

Message

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Sent: 25/03/2020 12:50:04
To: [redacted] NR [redacted]@hscni.net]; [redacted] NR [redacted]@hscni.net]; Alastair Campbell [alastair.campbell@health-ni.gov.uk]; Ryan Wilson (DoH) [ryan.wilson@health-ni.gov.uk]
CC: [redacted] NR [redacted]@northerntrust.hscni.net]; [redacted] NR [redacted]@hscni.net]
Subject: Critical Care Escalation

Good afternoon

I think we are going to need to set some clear boundaries on what is going to be realistic and clinically appropriate in terms of service expectations for critical care.

1. We need to recognise that we are starting from a position where our nursing workforce is not at capacity for the number of commissioned beds we have.
2. Our modelling suggests that increasing capacity to 180 concurrent ventilated patients (effectively doubling baseline maximum level 3 capacity) is likely to be feasible in the short to medium term **ONLY if** very large numbers of non-ICU staff across a range of disciplines are committed to ICU as staff.
3. Our modelling suggests that increasing capacity to 360 concurrent ventilated patients (effectively quadrupling baseline maximum level 3 capacity) is likely to be feasible in the short term **ONLY if** HUGE numbers of non-ICU staff across a range of disciplines are committed to ICU as staff.
4. There is no clarity on who these staff are, how they would be identified and “commandeered” for ICU, or what their service areas would do without them.
5. The Department will have to take a position on the level of priority they wish to give to ICU versus ward care, and make this decision explicit
6. The feasibility of providing training now or in the midst of severe surge to HUGE numbers of non-ICU staff is questionable.
7. It is likely that clinical standards could be maintained to an acceptable level (with minimal or acceptable impact on mortality) up to the 180 patient level.
8. As patient numbers escalate beyond 180 there will be an inevitable fall in the quality of care that can be provided.
9. At some point along the escalation path above 180 patients the fall in service quality will result in a substantial increase in mortality for all patients within the units from what is expected to be an already high percentage.
10. It is our view that this will occur well before 360 patients, and continuing to treat more critical care patients beyond this point will diminish outcomes for all and likely be futile.
11. Staffing levels will inevitably fall due to illness, bereavement and the psychological burden of dealing with relentless demand and multiple deaths
12. We do not feel increasing the number of ICU ventilators available to a level beyond 500 will be clinically useful or financially sensible because there will be insufficient staff to provide any meaningful level of care at that number, and as such admission to critical care would be futile.
13. The limiting factor in what level of service can be provided by critical care is not going to be equipment related
14. The availability of Intensivists, non-ICU medical staff, critical care nursing staff, the large number of non-ICU nurses capable of IV drug administration, and the large number of other support staff needed etc will be THE major determining factor for service provision in critical care
15. The availability of oxygen on a whole hospital and locally within hospital basis will be another major limiting factor for service provision in critical care and the wider hospital
16. The availability of PPE will be critical to maintaining staff confidence and staffing levels
17. Triage for admission to intensive care will be inevitable
18. Triage for suitability to continue ICU support will be inevitable
19. The public need to understand the limitations on the service and the difficult decisions that will have to be made
20. ICU clinicians need the full and unqualified support of the CMO and the Minister in undertaking their roles during and after this emergency

21. Triage for oxygen, and capping of oxygen supply to patients is likely to be inevitable

Based on discussions with colleagues I would suggest we continue ventilator purchasing until we have secured a functioning capacity of around 500 (accepting there will be a delay in some of these coming on stream). It would be essential to have a chart collating the points at which the various procured ventilators are expected to come on-stream and our total capacity.

If one is not already available, we need urgently to have a list of ALL acute and non-acute hospital sites, their oxygen supply type (VIE etc), and the capacity of their VIE in L/min so that we can model the numbers of patients without and outside ICU who can reasonably be treated in each facility. I don't know if there is a constituted estates group doing all of this but if not there would need to be, and in critical care we will need daily updates at our teleconference on O2 supply from the person who is coordinating that.

I spoke to a senior colleague in the Republic of Ireland today and they are looking to industry to see if additional VIEs can be moved from industry sites to hospitals with a view to tripling VIE capacity on some main sites.

High flows of oxygen from the VIE can result in freezing, and it may be necessary for estates to have a physical presence monitoring this 24/7.

Best wishes

NR

NR

Consultant in Critical Care Medicine

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