

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#)
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**This response was submitted to the [Health and Social Care](#)
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HSC 05

Ymateb gan: | Response from: FCIM, WICS, WCCTN



A Healthier Wales

Workforce Strategy for Health and Social Care

Evidence Submission Intensive Care Medicine: The Faculty of Intensive Care Medicine (FICM), Welsh Intensive Care Society (WICS) and Wales Critical Care and Trauma Network (WCCTN)

1 Introduction:

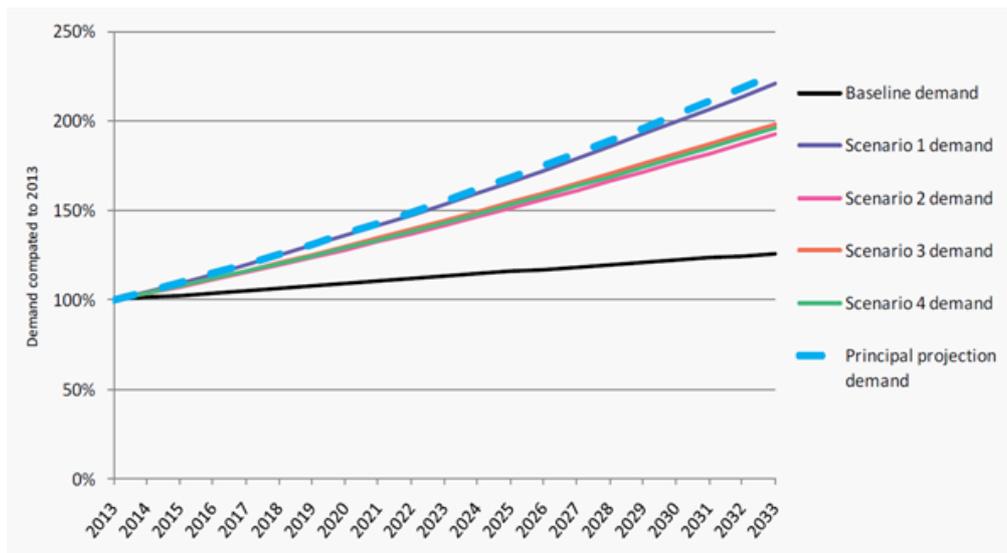
- 1.1 Intensive Care Medicine (ICM) was recognised by the General Medical Council as an independent medical specialty in the UK in 2010. The Faculty of Intensive Care Medicine (FICM) is the largest organisation of Critical Care medical professionals in the UK. The COVID-19 pandemic illustrated the unique expertise of ICM in treating the critically ill. Whilst understanding of the specialty of ICM has increased, considerable knowledge gaps continue to exist as to how ICM is integral to wider healthcare delivery. A better understanding and knowledge of ICM's role in the acute hospital environment is fundamental to modernising NHS Wales.
- 1.2 FICM is the professional and statutory body for the specialty of Intensive Care Medicine, the doctors who lead Critical Care Services, Advanced Critical Care Practitioners (ACCPs), and Critical Care Pharmacists. It has close professional links with the bodies representing nurses and Allied Health Professionals working in intensive care. The Faculty works on behalf of its members and the wider service to promote education and standards, influence and define national policy, and most importantly, improve patient outcomes.
- 1.3 In Wales, FICM works closely with the Welsh Intensive Care Society (WICS) and the Wales Critical Care and Trauma Network (WCCTN) in a combined effort to improve Critical Care services, inform service development and implement change across Wales.
- 1.4 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 enables the provision of organ support, the investigation, diagnosis, and treatment of acute illness, systems management and patient safety, ethics, end-of-life care. It also provides essential support for patients in their mental and physical recovery from critical illness and support for their families. Treatment can be delivered in a dedicated physical space (intensive care unit, high dependency unit or Critical Care unit) or as an outreach service to the wider 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.
- 1.5 Critical Care lies at the heart of 21st century secondary care, underpinning all other areas of acute hospital care. When Critical Care capacity cannot meet demand, other services (particularly elective services) will suffer as elective demand can be cancelled whilst demand from emergencies cannot.
- 1.6 Critical Care provides a crucial element and safety net within planned elective surgical pathways (e.g. cardiac, vascular, neurosurgery, and cancer). This vital role was illustrated during the first and second waves of the COVID-19 pandemic, when the necessary

expansion of Critical Care bed capacity for patients with COVID-19 brought many other hospital services to a standstill due to the lack of Critical Care capacity for almost anything other than care of patients with COVID-19 infection.

- 1.7 COVID-19 illustrates two other issues: Firstly, elective high risk surgical patients may only require a Critical Care stay of 1 to 2 days, whilst 25% of patients ventilated with COVID-19 had a Critical Care stay of > 25 days. One patient critically ill with COVID-19 could therefore result in more than 25 elective cases being cancelled. Secondly, patients with COVID-19 must be isolated from elective high-risk cases to ensure patient safety, which reduces Critical Care capacity for elective work. The more patients critically ill with an infectious disease such as COVID-19 that need Critical Care, the fewer staffed Critical Care beds there are for elective cases.

