NHS England

NoECCN North of England Critical Care Network

NHS Critical Care Operational Delivery Networks England, Wales & Northern Ireland

NHS England North (Cumbria and North East)

North of England Critical Care Network:

Adult Critical Care Escalation Framework

V1

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Document Management

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Linked Plans:

- **North of England Critical Care Network *Paediatric Critical Care Escalation Framework (PCCEF)*, December 2017**

- **North of England Critical Care Network *Ethical Framework for Utilisation of Critical Care in Response to Exceptional Demand*, October 2015**

- **North of England Critical Care Network *Guidelines for Escalation of Ebola Virus Disease* October 2015**

- **NHS England North (Cumbria and North East), *Mass Casualty Framework for Cumbria and the North East of England* August, 2017**

- **NHS England North (Cumbria and North East), Public Health England North East Centre. *North East Pandemic Influenza Framework*, July 2017** *(Does not cover Cumbria)*

Contents

This framework has been developed by the North of England Critical Care Network (NoECCN) which includes all the critical care units in the North East and the two units in North Cumbria Hospitals NHS Trust.

The Network is accountable to the NHS England North (Cumbria and North East).

Purpose

The purpose of this framework is to provide an effective operational response across the North East and North Cumbria health economy to unplanned increases in demand for Adult Critical Care which are sufficient to require this coordinated response.

Application

NHS England's requirements detailed within the relevant document[1] will be met by adoption of this framework by acute trusts, alongside the on-going review of internal trust plans for surge capacity within adult critical care. Former North East regional plans were tested during winter 2010/11 in the critical care response to unprecedented pressures on adult critical care capacity from influenza A (H1N1) 2009,17th September 2015 - Exercise Dark Star, 5th April 2016 - Exercise Swift Haven2, 30th May 2017 - Exercise Michelle, 14th September, 2017 - Exercise Stonehart and 3rd October, 2017 - Exercise Border Reiver.

Structure

- Actions for trusts in relation to developing internal plans for surge capacity are highlighted in section 3.

- The key response section of the framework is section 5 which outlines escalation levels, triggers for further escalation and mitigation actions.

Activation

- This regional framework will be activated in response to the triggers and levels identified in section 5.4 of the framework.

- NHS trusts will describe local pressure levels linked to ccOPELa (**c**ritical **c**are **O**perational **P**ressure **E**scalation **L**evel **a**dults) identified in section 5.3, and integrate this with individual trust surge/Major Incident Plans (MIPs).

- Escalation to Network ccOPELa 2 is a decision made by the North of England Critical Care Network (NoECCN) during usual working hours (Mon – Fri 08.00 – 17.00). Out of hours this decision will be made following discussion between the Intensive Care Consultants on call Ward 18, Royal Victoria Infirmary, Newcastle and GICU James Cook University Hospital, Middlesbrough. The NoECCN and the NHS England North (Cumbria and North East) will be informed the next working day by telephone.

- Escalation to Network ccOPELa 3 is a decision of the 'On-call' NHS England North (Cumbria and North East) Team Director, based on advice from the NoECCN (in hours) or the Intensive Care Consultants on call (out of hours). The NHS England North (Cumbria and North East) Director will inform the Clinical Commissioning Groups (CCGs). If NHS England North (Cumbria and North East) Area Team strategic command is already established, escalation will be a strategic command decision.

[1] Management of surge escalation in critical care services: standard operating procedure for adult critical care' (NHS England 2013)

- Once the Network Critical Care Control Group (NCCCG) is established at ccOPELa 3, it is the source of advice to the NHS England North (Cumbria and North East) strategic command if established.

- Escalation to Network ccOPELa 4 will in itself trigger the establishment of NHS strategic command, if this has not already been established in response to the underlying pressures/acute incident. This will usually be led by NHS England North (Cumbria and North East).

Further escalation actions will be determined by NHS Command and Control structures

NB: Significant pressures within Paediatric Critical Care may trigger activation of the Network ccOPELa at the appropriate escalation level.

De-escalation decisions are made by the group responsible at the higher level, for example at ccOPELa 3 the Network Critical Care Control Group (NCCCG) would determine de-escalation to ccOPELa 2.

Section 1: Background

The first iteration of this framework was developed in response to the influenza pandemic in 2009. The revised framework (plan) was implemented in response to the unprecedented pressures on adult critical care capacity due to influenza A (H1N1) 2009 in winter 2010/11.

The North East Adult Critical Care Escalation Plan (ACCEP) was developed in tandem with the *North East Paediatric Critical Care Escalation Plan (PCCEP)* to ensure compatibility. Both ACCEP and PCEEP are underpinned by the revised *Ethical framework for utilisation of critical care in response to exceptional demand.* These were all published as working documents by mid December 2010 to support response to the emerging pressures on critical care. The final V2.0 plan incorporated the lessons learned, in particular from the formal debrief meeting on 8 March 2011. Further major revisions (V3.0, V4.0) were required in March 2013 and September 2015 in response to changes in NHS structures. The plan was tested in September 2015 at exercise Dark Star, 5th April 2016 at exercise Swift Haven and last tested at exercises Michelle, Stonehart and Border Reiver in 2017. The plan has now been further revised to incorporate the national pressure descriptions 'Operational Pressures Escalation Levels Framework' (OPEL)[2] and will be referred to as the *Adult Critical Care Escalation Framework* (ACCEF) V1.0.

Section 2: Enabling measures – actions required

During the pandemic of influenza A (H1N1) in 2009, a number of enabling measures were put in place to deliver the required increase in adult critical care capacity. Some of these were fully implemented but others were not once the lower than expected impact of the second wave became apparent.

[2] Operational Pressures Escalation Levels Framework (NHS England, 2016)

In order to maintain surge capacity these enablers will need to be maintained, held on standby or retained as procedures to be reactivated.

Actions for the critical care network and for trusts in relation to internal plans for surge capacity/major incidents are highlighted in this section.

2.1 Facilities, equipment, consumables and supplies

Significant work has been undertaken in trusts to ensure sufficient space, equipment and supplies are available to support an increase in critical care. The maximum potential critical care capacity set out in section 5 is based on a regional mapping exercise undertaken in November 2017.

The Network implications of this are that:

1. The NoECCN should work with relevant regional medical engineering and estates leads to understand any oxygen supply risks associated with an increase in critical care capacity within critical care and in other areas.
2. NHS England North (Cumbria and North East) should maintain close on-going links with the NHS Supply Chain to identify any early warning indicators of consumable supply chain issues.

NHS Trust surge plans should:

1. Clearly show the physical location in each hospital of all additional critical care beds which may be opened as capacity is increased.
2. Include inventories which cover ventilators, infusion pumps and all other equipment required as part of an increase in critical care capacity

2.2 Increasing the workforce – staff identification and training

The implementation of this ACCEF will in a phased manner require staff from other services to provide level three critical care under the close supervision of experienced adult critical care trained staff. Staff will need to be fully supported before, during and after working in areas or in roles that are unfamiliar to them.

