Our Response to the 10 Year Health Plan for the NHS in England

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The Intensive Care Society was founded in 1970 and is the oldest intensive care professional body and membership organisation in the world. The Society is a registered charity.

The delivery of intensive care is a multifaceted and intensely multi-professional endeavour, involving highly specialist medical and nursing staff, pharmacists, psychologists, physiotherapists, speech and language therapists, dietitians, occupational therapists, advanced practitioners in critical care and other allied healthcare professionals. All of these professions are represented among our members.

Our members deliver the highest quality of care to the sickest of patients in UK hospitals.

Our response to the 10-Year Health Plan focuses on what our members do and the patients they see, and we do not seek to respond to wider issues except insofar as they relate to our areas of concern.

We would also stress that the impact on the intensive care sector and its people of the Covid-19 pandemic has been, and continues to be, devastating. No plans for the future can be made without recognising that legacy and the need to build from there. We have been pleased to be able to submit both written and oral evidence to the Covid-19 Inquiry and our proposals for the 10-Year Health Plan draw heavily on the work we have done to address lessons from the pandemic. The 10-Year Health Plan for the NHS must commit to accept and learn from the findings of the Covid-19 Inquiry.

The areas we would wish to see addressed in the Plan include:

A) **Retaining, recruiting, and developing intensive care staff**

The NHS workforce is in crisis. Unsustainable staffing shortfalls and escalating demands for care have created an insurmountable challenge for those who care for the critically ill. The care we provide is the most important service in any acute hospital. Our teams don't only operate within the confines of an intensive care unit, we also required to support patients and colleagues through outreach and in other areas of the hospital such as emergency medicine. We are the last line of defence for our patients, yet our service remains under resourced and understaffed, resulting in not every hospital being able to provide the same level of care. This makes implementation of initiatives such as Martha's Rule nation-wide incredibly difficult.

The Guidelines for the Provision of Intensive Care Services (GPICS), set by the Intensive Care Society and the Faculty of Intensive Care Medicine, stipulate that a consultant intensivist to patient ratio of 1:8 - 1:12 should never be exceeded. The most recent audit of UK intensive care units showed that 43% of surveyed hospitals cannot meet this standard. This dilution of staffing is seen across all professions which make up the intensive care team and has an impact on the quality of patient care and outcomes.

One in nine nurses left the NHS in June 2022, with a further four in 10 doctors planning to leave. Existing shortages and a continued inability to meet the staffing standards outlined in GPICS, carry the risk of accelerating an unprecedented staff exodus, exacerbated by the effect of over a decade of unrelenting pressures.

The plan needs to focus on investing in retaining the skilled staff already delivering intensive care in the UK. It takes many years to educate, train and build up these skills. Retention is step one to safeguarding services now and for a future pandemic.

We would call for investment in training to 'replenish' ICU staffing to an appropriate level and standard. With experienced staff choosing or feeling compelled to leave critical care, and with the gap in training caused by the pandemic, there is a dilution of experience and there are gaps that need to be filled. This would be a significant issue if there were to be another pandemic or any other noteworthy increase in demand on critical care. There is significant work to be done to upskill staff and to return staffing levels to better than pre-pandemic levels in order that critical care can survive another pandemic.

The shortfall in staff during the pandemic (in particular, nursing staff) undoubtedly had an impact on the physical and mental wellbeing of intensive care professionals. A 2021 paper (Greenberg, N, et al, Mental Health of staff working in intensive care during Covid-19. Occup Med (Lond)) indicates that, from data collected in June and July 2020, after the first wave, one in five nurses and one in seven clinicians working in ICU reported thoughts of self-harm at that time and 45% of clinicians had self-reported symptoms that may lead to a diagnosis of PTSD. Many staff reported moral distress as a result of having to work outside of GPICS ratios, and staff turnover is increasing. Reintroduction of pre-pandemic staff standards is thus fundamental to wellbeing and productivity, and to preventing psychological harm.

We would therefore stress the importance of the need to develop a formal psychological support programme for staff that involves employing psychologists within ICUs so they can provide proactive rather than reactive support to help staff to thrive at work and prepare them for another pandemic.

Significant support for frontline health care professional is provided through non-NHS structures. The 10 Year Plan needs to recognise and identify where resources may be more effectively channelled trough these routes.

We would encourage the Plan to identify where partnerships funded by NHSE may deliver value such as our work to train ICU staff to be Peer Supporters and act as the first line support for colleagues.

B) A rapid expansion of the provision of patient rehabilitation services to ensure all patients have the best chance of returning to life before critical illness

This is covered with more detail in Q2.

