



East of England Adult Critical Care Operational Delivery Network

Standard Operating Procedure – Adult Critical Care Capacity and Surge Management

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Context and Purpose

This document has been developed by the East of England Adult Critical Care Network based on the national surge and escalation plan¹ to clarify the management of increased pressure on critical care services over and above normal variations. It is for the use of the Network and individual units to clarify the recommended actions to continue to provide safe and equitable critical care access for the patients of the region. It provides clear triggers using the CritCon framework (which is monitored daily) to allow early recognition of pressures within the system and a coordinated and timely response within the capabilities of the available resources.

The aim is to ensure that there is equity of care for patients across the region, ensuring a co-ordinated response to high demand for Adult Critical Care in one or more parts of the region. The objective is to avoid inequity or serious compromises in one hospital or ICB within the region whilst others function almost as normal.

The purpose of this guidance is to specifically set out:

The process for the identification of current and potential Adult Critical Care capacity;

A consistent approach by which providers of Adult Critical Care Services can escalate very high² capacity pressures to commissioners and the ICBs;

How provider organisations, Adult Critical Care Network, ICBs and their stakeholders should respond to such escalations; and

The anticipated escalation process locally, regionally, and nationally across NHS England in support of Adult Critical Care Networks (including the NHS Strategic Command arrangements to be implemented by NHS England should they be required).

For the purpose of this document, 'critically ill' is defined as requiring a level of care greater than that normally provided on a standard hospital ward.

Levels of care are defined based on the monitoring and support patients require, rather than the location in which they are receiving care. They have been developed by the Intensive Care Society and set out in their Levels of Adult Critical Care Consensus statement² as described in Figure 1.

¹ Management of surge and escalation in critical care services, July 2022. NHS England.

² [2021-03 Levels of care second edition.pdf \(norf.org.uk\)](#)

Ward Care

- Patients whose needs can be met through normal ward care in an acute hospital.
- Patients who have recently been relocated from a higher level of care, but their needs can be met on an acute ward with additional advice and support from the critical care outreach team.
- Patients who can be managed on a ward but remain at risk of clinical deterioration.

Level 1 – Enhanced Care

- Patients requiring more detailed observations or interventions, including basic support for a single organ system and those 'stepping down' from higher levels of care.
- Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward.
- Patients who require ongoing interventions (other than routine follow up) from critical care outreach teams to intervene in deterioration or to support escalation of care.
- Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged on the basis of clinical circumstances and ward resources.
- Patients who would benefit from Enhanced Perioperative Care.⁽³⁾

Level 2 – Critical Care

- Patients requiring increased levels of observations or interventions (beyond level 1) including basic support for two or more organ systems and those 'stepping down' from higher levels of care.
- Patients requiring interventions to prevent further deterioration or rehabilitation needs, beyond that of level 1.
- Patients needing two or more basic organ system monitoring and support.
- Patients needing one organ systems monitored and supported at an advanced level (other than advanced respiratory support).
- Patients needing long term advanced respiratory support.
- Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, in particular maintaining their safety if severely agitated.
- Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure and/or the patient's condition and co-morbidities.
- Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere.
- Patients requiring nursing and therapies input more frequently than available in level 1 areas.

Level 3 – Critical Care

- Patients needing advanced respiratory monitoring and support alone.
- Patients requiring monitoring and support for two or more organ systems at an advanced level.
- Patients with chronic impairment of one or more organ systems sufficient to restrict daily activities (co-morbidity) and who require support for an acute reversible failure of another organ system.
- Patients who experience delirium and agitation in addition to requiring level 2 care.
- Complex patients requiring support for multiple organ failures, this may not necessarily include advanced respiratory support.

Figure 1: Levels of Care. From Intensive Care Society definitions

It is recognised that the escalation arrangements outlined in this guidance may not be required solely as a result of exceptional increased demand for Adult Critical Care Services, but also as a requirement to support increases in demand for interdependent services. Further information on these services can be found in Section 9.

To align with the "system first" approach, this guidance sets out stepped thresholds for decision making for each defined phase of surge. As such, this guidance supplements and should be read in conjunction with:

- Local escalation plans for health and social care services.
- Standard operating procedures for adult critical care transfer and other interdependent services.

- Other critical care service operational policies together with national and professional bodies' guidance.