In order to maximise the efficiency of critical care units and their trust's workforce it would only be in exceptional circumstances that there would be redeployment of staff between organisations. Although there is no hard and fast rule, in general the order in which additional staff support will be sourced is:

- Current critical care staff increase hours, annual and study leave restricted, inclusive of shifting SPA's (supporting professional activities) to clinical PA's
- Within trust redeployment of critical care trained staff (including registrars/speciality trainees) who are working in other areas of the Trust i.e. acute ward areas, anaesthetics, recovery and theatres
- Between organisation secondments of critical care trained staff working in non-clinical roles in organisations such as networks, universities, NHS England North (Cumbria and North East) etc.

- Between organisation secondments of staff with appropriate critical care training who are working in clinical roles within NHS England North (Cumbria and North East), and GP provider services.
- Guidance published by the Department of Health[3] confirms that "*employees directly employed by the NHS, acting in the course of their employment, are covered by their employer's indemnity, regardless of their actual work location. As long as a contract of employment is in place, staff will be indemnified - even if they are working on a different site or undertaking a different role that they are, and have been deemed competent, to carry out*."

The Network implications of this are that:

1. Although between organisation secondments / redeployments will only occur in *exceptional* circumstances, human resource directors should collectively consider the processes for doing this particularly for staff in networks, universities, and NHS England North (Cumbria and North East).
2. The NoECCN should maintain a regional overview of the training plans and arrangements in place to support any increase in critical care capacity.

NHS Trust surge plans should:

1. Be able to increase workforce by identifying individual staff who would be expected, after appropriate training to provide level three critical care under the close supervision of experienced adult critical care trained staff.
2. Detail the training and support arrangements that have been put in place to support staff (for adult and paediatrics).
3. Build this in to the Trust's annual training needs analysis.

2.3 Increasing the workforce – rota management

The ACCEF acknowledges that the speed of escalation through the various ccOPELa levels may be rapid and not necessarily linear. Preparations for surge should include the trust's strategy for staffing expanded critical care capacity.

NHS Trust surge plans should:

1. Include a strategy for staffing expanded capacity when patients are treated in areas external to critical care (theatres, recovery and resuscitation areas).

2.4 North of England Critical Care Network - communications

A key enabler to an effective regional surge response will be clear communications and the ability for clinical leads in critical care departments to share clinical learning about the presentation of cases and their appropriate management.

The NoECCN will initiate at ccOPELa 2 and above a daily status email to all clinical leads which can also be used as the basis for an email discussion group. Regular conference calls between clinical leads may also be introduced as appropriate.

[3] "PANDEMIC INFLUENZA: ADDITIONAL MEASURES TO MEET WORKFORCE SUPPLY", http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106388.pdf

The Network implications of this are that:

1. The NoECCN will initiate and facilitate regular updates via email and/or conference call discussions between clinical leads in critical care departments.
2. NoECCN / NHS England North (Cumbria and North East) Medical Director or Deputy at ccOPELa 3 and above will Chair the NCCCG.

NHS Trust surge plans should:

1. Include an internal Trust-wide Critical Care Control Groups (CCCG) with clear terms of reference and administrative support (Appendix 5).
2. Describe how critical care clinical teams will share and receive information and learning on the clinical management of patients with specific conditions in other units.

2.5 An equitable approach to the postponement of elective surgery

The postponement of elective surgery will have the greatest impact in terms of enabling an increase in critical care capacity across the region. NHS command structures will be responsible for ensuring an equitable approach. The following principles have been developed for guiding service response to surge:

- Minimise avoidable mortality and morbidity for all patients and all populations, under all circumstances;
- Acceptable standards of quality and safety must be maintained;
- Escalation decisions must be proportionate and timely;
- The burden and response should be shared equally between organisations through maximum use of mutual aid;
- No organisation should be penalised (in terms of operational or financial performance) for responding appropriately and effectively to the incident;
- No organisation should gain an advantage for having borne a lighter burden than others.

The Network implications of this are that:

1. The ACCEF and the above principles should assist the NHS command structures and trusts in ensuring that any decisions to postpone elective surgery are timely and proportionate.

NHS Trust surge plans should:

1. Ensure internal surge plans are aligned to the ACCEF and clearly identify when and how consideration will be given to the postponement of elective surgery and the communication processes to support this.

2.6 Patient flow / capacity management

Real time monitoring of critical care bed availability will be a key feature of the regional NHS response to surge. This requires:

- All critical care units to support the real time use of '*NHS Pathways and Directory of Services system (NHS Pathways DoS)* (via a password) at https://nww.pathwaysdos.nhs.uk
- All critical care units are expected to update the system ***every hour*** in times of surge (> ccOPELa 2) [4]
- Trusts to have detailed patient 'step down' bed arrangements

The Network implications of this are that:

1. The NoECCN should develop a standard operating procedure for monitoring critical care bed availability in line with the levels and triggers set out in this plan.

NHS Trust surge plans should:

1. Support the real time use of NHS Pathways DoS Live Bed Register throughout surge.
2. Update the DoS system ***every hour***
3. Detail 'step down' bed arrangements.

2.7 Critical Care transfers

Increased pressure on critical care services and the interdependencies of adult and paediatric critical care services at ccOPELa 2 and above will lead to increased pressure on critical care transfer services. It is likely that the capacity of the North East Ambulance Service (NEAS) will be stretched. In order to facilitate each transfer taking place in a timely manner a framework for describing each type of transfer and its urgency has been agreed (appendix 3).

Title	Description	Timescale for transfer
Emergency Critical Care Transfer (C2)	Undertaken due to clinical need e.g. major head injury, organ failure, specialist equipment etc.	Treat as an emergency with time agreed with the department – circa 18mins
Urgent Critical Care Transfer (C3)	Undertaken to create needed critical care capacity	Within 2 hours
Standard Critical Care Transfer (C4)	Based on the need to repatriate a patient	Within 3 hours

The Network implications of this are that:

1. The North East Ambulance Service and the NoECCN should ensure that existing systems to monitor critical care transfers across the region reflect

[4] Concept of Operations for Managing Mass Casualties (NHS England, 2017)

the above three types of transfer.

NHS Trust surge plans should:

1. Include and use the appropriate classification when requesting each critical care transfer in order that priority is given to those in greatest clinical need.

At Network ccOPELa 3 and above the NCCCG will discuss the need for support to transfers, where appropriate identifying those Trusts / Hospitals that are able to provide a transfer retrieval team, to assist Trusts / Hospitals that are under significant pressure with moving patients within and external to the region. This could potentially be achieved in part by utilising anaesthetists who are 'available' owing to cancellation of non-life threatening elective surgery requiring critical care.

2.8 Ethical framework

An *Ethical framework for utilisation of critical care in response to exceptional demand* has been developed which clearly states the principles and processes for ethical decision making when the available critical care resource is not sufficient and cannot be provided to all patients with ability to benefit. In this situation the threshold for access to critical care rises. Decisions then need to be made against that higher threshold and in effect therefore between patients. The patient with the higher clinical likelihood of benefit then has to be given precedence.

This process needs to be overseen both internally in each trust and regionally to ensure equity.

The Network implications of this are that:

1. A NCCCG will be activated and chaired by the NHS England North (Cumbria and North East) Medical Director or deputy to support ethical clinical decisions making in line with the escalation of the ccOPELa triggers.

NHS Trust surge plans should:

1. Have an identified critical care control group (CCCG) to be activated to support ethical clinical decision making in compliance with the regional ethical framework

Section 3: Principles underpinning the escalation framework

3.1 Organisational principles

- That supporting the delivery of adult critical care is a shared responsibility of **all** NHS organisations (excluding mental health trusts) in the North East and North Cumbria.