C) Research

We need ring-fenced funding to enable intensive care professionals to involve more patients in structured research studies and improve outcomes

Intensive care research saves lives. The GenOMICC study investigates the genetic factors that determine outcomes in critical illness. Established with funding support from the Intensive Care Society, it is the largest study of its kind globally and was integral to finding successful treatments for Covid-19. Without similar research support intensive care will not be able to meet the needs of patients in the future.

While all intensive care staff are required to undertake research to progress in their careers, there is currently a distinct lack of protected time and funding available to support this. Research in intensive care is crucial not only for the professional development of staff but also for the care and experience of critically ill patients.

D) Support a diverse workforce

We need structural change within the health service to foster a diverse, inclusive and psychologically safe working environment for all staff.

The Intensive Care Society's recent Equality, Diversity and Inclusion report found significant differences in the experiences of intensive care staff according to their socioeconomic status, gender, ethnicity, sexuality, ability, and other characteristics. It also exposed failings within the NHS to protect staff from discrimination, bullying, harassment or disadvantage occurring as a result of their backgrounds or other factors.

Intensive care professionals and patient experiences of healthcare in the UK should be universal, and an individual's personal characteristics and/or circumstances should have no bearing on their access to care or right to a positive working environment.

Finally, The NHS would not be able to function without its international workforce, who account for nearly 1 in every 5 people who work in the health service with an ever-growing demand to fill the extensive vacancies across country. Recent immigration policy changes [2024] now restrict dependents from being added under the Health and Care Worker visa. Those wishing to join their loved ones will need to source alternative pathways into the UK. This policy change may significantly slow down the vital international recruitment needed both now and, in the years, to come.

E) Deliver a Carbon Zero intensive care

We must accelerate the move to a Carbon Zero NHS.

The climate crisis is a global health crisis, and the NHS is both a contributor to this and a victim of its effects. As air quality deteriorates and we regularly see the impacts of both extreme heat and extreme cold, the health service cares for a steadily increasing stream of patients. Between 2017 and 2025 the effects of air pollutants will cost the NHS about £1.6 billion.

Healthcare globally accounts for about 5% of CO2 emissions, and critical care is a leading contributor to this. As one of the most resource intensive parts of a hospital our work caring for the critically ill comes with a serious impact on the planet.

The Society with partners has developed a range of resources to support our community and the wider NHS to move towards carbon zero. This can be accelerated but needs additional resources to be brought to bear. We would encourage the plan to identify resources to enable organisations such the Society to continue our leadership work in sustainability.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Our patients will always need to be cared for with a hospital. There are however many things that can be done to ensure all patients have the best chance of returning to life before critical illness by a rapid expansion of the provision of patient rehabilitation services.

Surviving critical illness is only the beginning for those who are treated in intensive care. The treatments administered, such as mechanical ventilation, sedation and other medications can take a significant toll on both the mind and body. For those survivors, many will need to re-learn to eat, walk, talk, or even swallow. These long-term effects mean that around one third of ICU patients do not return to work within five years.

Recovery and rehabilitation for ICU patients commences on the ICU and continues on the acute wards to which ICU patients are normally transferred. It then continues more long term on non-acute wards and in the community. Recovery from ICU is lengthy and costly and therefore a multi professional approach as early as possible is required for ICU patients.

While rehabilitation starts on the unit, patients can face a minimum of 18 months of recovery, but every rehab journey is unique as many will also need to adjust to a radically different way of life. At present, access to the necessary expertise and support is varied and depends heavily on where patients are located within England. This lack of access to post intensive care rehabilitation results in many suffering the impacts of their illness and hospitalisation far longer than is necessary.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The physical infrastructure of the NHS estate in England is crumbling. Many buildings are falling apart with outdated equipment, this is one of the biggest barriers to implementing new technologies and needs to be resolved urgently.

Beyond this we believe there needs to be a requirement for all hospitals to hold easily accessible and understandable data on oxygen and hospital schematics to enable the quick and efficient monitoring of the oxygen supply in each building. This will assist with the running of oxygen pressure tests, and it is vital to understand the schematics of each hospital in order to be able to do so. During the pandemic this took up much valuable clinical time to assess potential areas for expanded ICUs which had sufficient oxygen provision and importantly would not impact on supply to other essential clinical areas. Future hospitals need to be designed with the necessary infrastructure to enable planned and emergency expansion of intensive care and respiratory support units.

We need a review and recommendations for communication tools within hospitals, regionally and nationally. The bleep system used by many Trusts in the UK is antiquated and one of the reasons many adopted the use of direct personal mobile phones and messaging apps such as WhatsApp. There is an opportunity to standardise this to enable the most secure and accessible platform for the future.

