

Written evidence submitted by Faculty of Intensive Care Medicine (EPW0018)

Key FICM recommendations

1. The COVID-19 has placed enormous demands on critical care staff: nearly half of intensive care staff are thought likely to meet the threshold for PTSD, severe anxiety or problem drinking during the COVID-19 pandemic. Consequently, critical care units have lost staff essential for service delivery. Staff education and attainment of key skills needs to be prioritised and attainment of key critical care nursing skills should be rewarded. **Critical Care Staff wellbeing is a key area** and needs concrete measures to be put in-place. The Faculty of Intensive Care Medicine has made [key recommendations](#) for change.
2. **Reduce demand on critical care services.** In particular speed up the development of services that address the post pandemic procedural backlog without placing additional demand on existing critical care provision, such as '[Enhanced Perioperative Care](#)' services for elective surgery. Running alongside this needs to be wider discussion with patients, family, society, and healthcare professionals from primary through to tertiary care about realistic goals of medical treatment and the importance of patient choice: The CMO for Scotland has adopted this in its [Realistic Medicine](#) approach. The Faculty has developed this approach in its best practice [Care at the End of Life](#).
3. The pre pandemic intensive care workforce was too low for the UK and the pandemic response was supported by drafting in additional support from other medical specialties eg anaesthesia, surgery. These doctors are now needed for elective recovery of services. NHS Scotland and NHS Wales have seen yearly increases in National Training Numbers for Intensive Care Medicine (ICM) doctors. NHS England gave a welcome one-off increase of 100 extra doctors in 2020, but there has been no increase in 2021. **Targeted regional increases in ICM medical training places** are needed now and in future if we are to prevent other secondary services (e.g. anaesthesia) being drafted in again to support surges in intensive care demand e.g. during winter and thereby severely impacting elective recovery.
4. The Intensive Care National Audit and Research Centre (ICNARC) has shown large regional variations in people admitted to intensive care with COVID. This represents differences in supply of staffed critical care capacity ie staffed intensive care beds not ventilators. The [Getting It Right First Time](#) programme developed before the pandemic also shows a 2-3 fold variation in admission to critical care for patients with the same condition across England. **Targeted regional investment in critical care workforce and staffed beds** would help provide more equitable care across England and reduce workforce pressures, aid staff retention and future staff recruitment.

Background

1. Intensive Care Medicine (ICM) is a recognised medical specialty. COVID -19 has illustrated the unique expertise of the specialty in treating the critically ill. Whilst public understanding of the specialty has increased, considerable knowledge gaps as to how ICM is integral to wider healthcare delivery remain. Understanding the role of ICM in the acute hospital environment is fundamental to providing health care in the 21st century.
2. The Faculty of Intensive Care Medicine was founded in 2010 and currently has 4,254 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 Faculty includes the doctors (intensivists) who lead critical care services, Advanced Critical Care Practitioners (ACCPs), and Critical Care Pharmacists are also members. It has close professional links with those bodies

representing nurses and allied health professionals working in intensive care in the UK. The Faculty works on behalf of its members and other services to promote critical care education and standards, influence and define national policy, and, most importantly, improve patient outcomes.