- That critical care capacity will double their Level 3 capacity (and maintain for 96 hours in event of mass casualty)[4].

- That for incidents which impact (or are likely to impact) on critical care capacity across the network at ccOPELa 3 and above, NHS England North (Cumbria and North East) will command the critical care response as described in section 5.

- CCGs as commissioners of general adult critical care will be informed by NHS England North (Cumbria and North East) at ccOPELa 3

- Once a major incident is declared, CCGs will support overall response to the incident as directed by NHS England North (Cumbria and North East).

3.2 Clinical principles

- That adult critical care will be delivered to national clinical standards until fully staffed capacity is exceeded.

- That the ACCEF will be implemented to deliver critical care to adults clinically able to benefit, balancing increased capacity with the minimum possible reduction in standards of care.

- That clinical care at any time should adhere to the ethical principles of respect, best interest, minimising harm, fairness, and good decision making.

- That all clinical decisions will be underpinned by the *Ethical framework for utilisation of critical care in response to exceptional demand,* which is published alongside the two critical care escalation frameworks.

Section 4: Adult Critical Care Escalation Framework December 2017

08/12/2017		Current capacity								Potential capacity						
TRUSTS	**UNITS**	**Funded Level 3**	**Nurses In Post to support 1 2-1 care**	**Funded level 2**	**Nurses in Post to Support 1-2-2 care**	**Total L2 + L3**	**Total Nurses in Post to Support**	**Nurse Co-ordinators Req'd**	**Total Nurses + Co-ordinators**	**Existing level 3 beds**	**L3 Beds (upgraded from L2)**	**Additional L3 beds opened in critical care units**	**Additional L3 beds in non critical care areas inc recovery & theatre**	**Total Maximum level 3 beds**	**Existing L2 beds that will remain at L2**	**Total L2 + L3 (excluding any L2 beds opened on base wards)**
Newcastle Upon Tyne Hospitals NHS Foundation Trust	FRH Cardio Ward 21	16	16	6	4	22	19	2.5	22.5	16	3		4 aneasthetic machines in aneastheitic room cardio theatre plus 1 ventilated patient in recovery. 4 non ventilated beds in Cardio recovery if no patients in cardio theatre. .	19	6	27
	FRH ICCU Ward 37	10	10	12	6	22	16	2.0	18.0	10	12	0	22 theatres with anaesthetic machines and bed spaces theoretically allows 44 spaces assuming no theatre work, approx 20 recovery area spaces without ventilator or isolation capacity	22		
	RVI GICU Ward 38	10	10	10	5	20	15	1.9	16.9	10	10	0		28	0	28
	RVI N-ICU Ward 18	10	10	12	6	22	16	2.0	18.0	10	10	0	20 theatres with anaesthetic machines and bed spaces theoretically allows 40 spaces assuming no theatre work, approx 30 recovery area spaces (in 4 locations) without ventilator or isolation capacity	20		
		46	**46**	**40**	**21**	**86**	**66**	**8.4**	**75.4**	**46**	35	0		**89**	6	55
Northumbria Healthcare NHS Foundation Trust	NSECH	9	9	8	4	17	13	1.6	14.6	9	18	9	4	2	0	26
		9	**9**	**8**	**4**	**17**	13	**1.6**	14.6	**9**	18	9	4	**22**	0	26
Gateshead Health NHS Foundation Trust	QE	6	6	8	4	14	10	1.3	11.1	6	8	0	0	14	0	14
		6	**6**	**8**	**4**	**14**	10	**1.3**	11.1	**6**	8			**14**		14
South Tyneside NHS Foundation Trust	STDH	4	4	2	1	6	5	0.6	5.6	4	6	0	6	12	0	12
		4	**4**	**2**	**1**	**6**	5	**0.6**	5.6	**4**	2	0	6	**12**	0	12
City Hospitals Sunderland NHS Foundation Trust	SRH	8	8	8	4	16	12	1.0	13.0	8	10	10	12	30	0	30
		8	**8**	**8**	**4**	**16**	12	**1.0**	13.0	**8**	**10**	**10**	**12**	**30**	**0**	**30**
North Cumbria Acute Hospitals Trust	WCH	4	4	2	1	6	5	0.6	5.6	4	2		Additional capacity in theatre recovery to max number of 14 level 3 beds or combination of 10 x L3 + 4 x L2 or 8 x L3 + 5 x L2	14	0	14
	CI	5	5	4	2	9	7	0.9	7.9	5	4		Additional capacity in CCU to max number of 10 level 3 beds or combination of 8 x L3 + 2 x L2 or 6 x L3 + 3 x L2	10	0	10
		9	**9**	**6**	**3**	**15**	12	**1.5**	13.5	**9**	**6**			**24**		**24**
North Tees & Hartlepool NHS Foundation Trust	UHNT	10	10	6	3	16	13	1.6	14.6	10	3	4	0	17	0	17
		10	**10**	**6**	**3**	**16**	13	**1.6**	14.6	**10**	**3**	**4**	**0**	**17**	**0**	**17**
South Tees Hospitals NHS Foundation Trust	JCUH ICU2	8	8	0	0	8	8	1.0	9.0	8			35	8	0	0
	JCUH ICU3	8	8	0	0	8	8	1.0	9.0	8				8	0	0
	JCUH Neuro	0	0	8	4	8	4	0.5	4.5	0	0	0	0	0	8	0
	JCUH Spinal	0	0	4	2	4	2	0.3	2.3	0	0	0	0	0	4	0
	JCUH Cardio ICU	12	12	0	0	12	12	1.0	13.0	12	0	0	0	12	0	0
	JCUH Cardio HDU	0	0	10	5	10	5	1.0	6.0	0	0	0	0	0	10	0
	JCUH General HDU	0	0	16	8	16	8	1.0	9.0	0	0	0	0	0	16	0
	NFH	2	2	2	1	4	3	0.4	3.4	3		3		6	4	0
		30	**30**	**40**	**20**	**70**	50	**6.1**	56.1	**30**	**0**	**3**	**35**	**68**	**38**	**0**
County Durham & Darlington Trust	DMH *	5	5	6	3	11	8	1.0	9.0	5	7	1	0	12	0	12
	UHND	6	6	4	2	10	8	1.0	9.0	6	2	0	0	8	0	8
		11	**11**	**10**	**5**	**21**	16	**2.0**	18.0	**11**	**9**	**1**		**20**		**20**
North East and North Cumbria total		**133**		**128**		**261**								**283**		

*DMH due to theatre building work for the next 6 months recovery will be a temporary facility and would be difficult to escalate into

Section 5: Escalation: triggers, levels and actions

5.1 Assumptions

- That all clinical decisions will be underpinned by the *Ethical framework for utilisation of critical care in response to exceptional demand.*

- The ccOPELa levels enable an effective operational response to generic pressures (surge) which may be immediate, rapid or more “slow burn”.

- The ACCEF triggers and ccOPELa levels are defined in relation to a progressive increase in demand for adult critical care. The most likely scenario would be an outbreak of a serious communicable disease such as a pandemic influenza virus of greater severity than pandemic Influenza A (H1N1) 2009.

- However, progression through the ccOPELa levels may not be a linear process. An acute incident (such as terrorist attack, major accident or chemical poisoning involving many adults) may require a short term response at a high ccOPELa level.

