NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 2 June 2025**
Title:	**Update on the Interim Changes to NHS Ayrshire & Arran Critical Care Services**
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1. Purpose

This is presented to the Board for:
- Decision

This paper relates to:
- Emerging issue

This aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective

2. Report summary

2.1 Situation

In March 2023, NHS Ayrshire & Arran (NHSAA) Board were briefed on the proposal to centralise all Level 3 Intensive Care (ICU) beds at University Hospital Crosshouse (UHC), as an interim measure, to maintain the safety and sustainability of critical care services within NHSAA.

This report provides an update on progress to date since the change took place in March 2024, and seeks Board Members' approval to extend the interim arrangements further to allow required work to take place prior to re-providing a fully fit-for purpose ICU facility at UHC.

2.2 Background

Critical Care Services

Critical Care units look after the sickest patients in our health system. They are defined in the Guidelines for the Provision of Intensive Care Services (GPICS) as, 'specially staffed and equipped area of a hospital dedicated to the care of patients with life-threatening conditions. They encompass areas that provide Level 2 (high

dependency) and/or Level 3 (intensive) care as defined by the Intensive Care Society.' Definition of the levels of adult critical care is provided at **Appendix 1**.

Care in critical care units should be delivered by a multi-disciplinary team of doctors, nurses and AHPs. GPICS standards state that 'care must be led by a consultant in Intensive Care Medicine'.

Critical Care in NHSAA

Prior to the interim changes, NHSAA provided level 3 (ICU) care on its two acute sites: UHA and UHC. On each site, the ICU beds sat within a wider combined (ICU and HDU) critical care area. There were three level 3 and four level 2 beds at UHA and nine level 3 and six level 2 beds at UHC.

In both hospitals there are other Level 2 beds located elsewhere on the site which are not under the care of Critical Care Services. These are eight medical HDU beds at UHC and four medical high care (MHC) beds at UHA.

The pre and post-interim change bed provision is detailed in ***Table 1*** below.

The change sees all level 3 care consolidated at UHC (a total of 12 level 3 beds for NHSAA) whilst a new 8 bedded level 2 critical care unit is formed at UHA. This new UHA critical care unit encompasses the 4 HDU beds previously co-located with ICU and 4 MHC beds which have historically been located in the Combined Assessment Unit.

Table 1: Critical Care Bed Provision in NHSAA

	Pre- interim change	Post- interim change
University Hospital Ayr	3 Level 3 (ICU) beds 4 Level 2 (HDU) beds	8 Level 2 beds
University Hospital Crosshouse	9 Level 3 (ICU) beds 6 Level 2 (HDU) beds	12 Level 3 beds 6 Level 2 beds

Drivers for Change

The primary driver for change that was identified at the time was the inability to guarantee the sustainability of Critical Care services in NHSAA due to challenges with the medical staffing of the ICU at UHA.

Prior to March 2024, there were four consultant anaesthetist vacancies at UHA. Over the three year period before service changes were enacted, unsuccessful attempts to recruit to these posts had been made on three separate occasions.

It was posited that the reason for this failure to recruit to the UHA Consultant Anaesthetist rota was as a result of the significant changes to the specialty of Intensive Care Medicine (ICM) over the last decade, such that it is now a standalone specialty rather than a sub-specialty of anaesthesia. Doctors trained in ICM must undertake higher specialty training. Consultants who have committed to this training are more likely to seek employment in larger critical care facilities that meet modern standards.

Whilst there is a national shortage of ICM consultants, the particular difficulties of recruiting ICM consultants and consultant anaesthetists to UHA were in relation to

a) the size of the ICU which was the smallest in Scotland and therefore not attractive to consultants in ICM.
b) the requirement for all consultant anaesthetists to perform ICM as part of their core duties irrespective of whether they have undergone higher specialist training (or equivalent). This is not the case in other hospitals in Scotland (including UHC) where 'split-rotas' have been introduced to separate those consultants with an interest and training in ICM from those purely focussed on anaesthesia. The situation at UHA was not attractive to consultants in ICM nor consultant anaesthetists.

The consequence of no action being taken would have been a continued inability to recruit to these crucial posts. The potential result of a further reduction in consultant anaesthetist numbers at UHA would result in an unplanned collapse of the ICU service at UHA and this would have a significant destabilising effect on the delivery of all Critical Care services across NHSAA as well as other essential services such as acute medical and surgical receiving.

Ayrshire and Arran NHS Board supported the interim decision to centralise all Level 3 Intensive Care (ICU) beds at University Hospital Crosshouse (UHC) in March 2023. A nine to twelve month indicative timescale to realise this change was identified at that time.

