVID Response Cell (led by EPRR)		√
Use updated CRITCON levels on the basis of learning in wave 1 to allow regions to respond rapidly and identify the need for mutual aid		√
Support providers and regions in step up/step down plans for elective services with guidelines around procedure and patient prioritisation (see Service Protection Plans)		√
Support rapid development of enhanced care guidelines in collaboration with colleges, to enable regional development of enhanced care provision		√
Provide national transfer model and support the regions in the development of regional business cases to optimise access to revenue funding.		√
Develop and deliver a national dataset and single reporting point of entry for operational data		√

Appendix 12 – South West Critical Care Network (SWCCN) Restoration Planning / Guiding Principles

SWCCN Restoration Plan March 2021 (Guic

Appendix 13 - Principles of Capacity Transfers 'business as usual'

These principles apply to "business as usual" situations, where an individual trust has reached their commissioned capacity. There are modifications to re-balance services and protect critical specialist services during a pandemic where patient safety is better maintained by planning and predicting the need for capacity transfers.

Principles of Capacity Transfers SWCCN

Appendix 14 Adult Critical Care, Neonatology and Paediatric Intensive Care Huddle temporary

TEMPORARY Agenda (effective 18th August 2021)

1.	**Welcome & Introductions –** Peter Wilson / Steve Sylvester
2.	**Covid records management reminder –** Peter Wilson / Steve Sylvester
3.	**Neonatology** **1. Operational Issues by exception** **2. Reaching any triggers** **3. Transfer Services** **4. Update on any relevant national work programmes**
4.	**Paediatric Intensive Care** **1. Operational Issues by exception** **2. Reaching any triggers** **3. Transfer Services** **4. Update on any relevant national work programmes**
5.	**Adult Critical Care** **1. Numbers** **2. Sub regional operational issues by exception** **3. Reaching any triggers** **4. Transfer Services** **5. Update on any relevant national work programmes**
6.	**Any key actions or agreements required to be recorded and retained for audit purposes**
	Close

Adult Critical Care STANDING Agenda

No	Priority	Lead
1.	Welcome, National/Regional update and Action log	Steve/Peter

2.	• Status update
	• Position against escalation triggers
	• Clinical sub region updates
	  ○ Peninsula
	  ○ Severn
	  ○ South Wilts & Dorset
	• Triggers reached and consideration to use of resources and alternative avenues of capacity
	• Transfer services
	• Review of inter-regional mutual aid requirements
	• Review of escalation protocol – Wednesdays
		• Graham
		• Donna
		• Sam
		• Matt
		• Martin
		• Mark
		• SG/KP
		• Peter
		• Donna

3.	Sub regional delivery a. Delivery against bed plans at sub-regional level b. Equipment c. Use of provide capacity and resources	• Penny • Kujan • Mark
4.	Clinical Network updates	Martin & Sam
5.	Matters to refer to Regional Operations Centre	All
6.	AOB and review of frequency of meetings	Steve/Peter
	Close	

Appendix 15 SBARD

SBARD for capacity (004).doc

Appendix 16 Directory of Critical Care Network Contacts

DIRECTORY of CC Networks - July 2021.p

Appendix 17 CCCP Adult Critical Care Surge Plan Guidance

ACC Surge Plan Guidance Dec 2021.dc