

Meeting Title	Board of Directors		
Date	23 <sup>rd</sup> September 2021	Agenda item	Bo.9.21.23

## SERVICE AND STAFFING PRESSURES IN ACUTE SERVICES AND CRITICAL CARE

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Purpose of the paper	Note the information and risk related to GPICS staffing standards		
Key control			
Action required	To note		
Previously discussed at/ informed by	Discussed at West Yorkshire Association of Acute Trusts Chief Nurse meetings		
Previously approved at:	Committee/Group	Date	
	Executive Team Meeting (E.8(3).21.12)	16 <sup>th</sup> August 2021	

### Key Options, Issues and Risks

On the 26 July 2021 a letter was sent to all Acute Trusts (Appendix 1) on behalf of NHS England/Improvement (NHS E/I) from Dr David Black recognising the pressures faced in acute care due to both covid and non-covid related urgent and emergency pathways and on-going work to provide elective services. In addition to the letter the NHS E/I North East and Yorkshire (NEY) region incident management escalation and mutual aid plan to support local systems across the region (December 2020) was shared (Appendix 2).

The letter also acknowledges the challenges in acute paediatric care caused by high rates of respiratory tract infections. The letter stated that if there is a surge in demand for Paediatric Intensive Care (PIC) beds, children over the age of 12 may need to be cared for within adult critical care units. Surge planning is underway through Yorkshire and Humber Paediatric Critical Care Operational Delivery Networks (Y&HPCCODNs) at a Trust level with the Paediatric CBU.

### Analysis

#### 1. Actions for Acute providers

- Trusts to continue supporting the Critical Care Operational Delivery networks (CCODN) for Adult and Paediatric services working collaboratively across the system.
- Note that the NHS continues to operate in a level 3 incident and to acknowledge the North East and Yorkshire region incident management escalation and mutual aid plan.
- Note that across the four ICS some providers are not able to open all base line critical care beds within the Guidelines for the Provision of Intensive Care Services (GPICS standards) due to staffing shortfalls.
- Note that as per the incident management escalation and mutual aid plan, that staffing ratios may need to be reduced outside of GPICS following risk assessment (see section 8.0 'requesting mutual aid' on page 6, Appendix 2) to maintain sufficient capacity for Covid and non-covid related urgent and emergency pathways.
- Continue to optimise the provision of elective care, prioritising those patients in greatest need and ensuring that commissioners, including specialised commissioners, are informed regarding any

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difficulties in providing timely care to 'P1' and 'P2' patients.

## 2. Current position

### BTHFT position

Within the Critical Care (CC) CBU some elective P2 work has had to be cancelled due to both insufficient staff and beds. For the week commencing 2 August this resulted in two cases being cancelled. During the current surge CC have worked outside of GPICS for short periods of time to support surge pressure and demand from urgent unplanned cases on two occasions (22 and 23 July).

The Trust is not currently able to open all baseline CC beds within GPICS standards due to staffing shortfalls although we continue to optimise the provision of elective care, prioritising those patients in greatest need. When there are insufficient staffing levels or beds and CC is unlikely to be able to meet demand for all P1 and P2 cases without working outside of GPICS standards a clinical review of all patients is undertaken and clinically validated and reprioritised based on clinical assessment.

Reducing the ratio of specially trained intensive care nurses to patients must be a temporary measure and only used when it is absolutely necessary. The NHSE Advice on acute sector workforce models during COVID-19, (Appendix 3) was developed to support safe staffing during pandemic conditions, rather than to provide a mechanism to move away from GPICS standards in other situations.

During the latest wave of Covid CC have once again needed to conduct increased numbers of non-clinical transfers of patients out of ICU to other units within our CCODN in order to create acute capacity. The risks to the patients moved in this scenario are not insignificant and we would not use this approach to provide capacity for elective surgery.

In this scenario we would follow the mutual aid agreement in order to maximise capacity by following the NEY escalation and mutual aid plan (Appendix 2).