The planned changes came into effect in the week commencing Monday 11th March 2024, with the transfer of three Level 3 beds from University Hospital Ayr (UHA) to UHC. Critical care services were to be maintained at UHA through the delivery of Level 2 care and any patients on the UHA site who required ICU care would be transferred to UHC.

A paper was submitted to the 26 March 2024 meeting of NHSAA Board to appraise the Board of the pertinent detail of these changes and there was a request for a further update to be provided in one year's time. This paper serves that purpose.

2.3 Assessment

<u>NHSAA Critical Care Services Model of Care</u>

Since March 2024, Critical Care Services in NHSAA have been delivered as follows.

All patients requiring level 3 care in NHSAA receive this at UHC under the care of a single NHSAA Critical Care team. Patients who present to UHA and who require level 3 care or who become critically ill whilst an inpatient are transferred to UHC to receive this care.

The transfers are facilitated by the Scottish Ambulance Service with the patient cared for during the transfer by appropriately skilled nursing and medical staff. A dedicated rota has been developed and implemented to support transfers.

A new level 2 Critical Care Unit at UHA operates on a shared care model with daytime, weekday cover provided by an onsite consultant in Intensive Care Medicine

(ICM) from the NHSAA team. Out of hours (including at weekends) care is the responsibility of the patient's parent specialty (e.g. medicine, general surgery, and urology). Out of hours support is provided by the on shift and on call anaesthetic team for specific procedures and interventions. This includes the on call consultant anaesthetist for the UHA site.

The Critical Care Unit at UHC has expanded to accommodate the transfer of the three level 3 beds from UHA. There is 24/7 access to a consultant in ICM for the patients in this unit, irrespective of where in Ayrshire & Arran they reside. Patients from the UHA catchment area who have received level 3 care at UHC are transferred to UHA at the point the clinical team are confident they no longer have a requirement for this level of care.

Based on historic data, a planning assumption had been made of a maximum of 140 critical care transfers per year from UHA to UHC were to be expected. Extrapolating from the last six months of activity data indicates that over the course of the last year there has been 103 critical care transfers.

Impact on Patients Using Other Services

There have been no planned changes to pre-hospital patient flow, to Emergency Department services or to acute medical receiving at UHA as a result of the changes described in this paper.

UHA has maintained 24/7 consultant anaesthetic cover and a 24/7 emergency theatre which can be accessed by general surgery, urology and ophthalmology.

An agreed protocol is in place for emergency general surgical patients who present to UHA and who have the prospect of requiring level 3 care post-operatively to be considered on a patient by patient basis. The clinical team, including the on-call surgeon and anaesthetist at UHA and their counterparts at UHC, decide whether the patient would be better served having their operation at UHA and then transferring to UHC, should they require level 3 care, or whether they should be transferred to UHC to have their operation there.

The agreed pathway in place for emergency urological surgery patients who present to UHA and who have the prospect of requiring level 3 care is that they have their surgery carried out at UHA and then are transferred to UHC if required.

These patient pathways are now well established and subject to review through service clinical governance arrangements. Of particular note is the fact that no significant morbidity has been recorded as a result of a patient transfer.

A small number of elective patients who are undergoing a major general surgical or urological procedure and are thought likely to need access to level 3 care post-operatively now have their operation undertaken at UHC on a planned basis.

Nursing Workforce

Prior to the implementation of the interim change, a process following the principles of organisational change was concluded with effected staff in partnership with Trade Union colleagues. All staff who expressed a preference for work location have been accommodated.

Following implementation of the interim change, there were significant nursing vacancies in both the UHC and UHA Critical Care Units. At UHA there were 24.49 WTE in post against an establishment of 30.7 WTE and at UHC these numbers were 71.66 WTE and 85.24 WTE respectively.

Agency staff were block booked for the weeks immediately following the move in order to ensure both units were as well supported as possible during this period. Nursing and operational management teams developed and implemented recruitment plans for both sites which included the use of newly qualified nurses and international recruitment.

By the end of 2024/25 UHA Critical Care had fully recruited to its funded establishment. At UHC there are currently 79.94 WTE against the establishment of 85.24 WTE with a further 2.93 WTE at the shortlisting stage for recruitment.

This relative stabilisation of the nursing workforce has allowed the first cycle of staff rotation between the units to be undertaken in June 2025. This programme of rotation is a key enabler of building a resilient and skilled Critical Care Nursing workforce.

Medical Workforce

Members of the medical workforce who were subject to changes to their current working patterns have had this managed through the normal job planning process.

Consultant anaesthetist staffing at UHA, the primary driver for this interim change, has significantly improved. Appointments of three substantive consultants and one NHS locum consultant have been successfully made.