We know that the absence of a centralised hub of patient data made it logistically very difficult to compare and analyse the Covid-19 data that was being recorded during the pandemic. UK healthcare needs an integrated hub of live patient data across NHS Trusts. This will improve care and will also be a huge resource for the UK economy.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

The pandemic shone the light on the fact that much severe disease was preventable. Disproportionate impacts were felt in those with severe and preventable comorbidities. We need to strengthen public health systems and implement robust changes in transport, food, alcohol and tobacco policy such as to reduce these comorbidities.

Recent data from the Inequalities in Health Alliance shows that 75% of people were concerned that the health gap between wealthy and deprived areas is growing. This gap must be closed immediately.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- Quick to do, that is in the next year or so
- In the middle, that is in the next 2 to 5 years
- Long term change, that will take more than 5 years

Quick to do, that is in the next year or so

1. Invest in the retention of the existing intensive care workforce. The cost of replacing one fully trained nurse can be as high as £12,000, a clear financial incentive for retention efforts
2. Make the recruitment of intensive care staff an immediate priority and ensure that senior health care professionals who worked through the last pandemic are targeted for retention, as part of preparation for the next pandemic.
3. Allocate a dedicated fund for intensive care research to enable new investigations
4. Provide protected time for all intensive care staff undertaking quality improvement projects and/or involved in wider research
5. Commit to a cross-government strategy that considers the role of every government department and every available policy lever in tackling the factors that make people unwell in the first place as per the recommendations of the Inequalities in Health Alliance

6. Invest in enhanced equality, diversity and inclusion training for all intensive care staff to ensure they are quipped to provide a consistently high standard of care for all patients and their loved ones, regardless of their protected characteristics
7. Increase investment in equal access to education and training opportunities, including for those with protected characteristics, to expand access to pathways into working in intensive care
8. Embed better support and resources for staff trained internationally to ensure they are embedded as smoothly and quickly as possible into roles within the NHS
9. Facilitate the move away from fossil fuels and to green energy across all NHS properties
10. Mandate a review across the NHS to reduce the amount of waste created by unnecessary use of PPE and other sources

- In the middle, that is in the next 2 to 5 years

11. Ensure every member of the intensive care workforce has access to £1,000 of ring-fenced annual funding to facilitate continued professional development, to demonstrate their value and ensure they are equipped with the right skills to provide continued highly specialised care
12. Establish a reliable pipeline of intensive care staff, by increasing training places by a minimum of 10% and creating clear pathways into intensive care by 2026
13. Investment in rehabilitation with appropriate staffing levels to reduce the rate of hospital readmission of those who have experienced critical illness and help them return to the workforce sooner
14. Ensure rehabilitation services are using a full resourced and consistent model that enables equal access for our patients no matter their postcode
15. Require all hospitals to hold easily accessible and understandable data on oxygen and hospital schematics to enable the quick and efficient monitoring of the oxygen supply in each building.
16. Review and make recommendations for communication tools within hospitals, regionally and nationally

17. Embed a tool that captures our patients rehab needs and supports their recovery needs both on the unit and after they leave intensive care. For example, the Post ICU Presentation Screen developed by the Intensive Care Society
18. Improved infrastructure for data collection and reporting to better assess and meet rehabilitation needs
19. Implement improved infrastructure for intensive care data reporting to inform future research needs and opportunities by 2027
20. A full review and amend of the Health and Care Worker visa policy to ensure the process of international recruitment not only removes unnecessary barriers for our colleagues and their dependents to enter the UK, but also attracts the talent across the global intensive care community to the NHS
21. Work with suppliers and procurement teams to ensure all products commissioned and purchased meet sustainability standards during both production and use
22. Accelerate the milestones outlined in the NHS clinical waste strategy to ensure all waste generated is disposed of in the most appropriate and environmentally sustainable way
23. Work with professional bodies and their industry partners to identify and implement low-carbon alternatives and lean pathways

• Long term change, that will take more than 5 years

24. Invest in large scale critical care research to improve patient outcomes and long-term recovery
25. Introduce an integrated hub of live patient data across NHS Trusts.

SUPPORTING MATERIAL

The Guidelines for the Provision of Intensive Care Services (GPICS): available at: https://ics.ac.uk/guidance/gpics.html

Post ICU Presentation Screen (PICUPS) Tool: available at: https://ics.ac.uk/resource/picups-tool.html

Towards an Inclusive Future, ICS Equality, Diversity and Inclusion Census Report: available at: https://ics.ac.uk/membership/equality-diversity-and-inclusion.html

ICS Sustainability resources; available at: https://ics.ac.uk/membership/sustainability.html