

- 2.3 In this current wave of the COVID 19 pandemic there was an average of 44 COVID patients in critical care daily in August 2021. The range was from 34 to 52.
- 2.4 In developing a new Total Surge plan the need to maximise the utilisation of critical care capacity is key. Critical care is used as an umbrella term for intensive and high dependency care that has been classified as level 3 and level 2 respectively where:-
- Level 3 patients include for example those needing mechanical ventilation including via tracheostomy or acute dysfunction of 2 or more organ systems.
  - Level 2 patients include assisted respiratory support including NIV/CPAP/AIRVO and extubated patients or patients with tracheostomy not requiring ventilation. Includes Basic cardiovascular support.<sup>1</sup>
- 2.5 The regional average total occupied beds at level 3 care were 68, ranging from 59 to 80 occupied beds while the average total occupied beds at level 2 are 24, ranging from 15 to 31.(Based on data 17/08/21 to 23/09/21)
- 2.6 To maximise critical care capacity it is proposed that the numbers of level two patients are reduced, through admission avoidance or faster throughput and reducing length of stay by maximising discharge protocols, thereby maximise the capacity for level 3 care to an average of 12 occupied beds. This approach still allows for a small number of level two patients to access critical care. This suggested action is not without its challenges for Trusts as some of these patients may be ward ready but unscheduled care pressures impact on the ability to move these patients out of critical care.
- 2.7 Reducing level 2 beds in critical care units will also add additional pressures on respiratory teams who are already under significant pressure. Trust respiratory teams have been central to the management of COVID 19 throughout the pandemic. These teams also face the normal winter pressures with increases in respiratory illness anticipated.
- 2.8 Options to provide enhanced respiratory beds should be explored to support unscheduled admissions, prevent critical care admissions and facilitate critical care discharge. This will require enhanced nursing and medical staff input.

### **3.0 Staffing**

- 3.1 The availability of nurse and medical staffing has been crucial to the delivery of the COVID 19 pandemic response. The staff involved have delivered care at a consistently high level despite continued and sustained pressure.
- 3.2 The staff in all of the critical care units and respiratory wards are working under significant pressure. While Delivering Care will define more clearly the

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<sup>1</sup> Please note a complete definition of levels of care can be accessed at [https://www.ics.ac.uk/Society/Guidance/PDFs/Levels\\_of\\_Care\\_25\\_3\\_21](https://www.ics.ac.uk/Society/Guidance/PDFs/Levels_of_Care_25_3_21)

actual nurse staffing requirement for critical care services, it is important to note that the staffing situation is unstable in most Trusts.

- 3.3 Units that normally would expect at a minimum of one critical care nurse to one ventilated patient, have worked with one critical care nurse to two/three ventilated patients supported by redeployed nursing staff. This places particular pressure on critical care nursing staff through the additional supervisory responsibilities the impact of which is seen in increasing levels of sickness absence in some teams. The current absence rate regionally is **22%** however it is important to note that this varies considerably from **9%** to **43%**. These figures do not include short terms illness, secondments and those clinically extremely vulnerable who cannot work in this environment.
- 3.4 Trusts have accessed or provided training to a significant number of nursing staff to support the critical care teams. These redeployed nurses are crucial to the delivery of the level of critical care beds required for surge patients. Like their critical care colleagues many have felt anxiety and stress. These staff work now in areas which they are unfamiliar with, they manage seriously ill patients with complex treatment pathways, work with increasing levels of technology and work in an environment at high personal risk.
- 3.5 The availability of nursing staff has been key to each Trusts ability to move through surge levels in response to demand. Feedback from managers and staff at the frontline suggest that the energy and capacity to keep delivering surge capacity is unlikely to be sustained in the coming months. If a total surge plan is to be achieved then all options which support retention and recruitment of nursing staff should be explored.
- 3.6 Feedback in relation to the medical workforce indicates that there needs to be a significant growth almost doubling of trainees going into intensive care medicine. This needs addressed between DOH and NIMDTA as a matter of urgency. GPICS standards and recommendations for critical care need taken forward also as a matter of urgency.
- 3.7 Outside medical and nurse staffing cover NI critical care units are mainly staffed for other disciplines for 5 days per week (clinical scientists, pharmacy, AHP, HCA). This makes it difficult for nursing and medical staff to manage 7 days per week and during times of higher occupancy.

#### **4.0 Elective**

- 4.1 During this same period a significant number of the most critically ill patients who needed time critical surgery have been unable to access their surgery, despite the best efforts of Trusts.
- 4.2 Currently the Independent Sector are supporting the provision of care by facilitating 15 sessions per week for P2 patients who do not required critical care support.