1. Strategic Aims

- 1.1 This guidance aims to aid local and regional planning for and operational responses to exceptional circumstances³ when demand for critical care exceeds usual capacity.
- 1.2 The strategic aims of this guidance are to:
 - maintain high quality care to support the best possible outcomes for patients with providers working collaboratively across ICB (systems) and /or at regional level;
 - maintain access to Adult Critical Care for any patient that requires it and thereby, prevent avoidable mortality and morbidity;
 - maximise capacity in the critical care system in a range of scenarios through a coordinated escalation and de-escalation approach across geographical footprints;
 - avoid the transfer of critically ill patients wherever possible by ensuring all options to increase capacity have been exhausted prior to the consideration of implementing capacity transfers⁴; and
 - ensure provision of critical care as close to home as possible, whilst maintaining standards of care, including when the transfer of patients is necessary.

2. Principles

Core Principles

- 2.1 The following core principles should guide system responses when managing very high local surge and escalation pressures for Adult Critical Care Services:
 - the stepped increase in capacity in response to demand must be fully aligned with Regional Emergency Preparedness Resilience and Response (EPRR)⁵ principles.
 - “normal” clinical pathways for critically ill patients should be preserved for as long as possible.⁶
 - the provision of emergency, general and specialised services should be preserved for as long as possible.
 - equity of access to treatment should be maintained.
 - nationally recognised professional nursing and medical staffing ratios should be maintained wherever possible, in line with the Adult Critical Care Specifications; and a ‘system first’ approach to the management of Adult Critical Care should be adopted to ensure that capacity is co-ordinated across the system to meet demand.

³ Exceptional circumstances are defined as an increase in demand which results in 100% baseline occupancy with no discharges in the previous 24-hour period.

⁴ Capacity transfers are defined as “transfers for non-clinical reasons” see glossary

⁵ [NHS England » Guidance and framework](#)

⁶ Management of surge and escalation in critical care services, July 2022. NHS England.

Inter-hospital Mutual Aid

- 2.2 When there is persistent demand for critical care beyond usual capacity (i.e. surge conditions) inter-hospital mutual aid⁷ may be required as necessary as a mechanism to manage supply and demand across an ICS/ Regional/inter-regional footprint.
- 2.3 A unit may require decompression for a number of reasons, this includes the maintenance of safe staffing ratios, inadequate capacity to accept emergency admissions and on rare occasions the need to undertake life limiting/lifesaving treatment of another patient.
- 2.4 Inter-hospital transfers may be considered in the following categories:
- **Clinical transfer:** a patient's own clinical care requires expertise unavailable in their current critical care unit or hospital
 - **Repatriation:** the patient is being repatriated closer to home, family, friends, or carers ('repatriation')
 - **Capacity transfer:** the treating critical care unit needs to create capacity to facilitate emergency or urgent clinical care for another patient. This may occur outside surge conditions, in exceptional circumstances, to support urgent admission for another patient.
- 2.5 Key considerations prior to enacting capacity transfers include:
- All patients should have equitable access to critical care when required.
 - If critical care capacity is limited by issues with patient flow such as delayed discharges, these must be resolved before patient transfers are considered.
 - The referring Trust/system/ must have undertaken all reasonable measures to improve critical care capacity whilst maintaining safe staffing limits.
 - The decision to transfer a patient may be required in exceptional circumstances to facilitate another patient's life threatening/limiting surgery or intervention in the referring hospital when safe capacity in the critical care unit has been exceeded or is expected to be exceeded within hours.
 - Decompression of units can facilitate safe provision of critical care across a system when the system is faced with exceptional demand.
 - The decision of who to transfer should be made on a case by case basis following discussions between clinicians in referring and receiving units.
 - The reason for transfer should be explained clearly to the patient and family/next of kin in line with Duty of Candour⁸. Capacity transfers require patient consent or family/next of kin assent.

⁷ Mutual aid = sharing of resources between units, hospitals, trusts, systems or regions. This may occur outside surge conditions in times of shortages (e.g. medicines, equipment) but incorporates the sharing of resources (staff, equipment or disposables) or capacity by moving patients. Capacity transfers have previously been known as mutual aid or non-clinical transfers.

⁸ <https://www.professionalstandards.org.uk/what-we-do/improving-regulation/find-research/duty-of-candour>

Escalation factors

- 2.6 System approaches to co-ordination of the safe management of demand and capacity should be made in alignment to local command and control structures/governance and escalated to national levels in a consistent way.
- 2.7 It is imperative that the triggers to activate additional capacity are sensitive enough to give sufficient time to free up capacity before the system is grid locked.
- 2.8 It is recognised that the management of local surge and wider escalation pressures will be dependent upon the consideration of a number of factors
These factors include:
 - the availability of suitably trained staff, and equipment and specialist supplies. In the case of infectious disease outbreaks, this should include consideration of the additional workforce required to maintain safe staffing in separate cohorted areas.
 - the case-mix of patients in local units.
 - the expected length of stay of patients in local units.
 - the available or forecasted capacity.
 - any underlying disease rates impacting on critical care admission rates and
 - the size of hospitals within systems and the capability to extend critical care or increase surge capacity.