- In most acute scenarios it is likely that adults can be stabilised and relatively quickly transferred to other regions and only short term maximising of capacity in the Network will be required.

- However a massive explosion-type incident with many severe blast injuries will require immediate activation at regional ccOPELa 4 with sustained demand on critical care over many days.

- Once a ccOPELa level is reached a number of actions will be implemented. As a result of these actions:
  - The situation may be controlled but the level of pressure may remain (due to the on-going underlying problem);
  - The situation may continue to deteriorate leading to progressive escalation to a higher ccOPELa level;
  - The situation may improve with subsequent de-escalation to a lower ccOPELa level.

- The ccOPELa actions relate to a situation where there is excessive demand for adult critical care but not for paediatric intensive care. Where there is also excessive demand for paediatric critical care, actions will have to be modified. This is likely to cause more rapid escalation to a higher ccOPELa level.

5.2 Network escalation / de-escalation decisions

- This Network framework will be activated in response to the triggers and levels identified in section 5.4.

- NHS trusts will describe local pressure levels linked to ccOPELa (5.3 below) and integrate this with individual trust surge/Major Incident Plans (MIPs).

- Escalation to Network ccOPELa 2 is a decision made by the North of England Critical Care Network (NoECCN) during usual working hours (Mon – Fri 0800 – 17.00). Out of hours this decision will be made following discussion between the Intensive Care Consultants on call at Wd 18 Royal Victoria Infirmary, Newcastle and GICU James Cook University Hospital, Middlesbrough and NHS England North (Cumbria and North East) Director on-call informed. The NoECCN and will be informed the next working day by telephone.

- Escalation to Network ccOPELa 3 is a decision of the NHS England North (Cumbria and North East) Medical Director or Director on call, based on advice from the NoECCN (in hours) or the Intensive Care Consultants on call (out of hours). If NHS England North (Cumbria and North East) strategic command is already established, escalation will be a strategic command decision.

- Once the Network Critical Care Control Group (NCCCG) is established at ccOPELa 3, it is the source of advice to NHS England North (Cumbria and North East) and NHS strategic command if established.

- Escalation to Network ccOPELa 4 will in itself trigger the establishment of NHS strategic command, if it has not already been established in response to the underlying pressures/acute incident. This will be led by NHS England North (Cumbria and North East).

- Further escalation will be determined by the NHS strategic command structure.

- De-escalation decisions are made by the group responsible at the higher level, for example at ccOPELa 3 the Network Critical Care Control Group (NCCCG) would determine de-escalation to ccOPELa 2.

5.3 Framework for trust based ccOPELa triggers, levels and actions

Due to the size and speciality differences between the critical care units located within the Network, triggers, levels and actions may be different for individual trusts.

Table 5.1 provides a framework for trust critical care escalation plans which will then be incorporated in to individual trust's surge and major incident plans. The framework describes levels for trusts with no tertiary services - general adult critical care units only and comparison levels for trusts with tertiary services/specialist adult critical care units.

The Network ccOPELa triggers and levels (5.4) will be driven differentially by pressures in the tertiary units compared with pressures in local units. Not all triggers need to be met for escalation to be determined.

Table 5.1: Framework for Trust based ccOPELa triggers, levels and actions

Triggers levels and actions	Trusts with no tertiary services - general adult critical care units only	Trusts with tertiary services/specialist adult critical care units
ccOPELa 1 (*ACCEP1)*	**Current position and response to "expected" pressures. Units able to manage by internal transfer. "Expected" levels of cancellation of planned surgery requiring critical care**	**Current position and response to "expected" pressures. Units able to manage by internal transfer. "Expected" levels of cancellation of planned surgery requiring critical care**
Triggers to ccOPELa 2	Levels of cancellations of planned admissions are increasing. Non-clinical transfer(s) increasing. Unusual case mix or multiple numbers of patients with the same condition present in one or more units and impacting on unit capacity. Major incident declared with significant likely impact on critical care.	Levels of cancellations of planned admissions are increasing. Non-clinical transfer(s) increasing. Unusual case mix or multiple numbers of patients with the same condition present in one or more units and impacting on unit capacity. Major incident declared with significant likely impact on critical care. Particular pressures on specialist area(s).
ccOPELa 2 (*ACCEP2)*	**Unable to manage pressures by internal (trust site) transfer. Cancelling unexpected numbers of elective non-life threatening operations requiring post-operative critical care.**	**Unable to manage pressures by internal (trust site) transfer. Cancelling unexpected numbers of elective non-life threatening operations requiring post-operative critical care.** **Reduced capacity for urgent tertiary services cases/priority specialist care provision.**
Action	Inform NoECCN by phone (office hours 0800-1700) Update DOS system hourly Liaise with Bed Management System to facilitate transfers to ward areas. Trust wide review of all elective surgery to increase capacity for discharge from ACC to wards. Liaise via clinical contacts/NoECCN to enable within region transfers to equalise pressures. Out of region transfers to be considered (if pressure is local rather than national).	Inform NoECCN by phone (office hours 0800-1700) Update DOS system hourly Liaise with Bed Management System to facilitate transfers to ward areas. Trust wide review of all elective surgery to increase capacity for discharge from ACC to wards. Liaise via clinical contacts/NoECCN to enable within region transfers to equalise pressures. Out of region transfers to be considered (if pressure is local rather than national).
Triggers to ccOPELa 3	Transfers from ACCU to tertiary referral centres for specialist care are being refused. Out of region transfers out not possible as no capacity in other regions. Underlying problem continues.	No longer able accept transfers in from units in region for tertiary care/specialist services except for immediately life threatening conditions. No longer able to accept transfers in from other regions for quaternary services. Out of region transfers out not possible as no capacity in other regions. Underlying problem continues.

Triggers levels and actions	Trusts with no tertiary services - general adult critical care units only	Trusts with tertiary services/specialist adult critical care units
ccOPELa 3 (*ACCEP3)*	**Unable to manage pressure by external (within or outside of region) transfer. All current staffed ACC capacity is occupied. Unable to admit in next 24 hours.**	**Unable to manage pressure by external (within or outside of region) transfer. All current staffed ACC capacity is occupied Unable to admit in next 24 hours.**
Actions	***Priority is to fully staff all ACC beds and maximise capacity for admission for those most likely to benefit.*** Update DOS hourly Internal trust command arrangements in place. Trust CCCG to meet daily: • maintain log of decisions; • review all patients on "line list"; • stringent review for all elective surgery requiring ACC, with cancellation of all non-life threatening elective surgery requiring ACC; • Early discharge to ward areas where clinically feasible. Transfers from out of region no longer accepted. ***Standby arrangements for progressive cancellation of all elective non-life threatening adult surgery*** to free medical, nursing and anaesthetic staff to staff additional capacity. Populate the template rotas for increase in staff capacity. Standby arrangements to open additional beds external to units. Inform NHS England North (Cumbria and North East) duty director Inform NoECCN by phone (office hours 0800-1700). *Out of hours this decision will be made following discussion between the Intensive Care Consultants on call at Wd 18 Royal Victoria Infirmary, Newcastle and GICU James Cook University Hospital, Middlesbrough*.	***Priority is to fully staff all ACC beds and maximise capacity for admissions for those most likely to benefit.*** Update DOS hourly Internal trust command arrangements in place Trust CCCG to meet daily: • maintain log of decisions • review all patients on "line list" • stringent review for all elective surgery requiring ACC, with cancellation of all non-life threatening elective surgery requiring ACC • Early discharge to ward areas where clinically feasible. Transfers from out of region no longer accepted. DH alerted re quaternary services. Standby suspension or deferral of other specialist services (including elective cardiothoracic surgery). ***Standby arrangements for progressive cancellation of all elective non-life threatening adult surgery*** to free medical, nursing and anaesthetic staff to staff additional capacity. Provide additional staff rotas to cover the increased capacity. Standby arrangements to open additional beds external to units. Inform NHS England North (Cumbria and North East) duty director Inform NoECCN by phone (office hours 0800-1700). *Out of hours this decision will be made following discussion between the Intensive Care Consultants on call at Wd 18 Royal Victoria Infirmary, Newcastle and GICU James Cook University Hospital, Middlesbrough.*

