The Faculty of Intensive Care Medicine

Voices from the Frontline of Critical Care Medicine

November 2020

Executive Summary

The *Voices from the Frontline of Critical Care Medicine* survey reflects the recent experiences, and feelings of Faculty members to the first wave of the COVID-19 pandemic. The huge increase in demand for critical care due to SARS-CoV-2 infection was met by an equally impressive increase in supply, for which we should be proud. This required a considerable increase in work delivered by individuals, and in the absence of enough critical care staff, also by non-critical care staff. The Faculty promoted an increase in staffed critical care capacity before COVID-19 through our *Critical Condition*[1], and *Critical Futures*[2] reports; more recently through the publication of our *Enhanced Care*[3] guidance we have advocated for innovative ways of working that would allow better care whilst giving more flexibility to increase staffed critical care capacity if and when necessary in the future.

Key Findings

- 45% of respondents have seen a permanent increase in the critical care capacity of their directorates. However, when asked if they consider any increase in capacity to be adequately staffed only 18% of respondents agreed.

- 60% of respondents reported that their units are still attempting to follow the *Guidelines for the Provision of Intensive Care Services*[4] (GPICS V2) but 54% of respondents have seen some relaxation of those standards in their units, including to their medical staffing.

- 80% of respondents increased their working hours, and 71% report covering sick consultant colleagues. Future uncertainties affect the wellbeing of the Faculty's fellows and members. How hospital structures support those working in critical care is vitally important for both recruitment and retention.

- 88% of respondents had leave cancelled. Work/life balance is extremely important. Whilst the vast majority of respondents were happy to deliver the needed increase in work in the first wave, to do this over subsequent waves of the pandemic becomes increasingly difficult for individuals and their family. Supporting professional activities and agreed job plans will be even more important in subsequent COVID-19 waves.

- Faculty fellows and members understood the impact the first wave of COVID-19 had on non-critical care staff, and hugely appreciated their response to the crisis. The flexible increase in staffing was so important for care, although the drop in GPICS standards underlines the need to increase the underlying critical care capacity, and the multi-disciplinary workforce. The future impact of surge responses on other staff groups, as well as non-critical care work, should be reduced as much as possible.

Key Recommendations

1. GPICS standards exist for reasons of best care, safety and governance. Units should be attempting to adhere to them or working towards achieving them. Inability to meet GPICS standards needs to be brought to the attention of management structures within hospitals and plans for addressing deficiencies identified and implemented.

2. Supporting and maintaining the wellbeing of critical care staff is vitally important. Not only for recruitment by attracting multi-disciplinary team members in, but also for their retention in the specialty. Staff must not be taken for granted, and listening to the voices from the frontline is only the start of this process.

3. Enhanced Care recommendations, written and promoted by the Faculty, will allow for greater flexibility in future responses to surges in demand as well as safer care for those needing a higher level of care. Critical Care Directorates should make the case widely within their hospitals for enhanced surgical and medical care.

1. Faculty of Intensive Care Medicine. Critical Condition: Building a Sustainable Future for the Sickest Patients in the Hospital (2018)
2. Faculty of Intensive Care Medicine.. Critical Futures: A Report on the First Wave Survey (2017)
3. Faculty of Intensive Care Medicine and Royal College of Physicians. Enhanced Care: Guidance on service development in the hospital setting (2020)
4. Faculty of Intensive Care Medicine and Intensive Care Society. Guidelines for the Provision of Intensive Care Services (GPICS V2 (2019)

Introduction

The Faculty of Intensive Care Medicine (FICM) surveyed its consultant membership over a two-week period (from 1 to 15 October 2020). The *Frontline Critical Care Voices* forms a powerful testimony to how much effort the FICM membership has given, both as individuals and collectively, to reduce death and suffering from the SARS-CoV-2 infection.

It is clear that this effort has often come at considerable cost both physically and mentally, and also to many consultants' families. The additional work required has been remunerated in some hospitals, but sadly at the time of the survey, not in all.