ICM consultant staffing is now at full establishment following two rounds of highly competitive recruitment.

Changes to the training environment out of hours at UHA have meant anaesthetic doctors in training no longer participate on out of hours rotas at UHA. This element of service delivery is instead supported by a rota of eight substantively employed specialty doctors. Anaesthetic trainees still play an active part in the delivery of daytime services at UHA.

AHP Workforce

Following a phase of evaluating the AHP requirements for the increased critical care bed base at UHC, transfer of resource from South Health and Social Care Partnership (HSCP) to East HSCP for 0.7 WTE physiotherapy resource was agreed.

There is a current review of AHP resource within critical care with consideration to clinical risk and recommended staffing levels outlined in the GPICS standards. Current establishment across Speech and Language Therapy, Dietetics and Physiotherapy is 4.1 WTE below what is recommended in those standards.

Capital Works

The Critical Care Unit at UHC is located within a temporary location previously used for Day Surgery and Endoscopy. This location came into being because of changes made to Critical Care services to guard against service failure during the pandemic response and recovery, when the service moved from its previous purpose built location which only had capacity for eight patients.

The current location was understood to be an interim solution and offers sub optimal accommodation from which to deliver Critical Care services. It inhibits patient care and impacts patient experience in a manner that a purpose built facility would not. These limitations and their impact on the delivery of care are recorded in a schedule of derogations which is subject to risk assessment by a multi-disciplinary group including representatives from the service, Capital Planning, Estates, Infection Prevention and Control, Health and Safety and Risk Management.

The current location also inhibits patient flow through Day Surgery and Endoscopy and has reduced elective capacity in both these services.

Scottish Government have approved capital funding through the Board's Business Continuity Plan submission, subject to approval of a business case incorporating detailed project costs. This, together with locally available Capital Investment Plan funding, will be directed to design and deliver a new Critical Care Unit on the UHC site which will address the majority of identified derogations. An options appraisal exercise is currently underway to establish a preferred location on the site and support the business case.

These derogations would require to be addressed irrespective of the interim service change.

Executive and Operational Oversight Arrangements

An Executive Oversight Group is in place comprising the Executive Medical Director, Executive Nurse Director, Director of Acute Services and Director of Infrastructure and Support Services, along with key stakeholders to inform discussions. This group had been meeting monthly from February 2025 to March 2025 to provide Executive oversight and any issues of note would be escalated to the Corporate Management Team as required.

A monthly ICU Operational Oversight Group was also put in place, Chaired by the Director of Acute Services and with senior representatives across Nursing, Medical, Capital Planning, Infection Control and Operational Management. This group has oversight of the Capital Scoping Work, Infection Control arrangements and Risk and Derogations in relation to the interim ICU arrangements, and any escalation of issues would be to the Corporate Management Team.

The Group last met on 23rd April when a review of all current options for re-providing the ICU were considered. The group agreed that a detailed Options Appraisal would be brought forward to fully articulate and consider any risks, benefits and inter-dependencies, with a view to identifying a preferred solution in the coming weeks. A routine Highlight report together with any issues for escalation are taken to the monthly Executive Oversight Group.

The Executive Oversight Group has taken assurance that all matters are progressing under the oversight of the Operational Oversight Group with the Executive meeting temporarily stood down on April 2025 whilst the Options Appraisal process takes place. This can be re-instated at any point to provide additional oversight arrangements.

2.3.1 Quality/patient care

It is vital that we continue to review models of care in the context of external factors such as population health, recruitment challenges or national policy that can impact on our services, to ensure that we can continue to provide safe, effective and sustainable care to our patients. As described within this paper, the interim ICU arrangements were put in place to maintain a safe and sustainable critical care services.

Throughout this period we have continued to monitor and review these interim arrangements to ensure that we are continuing to provide safe and effective care within the hospital footprint and resource available.

2.3.2 Workforce

The appropriate HR and Organisational Change processes were followed as part of the implementation of the interim ICU changes. This interim change has impacted positively on recruitment as described in this paper.

There are no additional workforce implications as a result of this paper.

2.3.3 Financial

Revenue Costs

In response to the key enabling factors identified by the service in 2023, CMT approved investment of £612k in 8 WTE medical and advanced practice posts. Roughly half of these costs were already being incurred by the service as cost pressures as a result of changes to critical care service delivery driven by the demands of the pandemic.

No further revenue requirement has been identified as a result of these changes.

Capital Costs

As described in the Assessment section of this paper, a capital allocation has been sought through the Board's Business Continuity submission to the Scottish Government. If supported, this, along with locally available capital funding, will be directed to design and deliver a new Critical Care Unit on the UHC site which will address the majority of identified derogations. An options appraisal exercise is currently underway to establish a preferred location. There is an ongoing risk associated with Capital Funding if this does not cover the costs required for the replacement unit.