Triggers levels and actions	Trusts with no tertiary services - general adult critical care units only	Trusts with tertiary services/specialist adult critical care units
Triggers to ccOPELa 4	Underlying problem continues. Actions have not reduced the pressure.	Underlying problem continues. Actions have not reduced the pressure.
ccOPELa 4 *(ACCEP4)* **ccOPELa 4** *(ACCEP4)* **continued**	**All current staffed ACC capacity is occupied and adults requiring critical care are being ventilated temporarily in recovery, PACU areas *or* in resuscitation areas. Adults with ability to benefit from critical care are awaiting admission. Non urgent elective surgery requiring critical care is all deferred.** **OR** **Hospital / Trust suffers a disaster situation (e.g. major incident / evacuation/ critical infrastructure failure). Evacuation Patient Tracking Template (Appendix 7)**	**All current staffed ACC capacity is occupied and adults requiring critical care are being ventilated temporarily in recovery, PACU areas *or* in resuscitation areas. Adults with ability to benefit from critical care are awaiting admission. Non urgent elective surgery requiring critical care is all deferred.** **OR** **Hospital / Trust suffers a disaster situation (e.g. major incident / evacuation/ critical infrastructure failure). Evacuation Patient Tracking Template (Appendix 7)**
Once activated, NHS command and control structures will make escalation decisions or decisions to cease certain activities across the region.		
Actions	***Priority is to fully staff all additional ACC beds, progressively open all additional capacity to a maximum or priority to transfer patients to a place of safety*** Trust CCCG meeting daily: • maintain log of decisions; • review all patients on "line list"; • greater stringency will be required in deciding which patients should receive Level 3 care and the extent of the treatment interventions provided; • All non-life threatening surgery that requires level 3 care post operatively cancelled. • links with NCCCG The following to be implemented progressively as pressure increases: • Cancellation of annual leave (including study leave) for ACC trained medical, nursing and key support staff;	***Priority is to fully staff all additional ACC beds, progressively open all additional capacity to a maximum or priority to transfer patients to a place of safety*** Trust CCCG meeting daily: • maintain log of decisions; • review all patients on "line list"; • greater stringency will be required in deciding which patients should receive Level 3 care and the extent of the treatment interventions provided; • All non-life threatening surgery that requires level 3 care post operatively cancelled. • Links with NCCCG. The following to be implemented progressively as pressure increases: • Cancellation of annual leave (including study leave) for ACC trained medical, nursing and key support staff;

Triggers levels and actions	Trusts with no tertiary services - general adult critical care units only	Trusts with tertiary services/specialist adult critical care units
	• ***Cancellation of all major adult surgery including oncology*** where it is expected post-operative ACC support will be required (staged approach and speciality dependent); • Anaesthetic and recovery staff to support ACC (as electives progressively cancelled); • Opening of additional ACC beds; • Lowering of standards of care is the inevitable consequence of reduction in ACC trained nurse: patient ratios; • Team clinical management with ACC trained nurses supervising anaesthetic and recovery staff; • Limiting of complexity and period of intensive care support to individual adults. Decisions will be made in parallel in relation to the care which can be offered to children and adults in utilising critical care capacity.	• ***Cancellation of all major adult oncology surgical and cardiothoracic surgery*** where it is expected post-operative ACC support will be required (staged approach and speciality dependent); • Anaesthetic and recovery staff to support ACC (as electives progressively cancelled); • Opening of additional ACC beds; • Lowering of standards of care is the inevitable consequence of reduction in ACC trained nurse: patient ratios; • Team clinical management with ACC trained nurses supervising anaesthetic and recovery staff; • Limiting of complexity and period of intensive care support to individual adults. Decisions will be made in parallel in relation to the care which can be offered to children and adults in utilising critical care capacity.
All subsequent action will be determined by NHS command and control structures		

5.4 Network ccOPELa triggers and levels and actions

In considering the following Network ccOPELa triggers and levels, the actions are those which may need to be implemented within the ***next 24 hours***.

Network ccOPELa 1

Current position and response to "expected" pressures. Units able to manage pressures by internal transfer within the trust. "Expected" levels of cancellation of elective surgery requiring critical care.

Possible triggers to ccOPELa 2

- Non-clinical transfers increasing across the north east.
- Unusual case mix or multiple numbers of patients with the same condition present in one or more units.
- Eight, or less than 8, critical care beds declared within the Network.
- One Trust providing tertiary/specialist services (either Newcastle upon Tyne Hospitals NHS Foundation Trust or South Tees NHS Foundation Trust) declares ccOPELa 2.
- Two or more trusts which do not provide tertiary services declare ccOPELa 2
- Major incident declared with significant likely impact on critical care.
- Novel infection impacting on critical care identified elsewhere in country.

Network ccOPELa 2

Eight or less than 8 critical care beds declared within the region. Unexpected pressures in some/all of the Network being managed by an increase in out of trust transfers.

Actions

Priority is to equalise pressure across the region

- NoECCN validates information on capacity from each unit.
- NoECCN ensures NEAS alerted.
- NoECCN ensures bed status system is up to date.
- NoECCN provides a daily status email (agreed with NHS England North (Cumbria and North East)) at a set time to all clinical leads cc Medical Directors:
  - Update on any known underlying problem driving pressure on ACC;
  - Current ccOPELa levels all trusts;
- NoECCN provides a regional critical care capacity proforma which also provides current position in other regions if necessary.
- NoECCN assists as needed with in-region transfers to equalise pressures, liaising with NEAS
- NoECCN / NHS England North (Cumbria and North East) consider the need for Network teleconferences involving clinicians from all trusts.

Possible triggers to ccOPELa 3

- Underlying problem continues.
- No longer able to accept transfers in to tertiary/specialist units from local units in region for tertiary care/specialist services except for immediately life threatening conditions.
- Increasing difficulty in accepting transfers in from other regions for quaternary services.
- Transfers out of region not possible as no capacity in other regions.
- Actions have not reduced pressure

Network ccOPELa 3

Unable to manage pressure by within or outside of region transfer. Less than 2 critical care beds available within the region with patients awaiting admission for critical care.