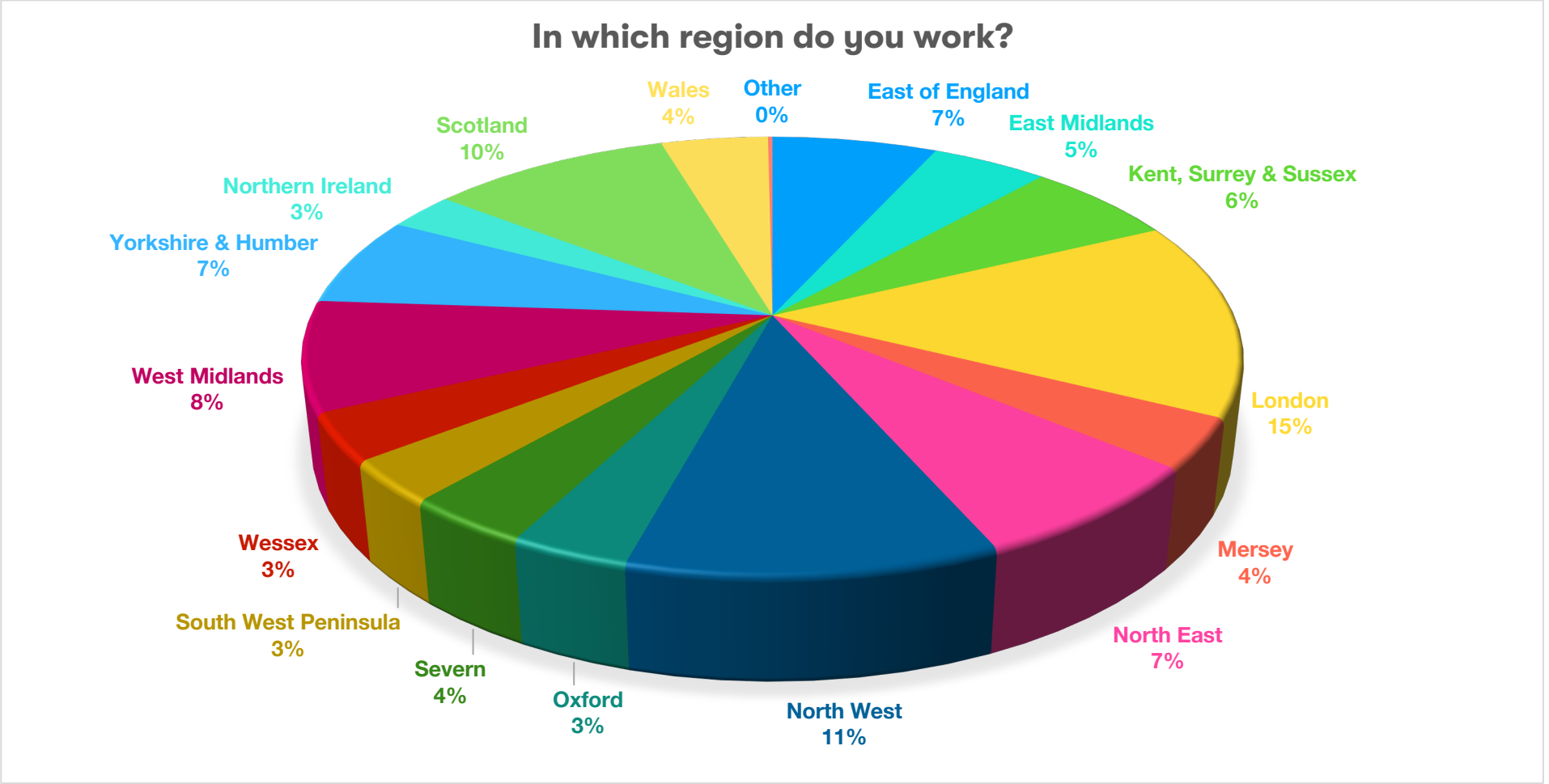
The FICM membership should be very proud of their own personal achievements, the achievements of their directorates to rapidly expand capacity, and also the great response of those drafted into critical care following a "call to arms". The gratitude to our nursing staff, junior intensive care doctors, ACCPs, physiotherapists, pharmacists, psychologists, anaesthesia, and respiratory medicine colleagues is particularly noted, but also to novel proning teams that included in some units surgeons, orthopaedics and medical students.

There is also a clear signal of concern, a warning for the future. Some are already deep in the second wave and others wait for it to break. The FICM will continue in our endeavour to ensure your voices are heard above the considerable background noise. The survey was sent by email to the 2484 members of the Faculty eligible to respond. There were 549 responses (22%) with a large number responding with free text.

