Focusing on the Future of Critical Care Across All Four Nations of the UK - CCLF Statement on Module 3 of the UK Covid-19 Inquiry

The Critical Care Leadership Forum (CCLF) was established as a point of reference for accessing specialist advice for national policy initiatives, commissioning, research, audit, education, professional standards and clinical practice regarding the specialty of Intensive Care Medicine (also known as Critical Care). The primary role of the CCLF is to promote UK-wide high-quality care for patients with, or at risk, of critical illness through integrating the energies and skills of its participating organisations. The 27 organisations currently represented on the CCLF constitute the professional arm of UK critical care services and work collaboratively with specialist commissioning, clinical reference and other managerial boards of UK health services.

Module 3 of the UK Covid-19 Inquiry will shortly begin hearing evidence on the impact of Covid-19 on healthcare including a detailed analysis of the critical care response to the pandemic. Important lessons will be drawn not just on the Covid-19 response but on the future of UK intensive care services.

The CCLF believes that creating a sustainable future for intensive care services and the patients it treats is an important lesson from the Covid pandemic and for any future UK pandemic response.

We feel a focus on the following 3 areas is key:

1. Investment

1.1. In our workforce

The ambitions of the Long Term Workforce Plan (LTWP) for England need to be built on to deliver a resilient workforce capable of meeting the growing demands of the older, multimorbid population. Many of the points made in the plan apply equally to Scotland, Wales and Northern Ireland.

Investment in critical care should address:

- **Safe staffing levels** in critical care as they are linked directly to patient safety. Levels are most under threat for registered nurses, medical staff, pharmacists and allied health professionals (AHPs) e.g. critical care dietitians. Many services are heavily reliant on internationally educated staff who need supportive immigration policies. The LTWP is entirely absent of detail on higher specialist training numbers; this is a critical issue for Intensive Care Medicine. The pre-Covid lack of specialist trained doctors in ICM has continued post-pandemic and must be addressed.

- Implementation of roles to **support staff mental health and wellbeing** e.g. Professional Nurse Advocates (PNAs).

- The limited **career progression** for many groups e.g. AHPs and pharmacists, further worsening staff attrition. Improving the accessibility of advanced practice training, support for professional frameworks e.g. the UKCCNA

workforce optimisation plan and widening prescribing rights can ensure patients get the right treatment at the right time.

1.2. In our hospitals

Capital building projects have been paused or significantly amended as the economy across our nations has not been as strong as predicted. Consistent and sustained investment in the fabric of the NHS is required so that critical care units can deliver services in buildings appropriate to modern healthcare and respond safely to future pandemics without impacting on other services.

1.3. In our patients

- **Critical Care Outreach** funding is not universal across the UK, and services are configured very differently. Guaranteed funding, alongside a minimum Critical Care Outreach Team (CCOT) service specification, is needed to offer the reassurance and safeguards of Martha's Rule/Call 4 Concern across the majority of UK hospitals that do not have funded 24-hour critical care outreach services.

- Investment in our patients' **Post ICU Care**. Community, peer-to-peer support and recovery services is needed. There are not enough resources to reach all post ICU patients to support their on-going recovery by way of mental health, community and recovery services. This means many patients return to hospital prematurely and do not recover with the ability to integrate back into family and working life and in turn, society.

2. Innovation

2.1. For service delivery

Intensive care medicine is a specialty dependent on technology for patient care. **Investment in IT and equipment** are fundamental to ensuring our staff can perform in their roles.

2.2. For service transformation

- Intensive care services in smaller and more remote hospitals are under threat as they struggle to attract and retain staff, exacerbating inequalities of provision. **Collaborative working** across systems, funding of transfer services and adoption of new technologies can provide innovative solutions and remote support to these units.

- Valuing our workforce by encouraging collaborative learning and working across our multidisciplinary teams, protecting and recognising the value of **time for training** and the role of educators.

- The value of **research** was demonstrated in the rapidly improved intensive care survival rates during Covid. Dedicated support for staff to undertake research across the wider intensive care patient population would be of significant benefit to the critical care community and the patients we serve.

3. Addressing Inequality

3.1. In our patient population

- Health outcomes are not equal across all sections of society with deprivation adversely affecting outcomes from intensive care e.g. drug deaths in Scotland are higher than in the rest of the UK. Addressing societal issues such as **drug and alcohol**

misuse would improve health outcomes for those in poorer socioeconomic groups and relieve NHS pressure across all 4 nations.

- Survival from critical care is only the start of the patient journey, and there has been no national investment in managing the aftermath of complex critical illness in stark contrast to heart disease, head injury or stroke, which all have well defined **rehabilitation pathways**. Patients have no clear avenue to help them when appropriate help could have easily improved their outcome,

3.2. In provision of intensive care beds

Covid highlighted the **variation in provision** of intensive care services across the UK e.g. there was no increase in staffed critical care bed capacity in Wales between 2010 and 2020. There needs to be greater focus on meeting this deficit directed at the areas of most need. An immediate commitment to achieving 10 intensive care beds per 100,000 population across the UK would be a tangible benefit to patients.

This statement is endorsed by the following CCLF members:

- Dr Anna Batchelor, Getting It Right First Time Critical Care Lead
- Association of Chartered Physiotherapists in Respiratory Care (ACPRC)
- Critical Care Specialist Group (CCSG) of the British Dietetic Association (BDA)
  British Dietetic Association Manifesto 2024
- Faculty of Intensive Care Medicine (FICM)
- ICUsteps
- Intensive Care Society (ICS)
  Building Better Intensive Care: 2024 General Election Priorities. ICS
- National Outreach Forum (NOrF)
- Northern Ireland Intensive Care Society
- Paediatric Critical Care Society (PCCS)
- Royal College of Nursing
- Scottish Intensive Care Society (SICS)
- UK Critical Care Nursing Alliance (UKCCNA)
- UK Clinical Pharmacy Association (UKCPA)
- Welsh Intensive Care Society (WICS)