GIRFT critical care report outlines steps to help the NHS cope with future COVID-19 surges

The Getting It Right First Time (GIRFT) adult critical care report outlines a new model for critical care services which could help the NHS in England cope with future surges of the COVID-19 pandemic.

Staffing and equipping units to provide more 'enhanced care', including non-invasive ventilation, as well as funding and developing transfer services to enable adult patients to be moved more easily, are among the measures in the report designed to ease some of the pressures on critical care services and ensure patients have equal access wherever they live.

The report – written by Dr Anna Batchelor, a consultant anaesthetist and intensivist at Newcastle upon Tyne Hospitals NHS Foundation Trust – is based on visits to more than 100 critical care units in England before the pandemic hit, but is also informed by insights gained from caring for COVID-19 patients from spring 2020 onwards.

The data-driven review found variation in bed numbers and workforce levels between hospitals, with capacity, culture and resources affecting local decisions on who can be admitted to critical care. There is a need for more beds generally, but the report acknowledges that increasing the number of highest level beds (Level 3, offering advanced respiratory support) on standby for severely ill patients during COVID-19 surges is not practical.

Instead, a series of recommendations in the report aim to maximise the capacity in units to help cope with future waves, and avoid the need to delay or cancel surgery for other patients. These include:

Developing more 'enhanced care' areas – hospital wards staffed and equipped to provide flexible enhanced care, including non-invasive ventilation, can be used for post-operative care and to help the transfer of patients back from critical care to other wards, but can also be switched to care for COVID-19 patients during surges.

Establishing and funding adult transfer services – developing transfer services at a system level can ensure equal access for all patients, especially those in rural and remote areas, and allow regional cohorting of COVID-19 patients so that critical care units can maintain a 'normal' service.

Increasing hospital outreach – identifying patients from across the hospital whose condition is at risk of deterioration and taking steps to stabilise their condition can prevent organ failure and admission to critical care. This can lead to better patient outcomes and helps free up critical care beds for other patients.

Around 200,000 people per year in the UK are admitted to critical care units, including those with severe cases of COVID-19, patients who have been in road traffic accidents or suffered serious burns, or patients recovering from planned surgery. The aim is to admit patients who have the capacity to recover from their condition. Nevertheless, 15–20% of patients admitted to UK intensive care units die in hospital.

As well as addressing the specialty's high demand and constraints in staffing, equipment and space, the GIRFT report also makes recommendations for improvements to end of life care and organ donation protocols, calling for Advance Care Planning (ACP) to help understand a patient and their families' end-of-life wishes and for every trust to have a clinical lead for organ donation (CL-OD) working with a specialist nurse for organ donation (SN-OD) so that donations can occur in a timely way.

Other key recommendations focus on patient recovery and rehabilitation. Developing post-operative pathways and rehabilitation, starting in critical care and following through to primary care after discharge, can help patients (including those who have survived COVID-19) cope with the physical, psychological and social consequences of their critical illness. There is a need to improve the data on long-term outcomes for critical care patients, including mortality, readmission to hospital, quality of life, new frailty and results of rehabilitation, to better inform decision-making around whether or not to admit a patient.

Report recommendations

1. Increase critical care and enhanced care beds. This should be particularly focused on Level 2 and enhanced care beds, but also more Level 3 beds in some areas where required.
2. Consider and develop national postoperative pathways for patients requiring enhanced or critical care management to ensure consistency.
3. Promote the development of enhanced care areas, ensuring appropriate governance and staffing arrangements for patients are in place.
4. Fund and develop adult critical care transfer services based on Operational Delivery Networks (ODN) or Sustainability and Transformation Partnerships (STP)/Integrated Care Systems (ICS) footprints to support equitable access and future COVID-19 surge.
5. Implement full 24/7 outreach services in every hospital with a critical care unit. If using a Hospital at Night service as part of this provision, the team members should have sufficient critical care training.
6. Put Advance Care Planning and shared decision-making protocols in place, in order to know patient and families' wishes and help to inform appropriate referrals to critical care.
7. Ensure there is a Clinical Lead for Organ Donation (CL-OD) that links with a Specialist Nurse for Organ Donation (SN-OD) for each trust with a critical care unit to enable national pathways to be followed and for donation to occur in a timely manner.
8. Ensure critical care discharges are discussed pre-emptively at hospital-wide daily bed management meetings and given the same level of priority as hospital admissions to ensure optimal patient flow and allow for new critical care admissions to be made in a timely manner.
9. Develop a patient multidisciplinary rehabilitation pathway starting in critical care and following through to primary care after discharge. Obtain necessary funding to support this.
10. Develop pathways for post-critical care follow-up, and consider which approach best meets patient needs.
11. Meet GPICS2 Guidelines standards for the critical care workforce (where stated) and where no numbers are currently recommended, trusts should ensure all patients able to access appropriate care.
12. Develop national, evidence based, costed recommendations for the employment of critical care pharmacists.

13. Develop a sustainable mechanism for training more Advanced Care Critical Care Practitioners (ACCPs) and possibly develop networks, to make it easier for smaller hospitals to employ them.
14. Use learning from COVID-19 and subsequent research as a basis to develop a robust evidenced-based nursing workforce model for the future.
15. Ensure research and quality improvement are an integral part of the work of each critical care unit to build on the momentum of COVID-19, exemplified by the RECOVERY, RECOVERY-RS and REMAP-CAP research studies. This would include contributing to the delivery of *Best Research for Best Health: The Next Chapter* through NIHR portfolio studies, as well as national benchmarking data sets, such as ICCQUIP, and QI programmes.
16. Collect Patient Related Outcome Measures (PROMs) following critical care.
17. Identify gaps in research and develop a national research strategy. This to include understanding more about outreach services.
18. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.
19. Reduce litigation costs by application of the GIRFT programme's five-point plan.