> "Ensure engagement with all staff at all times; be imaginative; bend the rules; don't let 'management' drive the agenda; be tough when defending safe practice; beware of PPE hysteria - sensible but pragmatic approach to PPE guidance; accept and maintain a sense of risk 'proportionality' in terms of PPE, cohorting etc

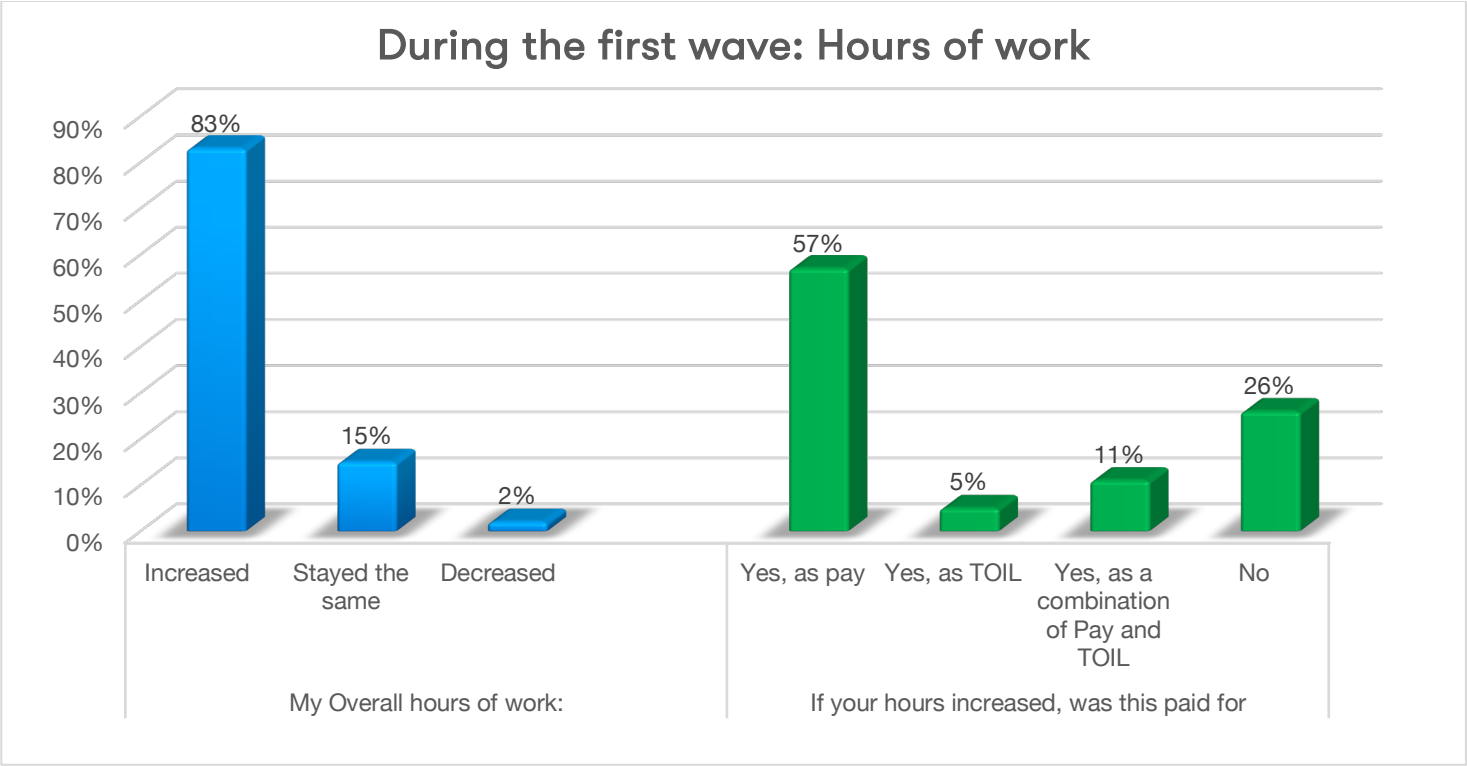
> "Guidance on wellbeing and resilience. We want to work and be useful. This is the hour of need. We don't want to sit back or make big demands, this is all about patient care. But we do want the trusts to recognise that we are doing this and that we are going above and beyond!

The survey had a good response rate from across the whole of the UK.

