

19 December 2024

**THE ROYAL COLLEGE OF ANAESTHETISTS, THE FACULTY OF INTENSIVE CARE
MEDICINE AND THE ASSOCIATION OF ANAESTHETISTS**

Written Closing Submission

Introduction, thanks and thoughts

1. We wish to start by thanking the Inquiry for its ongoing work; reiterating that our thoughts remain with all those impacted by Covid-19; and acknowledging the concerning inequalities of outcomes raised by other witnesses in this Inquiry.
2. We also wish to pay tribute to the skills, dedication, and immense personal sacrifices made by our members during the pandemic.
3. Without their work, and that of wider healthcare teams, the impact of Covid-19 on the nation would have been considerably worse, and many more lives would have been lost. Our members worked to treat patients in the most stressful of conditions, which took its toll on their mental and physical health and exposed them to unusual levels of moral distress. Those in training provided crucial clinical services in the face of disruptions to their own training, qualifications and development. Their contributions and sacrifices must be acknowledged and applauded.

Purpose of this submission

4. In this written closing submission we will reinforce some of our key points made in earlier evidence, add additional context regarding decisions about admission to intensive care, and reiterate some of our key recommendations to support planning for any future pandemic or crisis.

Staffing and capacity

5. Intensive care units (ICUs) are where the most critically ill patients are treated and supported in hospital. Data from the Intensive Care National Audit & Research Centre (ICNARC) shows that during the pandemic around 400,000 patients were treated in ICUs, including around 50,000 of the very sickest Covid-19 patients.¹

¹ INQ000480138, Intensive care national audit & research centre, overview of key statistics gathered, dated 23 May 2024

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6. We wish to reinforce how precarious capacity in intensive care was prior to the pandemic. As early as 2018, the bed fill rate in ICUs had almost reached recommended safe limits in Scotland, and was already surpassing it in England, Wales and Northern Ireland.²
7. The emergence of Covid-19 resulted in the requirement for herculean efforts to expand capacity, demanding extensive physical remodelling and inventiveness.
8. Efforts included shutting down other hospital services, converting non-ICU spaces into makeshift ICUs, and sourcing or repurposing essential equipment such as ventilators to fill these spaces. This had significant consequences for waiting lists which continue to impact on patients to this day.
9. Expanding capacity also required cancellation of leave; reduced staff to patient ratios; the curtailment of normal educational opportunities for doctors in training; and redeploying staff, often to act outside their normal skill set. While the efforts of those staff were hugely important and much appreciated, those without specific training in intensive care medicine cannot be viewed as full substitutes for regular ICU staff.
10. Therefore, while ICU capacity was increased, with staffed beds rising from around 4,100 to over 6,000 in England³, this came at considerable cost and was not necessarily delivered to agreed UK pre-pandemic staffing standards.
11. It is also important to acknowledge that ICU expansion was achieved unequally between nations and within English regions, with expansion rates ranging from 45% in Yorkshire and Humber, to 100% in the North-East.⁴ This may reflect the known unequal provision of ICU beds across England prior to the pandemic.
12. Unfortunately, following the pandemic, ICU capacity has not improved in a uniform way, and this potentially adds to pre-existing health inequalities.

² INQ000352888, Report from The Faculty of Intensive Care Medicine titled Critical Capacity: A Short Research Survey on Critical Care Bed Capacity, dated March 2018.

³ INQ000352878, Web Article from the King's Fund titled Critical care services in the English NHS, dated 25/11/2020; Oral briefing by NHSE.

⁴ INQ000389244, DB1 - Witness Statement provided by Dr Daniele Bryden on behalf of Royal College of Anaesthetists, Faculty of Intensive Care Medicine, and Association of Anaesthetists, dated 18/12/2023.

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13. The role of anaesthetists is vital: they are central to surgery; can lead enhanced perioperative care services; and offer critical support in maternity care and a range of other emergency and planned services.
14. In early 2020, the shortfall of anaesthetists across the UK had reached 1,400.⁵ Anaesthetic workforce shortages were a key factor behind the steadily growing surgical waiting lists in preceding years – and these significantly increased when anaesthetists were redeployed to bolster ICU capacity during the pandemic.
15. Redeployment also impacted on other services that rely on anaesthetists, such as maternity services, where there is a constant need for their expertise. In maternity services anaesthetists are a vital part of the team providing anaesthesia, pain relief and resuscitation services during caesarean sections and other procedures, including life threatening emergencies. In most cases, this work was able to continue during the pandemic, but there were a minority of cases where women in labour were affected by lack of anaesthetists to administer epidurals for pain relief.⁶
16. The shortfall of anaesthetists now stands at 1,900.⁷ This limits the rate at which the NHS can perform operations and risks a repeat of untenable waiting list increases and understaffed maternity units were another crisis to occur.
17. We therefore emphasise to the Inquiry the importance of investment to boost anaesthetist numbers in order to provide reserve capacity for ICU; address the post-pandemic backlogs; and to ensure women have timely access to the full range of anaesthesia services that they might need during childbirth.

Admission to intensive care

18. We note that the Inquiry has paid particular attention to ICU admission decisions, and the lack of guidance for how clinicians should act if demand for ICU exceeds supply. This was an issue of concern to some of our members during the first wave of the pandemic.

⁵ INQ000352934, Written evidence submitted by the Royal College of Anaesthetists, dated September 2021.

⁶ COVID-19 and access to labour epidural analgesia in UK hospitals, May 2020 [<https://pmc.ncbi.nlm.nih.gov/articles/PMC7272840/>].