3. CRITCON Levels

CRITCON is a combination of objective criteria AND judgement of frontline clinical leaders, to reflect the strain experienced by critical care units

1. The CRITCON definitions are a set of guidelines for frontline clinical leaders, to help them clearly express the scale and severity of local pressures. They are not didactic definitions.
2. They exist because standard metrics (bed and head counts) do not always represent the totality of pressures experienced.
3. They represent a complex assessment of a complex system, which in turn requires the expert judgement of experienced frontline clinicians who are present at the point of assessment
4. Strain is a reflection on the rate of arrival and/or volume of critically ill patients that a trust or system can accommodate before decompensation.

The purpose of the CRITCON methodology is that it provides a critical care unit pressure score, which takes patient acuity into account alongside an evaluation of the unit's ability to cope and whether mutual aid or other support is required. There is a variation between critical care services ability to cope with surge pressure due to a variety of reasons including staff expertise, equipment, staffing levels etc. This may mean that at CRITCON 2 some hospitals may need to undertake transfers but others will not.

Table 1: CRITCON definitions

CRITCON CRITERIA	LEVEL
BUSINESS AS USUAL <i>Consistent delivery of usual care without impact on other services</i>	0
<p>ALL of the following:</p> <ul style="list-style-type: none"> • Within funded or physical bed base and level 3 equivalent occupancy <100% • Critical Care nurse and medical rota within GPICS staffing ratios • All education, training, audit, and governance arrangements are delivered as normal 	
GROWING PRESSURE <i>Delivery of best possible care in the context of available resources and staff</i>	1
<ul style="list-style-type: none"> • Within funded or physical bed base • Critical Care nurse and medical rota within GPICS staffing ratios <p>WITH ANY of the following:</p> <ul style="list-style-type: none"> • Occupancy 100% against funded or physical bed base, or level 3 equivalent occupancy ≥100% • Cancelled planned surgery because of a lack of staffed critical care bed • One capacity transfer planned, in process or completed • Cancellation of education, training, audit, or governance events in order to achieve bedside staffing standards for at least 24 hours. • Staffing ratios only maintained by redeploying staff from other key critical care services e.g. coordinator, practice educators, follow up clinic, IT or outreach 	
SURGE <i>Derogation of some elements of usual care for some critically ill patients within a Trust/Health Board</i>	2
<p>ANY of the following:</p> <ul style="list-style-type: none"> • Critical care patient numbers mandating expansion beyond funded or physical bed base into escalation areas (theatre recovery, other acute areas) for more than 24 hours • Unable to meet nurse OR medical rota GPICS staffing ratios for up to 48 hours • Cancelled planned surgery because of a lack of staffed critical care beds for 2 or more consecutive days • More than one capacity transfer in 48 hours • Other resources becoming limited because of high demand e.g. monitors, renal replacement therapy 	
SURGE CAPACITY EXCEEDED <i>A sustained derogation from usual care, for all critically ill patients within a Trust/Health Board</i>	3
<p>ANY of the following:</p> <ul style="list-style-type: none"> • Sustained (more than 48h) use of stretched staffing ratios AND use of redeployed non-critical care staff necessary to support critical care • Critical care and escalation areas (theatre recovery, other acute care areas) saturated at full physical OR technological capacity at any point, with no ability to admit more critically ill patients <p>CRITCON 3 should trigger immediate and unhindered mutual aid. The prime imperative during CRITCON 3 must be to prevent any region entering CRITCON 4</p>	
REGIONAL DECOMPENSATION <i>Significant and sustained derogation from usual care, for all critically ill patients within a region or more than one Health Board</i>	4
<ul style="list-style-type: none"> • Service operating at risk despite all local and regional efforts to mitigate sustained pressures <p>AND</p> <ul style="list-style-type: none"> • 10% or more of units within a network at CRITCON 3 OR • Any capacity transfers outside of usual (regional or network) transfer boundaries due to inadequate capacity within usual boundaries 	
NATIONAL DECOMPENSATION <i>Significant and sustained derogation from usual care, for all critically ill patients across several regions or a nation</i>	5
<ul style="list-style-type: none"> • Service operating at sustained risk (CRITCON 4), in more than one region despite all local, regional, and national efforts to mitigate. This requires Government level escalation and enacting extraordinary national contingency measures 	