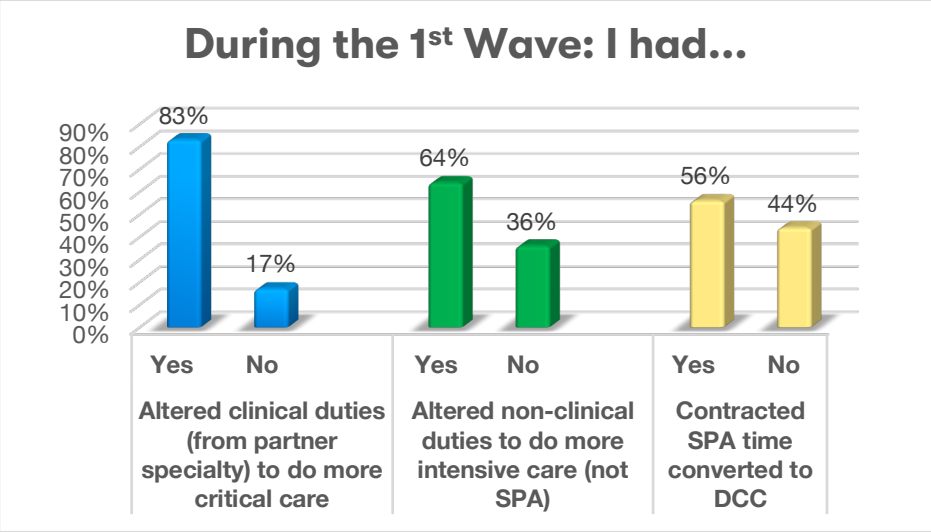


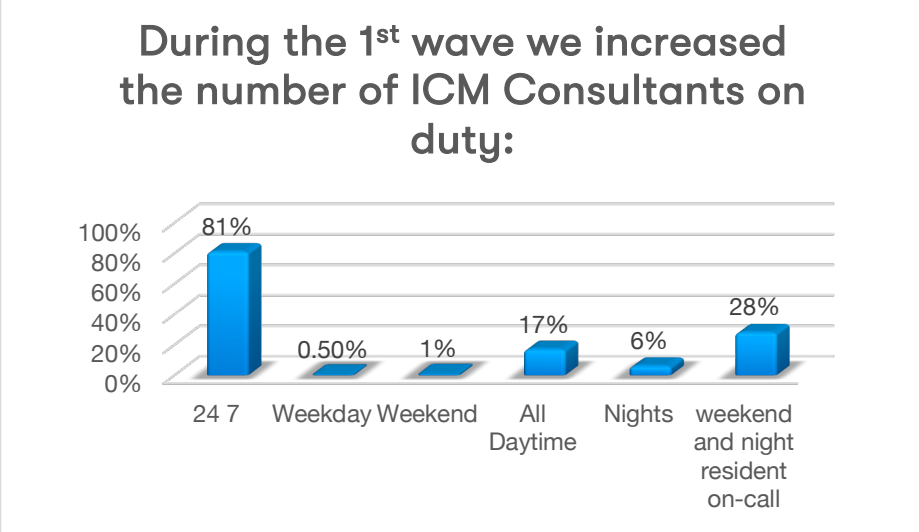
More than 80% of respondents increased their total working hours due to COVID-19. During the worst months, more than 70% had to cover colleagues' sick leave. Many consultants had the COVID-19 infection themselves, some with lasting effects: "I am on sick leave with 'Long COVID' symptoms so am uncertain as to my future". In addition most had annual leave cancelled, and sessions in their other specialty (anaesthesia mainly) converted to critical care sessions. Many clearly miss doing their second specialty, and whilst acknowledging the need to drop this at the time, now want to return to their original job plans.

The large increase in work by individuals has been remunerated in 57% of cases by pay, 5% as Time Off In Lieu (TOIL = annual leave), and 11% as a combination of pay and TOIL.. However, in 26% of cases individuals have not been recompensed for this additional work. This represents a delay in payment in a quarter of cases, and demonstrates the disparity between some hospital administrations and others in their response to their workforces' work, time, and effort. Human Resources departments have been involved in changes in pay and job plans in fewer than 20% of cases according to our respondents.

