Joint Position Statement on Critical Care Staffing Standards

The Intensive Care Society, Faculty of Intensive Care Medicine (FICM) and UK Critical Care Nursing Alliance (UKCCNA) along with our partner organisations **continue to recommend adherence to minimum critical care staffing levels as laid out in the Guidelines for the Provision of Intensive Care Services (GPICS).**[1] These multi-professional consensus guidelines exist to provide standards and recommendations for safe and effective delivery of critical care to some of the sickest patients in hospital; the ratio of staff to patients is a central part of this. GPICS guidelines provide the best evidence currently available for providing a quality of critical care expected by patients and healthcare professionals.

During periods of excess demand in the COVID-19 pandemic it became necessary to dilute critical care staff to patient ratios in order to provide a minimum level of critical care to as many patients as possible.[2] Staff were also redeployed from other areas to support the emergency level 4 national incident response.[3] These measures were unavoidable at that time and taken 'at risk'. The unintended consequences of these necessary actions are, as yet unquantified negative impacts on patient outcomes, staff welfare, staff recruitment and staff retention. This applies to both critical care and in other affected areas.

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[1] FICM/ICS (2019) Guidelines for the Provision of Intensive Care Services 2. London: FICM/ICS. Available at: https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services.

[2] UKCCNA (2021) Position Statement on Staffing. Available at: https://www.ficm.ac.uk/sites/ficm/files/documents/2022-01/UKCCNA%20position%20Sep%202021%20FINAL.pdf

[3] NHS England (2021) Preparing the NHS for the potential impact of the Omicron variant and other winter pressures. Available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/C1487-letter-preparing-the-nhs-potential-impact-of-omicron-variant-and-other-winter-pressures-v4.pdf

As outlined in previous statements, as we move out of an emergency level 4 national incident situation into a recovery period, a planned or sustained derogation of staffing ratios is not appropriate.[2,4]

The following situations should also be avoided:

1. Transferring patients to other hospitals to facilitate planned surgery.[5] Whilst this may enable GPICS staffing ratios to be maintained it should not need to happen outside of a national incident situation and with adequate staffing at the base hospital.
2. Proceeding with planned surgery if this then results in a predictable shortage of staff to provide the necessary care for existing critical care patients.
3. Reallocating critical care staff from other essential roles (e.g. education, research, appraisal, governance, follow up clinics, rehabilitation and outreach services) to re-balance the clinical staffing ratios outside of exceptional circumstances.
4. A dilution of critical care staffing standards because of any significant delays in discharges for ward ready patients.

The only sustainable solution to an increase in critical care demand is an increase in funded and staffed critical care (Level 2 and 3) beds.

GPICS standards remain the goal. Any derogation must be time-limited with a clear strategy for meeting multi-professional staffing standards. It is accepted that prior to the pandemic there have been difficulties in funding and recruiting to elements of the critical care workforce, particularly within the AHP and Pharmacy groups. Any further dilution of established staffing ratios and inclusion of other multi-professional groups should only be considered in the context of pandemic surge or high quality research. Representatives from relevant professional groups should be involved in staffing planning.

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[4] ICS (2021) Recovery and Restitution of Intensive Care Services. Available at: https://www.ics.ac.uk/Society/Policy_and_Communications/Articles/Recovery_and_Restitution_of_intensive_care.aspx

[5] ICS (2021) Capacity Transfer of Adult Critical Care Patients. Available at: https://www.ics.ac.uk/Society/Policy_and_Communications/Articles/Capacity_Transfer_Statement.aspx

For critical care to provide consistent high standards and safety we should be focussing on recruitment and retention of staff to ensure any pre-pandemic gaps in workforce are bridged and any predicted increase in demand which will widen these workforce gaps are met. This requires a staffing model which allows some flexibility for emergency demand and ensures staff development and experience is prioritised.