3. Intensive Care (often used interchangeably with Critical Care) treats patients, with, at risk of, or recovering from life-threatening failure of one or more of the body's organ systems. It includes the provision of organ support, the investigation, diagnosis, and treatment of acute illness, systems management and patient safety, ethics, end-of-life care, through to support of patients and families in their mental and physical recovery from critical illness. Treatment can be delivered in a physical space (intensive care unit, high dependency unit or critical care unit) or as an outreach service to the rest of the hospital. Where the intensive care team provides outreach support to the hospital, the intention is to prevent further patient deterioration or to support the recovery of those who have been critically ill.
4. Critical Care lies at the heart of 21st century secondary care crucially underpinning all other areas of acute hospital care. When critical care capacity cannot meet demand, other services particularly elective surgical services will suffer as demand from this elective quarter can be cancelled, whilst demand from emergencies cannot. The impact on other secondary care services of excess demand on critical care services was and continues to be clearly demonstrated by COVID-19.
5. Critical Care, not just in England but across the UK was at significant risk in the event of even minor increases in demand. Prior to the pandemic FICM produced a report called, [Critical Condition](#) in 2018, highlighted the issues of critical care capacity, demand, and supply. Overall the situation is now worse than 2018 due to loss of critical care staff from the workforce. The biggest issue facing units is nurse staffing; meeting critical care nurse recruitment and retaining them in critical care remains very challenging.
6. There are around 3756 staffed critical care beds in England. The number of critical care beds per capita is amongst the lowest in Europe (Germany 27 beds/100,000 population, versus England 8 beds/100,000 population). The figure for England hides a wide regional variation in staffed critical care bed capacity per capita. The impact of this can be seen within the [regional COVID-19 critical care admission data](#).
7. Critical Care beds are used to treat patients admitted to hospital as an emergency e.g. after road traffic accidents, heart attacks, strokes etc. and to provide post operative support for patients having major surgery e.g. cancer surgery, neurosurgery. Critical care bed occupancy pre pandemic ran at over 87%; more than 10% over the recommended 75% occupancy. The higher the bed occupancy the more likely elective surgical cases will be cancelled in a hospital due to lack of critical care bed, and the more pressure the workforce is placed under.
8. Even without COVID-19, the Intensive Care National Audit and Research Centre (ICNARC) and the Centre for Workforce Intelligence (CfWI) both projected an annual increase in demand for critical care services of around 4% per annum. There is no reason why COVID-19 will reduce this and more likely it will increase bed use due to longer critical care stays. Population increase, ageing demographic, and increased public and professional expectations all account for increased demand.
9. The Faculty of Intensive Care medicine surveyed its members in November 2020, [Voices from the Frontline](#). The report highlights the efforts made to provide to provide an excellent critical care service. Planned increases in staffed critical care capacity needs to be made to make surges in demand sustainable without major impacts on other services e.g. anaesthesia and elective surgery.

10. Excess demand brings additional pressures on the critical care workforce making it harder to recruit and retain staff.

Feedback on specific policy areas and commitments

Planning for the workforce

1. Ensure that the NHS and social care system have the nurses, midwives, doctors, carers, and other health professionals that it needs.

[Guidelines for the Provision of Intensive Care Services](#) (GPICS v2) outlines the recommendations for critical care staffing level and ratios. There is a clear need to increase the provision of critical care services across most of the UK, with a clear concomitant need to increase trained staff and retain them in healthcare. There are work streams looking at how to address the backlog in surgical cases and these require increases in critical care capacity as well as increases in enhanced care provision.

Building a skilled workforce

2. Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.

Critical care supply in the UK has been shown to be too low to meet demand even without a pandemic. The COVID pandemic highlighted the paucity of ICM services and the impact on other hospital services. Despite this we have seen very little increase in National Training Numbers (NTN) to develop the future consultant workforce in intensive care medicine. Despite having more than 2 applicants for every ICM NTN we cannot appoint into posts that haven't been allocated to ICM. There needs to be targeted investment in the medical ICM workforce. The issues facing the ICM nurse workforce are recruitment and retention of trained staff. Education and value need to be more clearly recognised. The specialist skills of the ICM nursing workforce are not valued or rewarded and we haemorrhage staff. Putting in rewards to incentivise specialist skills would help address this.

3. £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities.

The COVID pandemic has highlighted the need to address an ageing NHS infrastructure in ICM services. The inability to isolate patients with an infectious disease within critical care and outside units has meant a need to "cohort" patients use additional areas which has heavily impacted on other services e.g. elective surgery, cardiology, respiratory medicine. Critical care units should have at least 20% of their beds as single rooms. This needs investment in physical infrastructure of many units.

Wellbeing at work

4. Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.

The Faculty has released a document addressing wellbeing as part of its [Critical Staffing](#) series. We welcome any concrete measures to improve access to mental health as well as musculoskeletal services.

5. Reduce bullying rates in the NHS which are far too high.

The Faculty fully supports an initiative to reduce bullying. We are not aware that this is a problem specific to critical care, but we should not be complacent and welcome attention in this area across NHS services.

6. *Listen to the views of social care staff to learn how we can better support them – individually and collectively.*

The specialty of ICM needs to work with social and primary care to optimise recovery of patients who have been critically ill. Work on '[Life After Critical Illness](#)' recognises this as a key metric in the development of the specialty. Earlier identification of who might benefit from critical care needs to be addressed prior to people becoming critically ill. Everyone is critically ill before they die but not everyone needs or would want critical care. These difficult areas about illness, death and end of life care need to be jointly addressed by patients, their families, society, and health care professionals from primary through to tertiary care.

May 2022