4. Transfer services

- 4.1 Within the East of England there is a dedicated Adult Critical Care Transfer Service (ACCTS) which serves patients from every hospital in the East of England for adults over the age of 16 who by way of illness or injury are in need of intensive care. As of October 2023 this service is operating 24/7.
- 4.2 As pressures increase within both the ambulance service and adult critical care units and the surge escalation process is invoked, the ability of both services to provide the usual level of escort could be severely compromised. This will require alternative approaches from both services to ensure patients are adequately monitored and cared for during any required transfer. The ultimate decision on the patient transfer and available transfer team lies with the referring critical care consultant (with an understanding of the patient/s condition and stability) in partnership with the relevant ambulance service linked to the transfer escalation stage.

5. Escalation Thresholds and Key Actions

- 5.1 Requirement to surge Critical Care capacity can be extremely rapid and can occur over a 48 to 72-hour period. Not all hospitals in the region will surge at the same time. There may be significant geographical/system variation.

The description of Critical Care escalation phases⁹ are:

- *Pre-surge phase* occurs during most periods of higher activity (e.g. average winter) and is defined as the majority of critical care units within a system are declaring CRITCON 0-1.
- *Pre-surge phase – local strain* occurs during general periods of higher activity but is specifically relevant when one or more individual units are under significant and persistent strain despite all local efforts to resolve this.
- *Surge phase* represents expected winter pressures where critical care units, systems and the region are operating within regional winter planning assumptions with the majority of units declaring CRITCON 2.
- *Escalation phase* occurs when critical care units, systems and regions are operating above expected winter pressures with the majority of units declaring CRITCON 2 and an increasing number of units declaring CRITCON 3.
- *Heightened escalation phase* occurs when critical care units, systems and regions are operating under severe pressures, and multiple capacity transfers are required within and between adjacent regions each day. There are an increasing number of tertiary units reporting CRITCON 3.

Table 2 sets out more detailed threshold definitions and key actions to be taken at a local, regional, or national level to support escalation in response to surges in demand.

- 5.2 Each Adult Critical Care Service must complete the national Critical Care Capacity Dataset reporting twice daily, this is found via Directory of Service¹⁰ This dataset provides reporting of bed availability and each unit's CRITCON status. The East of England Adult Critical Care Operational Delivery Network monitors completion rates and data entries on a daily basis, reviewing capacity, CRITCON scores and workforce.

⁹ Management of surge and escalation in critical care services, July 2022. NHS England.

¹⁰ <https://www.directoryofservices.nhs.uk/app/controllers/home/home.php>

For consistency, the following definitions are used:

- *Baseline bed/funded bed*: any Adult Critical Care bed that is recognised in the commissioning arrangement for the Trust
 - *Surge bed*: any Adult Critical Care bed that is not usually recognised in the commissioning arrangement for the Trust but is opened to meet increased demand
 - *Available bed*: any Adult Critical Care bed that is open, staffed, and able to accept a patient
- 5.3 The number of overall beds is defined by those open, staffed, and available on the day of reporting. It excludes those beds ring-fenced for elective surgery (green pathways) and those ring-fenced for specialised services (where these are in place). It is therefore expected that the denominator will change over time.
- 5.4 At times of very high demand, consideration should be given as to whether some beds should be ring-fenced to protect P1 and P2 surgical activity, in order to protect the interests of patients who have life-threatening conditions not related to the cause of surge.
- 5.5 The impact and decisions set out in the escalation levels below aim to ensure the continued provision of treatment for life limiting/threatening conditions (including P1 and P2) for as long as possible.

Table 2: Surge thresholds and action

Escalation threshold	CRITCON scores	Descriptor	Actions
<p>Pre-surge Sustain</p>	<p>Majority of units reporting CRITCON 0 - 1</p>	<p><100% of baseline beds occupied and <50% of baseline beds occupied by patients requiring cohorting for any reason</p> <ul style="list-style-type: none"> - Treatment available and supply is greater than demand. - Normal, able to meet all critical care needs, without impact on other services. - Typical winter levels of non-clinical transfer and other overflow activity. 	<p><u>Network, System and Regional action</u></p> <ul style="list-style-type: none"> - None except for usual monitoring via the ODNs. - ODNs must ensure DOS is updated twice daily by Trusts within Network and region. <p><u>National action</u></p> <ul style="list-style-type: none"> - No national input required.
<p>Pre-surge Local strain</p>	<p>1 or more units reporting CRITCON 2</p>	<p>Individual units unable to return to lower CRITCON level despite repeated transfer and other mitigating actions</p> <ul style="list-style-type: none"> - Most units still at CRITCON 0-1, but individual units with difficulties that appear not be immediately locally resolvable. 	<p><u>Trust actions</u></p> <ul style="list-style-type: none"> - May require redeployment of support staff to enable cohorted capacity and increased acuity of patients and maintain acceptable staffing ratios. - All local efforts undertaken to offload excess critical care capacity (discharges, repatriations). - Ensure that the ODN and ICB are informed of the position and local actions taken and their effect. <p><u>System and regional actions</u></p> <ul style="list-style-type: none"> - ICB may need to consider local diversion plans particularly in relation to elective surgery. - ICB may need to discuss support with neighbouring systems. <p><u>Network actions</u></p> <ul style="list-style-type: none"> - Network to monitor, support and advise with respect to surrounding capacity and measures to mitigate the pressures. - Network to liaise with transfer service, region and ICB to ensure current position and actions are known.