Without staffing standards being maintained there is a risk to patient safety and a longer-term recruitment and retention crisis due to the impact on staff experience and potential psychological harm. For instance, studies have indicated that after the first wave of the COVID-19 pandemic, up to 20% of staff working in ICU reported thoughts of self-harm, up to 45% of clinicians self-reported PTSD symptoms, and up to 50% reported psychological distress.[6,7,8,9] Many staff perceive a lack of safety and resulting loss of confidence working outside of GPICS ratios, with consequent staff turnover, intention to leave and career change remaining high.[10,11]

We need to ensure prevention of harm through improvements in working conditions, critical care capacity, education, leadership, and therby ensure good patient care. This sits alongside useful secondary and teritary interventions to support wellbeing , through the support of ICU Psychologists, occupational health and resilience hubs, professional nurse advocates[12] and peer support[13] (Intensive Care Society).

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[6]Greenberg N et al (2021) Mental health of staff working in intensive care during Covid-19. Occup. Med. 71(2):62-67

[7] Ezzat A et al (2021) The global mental health burden of COVID-19 on critical care staff. B J Nurs.20 (11) 634=642

[8] Couper K et al (2022) The impact of COVID-19 on the wellbeing of the UK nursing and midwifery workforce during the first pandemic wave: A longitudinal survey study .Int J Nurs Stud. 2022 Mar; 127: 104155

[9]Roberts T, et al. (2021) Psychological distress during the acceleration phase of the COVID-19 pandemic: a survey of doctors practising in emergency medicine, anaesthesia and intensive care medicine in the UK and Ireland. *Emerg Med J*. 38(6):450-459

[10]Montgomery CM et al (2021) Critical care work during COVID-19: a qualitative study of staff experiences in the UK *BMJ Open* 2021;**11:**e048124

[11]CC3N National Critical Care Nursing Workforce Survey Report July 2020. https://www.cc3n.org.uk/uploads/9/8/4/2/98425184/national_critical_care_nursing_workforce_survey_report_july_2020_final_v.._.pdf

[12] Professional Nurse Advocate. Available at https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate/

[13] Peer Support. Available at https://www.ics.ac.uk/Society/Wellbeing_hub/Peer_support_programme

Recommendations

- Maintain GPICS Critical Care staffing standards

- Ensure the discharge of patients from Critical Care is given sufficient priority to optimise the flow of emergency and planned admissions without compromising staffing ratios

- Support the development of Enhanced Care services[14, 15, 16]

- Ensure Critical Care has adequately funded and staffed beds to deliver the services needed. There will inevitably remain a need for many trusts to increase their capacity for the following reasons:

    - There is a chronic shortage of staffed critical care beds[17]
    - Elective and emergency demand has increased[18, 19]
    - Need for more complex surgery, significant co-morbidities and pandemic related delays to surgery will translate into a need for more critical care support as activity increases[20]

[14] FICM (2020) Enhanced Perioperative Care. London FICM. Available at: https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-perioperative-care
[15] CPOC (2020) Guidance on Establishment and Delivery of Enhanced Perioperative Care Services. Available at: https://cpoc.org.uk/guidance-establishing-and-delivering-enhanced-perioperative-care-services
[16] ICS/BTS (2021) Respiratory Support Units: Guidance on Development and Implementation. Available at: https://ics.ac.uk/Society/Guidance/PDFs/Respiratory_Support_Units
[17]The Kings Fund (2020) Critical Care Services. London: Kings Fund Available at: https://www.kingsfund.org.uk/publications/critical-care-services-nhs
[18]The Kings Fund (2021) Waiting times for elective (non-urgent) treatment. https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/waiting-times-non-urgent-treatment
[19]BMA (2022) NHS Data Backlog Analysis. London: BMA. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis
[20]BMA (2022) NHS hospital beds data analysis https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-hospital-beds-data-analysis#:~:text=The%20UK%20entered%20the%20pandemic,having%20risen%20over%20the%20years

Endorsing Organisations

- British Association of Critical Care Nurses (BACCN)
- Royal College of Nursing (RCN)
- Scottish Intensive Care Society (SICS)
- The Critical Care National Network Nurse Leads Forum (CC3N)
- The National Outreach Forum (NOrF)
- Welsh Intensive Care Society (WICS)
- Paediatric Critical Care Society (PCCS)