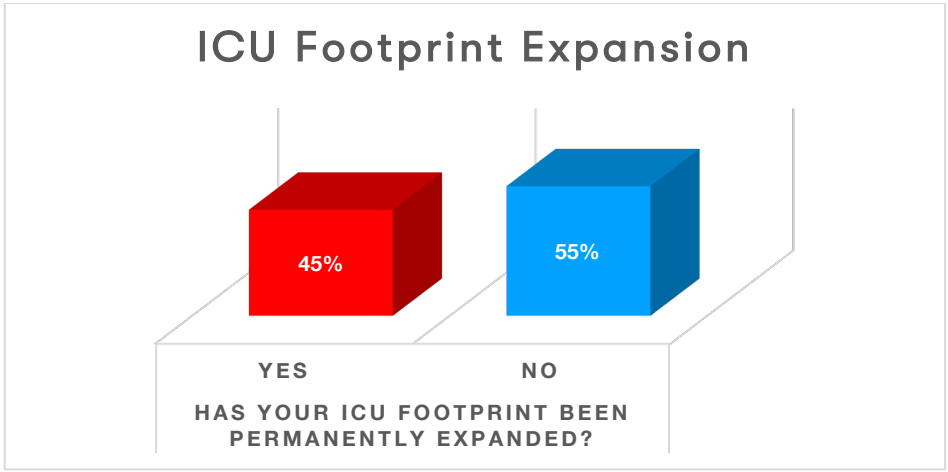


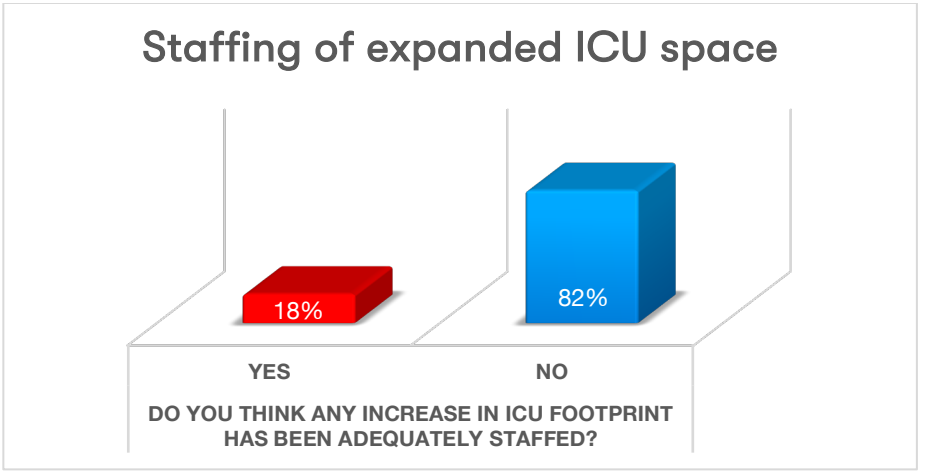
Many consultants had their supporting professional activities (SPA) converted into clinical sessions. This then meant they spent large amounts of their own time avidly trying to learn about COVID-19, including how best to deliver supportive care, and how best to treat a new disease. Consultants' own time was often spent writing directorate guidelines, implementing standard operating procedures, and trying to ensure safe working conditions for our workforce including ensuring there were adequate supplies of personal protective equipment, and demonstrating how to don and doff it safely. Consultants were also teaching non-intensivists how to manage critically ill patients and trying to maintain a learning environment for our junior medical staff.