Escalation threshold	CRITCON scores	Descriptor	Actions
			<ul style="list-style-type: none"> - Consider standing up local Critical Care capacity meetings. <p><u>National action</u></p> <ul style="list-style-type: none"> - No national input required.
<p>Surge Monitor</p>	<p>>50% of units reporting</p> <p>CRITCON 2</p>	<p>Up to 100% of baseline beds which are staffed and occupied or implications of cohorting impacts on capacity</p> <ul style="list-style-type: none"> - Expected winter pressures but present widely across region. - Operating within regional winter planning assumptions. - Some usual high dependency unit (L2) beds may be converted to L3. - Enhanced Care beds are used optimally (if available). - Usual funded critical care capacity full. Some capacity transfers. 	<p><u>Trust actions</u></p> <ul style="list-style-type: none"> - May require redeployment of support staff to enable cohorted capacity and increased acuity of patients and maintain acceptable staffing ratios. - Potential temporary reduction in elective surgery activity. - Peri-operative pathways altered for some lower acuity patients to be cared for outside of level 2/3 adult critical care settings. <p><u>System and regional actions</u></p> <ul style="list-style-type: none"> - UEC monitoring and reporting of capacity and demand within Trusts and systems as part of usual winter pressures process. - Initiate Critical Care monitoring and reporting arrangements at regional level such as the Cell structures defined in the EPRR structure. - Regions preparing to increase capacity to meet regional surge plan levels. <p><u>Network Action</u></p> <ul style="list-style-type: none"> - Stand up local Critical Care capacity meetings. - Liaise with Regional senior leadership personnel regarding capacity, workforce position and any relevant intelligence. - Understand and support units with their preparations to potentially increase capacity. - Liaise with the regional transfer service regarding capacity and position across the region.

Escalation threshold	CRITCON scores	Descriptor	Actions
			<p><u>National action</u></p> <ul style="list-style-type: none"> - Critical Care Capacity Panel (CCCP) meetings in place. - Monitoring of interdependent services. - Consideration of any cross-region capacity transfer.
Escalation Phase	<p>Majority of units declaring CRITCON 2 and 1 or 2 units declaring CRITCON 3</p> <p>(Region may well progress into CRITCON 4 during this phase)</p>	<p>100% to 150% of capacity occupied</p> <ul style="list-style-type: none"> - Exceeding expected winter pressures - Expanded into enhanced care areas or expanded into next identified surge area - Usual funded critical care capacity full – overflow into quasi-critical care areas or identified surge areas - Increased conversion of L2 to L3 beds - High level of non-clinical transfers - Treatment currently available within the system utilising surge areas in trusts but majority of units maybe declaring CRITCON2 - Other resources may be becoming limited, e.g. Renal replacement therapy 	<p><u>Trust actions</u></p> <ul style="list-style-type: none"> - Continue actions as set out above. <p><u>System and Region actions</u></p> <ul style="list-style-type: none"> - Regional Command and Control structures in place - Cancellation of elective surgery in line with clinical prioritisation to commence - Capacity transfers and other mutual aid across systems and within regions - Surge beds to be used optimally - Critical care cells meeting regularly - Enhanced monitoring and reporting by ACC commissioners and UEC winter teams - Daily submission of regional transfer requirements - Daily reporting and review of ACC occupancy at a system and regional level - Maintaining acceptable staffing ratios through redeployment of non-critical care staff, although these may not be GPICS¹¹ compliant. <p><u>Network actions</u></p> <ul style="list-style-type: none"> - Compliance to the regional command and control structures. - Attendance at the Regional Critical Care Cell meetings. - Provide daily intelligence to the Critical Care Cell.

