Written evidence for submission to the Health and Social Care Select Committee
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Executive Summary

- Guidance, from Public Health England (PHE), on the use of Personal Protective Equipment (PPE) must be clear and consistent.
- Covid-19 testing for front line healthcare workers (HCW) must be prioritised urgently
- Statutory bodies such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC), General Dental Council (GDC) etc, must give reassurance for its members when working outside of their normal scope of practice.
- A review of Intensive Care Medicine (ICM) services in England must be undertaken, when the current pandemic is over, to ensure that the system is able to manage its normal capacity and be better prepared for expected increases in demand.

1 The Faculty of Intensive Care Medicine (FICM) was founded in 2010 and has well over 3,500 members, making it the largest organisation of critical care medical professionals in the UK. The Faculty is the professional and statutory body for the specialty of intensive care medicine, the doctors who lead critical care services and Advanced Critical Care Practitioners. The Faculty works on behalf of its members and our wider services to promote education and standards, influence and define national policy, and, most importantly, improve outcomes for our patients and their families. This includes statutory roles of curricula and training, national recruitment and wider responsibilities around workforce, clinical standards and quality.

2 The FICM has developed, in collaboration with The Royal College of Anaesthetists, and associated specialty membership organisations (the Intensive Care Society, and the Association of Anaesthetists) a joint intensive care medicine and anaesthesia website (www.icmanaesthesiacovid-19.org), to provide the UK intensive care and anaesthetic community with information, guidance and resources required to support their understanding of and management of COVID-19. New clinical guidance is being developed and uploaded here regularly. This includes resources for cross-skilling staff who would not normally care for the critically ill but are likely to find themselves doing so as part of a team.

3 There has been widespread concern from the profession about personal protection during the pandemic, not only because of inadequate supply but as a result of inconsistent advice from PHE. This has led to individuals, organisations and medical Royal Colleges and Faculties interpreting the advice differently. The confusion caused by this inconsistent approach has resulted in front line HCWs being unnecessarily exposed to covid-19 and, therefore, being unable to care for patients during the required isolation period.

4 The FICM appreciates the difficulties when faced with a sudden increase in demand for certain products and services. Indeed this is a situation that our specialty, in particular,

experiences on a daily basis. However clear and consistent messaging is key if we are to trust the advice that government is issuing. We would welcome a more unified approach from NHSE and PHE by involving key Royal Colleges and Faculties, to provide expert knowledge, before issuing advice.

5 As well as HCW having to isolate due to exposure to covid-19 in the workplace the changes to self-isolation advice have resulted in a significant reduction in the available workforce. This obviously has a negative impact on our ability to care for patients but is extremely frustrating for HCW who are highly trained and physically able to work but cannot leave their homes. The wellbeing of staff should always be a high priority but, especially during this pandemic, anything that government can do to help us look after our staff would be welcome. Although we wouldn't wish to see unreliable testing introduced key HCWs must be tested early to ensure they can continue to work and care for patients.

6 There has been an amazing response from non-intensive care staff, medical students, dental staff etc to step outside their normal scope of practice to help provide safe care for patients. Many HCWs have concerns, despite undergoing rapid, local induction and cross-skilling, that they could be leaving themselves open to criticism and some are, understandably, hesitant. Statutory bodies must support their members in this if we are to create clinical teams to help deliver safe patient care.

7 We know that in the UK, the ratio of critical care beds to size of population is below many comparable western countries. 2012 figures have the UK at 6.6 beds per 100,000 of the population, compared to 29.2 in Germany, 12.5 in Italy, 11.6 in France and 10.6 in South Korea. To be prepared for temporary increases in demand it is recommended that, under normal circumstances, only 85% of beds are occupied. Over the last 10 years there has been a 4% year on year increase in demand for critical care, without a corresponding increase in capacity, resulting in many units running at 100% occupancy. This means that there are occasions when elective operations are cancelled due to lack of capacity, even when the NHS is not under exceptional pressure.

8 The population is ageing; over the next 50 years, over one quarter of UK residents will be over 65. Patients are more likely to have multiple comorbidities and undergo complex procedures due to scientific advances. Although the care required in these situations does not fit the criteria for admission to ICU, patients cannot safely be managed in a general ward environment due to the frequency of observations or specialist monitoring required.

9 The FICM would like reassurance that provision of critical care in England undergoes a timely capacity review, once this pandemic is over. We appreciate that Critical Care is expensive in terms of cost and staffing so it is important to ensure that there is targeted investment for maximal impact. There is no doubt that we need an increase in resource but there are also innovated changes to the way services can be delivered. For example, the FICM and the three Royal Colleges of Physicians have developed a model of care provision (known as Enhanced Care) that would make efficient use of any financial investment. We would be happy to share this work at an appropriate time.