Actions

Priority is to fully staff all ACC beds and maximise capacity for admissions across the region, ensuring equity of access based on clinical ability to benefit

- Network Critical Care Control Group (NCCCG) activated. Accountable to the responsible NHS England North (Cumbria and North East) Director on call (NHS strategic commander if NHS strategic command established).Chaired by the Medical Director or senior medic as nominated by the NHS England North (Cumbria and North East) Medical Director or Director on call.
- NCCCG will:
  - Direct and facilitate operational response inclusive of daily status report (trust triggers/levels/actions) and teleconference (this will include regional paediatric intensive care status via the Newcastle Hospitals Critical Care Control Group)
  - Ensure accurate regional bed status;
  - Require explicit feedback on implementation of local actions;
  - Decide on de-escalation/escalation/maintaining current status;
  - Provide any feedback required to DH and other regions (via NHS England);
  - Circulate agreed daily information;
    Determine issues in relation to highly specialist and quaternary services, liaising with national commissioners (NHS England North (Cumbria and North East))
  - Provide single regional point of advice to trusts and intensive care clinicians
  - Discuss the need for support to transfers, where appropriate identifying those Trusts / Hospitals that are able to provide a transfer retrieval team, to assist Trusts / Hospitals that are under significant pressure with moving patients within and external to the region.

Possible triggers to ccOPELa 4

- Underlying problem continues.
- Actions have not reduced the pressure.

Network ccOPELa 4

All current staffed ACC capacity is occupied and adults requiring critical care are being ventilated temporarily in areas not designated as critical care such as recovery, PACU areas *or* in resuscitation areas. Adults with ability to benefit from critical care are awaiting admission.

OR

Significant critical care capacity is lost at a tertiary unit or large general adult intensive care unit through major incident / evacuation /critical infrastructure failure. Evacuation Patient Tracking Template (Appendix 7) can provide a record of the patients to be moved and the staff and equipment available.

OR

A massive explosion-type incident occurs in the region with multiple severe blast injuries

OR

A (Marauding Terrorist Firearms Attack) MTFA

Actions

Priority is to fully staff all additional ACC beds, progressively opening all additional capacity to a maximum, ensuring equity of access based on clinical ability to benefit

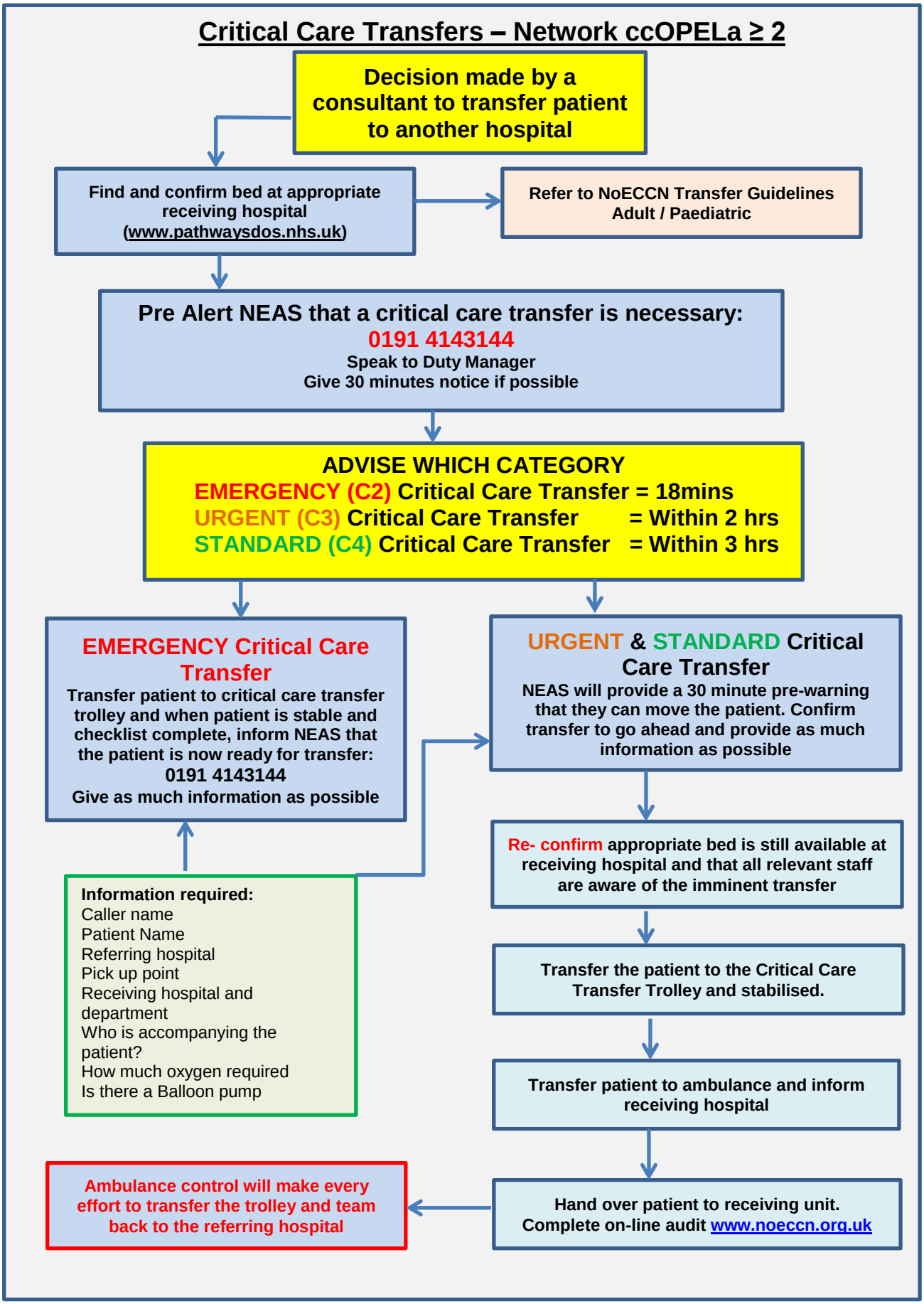
- Update DOS hourly
- NHS strategic command activated. NCCCG now part of the command structure.
- Regional communication structures activated.
- NHS strategic command may make escalation decisions or decisions to cease certain activities across the region.
- NCCCG will manage queries/issues arising from individual trust Critical Care Control Groups.
- NCCCG will.
  - Continue all ccOPELa 3 actions;
  - Ensure all additional capacity is in place;
  - Issue clear statements supporting ethical and equitable decision making, endorsed through NHS strategic command.

