Monthly Trust SitRep (MSitRep)

Critical Care Bed Capacity and Urgent Operations Cancelled

Definitions and guidance

Version	Date issued	Changes made
1.00	18 December 2006	
1.01	31 March 2008	• Indicator of response to pressures on system (G1) has been removed from the collection • The derived fields have been removed from the guidance. • Cat A and B details recorded lines are now voluntary. • New line added - number of category B calls responded to within 19 minutes of call connection to control room.
1.02	18 January 2010	• Paediatric Critical Care fields have been updated to Paediatric Intensive Care. • Paediatric Intensive Care definitions have been updated.
1.03	21 July 2010	• Updated contacts. • Removed Ambulance and Delayed Transfers of Care guidance. • Updated to include Independent Sector providers.
1.04	07 September 2010	• Updated the A&E Type 3 department definition so that it is aligned with the QMAE definitions. The same departments should be reported on both returns.
1.05	25 July 2011	• Removed A&E
1.06	02 April 2013	• PCTs replaced by CCGs. • SHAs removed. • Voluntary data items removed.
1.07	27 April 2014	• Cancelled Urgent Operations definition has been updated.
1.08	November 2018	• Clarification of Paediatric Intensive Care definitions

Monthly SitRep: Definitions and guidance

Version number: 1.08

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Contents

1 Summary of Monthly SitRep data lines

Data item	Data item description	Mandatory?
C2i	Number of urgent operations cancelled.	✓
C2ii	Number of urgent operations cancelled for the 2nd or more time	✓
F1i	Number of adult critical care beds open	✓
F1ii	Number of occupied adult critical care beds	✓
F2i	Number of paediatric intensive care beds open	✓
F2ii	Number of paediatric intensive care beds occupied	✓
F3i	Number of neonatal intensive care cots (or beds) open	✓
F3ii	Number of occupied neonatal intensive care cots (or beds)	✓
F4i	Number of non medical critical care transfers	✓

2 Cancelled Operations

C2i) Number of urgent operations that were cancelled

Count all urgent operations that are cancelled by the trust for non-medical reasons, including those cancelled for a second or subsequent time.

Include all urgent cancellations irrespective of *when* they are cancelled, i.e. not just those cancelled at the last minute.

Include all urgent operations that are cancelled, *including emergency patients* (i.e. non-elective) who have their operations cancelled. In principle, the majority of urgent cancellations will be urgent elective patients but it is possible that an emergency patient has their operation cancelled (e.g. patient presents at A&E with complex fracture which needs operating on. Patient's operation is arranged and subsequently cancelled).

Definition of "urgent operation"

The definition of 'urgent operation' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Perioperative Deaths (NCEPOD) should be followed. Broadly these are:

I. Immediate - Immediate (A) life saving or (B) limb or organ saving intervention. Operation target time within minutes of decision to operate.

II. Urgent – acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate.

III. Expedited – stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival. Operation target time within days of decision to operate.

IV. Elective – Surgical procedure planned or booked in advance of routine admission to hospital

Broadly, (I), (II) and (III) should be regarded as 'urgent' for the purpose of meeting this requirement. The full text of the NCEPOD Classification of Interventions is available online at http://www.ncepod.org.uk/pdf/NCEPODClassification.pdf

An operation which is rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. For postponements, the following apply:

- the 24 hour period is strictly 24 hours and not 24 working hours, i.e. it includes weekend/other non-working days
- the patient should not be discharged from hospital during the 24 hour period
- a patient cannot be postponed more than once (if they are then they count as a cancellation)

C2ii) Number of urgent operations that were cancelled for a second or subsequent time

Count only those urgent operations that have already been cancelled on one or more occasions before. This is a subset of item C2i and the definition is as for item C2i above.

3 Critical Care: Adult Critical Care

F1i) The total number of adult critical care beds open at midnight on the last Thursday of the reporting period

F1ii) The total number of occupied adult critical care beds at midnight on the last Thursday of the reporting period

Guidance / Definition:

Count all adult critical care (ITU, HDU or other) beds that are funded and available for critical care patients (Levels 2 and 3) at midnight on the last Thursday of the reporting period. Note that this should be the actual number of beds at that time and not the planned number of beds. Beds funded but not available due to staff vacancies should not be counted unless the vacancies have been filled by bank or agency staff. Beds that are not funded, but are occupied should be counted.

This count should be consistent with that provided for the KH03a return.

The definitions of critical care levels are:

Level 1 – Patients at risk of their condition deteriorating or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional

advice and support from the critical care team. ***(NB These patients are NOT included in SitRep returns).***

Level 2 – Patients requiring more detailed observation or intervention including support for a single failing organ system or post operative care and those "stepping down" from higher levels of care. Also known as High Dependency.

Level 3 – Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure. Also known as Intensive Care.

4 Critical Care: Paediatric Intensive Care

F2i) The total number of paediatric intensive care beds open at midnight on the last Thursday of the reporting period.

F2ii) The total number of paediatric intensive care beds occupied at midnight on the last Thursday of the reporting period.