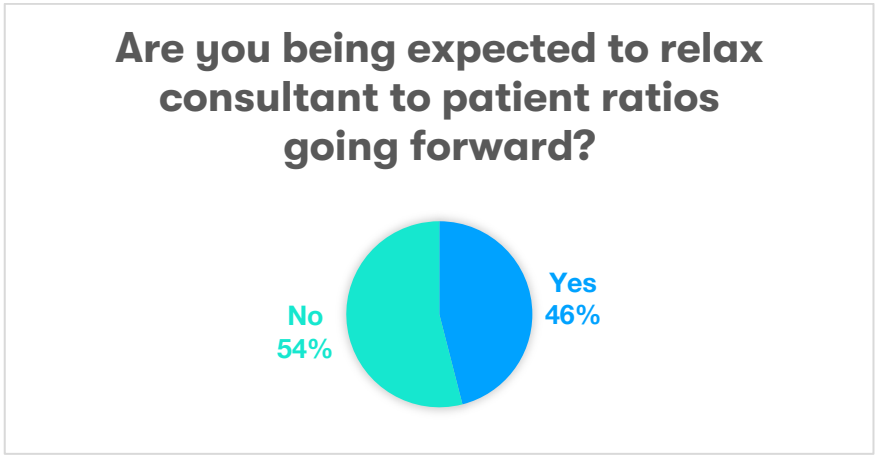


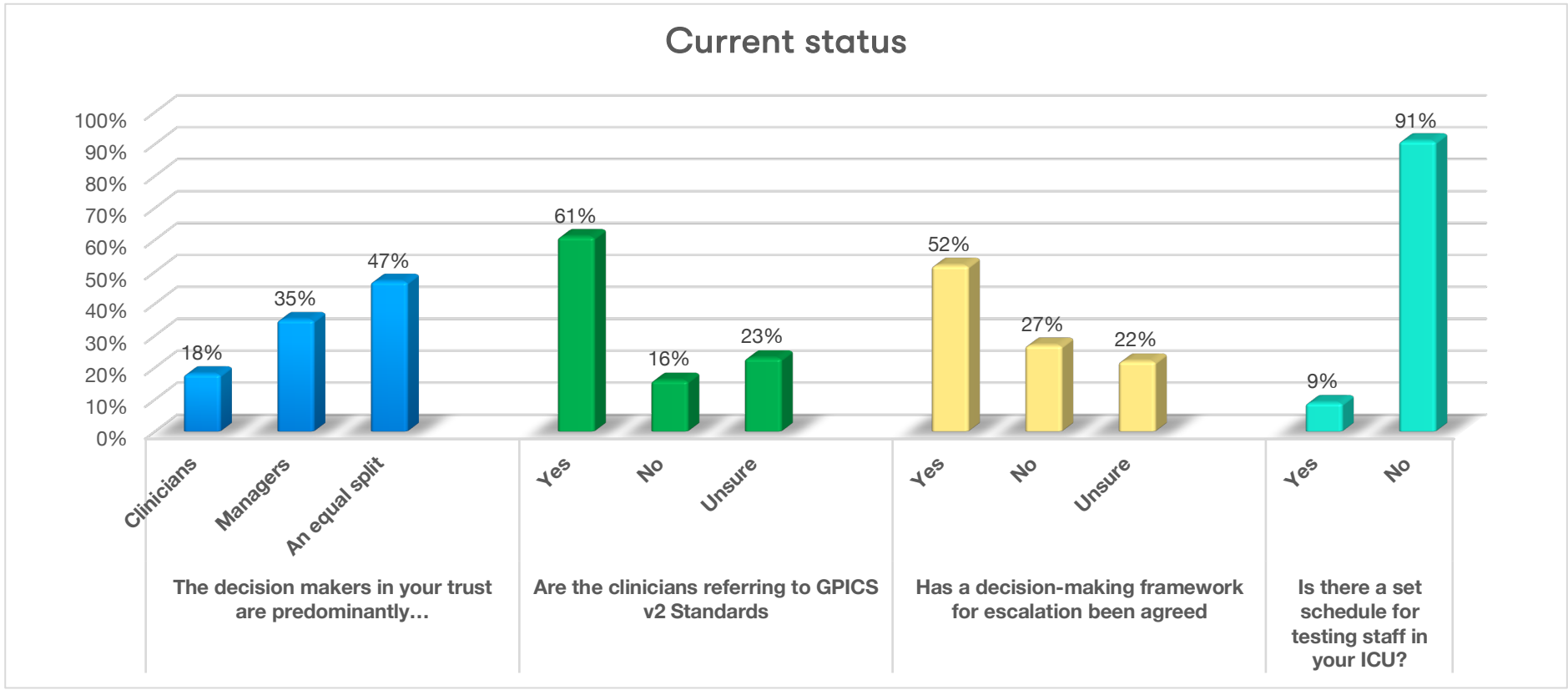
45% of respondents have seen a permanent increase in the critical care capacity of their directorates. However, when asked if they consider any increase in capacity to be adequately staffed only 18% of respondents agreed.