¹¹ [gpics-v2.pdf \(ficm.ac.uk\)](http://ficm.ac.uk/gpics-v2.pdf)

Escalation threshold	CRITCON scores	Descriptor	Actions
			<ul style="list-style-type: none"> - Daily calls with the Critical Care units and transfer service regarding capacity needs and transfers. <p><u>National actions</u></p> <ul style="list-style-type: none"> - Increased national and regional commissioning input may be required - National Critical Care Capacity Panel (CCCP) to provide strategic direction for inter-regional capacity transfers
Heightened escalation	Region will be at CRITCON 4	<p>150% to 200% of capacity occupied</p> <ul style="list-style-type: none"> - Expanded into identified suitable surge areas AND - Expanded into non-conventional areas (if applicable) OR - In final expansion area (for local escalation) - Expansion into non-critical care areas (e.g. wards) and/or use of paediatric facilities for adult critical care where appropriate. - Trust operating at or near maximum physical capacity. - Maximum capacity transfers between Trusts, with network and regional NHSE co-ordination. 	<p><u>System and Region actions</u></p> <ul style="list-style-type: none"> - Regional Command and Control structures in place - All non-life threatening/lifesaving elective inpatient surgery to stop. - Review of prioritisation and cancellation of some specialist elective surgery - Mutual aid and capacity transfers across systems to maintain urgent activity. - Daily identification of suitable patients for inter-regional transfer by regions under surge (as per guidance) - GPICS staffing ratios may not be maintained in some clinical areas (e.g. multi-bed cohorted areas) <p><u>Network actions</u></p> <ul style="list-style-type: none"> - Compliance to the regional command and control structures. - Attendance at the Regional Critical Care Cell meetings. - Provide daily intelligence to the Critical Care Cell. - Daily regional data collection and reporting. - Daily calls with the Critical Care units and transfer service regarding capacity needs and transfers. - Support coordination of capacity transfers through the daily morning critical care community call. - Liaison with the Regional Transfer Service regarding increasing number of teams required to support capacity transfers.

Escalation threshold	CRITCON scores	Descriptor	Actions
			<ul style="list-style-type: none"> - Monitoring of workforce ratios across the region. <u>National action</u> - Escalation of need for inter-regional capacity transfers to decompress multiple hospital sites - Enhanced monitoring and reporting will be in place - Enhanced national and regional commissioning support will Be required - Monitoring and coordination of escalation of interdependent services - Potential for devolved nation engagement for mutual aid and capacity transfers - Increased frequency of CCCP meetings

5.6 In particular, this guidance requires:

- Adult Critical Care Units to submit information on their bed capacity through NHS Pathways Directory of Services (DoS)¹² twice daily at 8am and 8pm
- Groups of Adult Critical Care Units associated to an ICB and potentially wider geographically to work jointly together through a networked approach co-ordinated by East of England Regional Critical Care Cell and the East of England Adult Critical Care Operational Delivery Network.
- Region and ICBs to be assured that all Adult Critical Care Units and Trusts in their locality have adequate escalation and business continuity plans in place. These plans are required to have clear escalation triggers to EPRR structures and are co-ordinated at a regional level by regional Critical Care cells.

Alignment with system, regional and national incident management

- 5.7 Ongoing acute surge of all types is best managed via the Urgent and Emergency Care (UEC) teams in systems. Escalation in systems tends to flow from the Critical Care Cell, to UEC teams, to Emergency Preparedness Resilience and Response (EPRR) teams.
- 5.8 EPRR teams are key to assisting hospitals in the management of surge in acute demand. Clinicians and managers should understand how and when to communicate with and escalate concerns to EPRR. The East of England Adult Critical Care Operational Delivery Network and the regional Critical Care Cell act as a conduit to ensure a coordinated regional response. Begin dialogue with regional EPRR before the consequences of surge begin to limit the hospital's capacity to deliver care.
- 5.9 Regions and Systems will use the EPRR structures to ensure escalation through the levels is understood and enacted consistently; and to ensure mutual aid and capacity transfers are enacted appropriately.

¹² <https://www.directoryofservices.nhs.uk/app/controllers/home/home.php>

6. Inter-regional Mutual Aid

- 6.1 Any region can make a request to the national Critical Care Capacity Panel for interregional mutual aid and/or capacity transfers as part of the surge escalation process. These will be considered by regional comparison of key criteria including:
- Critical Care occupancy
 - Surge capacity and potential to increase surge provision
 - Staffing ratios
 - Tertiary and specialist occupancy
 - CRITCON score
 - Local intelligence including the balance of emergency vs. elective activity
- 6.2 If transfers be agreed, the process outlined in the national service specification for adult critical care transfer¹³ will be enacted.