Defined as:

- Paediatric intensive care at level 3, also known as paediatric advanced critical care (provided by Trusts commissioned to deliver this care). In order to provide the appropriate level of care for paediatric intensive care (level 3), a minimum nurse to patient ratio of 1:1 is required[1]. There are 21 Trusts who are commissioned to provide Paediatric Intensive care (Level 3) across England (equating to 23 units)[2]

- This collection aims to look at capacity levels. Therefore, all open level 3 beds should be counted and figures for occupied beds should include all patients in level 3 beds (regardless of patient characteristics and the nature of care they receive).

[1] PICANet 2017 Annual Report and Paediatric Intensive Care (PICS) Nurse Workforce Planning for level 3 Paediatric Critical Care Units
[2] Paediatric Intensive Care Surge Standard Operating Procedure

5 Critical Care: Neonatal Intensive Care

F3i) The total number of neonatal intensive care cots (or beds) open at midnight on the last Thursday of the reporting period

F3ii) The total number of occupied neonatal intensive care cots (or beds) at midnight on the last Thursday of the reporting period

Defined as:

High dependency care

Higher levels of clinical care including babies recovering from intensive care. This includes babies receiving oxygen for immature lungs as they breathe on their own, sometimes assisted by higher pressure given via nasal prongs; babies on intravenous nutrition or treated with chest drains or for convulsions, infections or metabolic problems.

Neonatal Critical Care

Babies born prematurely, simply to support organ systems until they have matured; and babies who are ill or who have congenital disorders. This includes support in breathing (often with mechanical ventilation), to protect from infection and to achieve growth equivalent to that which occurs in the womb. Even “well” very premature babies require intensive care simply to support their life until their organ systems undergo maturity. Short term intensive care may also be provided for less immature babies who need mechanical assistance from a ventilator to breathe and for some this may only be for 1 to 2 days as the effect of artificial substances (surfactant) given through the breathing tube located in their lungs takes effect and they can move to high dependency care.

Sophisticated mechanical ventilation with oxygen, intravenous feeding, and the use of incubators to control body temperature and protect from infection. Care may also involve treatment of illnesses that are more common in vulnerable babies. NIC is also required for a small number of larger, more mature, babies who become ill from complications of delivery, from infection or metabolic disorders or when surgical or other treatment is required for congenital anomalies such as congenital heart disease, disorders of the lung or gut, or of other organs.

6 Critical Care: Timing of Snapshots

The monthly SitRep reporting period is 00.01 on the 1st calendar day of the month to 24.00 on the last calendar day of the month. In most cases, total counts between these times should be reported. Some items reported in SitRep are snapshots as at a particular point in time (rather than a cumulative total during the period). Snapshots are reported for the following items:

- counts of capacity (acute beds, medical beds, critical care beds (adult and paediatric), neonatal intensive care)
- medical outliers

Such snapshot counts should report the position at midnight on the last Thursday of the reporting period (i.e. 24.00 on the Thursday).

7 Non-medical Critical Care Transfers

F4i) The total number of non medical critical care transfers during the reporting period

Defined as:

All critical care transfers that take place between hospitals *for non-medical reasons* should be reported. Such transfers between hospitals within the same Trust should be included. Only the trust that is transferring the patient out should report the transfer – the trust receiving the patient does not need to report a transfer on their SitRep. **All transfers from specialist hospitals/ units for non-medical reasons (e.g. lack of capacity) also need to be reported**.

All non-medical critical care transfers that take place between hospitals not in the same approved transfer group must be reported. These transfers should be regarded as adverse incidents and the NHS Trust from which the transfer took place must ensure that the Chief Executive of the local commissioning body is informed of the transfer within two working days of occurrence.

Repatriation of critical care patients (from one hospital's critical care unit to the critical care unit of the patient's local hospital) should **not** be counted as a "non-medical critical care transfer". In practice however, most repatriations will involve patients who are transferring back to their local hospital for further acute care (i.e. not critical care).

Paediatric / Neonatal Transfers

Transfers of children and neonates are an accepted part of the provision of care, where the transfer is undertaken to improve the capability of the necessary intervention and provide for the best possible outcome. Therefore, provided that the transfer is in the medical interests of the child, e.g. to provide enhanced or specialist care, then the normal rules apply and this transfer should be regarded as for "medical reasons".

For example, the transfer of a child or neonate from a critical care unit (adult, paediatric or neonatal) to a specialist paediatric critical care unit for specialist care should be regarded as a transfer for medical reasons and should not be reported. Similarly, the transfer from a unit capable of providing up to Level 2 paediatric intensive care to a paediatric unit capable of highest level of intensive care (Level 3) care (and the return to Level 2 when the child is stable) would also be regarded as in the medical interests of the child.

As with adults, transfers from a paediatric intensive care unit to the child's "local" or “home” hospital (repatriation) after intervention has been concluded should also not be *counted as a* "non-medical reasons" transfer.

If a child or neonate is transferred from a paediatric critical care unit or neonatal unit capable of Level 2 critical care to a unit offering the same level of care in another hospital because the first unit is full or needs to clear the bed for a more seriously ill patient, then this **SHOULD** be counted because the transfer was not in the medical interests of the transferred child. Full details must be provided in the critical care text box in the SitRep and an adverse incident report made if appropriate.

8 Contact details for further information

Data collected via the Monthly SitRep are published on the NHS England statistical webpages:

https://www.england.nhs.uk/statistics/statistical-work-areas/critical-care-capacity/

Further queries regarding this collection please e-mail:

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