2. Critical Care capacity in Wales:

- 2.1 There is limited Critical Care capacity in Wales even during normal times.' This capacity deficit was brutally exposed by the first waves of the current pandemic, though Critical Care services responded, as best they were able to the challenge. A response to increased demand has become increasingly hard to maintain over time by those working in Critical Care. Critical Care staffing across the multidisciplinary team, and the recruitment and retention in the specialty just to maintain the current service, is a constant challenge for many units. The necessary expansion will require a strong coordinated response by directorates, Health Boards, Health Education and Improvement Wales (HEIW) and Welsh Government.
- 2.2 The limited Critical Care capacity and scale of need were recognised by Welsh Government prior to the pandemic. https://gov.wales/sites/default/files/publications/2019-07/task-and-finish-group-on-critical-care-final-report_0.pdf
- 2.3 The COVID-19 pandemic has demonstrated that Critical Care capacity should be viewed as a national resource. Improving Critical Care capacity in Wales, in-line with economically comparable countries would provide much greater resilience in the event of later crises. It would help prevent a severe backlog of demand from other NHS services, improve standards of care and improve outcomes across a range of NHS services. It would also improve the physical and mental health of staff in Critical Care.
- 2.4 There are 152 intensive care beds in Wales. This number of Critical Care beds per capita is the lowest of all the Home Nations and amongst the lowest in Europe (Germany 27 beds/100,000 population, versus England 8 beds/100,000 population, versus Wales 5.4 beds/100,000). The increasing gap between Welsh and wider UK Critical Care provision is described in a recent study by the [Welsh Intensive Care Society](#), and illustrates how Critical Care capacity has been unable to keep pace with the needs of an ageing population in Wales.
- 2.5 Critical Care bed occupancy pre-pandemic ran at over 95%, which is more than 20% over the recommended 75% occupancy. The higher the bed occupancy the more likely elective cases will be cancelled, and the greater the unintended impact on response to deteriorating patients in the wider hospital, and on other services e.g anaesthesia and emergency departments.
- 2.6 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 (see below). There are no grounds to suspect COVID-19 will reduce this trend; it is more likely COVID-19 will increase bed use due to long Critical Care stays.



The increasing population in Wales, an ageing demographic, clinical advances, and increased public and professional expectations all contribute to increased demand. Thus, even pre-pandemic there was a significant case for increase in staffed Critical Care capacity and more efficient use of existing resources.

3. How might the organisation and work of NHS Wales and care services in Wales be reformed?

- 3.1 The lack of staffed Critical Care capacity in Wales needs to be addressed urgently. The key issues are a need for increased staffing across the multidisciplinary team and for Critical Care infrastructure. If capacity is not increased, patients will suffer, and services dependent on Critical Care support will also suffer, particularly when trying to meet demands for elective higher risk surgery and urgent cancer care. To address Critical Care capacity and staffing requires a coordinated, orchestrated approach with implementation by NHS Wales, Welsh Health Boards, Critical Care Directorates, FICM, WICS, HEIW and WCCTN. Health Education and Improvement Wales have a fundamental role in recruitment of staff and their retention.
- 3.2 A phased expansion in Critical Care services is required independent of pandemic demands. This requires the recruitment of nursing, medical and allied health professionals to meet national standards. Without increased capacity, future surges in demand will continue to require staff redeployment from outside Critical Care such as anaesthesia, theatre staff, and recovery areas.
- 3.3 The Faculty suggests a clear focus on the right patient, in the right place at the right time. Critical Care is a precious resource and should be equally available for those who need it, when they need it. Where Critical Care is delivered however is dependent on the ability to provide necessary specialist care. Increasingly care is initially delivered in a specialist tertiary setting with subsequent transfer back to a patient's own Local Health Board. A network approach is required with resources, including staffing and transfer services, reflecting these changing clinical requirements. Critical care delivered as close to home as possible remains a necessity.
- 3.4 There are two key patient groups whose care could be delivered outside of acute Critical Care units freeing up acute capacity. With appropriate system re-organisation and targeted investment, Enhanced Care Units and Long-Term Ventilation units, alongside a necessary expansion in Critical Care provision for acute hospitals, could significantly ease capacity constraints.
 - 3.4.1 **Enhanced Perioperative Care Units:** Most high risk elective surgery traditionally thought to need critical care support could in fact be better and more efficiently

delivered by an [Enhanced Care service](#). This would free up acute Critical Care beds for those critically ill and provide a more efficient elective service for those requiring supportive care. In most hospitals, the [Enhanced Perioperative Care Service](#) would be geographically separate from Critical Care and only take elective surgical cases (non-COVID patients), whilst being staffed more efficiently by an elective surgical/anaesthetic team. The Faculty has developed specific guidance for the staffing and standards required to develop such a service.