2.3.4 Risk assessment/management

Relevant entries on the Operational Risk Register include those relating to consultant anaesthetist staffing at UHA (risk 721) critical care nurse staffing (risk 859) and critical

care estate at UHC (risk 817). All of these risks have been subject to three monthly review since March 2024. Over this time period;

- Risk 721 has reduced from a High risk (score = 15) to a Moderate risk (6) and is on a de-escalating trend as a result of the progress outlined at 2.3.2b of this paper
- Risk 859 has reduced from High (12) to Moderate (9) and is also on a de-escalating trend as a result of the progress outlined at 2.3.2a
- Risk 817 has increased from High (16) to Very High (20) following the most recent multi-disciplinary stakeholder risk assessment undertaken at a workshop in March 2025. This increasing trend is a result of mitigating factors initiated in the context of the pandemic becoming less effective as time elapses. Further scope to mitigate this risk is very limited whilst the Critical Care Unit remains in the current location.

The ICU Operational Oversight Group, chaired by the Director of Acute Services will continue to oversee these risks and any other emergent risks identified. Escalations will be reported as required to the ICU Executive Oversight Group and Corporate Management Team.

Clinical governance and quality improvement is managed through the normal Service, Divisional and Acute Directorate structure.

2.3.5 Equality and diversity, including health inequalities

As we move forward with the Options Appraisal and an agreed solution is identified, an Equality Impact Assessment will be completed as part of this project.

2.3.6 Other impacts

None to note.

2.3.7 Communication, involvement, engagement and consultation

Given the interim nature of this change and the drivers for change relating to maintaining safe patient care, no formal external engagement or consultation has been undertaken.

Internal engagement has been managed under the Organisational Change policy where applicable and through regular stakeholder meetings and communications in the initial stages. Communication with internal stakeholders now follows standard business processes.

2.3.8 Route to the meeting

This paper is provided as a requested update to an earlier paper which went to the March 2024 Board meeting.

This is the first time this version of the paper has been presented.

2.4 Recommendation

For decision. Members are asked to note the impact of the interim changes to NHSAA's critical care services, and to take assurance from the various measures in place to continually review and monitor the interim arrangements to ensure any risks and derogations are mitigated as far as practicably possible.

Members' approval is sought to extend the interim arrangements for a further year to allow the options appraisal to be concluded and required capital works to take place, with operational oversight established via the ICU Operational Oversight Group and reporting as required to Corporate Management Team.

3. List of appendices)

The following appendices are included with this report:

- Appendix 1, GPICS Levels of Adult Critical Care

Appendix 1: GPICS Levels of Adult Critical Care (Faculty of Intensive Care MEDICINE/ Intensive Care Society (July 2022), GPIC v2.1, Intensive Care Society | GPICS V2.1)

Ward Care	• Patients whose needs can be met through normal ward care in an acute hospital. • Patients who have recently been relocated from a higher level of care, but their needs can be met on an acute ward with additional advice and support from the critical care outreach team. • Patients who can be managed on a ward but remain at risk of clinical deterioration.
Level 1 – Enhanced Care	• Patients requiring more detailed observations or interventions, including basic support for a single organ system and those 'stepping down' from higher levels of care. • Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward. • Patients who require ongoing interventions (other than routine follow-up) from critical care outreach teams to intervene in deterioration or to support escalation of care. • Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged on the basis of clinical circumstances and ward resources.
Level 2 – Critical Care	• Patients requiring increased levels of observations or interventions (beyond Level 1), including basic support for two or more organ systems and those 'stepping down' from higher levels of care. • Patients requiring interventions to prevent further deterioration or to support ongoing rehabilitation needs, beyond that of Level 1. • Patients needing two or more basic organ systems monitoring and support. • Patients needing one organ system monitored and supported at an advanced level (other than advanced respiratory support). • Patients needing long-term advanced respiratory support. • Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, in particular maintaining patient safety if severely agitated. • Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure and/or the patient's condition and comorbidities. • Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere. • Patients who require nursing and therapies input more frequently than available in Level 1 areas.
Level 3 – Critical Care	• Patients who need advanced respiratory monitoring and support alone. • Patients who require monitoring and support for two or more organ systems at an advanced level. • Patients with chronic impairment of one or more organ systems sufficient to restrict daily activities (comorbidity), and who require support for an acute reversible failure of another organ system.

	• Patients who experience delirium and agitation in addition to requiring Level 2 care. • Complex patients requiring support for multiple organ failure; this may not necessarily include advanced respiratory support