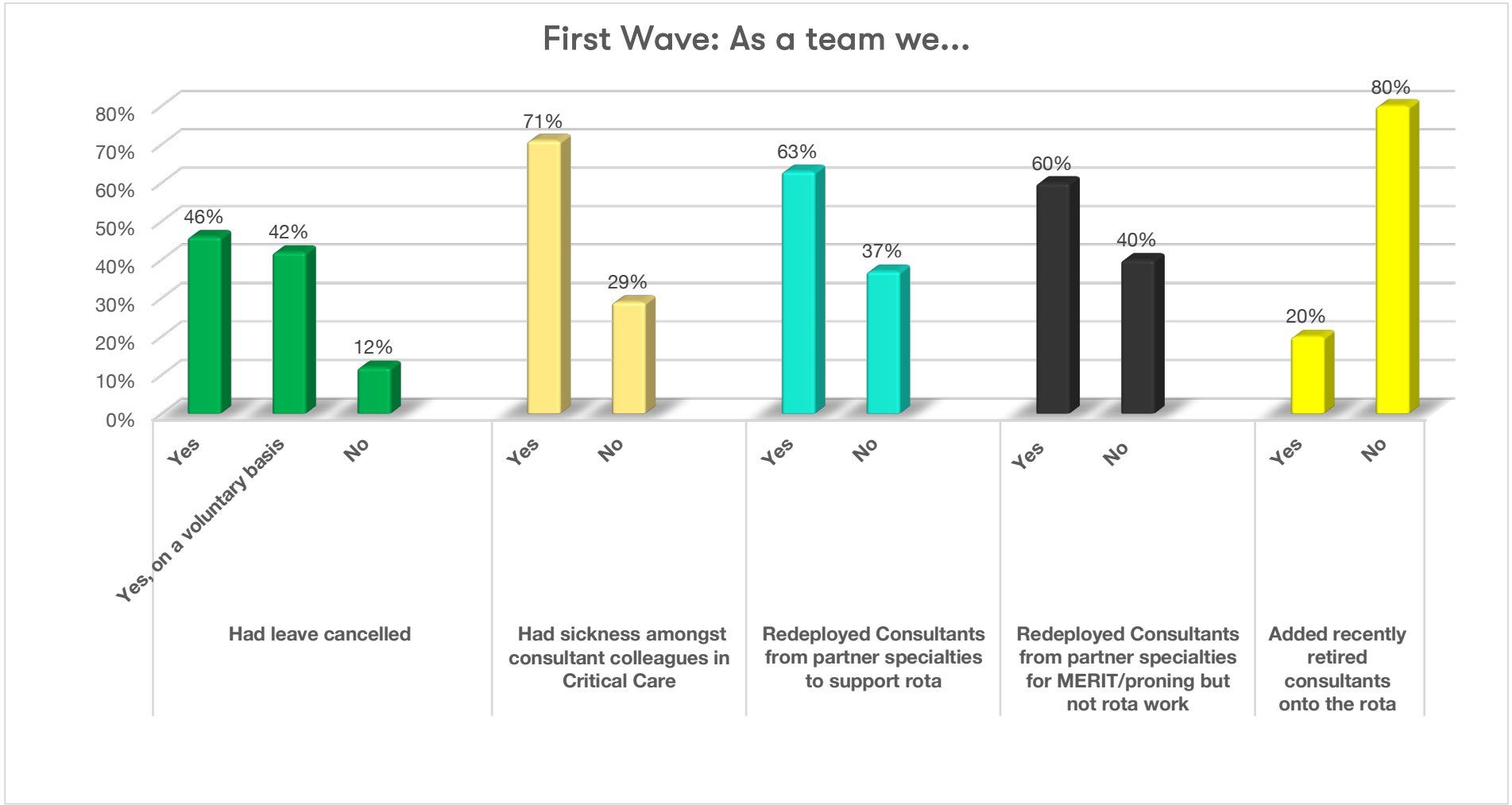


60% of respondents reported that their units are still attempting to follow the *Guidelines for the Provision of Intensive Care Services* (GPICS V2) but 54% of respondents have seen some relaxation of those standards in their units, including to their medical staffing.

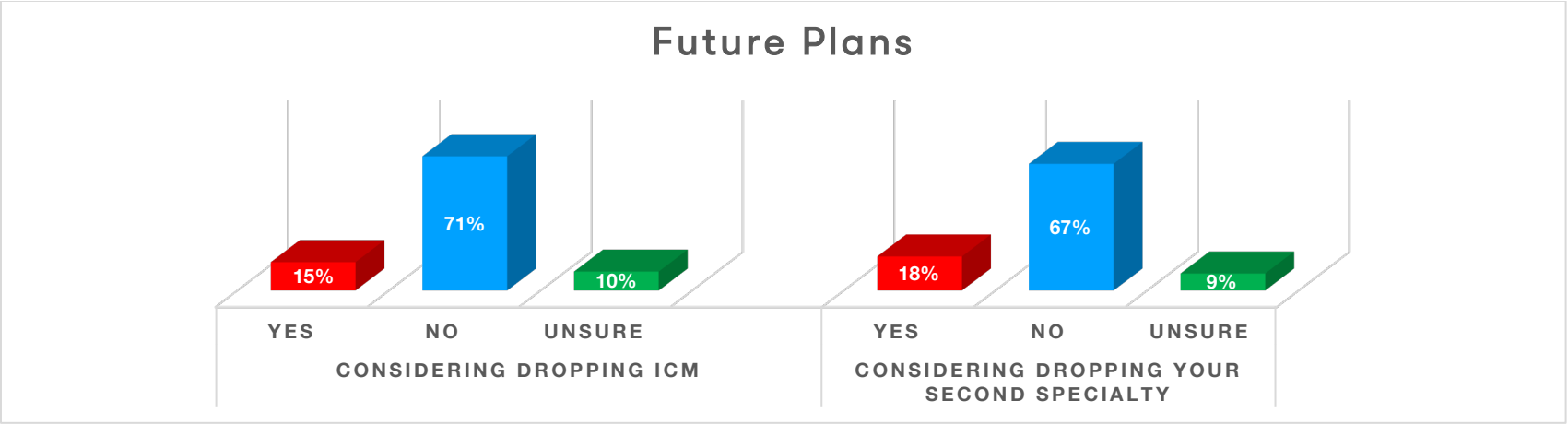




Due to the huge increase in clinical demand on a much-stretched workforce, some without enough critical care competencies, many consultants were resident on-call, and many had a large increase in weekend working, impacting significantly on their family life.