To optimise the provision of P1 and P2 cases the following steps are recommended by the NEY incident management escalation and mutual aid plan before escalation for mutual aid from the wider ICS:

- Accelerated discharge of patients supported by positive risk taking.
- Increased their own capacity by opening any closed wards with available staffing and equipment.
- Postponed non-urgent elective care (P3 and P4) including outpatients to enable the release of staff and to create bed capacity to support both themselves and partner trusts in their system.
- Re-deployed clinical staff from non-patient facing roles to support wards and stood down where possible any non-clinical time in job plans and training.
- Reduced staffing ratios to open all on site beds following appropriate risk assessments.
- Reopened beds on Covid wards closed due to social distancing.

Feedback from the West Yorkshire Association Acute Trust Chief Nurse group reports that critical care units in the region are operating within GPICS however staffing pressures are increasing.

### ICU Working Model

An 8 am handover meeting occurs every day on CC where the Consultant in charge for ICU reviews the known demand for ICU beds with the nurse in charge. This includes any patients known to be deteriorating on the wards or requiring admission from A&E and any elective surgical patients that need critical care post operatively. Capacity for each shift will depend on bed occupancy and staffing. Looking at these factors and

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any anticipated discharges from the unit, a plan is made for the day. A decision to proceed with elective surgery (P1 and P2) will be made at this meeting based on individual patient clinical need balanced against the ability to safely staff all patients on the unit. At all times the clinical team must be clear on how the next emergency ICU bed and nurse would be provided as emergency admissions are usually time critical. In practise this means that CC would not usually be able to proceed with elective activity if this meant filling the last available ICU bed.

All options are explored in order to avoid cancelling elective surgery, including the use of extended recovery area stays. The critical care outreach team support patients who should be on a HDU and being admitted postoperatively to monitored beds outside of the ICU. This is not ideal, and is a compromise. In these cases the risk of delaying surgery is higher than the risk of not providing postoperative critical care.

All delayed discharges are reviewed and escalated to the command centre to facilitate transfer to a ward in order to admit elective cases. If discharges cannot be facilitated and elective cases cannot be accommodated, they are cancelled. 7 patients were cancelled in July.

We currently have 16 CC beds and established staffing to provide 8 level 3 and 8 level 2 beds. The configuration of beds to support Covid and non-covid patients can be adapted depending on the number of Covid positive patients on the unit as follows:

Total Beds	Red beds	Green beds	CC Unit
16	2	14	Current
16	4	12	Current
16	8	8	Current
16	16	0	CC surge on W14 – 10 green beds

### Nurse staffing

The critical care nursing workforce work extremely flexibly in order to maximise the efficiency to run the unit. When bed occupancy allows, we roster fewer nurses in order to 'store up' hours of working time, which nurses then use up at busier times when more nurses are required.

In addition, when needed, nurses agree to be on call and available for work, without physically coming in, until an acute admission when nurses are called in from home.

This system has worked very well over the years, with periods of lighter demand allowing staff to reduce workload and prepare for times of higher demand. Traditionally, CC store up hours over the summer and use them for winter surge times. CC has been fortunate in having a highly motivated and engaged workforce who has always been willing to take on extra shifts at particularly busy times. However, the ability of the workforce to continue offering high levels of overtime work is increasingly constrained (see sickness absence, below).

CC provide nursing outreach support (B6 or above, 24/7) to support review of the deteriorating patient, to

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prevent admission to CC and to promote better outcomes for patients in ward and department areas. In addition, consultant delivered outreach support is provided during the day if possible and/or as required, depending on acuity, the number of patients on NIV and the demand for consultant cover elsewhere. In extremis, the nursing outreach support role is temporarily suspended to support the team on the unit if the GPICS standard is to be compromised.

An additional supernumerary support role (B5/B6) is rostered 24/7 to provide enhanced level 3 care to patients requiring for example, haemofiltration (renal replacement therapy), proning support or transferring patients to other critical care units or to access diagnostics (for example transfer of ventilated patients to and from the radiology department).