⁷ RCoA Manifesto, Anaesthesia: solutions for an NHS in crisis, dated 8 May 2024

19. It is important to acknowledge that before, during, and after the pandemic, ICU admission decisions were and continue to be made based on a patient's condition, the trajectory of the condition, its treatability, and any wishes they may have declared. A judgement is made about whether the patient needs, and would benefit from, ICU treatment, or whether other forms of care and treatment are more appropriate.
20. This fundamental decision-making process remained in place throughout the pandemic. However, in the first wave, clinicians were forced to make decisions knowing little about Covid-19, or how intensive care treatments would affect its progression, meaning the benefits of ICU treatment could not be effectively balanced against the potential burdens. As the pandemic progressed, knowledge developed rapidly and by the second wave decision-making was more informed.
21. During the pandemic there was also a need to shift exploration of the appropriateness of ICU treatment to earlier in the admission pathway. Prior to Covid-19 these discussions would usually be held by the intensive care team at the point of referral. However, during the pandemic, intensive care staff were so stretched that ward-based teams were required to take on a greater role than usual in these discussions. To facilitate this, the NICE guideline NG 159, and an accompanying toolkit of resources, was produced.
22. One concern, held by some of our members, particularly during the first wave, was that situations could have arisen where the number of patients needing ICU treatment could have exceeded capacity.
23. Such eventualities could not be ruled out and we believe they should have been planned for. FICM advocated for a statement related to such planning during the development of NICE guideline NG 159. Despite such efforts, FICM did not have final sign off on the guidance and ultimately references to such situations were not included.
24. We were also of the view that if any guidance was produced for such situations, it needed to be from a national statutory body, such as NICE, and have applicability across all four nations, with wide support from the medical profession and public. This was for many reasons, including giving reassurance to doctors concerned about legal challenge to their decisions, ensuring consistent nationwide advice, and maintaining patient and public confidence through transparent and consistent decision-making.
25. Fortunately, during the pandemic, the need for such guidance did not occur as intensive care capacity was expanded sufficiently to meet demand, albeit with reduced standards,

such as much lower staffing ratios. However, had these standards been maintained, critical care resources would have been limited, necessitating difficult triage decisions. Also at the outset of the pandemic, there was no guarantee that capacity would be sufficient – nor is there any guarantee that it will be sufficient in any future pandemic. Forward planning is, therefore, important.

Recommendations

26. In light of our members' collective experiences prior to and during the pandemic, and to aid preparedness for any future crisis, we would like to take this opportunity to highlight a number of points for consideration as recommendations.
27. We propose that intensive care capacity should be viewed and managed as a national resource. To achieve this, baseline intensive care capacity should be expanded across the UK, backed by investment in beds, infrastructure, PPE, equipment, and most importantly, staffing. This must be supported by a clear and consistent UK-wide methodology for objectively measuring bed occupancy and workload strain across individual units. Such a measure does not currently operate.
28. Anaesthetist numbers must also be increased to ensure elective and emergency operations can take place, support maternity and other services, and the provide reserve ICU capacity were another pandemic to hit.
29. To support this, we propose that the government allocates additional funding to allow more doctors to enter specialist intensive care medicine and anaesthetic training posts.
30. The alarming bottleneck in the medical training system between foundation training and speciality training needs to be addressed. Last year across the UK around 20,000 foundation-level doctors applied for just 8,000 speciality training places – leaving 12,000 unable to progress.⁸ At a time when the NHS is in desperate need of more doctors, this bottleneck must be urgently addressed.
31. While some efforts have been taken to boost staffing levels – including a one-off allocation of 114 extra ICU training places in 2020⁹, and an increase of 70 extra higher anaesthetic

⁸ RCOA, Anaesthesia: Solutions for an NHS in Crisis, Manifesto 2024

[https://rcoa.ac.uk/sites/default/files/documents/2024-05/RCoA-Manifesto2024_FINAL.pdf]

⁹ FICM Workforce Databank for Adult Critical Care, May 2021

places in 2022 recurring for the following two years¹⁰ - going forward, increases like these must be made permanent and built upon, as need is far higher. In anaesthesia, the training system could accommodate at least 59 extra core training places and 81 higher training places per year over and above the aforementioned allocation.¹¹

32. FICM, in conjunction with the Intensive Care Society (ICS) have also developed clear staffing standards in the 'Guidelines for the provision of intensive care services'.¹² We urge the Inquiry to recommend that all UK ICUs are adequately supported to meet these standards.
33. Finally, improved pandemic planning and preparation should be established across the healthcare system, with clear frameworks to facilitate stakeholder collaboration during future surges. We recommend this should include the creation of a framework to develop such guidance rapidly for any future pandemic where demand for ICU treatment may exceed supply. This framework should focus on identifying the necessary stakeholders to develop such guidance, with a defined process for collaboration and communication.
34. We recommend that any guidance takes account of ICU capacity across all UK nations and allows for patient transfers between the nations where necessary. This would help avoid situations where one part of the UK was forced to limit ICU admission even though capacity existed elsewhere. Restrictions in one part of the UK, but not others, could exacerbate pre-existing health inequalities.

Conclusion

35. We would like to conclude by thanking the Inquiry for including our organisations as Core Participants in Module 3, and we offer our support in the development of the Inquiry's report and the implementation of its recommendations.

¹⁰ RCOA, The Anaesthetic Workforce: UK State of the Nation Report 2024

[<https://rcoa.ac.uk/policy/policy-public-affairs/anaesthetic-workforce-uk-state-nation-report-2024>]

¹¹ Ibid

¹² INQ000361989 - Guidance from Faculty of Intensive Care Medicine and Intensive Care Society, titled Guidelines for the Provision of Intensive Care Services, dated July 2022.