First Wave: As a team we...
80%
70%
60%
50%
40%
30%
20%
10%
0%
46%
42%
12%
71%
29%
63%
37%
60%
40%
20%
80%
Yes
Yes, on a voluntary basis
No
Had leave cancelled
Yes
No
Had sickness amongst consultant colleagues in Critical Care
Yes
No
Redeployed Consultants from partner specialties to support rota
Yes
No
Redeployed Consultants from partner specialties for MERIT/proning but not rota work
Yes
No
Added recently retired consultants onto the rota

Despite the pressure on consultant intensivists, more than 70% are not considering dropping Intensive care work. There is clearly a lot of pride in what has been achieved, but also a lot of concern for the future.



More than 80% do not think the working pressures they endured during the first wave are sustainable going into a second wave. The major reasons for this were working too many hours, missing parts of their job they usually do, and the change in work patterns. Many consultants' families bore a considerable burden - "family life is suffering" and "difficult to manage impact on family" were common themes in the survey.

In an already understaffed consultant intensivist workforce, the loss of any consultant from stress or burnout will have a significant effect on the ability of a hospital to manage a second COVID-19 wave, and a significant direct impact on their colleagues. This is especially so for small departments. There are some consultants who already appear burnt out "the mental toll of this pattern of work and the sheer mortality and morbidity associated with the increased ICU work will seriously affect my mental and physical health. I already had developed significant insomnia in the first wave and am dreading the second wave". Hospital administrative boards need to actively seek to minimise the loss of consultant intensivists by putting measures in place to mitigate the demands on the critical care workforce, and to reward them fairly, in good time, and in good faith. This has not been the case equally across the UK and leads to disillusionment, and devaluation. Attention to wellbeing is crucial to retain staff in critical care, and to attract others in.

If demands on ICM consultants increase too far in the second wave, then despite the declared intention to maintain all other NHS services, additional support will be required in critical care, thus impacting on the ability to run other secondary care NHS services. Many intensivists dread the loss of help provided by anaesthesia, but also from others such as respiratory medicine, infectious diseases and surgical proning teams. The junior critical care staff have really stepped up, many into consultant work, and have provided an invaluable service.

To finish we'd like to end on a single quote taken from a Frontline Critical Care Voice that encapsulates the desire to help as well as the caring attitude of colleagues. We would recommend reading more from the notice board of quotes.

> "Retired from clinical duties 2017, re-licensed and told my colleagues to put me back on the clinical rota but they chose to protect me from direct clinical work.

We hope you find this interesting and useful. The Faculty would like to take this opportunity to thank everyone who responded to the survey during this incredibly busy time for critical care, and thanks also to FICM's Careers, Recruitment and Workforce Committee for their work on the survey and report. If you would like to comment please contact the Faculty at contact@ficm.ac.uk.

We increased our ICU foot print from 4 units to 6 units. To cover the extra 2 units we converted our anaesthetic sessions into ICU sessions. We felt that the fact we were not resident and did our rota pattern in our usual shift times helped.

Proning teams were amazing. Physio led, staffed by willing and specifically trained orthopods...with an airway doctor joining from the unit. A proning checklist was used and it was a safe procedure. We ran out of FFP3 masks 2 weeks in so a pragmatic decision was taken to purchase thousands of reusable full face respirators with filters that are changed monthly. We also purchased reusable theatre gowns and a contract for their laundry. So the PPE was excellent and SUSTAINABLE. this was one of the most valuable things.

Workforce arrangements during first wave are non sustainable long term. Fears of ignoring GPICS standards and apply surge arrangements as long term plan. Worries about changing doctors and nurse:patient ratios. Significant increase among staff of stress, anxiety and burn out.

A coming together of a wider committed multispecialty critical care enabled team is of utmost importance and this is how London in particular coped during the first wave.

There is just not enough consultants and ICU nurses - we need to expand the workforce significantly in the near future to have any chance of dealing with surges in the future. We simply do not have enough ICU beds. A massive expansion drive is badly needed with a maximum 80% occupation limit on these beds in the future. Our norm pre-COVID was more than 100% occupancy most of the time. A recipe for disaster.

It's been refreshing to work directly with colleagues I wouldn't otherwise work alongside. Despite the obvious challenges it has been overall a positive experience professionally

Experienced excellent team-working between critical care and non-critical care nursing staff supporting each other to the best of their abilities.

We fought so hard for quality and standards with GPICS and now it seems we are happy to just forget this all and accept these ratios and substandard care. I know we are in the pandemic but where is the evidence that this is safe care?

We had a lot of brilliant redeployed nurses and junior docs.

One thing we did which we afterwards thought was a mistake was that we moved from block working to odd days and the consultants missed the continuity of block working and we are planning to retain it for the second wave.

I do not see how elective work can continue whilst providing safe patient care in the critical care areas without help from colleagues.

The Faculty of
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