All subsequent action will be determined by NHS command and control structures

Appendix 1: Network Medical Critical Care Unit Leads

Name	Unit	Trust
ADULT ICU	**ICU = L3**	**HDU = L2**
Jon Walton	Freeman Hospital ICCU Ward 37	Newcastle upon Tyne Hospitals NHS FT
Kevin Brennan	Freeman Hospital Cardio ICU Ward 26	Newcastle upon Tyne Hospitals NHS FT
Ian Clement	RVI GICU/HDU Ward 38	Newcastle upon Tyne Hospitals NHS FT
Sarah Platt	RVI NICU/HDU Ward 18	Newcastle upon Tyne Hospitals NHS FT
Matthew Gaughan	Queen Elizabeth Hospital ICU/HDU	Gateshead Health NHS FT
Jon Sturman	Cumberland Infirmary ICU/HDU	North Cumbria Acute Hospital Trusts
Mark Holliday Mike Hodgson	West Cumberland ICU/HDU	North Cumbria Acute Hospital Trusts
Peter Hersey	Sunderland Royal Hospital ICU/HDU	City Hospitals Sunderland NHS FT
Govindan Balaraj	South Tyneside General Hospital ICU/HDU	South Tyneside NHS FT
Karen Connelly	Northumbria Specialist Emergency Care Hospital ICU / HDU	Northumbria Healthcare NHS FT
Krishnan Paramaswamy	Darlington Memorial Hospital ICU/HDU	County Durham & Darlington NHS FT
Matthew Wayman	University Hospital North Durham ICU/HDU	County Durham & Darlington NHS FT
Vijay Jagannathan	University Hospital of North Tees ICU/HDU	North Tees & Hartlepool NHS FT
Stephen Bonner	Friarage Hospital ICU/HDU	South Tees NHS FT
Stephen Bonner	James Cook University Hospital ICU/HDU	South Tees NHS FT
Sarah Round	James Cook University Hospital Cardio ICU/HDU	South Tees NHS FT
PAEDIATRIC CRITICAL CARE		
Susan Johnson	Great North Children's Hospital PICU/HDU L1 –L3	Newcastle upon Tyne Hospitals NHS FT
Yam Thiru	Freeman Hospital Cardio PICU/HDU L1 – L3 (ECMO)	Newcastle upon Tyne Hospitals NHS FT
Jonathon Grimley	James Cook University Hospital PICU/HDU L1 – L2	South Tees NHS FT

Appendix 2: Critical Care Transfer Flow Chart



Appendix 3

NETWORK CRITICAL CARE CONTROL GROUP (NCCCG)

Terms of Reference and Membership

Overall aim

At a Network level provide a credible forum for communication between senior clinicians to support decisions that enable the fair and effective use of critical care capacity in the event of exceptional demand and coordinate an operational response when directed by NHS strategic command.

Broad Remit of the Group

- To advise on the effective utilisation of critical care resources within the North East and North Cumbria region.
- To advise on the use of the regional *Ethical framework for utilisation of critical care in response to exceptional demand* which underpins all decisions at all times.
- To support ethical clinical decision making in line with the escalation of the ccOPELa triggers
- To facilitate effective and coordinated channels of communications between Trust Critical Care Control Groups; NHS England North (Cumbria and North East), North of England Critical Care Network (NoECCN) and individual clinicians.
- To provide peer support to colleagues making difficult ethical decisions
- Consider and advise upon management, staffing and logistic issues associated with exceptional demand when directed to do so by NHS strategic command.

Timing and Operation

- The NCCCG will be convened in line with the escalation of the ccOPELa triggers by the NoECCN and / or NHS England North (Cumbria and North East)
- The establishment of NCCCG may be at short notice and will be driver dependant
- The NCCCG will communicate via conference call once or twice daily in line with ccOPELa
- The conference call will be recorded and key decisions documented and emailed out to agreed circulation within two hours of the teleconference.

Membership

The NCCCG will be chaired by NHS England North (Cumbria and North East) Medical Director or senior medic as nominated by NHS England North (Cumbria and North East) Medical Director or Director on call.

And include:

- A member of each Trust's Critical Care Control Group
- The senior duty Intensivist (NoECCN Medical Lead or delegated deputy)
- NoECCN Director/Manager
- NEAS dedicated liaison officer
- Nursing and AHP's as appropriate
- CCGs as appropriate
- Add hoc partners as appropriate

Governance

The NCCCG will be accountable to the NHS England North (Cumbria and North East) Director

Administration and Coordination

Secretariat to NCCCG will be provided by NoECCN

Appendix 4:

Suggested core elements for terms of reference for Trust Critical Care Control Groups

TRUST X CRITICAL CARE CONTROL GROUP (CCCG)

Terms of Reference and Membership

Overall aim

To coordinate, monitor, and direct a trust wide response to an exceptional demand for critical care.

Broad Remit of the Group

- To monitor and coordinate adult (and when appropriate paediatric) critical care patients, staffing (nursing, medical, admin), disposables and equipment for critical care services across the organisation
- To assess critical care demands and advise the Hospital Tactical Control Team on the appropriate reallocation of staff, beds, equipment, disposables and drugs
- To monitor admissions, access and throughput to critical care beds and direct the appropriate expansion and cohorting across the organisation
- To advise the Trust on any changes to normal critical care standards of care e.g. equipment and staffing
- To prioritise and direct the delivery of staff education and training to support the staffing requirements of critical care.
- To coordinate staffing rotas/off-duty and support the Hospital Tactical Control Team with organisation and coordination of critical care services throughout the Trust.
- To ensure the use of the regional '*Ethical framework for utilisation of critical care in response to exceptional demand'* this underpins all decisions at all times. (A multi-professional team with no less than two consultants will decide on the admission and access to critical care beds and limitation on treatment. When appropriate withdrawals of treatment will be discussed at the daily meeting and will be recorded in meeting notes)
- To maintain and review a log of ethical decisions
- To review all patients on the 'line list'
- To perform a stringent review of all elective surgery requiring ACC, with a view to cancellation of surgery in accordance with the Trusts' Major Incident Plan and the Network ccOPELa level
- Facilitate early discharge to ward areas where clinically feasible.
  To interact with and inform the 'North of England Critical Care Network' and NHS England North (Cumbria and North East) on Trust Critical Care capacity and demand.

- Provide appropriate representation (possibly at short notice) to represent the Trust on the Network Critical Care Control Group (NCCCG) in accordance with the NE ccOPELa.

Timing and Operation

- The Trust CCCG will be convened in line with the Trusts' Major Incident Plan and at Network ccOPELa 3.
- The establishment of Trust CCCG may be at short notice and will be driver dependant
- The group will meet daily / weekly dependent upon on activity and driver to coordinate critical care activities
- The chair of the group will report to the Trust Hospital Control Team
- A teleconference facility will be provided for staff to dial in from their units. The dial in number is ***(insert)***
- The conference call will be recorded and key decisions documented

Membership

- The Trust's Clinical Control Group will be multi-professional
- A Consultant Intensivist and at least one other Medical Consultant
- Senior ACC Nursing staff and AHP's as appropriate
- Senior Pharmacist
- Senior Trust Manager / Emergency Planning Officer
- Senior Bed Manager
- *Others as appropriate such as outreach for early discharge planning situations*

Governance
The Trust CCCG will be accountable to the Trust Tactical Command.

Administration and Coordination
Secretariat to CCCG will be provided by a member of the Critical Care / Anaesthetic admin team or an appropriate person as designated by the chair of the group.