7. Impact on Elective Activity

- 7.1 During periods of heightened pressure, the NHS sometimes makes decisions to postpone elective activity and redeploy staff to support other services, including the sickest patients in adult critical care. These decisions should be made at a system level in discussion with NHS England regional team and support and expertise from the East of England Adult Critical Care Operational Delivery Network and take into consideration:
- a) Elective activity priorities must be determined across a system and applied to the system as a whole and not as single sites.
 - b) The system approach may relocate some or all elective activity to other providers within a system, including the independent sector.
- 7.2 Clinical validation of waiting list should be undertaken when elective activity is impacted and should be regularly reviewed.
- 7.3 The prioritisation categories are based on the prioritisation tool produced by the Federation of Surgical Specialty Associations and endorsed by all surgical colleges. The prioritisation of elective surgery should continue to be carried out at a Trust level based on FSSA¹⁴ guidance:

¹³ <https://www.england.nhs.uk/wp-content/uploads/2021/06/Service-Specification-Adult-Critical-Care-Transfer-services.pdf>

¹⁴ https://fssa.org.uk/_userfiles/pages/files/covid19/prioritisation_master_261121.pdf

8. Prioritisation categories:

Prioritisation Category	Definition
P1a	Emergency procedure to be performed <24hrs
P1b	Procedures to be performed <72hrs
P2	< 1 month
P3	< 3 months
P4	>3 months, delay 3 months possible
P5	Patient wishes to postpone surgery because of COVID-19 concerns
P6	Patient wishes to postpone surgery due to non-COVID-19 concerns

NB Categories P5 and P6 will be reviewed over time.

9. Workforce Considerations

- 9.1 Workforce of all specialties including medical, nursing, pharmacy and allied health professionals are integral to the implementation of any surge plan. As such, consideration of the ability to flex staffing levels¹⁵, to meet rising demand whilst maintaining safe, quality care for patients is central to implementing this guidance.
- 9.2 Key considerations are:
 - a) the need to maintain safe staffing
 - b) the availability of suitably trained staff, equipment, and specialist supplies
 - c) ensuring all critical care nurses are trained and competent to care for level 3 patients to build flexibility within the workforce to meet increased casemix acuity within the unit
 - d) redeployment of support staff and non-critical care staff, to enable cohorted capacity, and to meet increased demand in number or acuity of patients
- 9.3 Surge conditions can contribute to poor mental health and wellbeing in critical care staff and surge support staff. Support should be in place to provide mental health and wellbeing support, including highlighting local, regional and national resources. Means of accessing local psychology and mental health services should be highlighted.
- 9.4 Primary prevention of mental health and wellbeing challenges may be supported by ensuring training and support is provided to surge staff, ensuring time is provided for debriefs and reflection even during surge conditions, and enabling mental health support staff within units (e.g. Professional Nurse Advocates) to deliver their duties.

¹⁵ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0833_advice-on-acute-sector-workforce-models-during-COVID_with-apps_10dec.pdf

¹⁶ https://www.baccn.org/static/uploads/resources/UKCCNA_position_Sep_2021_FINAL.pdf

10. De-escalation and Debrief

- 10.1 As pressure and demand on Adult Critical Care services reduces there should be a clear staged approach to de-escalation across systems and the production of lessons learnt documentation for cascade. An essential part of this process is to ensure all staff are able to participate in reflective debrief sessions to identify good practice, to set out opportunities for learning and to ensure staff are able to access health and wellbeing support. Feedback from the debrief sessions should be used to update plans to ensure continuous improvement and ideally lead to a reduction in future occasions where escalation plans need to be activated.

11. Interdependent services

- 11.1 It is recognised that there are complex interdependencies between Adult Critical Care and other services, which require close oversight and coordination at a national, regional and system level (e.g. ECMO). When one service is experiencing increased demand, it is likely that other or all services will be under the same level of increased pressure.
- 11.2 The coordination of capacity for interdependent services is a responsibility of the national Adult Critical Care Capacity Panel. As such capacity and demand for the interdependent services will be reported by Regions to this group, escalating concerns at the earliest opportunity. This will enable the coordination and prioritisation of staffing resource and estate capacity to maintain equitable service provision.
- 11.3 Plans have been developed for the six interdependent specialised services which would provide direct care to a rapidly rising number of patients within an adult critical care setting, in a surge scenario. They are listed here and links to further information are included.
- a) Respiratory Extracorporeal Membrane Oxygenation (ECMO)
 - b) Renal Replacement Therapy in Critical Care
 - c) Burns
 - d) Paediatric Intensive Care
 - e) Adult Transfer Services
 - f) Solid Organ Transplant services