### **Vacancy position**

The CC CBU has a registered nurse vacancy of 8 wte band 5 nurses. 2.8 wte new staff started week commencing 21 June; 1 wte due to start in September with a further 2 wte recruited last week, and waiting for confirmed start dates. We have not recruited any international nurses into ICU from the recent overseas nurse recruitment tranche.

### **Current sickness absence**

9 wte nurses reported sick (8 registered (11.9%) and 1 unregistered (16%)) – all LTS; 5 due to work stress / PTSD; 2 bereavement and 2 other health issues.

### **Training and development**

There is a national competency framework (Step 1 programme) for registered Nurses in Adult Critical Care to complete on induction. There is no standardised approach across the network due to the configuration of individual critical care units, although the West Yorkshire Critical Care Network (WYCCN) recommends that the minimum requirement for a new starter is an 8 week supernumerary period, and would need to have completed all the recommended sections in the Step 1 booklet to demonstrate competence.

The new staff that started in June are receiving a shortened version of the BTHFT 10 week induction programme completing 7 weeks supernumerary (with 1-2 education days per week), and 3 weeks working with an experienced member of staff as part of the overall staffing numbers. The 2.8 wte nurses recruited in June have been working since mid-July as support nurses, similar to the model that we used with theatre staff. The Professional and Practice Development Nurse is looking at options to run a hybrid model of support and supernumerary time.

### **Paediatric critical care**

BTHFT works in partnership with Leeds Teaching Hospital (LTH) and Sheffield Children's Hospital to manage surge capacity. There is currently an issue with paediatric critical care capacity and LTH are working with 12/14 beds daily but are currently full. They have been operating like this for a number of weeks (1 in 1 out). LTH deliver high priority specialist services e.g. cardiac surgery which must be maintained. Sheffield Children's hospital has paediatric capacity but it is very limited. This is all due to a mixture of sickness absence and vacancy.

There are reported staffing issues within Embrace with gaps in the middle grade rota in the coming months and Consultant shortages too.

It is predicted that we will have a hiatus in acute hospital admissions while children and families take holiday

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from school; this is currently being seen regionally. We continue to experience large numbers of children attending AED.

The children likely to be admitted in numbers with respiratory problems are those aged 2 and under (at home during Covid but now mixing). With the above paediatric critical care bed capacity and Embrace issues (if we surge) it is likely that we will have prolonged periods providing critical care support for ventilated children. This requires 1:1 support from an ICU nurse and an ICU Consultant. We have 3 stabilisation spaces; 2 spaces side by side and a third separate stabilisation space. When we have an intubated child the anaesthetist has to remain until Embrace arrives and leaves before the anaesthetist can depart. This is managed in partnership with the paediatricians.

The annual figures for the 19/20 stabilisation report; 6/48 children were admitted to stabilisation aged 10+. 20/21 report, 7/31 children were admitted to stabilisation aged 10+. Children admitted to stabilisation do not always require intubation and transfer and many children are admitted for a period of observation.

### Recommendation

The Board of Directors are asked to note the content, the current position to optimise the care of P1 and P2 patients and the escalation plans in place to support surge demand and an increase in Covid patients.

Continue to support operating within GPICS standards.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

<b>Benchmarking implications (see section 4 for details)</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input type="checkbox"/>

<b>Regulation, Legislation and Compliance relevance</b>
<b>NHS Improvement: (please tick those that are relevant)</b> <input type="checkbox"/> Risk Assessment Framework <input type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
<b>Care Quality Commission Domain:</b> Choose an item.
<b>Care Quality Commission Fundamental Standard:</b> Choose an item.
<b>NHS Improvement Effective Use of Resources:</b> Choose an item.
<b>Other (please state):</b>

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Appendices</b>
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Appendix 1 – Letter to MDs and DoNs regarding service and staffing pressures.

Appendix 2 – NEY Escalation and Mutual aid plan to support local systems across the Region.

Appendix 3 – Advice on acute sector workforce models during Covid-19.