Appendix 5:
Standard Operating Procedure (SOP) for Network Personnel

Triggers: Network ccOPELa 2

- Where there are < 8 Level 3 Critical care Beds
- Non-clinical transfers increasing across the region
- Unusual case mix or multiple numbers of patients with the same condition present in one or more units
- One Trust providing tertiary/specialist services (either Newcastle upon Tyne Hospitals NHS Foundation Trust or South Tees NHS Foundation Trust) declares ccOPELa 2
- Two or more trusts which do not provide tertiary services declare ccOPELa 2
- Major incident declared with significant likely impact on critical care
- Novel infection impacting on critical care identified elsewhere in country

Actions: Network ccOPELa 2

- NoECCN validates information on capacity from each unit
- NoECCN ensures NEAS alerted
- NoECCN ensures bed status system is up to date
- NoECCN provides a daily status email (agreed with NHS England North (Cumbria and North East)) at a set time to all clinical leads cc Medical Directors:
  - Update on any known underlying problem driving pressure on ACC
  - Current ccOPELa levels all trusts
- NoECCN provides a Network Critical Care capacity proforma which also provides current position in other regions if necessary
- NoECCN assists as needed with in-region transfers to equalise pressures, liaising with NEAS
- NoECCN initiates and facilitates conference call discussions between clinical leads within the Network as necessary

Triggers: Network ccOPELa 3

- Underlying problem continues.
- No longer able to accept transfers in to tertiary/specialist units from local unit's in-region for tertiary care/specialist services except for immediately life threatening conditions.
- Increasing difficulty in accepting transfers in from other regions for quaternary services.
- Transfers out of region not possible as no capacity in other regions.
- Actions have not reduced pressure

Actions: Network ccOPELa 3

- Network Critical Care Control Group (NCCCG) activated. Accountable to the responsible NHS England North (Cumbria and North East) Director on-call.
- NCCCG will:
  - Direct and facilitate operational response inclusive of daily status report (trust triggers/levels/actions) and teleconference (this will include regional paediatric intensive care status via the Newcastle Hospitals Critical Care Control Group)
  - Ensure accurate regional bed status
  - Require explicit feedback on implementation of local actions
  - Decide on de-escalation/escalation/maintaining current status
  - Provide any feedback required to DH and other regions (via NHS England North (Cumbria and North East))
  - Circulate agreed daily information
  - Determine issues in relation to highly specialist and quaternary services, liaising with national specialist commissioners (via NHS England North (Cumbria and North East)
  - Provide single regional point of advice to trusts and intensive care clinicians

Triggers: Network ccOPELa 4

All current staffed ACC capacity is occupied and adults requiring critical care are being ventilated temporarily in recovery, PACU areas *or* in resuscitation areas. Adults with ability to benefit from critical care are awaiting admission.

Or

Significant critical care capacity is lost at a tertiary unit or large general adult intensive care unit through major incident / evacuation / critical infrastructure failure.

Actions: Network ccOPELa 4

- **NHS strategic command activated. NCCCG now part of the command structure.**
- **Regional communication structures activated.**
- **NHS strategic command may make escalation decisions or decisions to cease certain activities across the region.**
- **NCCCG will manage queries/issues arising from individual trust Critical Care Control Groups.**
- **NCCCG will:**
  - **Continue all ccOPELa 3 actions**

All subsequent action will be determined by NHS England command and control structures in what will be a severe national emergency. These actions will be determined by the underlying problem, in particular its severity and likely duration.

May enter the ccOPELa at any level dependent upon the driver and the movement through the ccOPELa levels may not be a linear process

Appendix 6: NoECCN Personnel and Paediatric Contacts

Table of NoECCN Personnel Contacts		
	'Normal Hours' 8.00-17.00 Monday to Friday	**'Out of Hours' 17.00-08.00 (Monday-Friday) Weekends**
North East & Cumbria Locality	Lesley Durham (Director) **07824498625** Dave Cressey (Medical Lead) **07941167155** Jan Malone (Administrator) **07827978559**	Consultant Intensivist on call (RVI – Ward 18 Neuro-Trauma ICU) **0191 2821788**
Tees Valley & South Durham Locality	Julie Platten (Manager) **07881832184** Isabel Gonzalez (Medical Lead) **07977153036** Sarah Gray (Administrator) **07765253098**	Consultant Intensivist on Call (JCUH – GICU) **01642 282680**
Paediatric Critical Care Leads	Susan Jackson (Paediatric Medical Lead) **07771 930315**	Consultant Paediatric Intensivist on call GNCH PCCU (RVI Newcastle) **0191 282 6012**
	Lynda Pittilla (Paediatric Nurse Lead) **07791 041915**	Consultant Paediatric Intensivist on call JCUH PCCU **01642 854 667**
North East Children's Transfer and Retrieval (NECTAR) Phone number – 0191 2826699		

PAEDIATRIC ICU		
Susan Jackson	GNCH PICU RVI	Newcastle Hospitals NHS FT
Yam Thiru	Freeman Hospital PCICU	Newcastle Hospitals NHS FT
Jonathon Grimbley	James Cook University Hospital PCCU	South Tees NHS FT
Aravind Kashyap	North East Children's Transport and Retrieval (NECTAR)	Newcastle Hospitals NHS FT

Appendix 7: CNE Critical Care unit locations within Trusts

Hospital	Unit	Location	Known as
Royal Victoria Infirmary Great North Children's Hospital	ITU/HDU General / burns ITU / HDU Neuro / Trauma ICU / HDU Paed	Victoria Wing, Level 4 Leazes Wing, Level 5 Victoria Wing, Level 5	Ward 38 Ward 18 PICU Ward 12
Freeman Hospital	ITU / HDU general ITU/HDU Cardio ITU/HDU Paed Cardio	Institute of Transplantation Level 3 Level 3	ICCU - Ward 37 Ward 21 PICU
West Cumberland	ITU / HDU	Level 3, New Building	Critical Care
Cumberland Infirmary	ITU / HDU	1st Floor, Red Zone	Critical Care
Queen Elizabeth Hospital, Gateshead	ITU / HDU	Level 3 Surgical Block	Critical Care
Sunderland Royal Hospital	ITU / HDU	Level C	ICCU
South Tyneside District Hospital	ITU / HDU	Ingham Wing	Critical Care
Northumbria Specialist Emergency Care Hospital	ITU/ HDU	1st Floor (rear of building)	Critical Care
University Hospital of North Durham	ITU/ HDU	2nd Floor	Critical Care
Darlington Memorial Hospital	ITU / HDU	1st Floor	Critical Care
University Hospital of North Tees	ITU / HDU	1st Floor	Critical Care -Ward 20
James Cook University Hospital	Spinal HDU Neuro HD ITU 2 & 3 General HDU Cardio ITU / HDU Paed ITU / HDU	Ground floor 1st Floor 1st Floor 1st Floor 1st Floor 1st Floor	Spinal Injuries Ward 24 Intensive Care General HDU Cardiac ITU
Friarage Hospital, Northallerton	ITU / HDU	Ground Floor	Critical Care

Appendix 8: Evacuation Patient Tracking Template

Hospital _____ Number of Patients to Transfer _____

Patients

Time	Pt. Name /initials	Pt. Age/ gender	Level + Main Diagnosis	Organ Support	Issues (eg DNAR etc)	Destination Location Hospital & ward/unit	Accompanying Staff	Confirmed by	Estimated time for transfer	Actual time of transfer
0945	*AB*	*47M*	*3, ARDS, ARF*	*ETT, V .6, RS*	*For Resus*	*St Elsewhere*	*SW & RB*	*Sr C Jones*	*1100*	*1100*

Key: ETT Endotracheal Tube T Tracheostomy V Ventilated NIV Non-invasive ventilation RS Renal Support I Inotropes

Staff & Equipment Available

Time	Staff Member	Skills	Competent in Transfer Training	Equipment	Location Hospital & ward/unit	Time Available
1100	*Dr Ian Ryan ,SN Bob Jones*	*Anaesthetist/CC*	*√*	*Full Kit*	*From JCUH (retrieval team)*	*1100*

Name of person completing the form _____ Date _____