Respiratory Extracorporeal Membrane Oxygenation (ECMO)

[Management-of-surge-and-escalation-for-adult-respiratory-extra-corporeal-membrane-oxygenation-revised.pdf \(england.nhs.uk\)](https://www.england.nhs.uk/wp-content/uploads/2019/05/rrt-annex-to-acc-service-specification.pdf)

Renal Replacement Therapy

<https://www.england.nhs.uk/wp-content/uploads/2019/05/rrt-annex-to-acc-service-specification.pdf>

Adult and Paediatric Burns Services

<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0656-nhsei-burns-critical-care-surge-and-escalation-sop.pdf>

Paediatric Intensive Care

<https://www.england.nhs.uk/wp-content/uploads/2016/12/Paediatric-Intensive-Care-Winter-Surge-Standard-Operating-Procedure.pdf>

Adult Critical Care Transfer Services

<https://www.england.nhs.uk/wp-content/uploads/2021/06/220501S-Adult-critical-care-transfer-services.pdf>

Solid Organ Transplant surge guidance

<https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/21165/pol301.pdf>

12. Glossary

Phrase	Definition
Adult Critical Care	As set out in ICS Consensus statement
Baseline beds	The total number of adult critical care beds usually commissioned
Capacity	The total number of staffed beds which could accept a patient requiring critical care
Capacity transfer	The transfer of a patient to create capacity for other patients. This has previously been known as non-clinical or mutual aid transfer
Casemix	The clinical profile of patients within a service
Clinical transfer	The transfer of a patient for clinical reasons
Critical Care Capacity Panel	National meeting to oversee management of critical care UK wide, to discuss capacity and workforce issues and potential intelligence
Critical Care Cells	Provide regional oversight of operational delivery and are the first escalation point within systems. The membership includes ODNs, medical leads and commissioners. This group reports into UEC and EPRR structures
Decompression	This includes a range of measures to reduce the pressure on capacity within a Critical Care unit or system.
EoEACCODN	East of England Adult Critical Care Operational Delivery Network
EPRR	Emergency Preparedness Resilience and Response teams as set out in https://www.england.nhs.uk/ourwork/eprp/gf/
ICS	Integrated Care Systems are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas
Local escalation plans	Plans that are agreed by leaders at a system or regional level
Mutual aid	Sharing of resources between units, hospitals, trusts, systems, or regions. This may include staff redeployment, sharing of medicines or equipment. It may also include the transfer of patients from one unit to another to better balance service pressures (capacity transfers)
Normal clinical pathways	Existing treatment and care process for patients that have not been implemented solely as a response to the capacity constraint
Operational Delivery Networks (ODNs)	Commissioned to provide coordination and oversight of Adult Critical Care within systems (or specified regional)
Surge	Increasing capacity beyond usual footprint to meet increasing demand
Staffing ratios	As set out in GPICS published guidance
Secondary care	Secondary care, which is sometimes referred to as 'hospital or acute care', can either be planned (elective) care, or urgent and emergency care (non-elective)
System first	Decisions made at a local level within an Integrated Care System as the first level response
Tertiary services	Tertiary care refers to highly specialised treatment
Very high local surge	100% baseline capacity occupied with no discharges in the previous 24 hours

Appendix 1 – Bed numbers by hospital and unit

(Current as of November 2025)

	ALL BEDS	LEVEL 3	LEVEL 2	TOTAL LEVEL 3 EQUIVALENT	ESTIMATED POPULATION
Hinchingbrooke	6	4	2	5	3,298,928 (Will be the largest in the country)
Peterborough	14	8	6	11	
CUH JVF	32	20	12	26	
CUH NCCU	27	21	6	24	
Royal Papworth	36	36	0	36	
Lister	18	12	6	15	
Watford	19	10	9	14.5	
Milton Keynes	10	4	6	7	
Luton and Dunstable	12	6	6	9	
Bedford	10	6	4	8	
Southend	17	10	8	14	1,954,248
Basildon General	18	10	8	14	
Basildon CTC	14	8	6	11	
Broomfield	18	10	8	14	
The Princess Alexandra	10	5	5	7.5	
Colchester	15	7	8	11	
Ipswich	14	6	8	10	1,856,023
West Suffolk	9	6	3	7.5	
James Paget	12	6	6	9	
Norfolk and Norwich	28	14	14	21	
Queen Elizabeth	13	5	8	9	
TOTAL:	352	214	139	283.5	