3.4.2 Long-term ventilation (LTV) and weaning units: After a protracted period of ventilation, some patients are considered stable and no longer critically ill. Such patients' needs are better met in units designed for this purpose, enabling long-term weaning from ventilatory support (with specialist rehabilitation input), or enacting steps required for life-long ventilation at home. Currently, many of these patients are cared for in acute Critical Care units in Wales as there is insufficient capacity in the regional service. LTV needs physical expansion and staffing.

3.5 Infrastructure of Critical Care services: Many units do not meet the recommendation that 20% of their bed capacity is single room occupancy (NHS Health Building Note 04-02). COVID-19 highlighted the impact of an infectious disease and consequent Infection, Prevention and Control measures. This infrastructure deficit needs addressing through estates development. If modernisation does not occur, many units will continue to expand into other areas of the hospital at times of increased community prevalence of infectious diseases e.g., influenza or SARS-CoV-2, and thereby impact on elective services. There is a risk that elective surgery will be impacted by seasonal winter pressures and on-going SARS-CoV-2 waves.

4. What can be done to help?

4.1 Recognition of Advanced Critical Care Practitioners (ACCPs). ACCPs are clinical professionals that form part of the multidisciplinary team responsible for patient care during their Critical Care admission. The ACCP role is a way of working for health professionals, which crosses historic professional boundaries. These are highly experienced and educated practitioners who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions to ensure that patients receive timely, personal, and effective care. The Department for Health and Social Care's (DHSC) review of Medical Associate Professionals (MAPs) in 2019 did not include ACCPs. ACCPs are currently developed from experienced nurses, physiotherapists, paramedics or other related health care professionals: this further denudes a Critical Care and acute hospital workforce. If the DHSC recognised ACCPs as MAPs, it is envisaged that ACCPs may also be drawn from other emerging healthcare roles including those entering healthcare from science backgrounds.

4.2 Advance Care Planning and End of Life Care. Educating the public is necessary to enable realistic expectations at the end of life. The pandemic has illustrated the importance of individuals being included in decisions regarding their care, particularly those who are elderly and frail or those with significant chronic illnesses. Shared decision-making is regarded as best practice, but an individual's lack of capacity when critically unwell often precludes their involvement in decisions about treatment. Information regarding patients' expressed wishes and beliefs is needed to minimise confusion and conflict. Clear communications about advance care planning and whether treatment involving intensive care admission is likely to achieve a desired outcome would be beneficial to all concerned.

4.3 Life After Critical Illness and Intensive Care Services. Historically, there has been no national and only limited local investment in managing the aftermath of complex critical illness. This means patients are frequently left with no clear avenue to find help with the physical, psychological, cognitive, and social consequences of critical illness. It has also led to a progressive inequality, with care available dependent on a location that a patient falls

critically ill. Such patients frequently struggle to return to their previous quality of life, whereas appropriate help could have improved their outcome if provided by those with an understanding of their recovery. This contrasts starkly with single organ disease, such as heart, respiratory, head injury or stroke, which all have well defined rehabilitation pathways. The pandemic will be responsible for a large unmet need in the recovery phase of the illness.

- 4.4 **Increase National Training numbers in Wales through HEIW.** There was a pre-existing deficit in trained Intensive Care doctors (intensivists) in Wales that the SARS-CoV-2 pandemic highlighted. Additional medical staff were redeployed, particularly from Anaesthesia and Respiratory Medicine where transferable skills were most readily available to fill this deficit. We need an expansion of the intensivist workforce such that Critical Care needs are not reliant on other services: we cannot continue to deplete other services of their workforce when they are needed for the own work and changing demand. National Training Numbers (NTNs) are allocated by HEIW. ICM has seen a steady increase in NTNs in Wales, but many Intensive Care Units are not staffed by trained intensivists. In future we need an increase in ICM NTNs to staff an increase in routine ICM capacity, provide more ICM workforce resilience and reduce demand on other services for surges in demand.
- 4.5 **Looking after staff:** The mental wellbeing of NHS staff during the pandemic has been well documented. The impact on Critical Care staff has been particularly harsh. Efforts to support staff and address mental health have been made but on-going support and recognition will help recruit and retain staff in the Critical Care workforce.
https://ficm.ac.uk/sites/default/files/critical_staffing_2_a_best_practice_framework_for_well_being_and_sustainable_working_in_critical_care.pdf
- 4.6 **Public Health and Education:** The health of the people of Wales is crucial to managing Critical Care demand. The COVID-19 pandemic has starkly illustrated that obesity and social deprivation are closely linked to Critical Care demand, and together increase the risk of critical illness and death. If obesity and social deprivation aren't tackled, the requirement for Critical Care beds per head of the population will be higher.
- 4.7 **The Environment:** Our environment and sustainable health care should be seen as priorities. Good access to Wales's natural resources is good for mental and physical health. Environmental pollution is recognised as increasing the risk of illness, e.g. acute asthma and the need for health care services including Critical Care.
- 4.8 **Research:** Critical Care research in Wales during the pandemic has been a highlight of the NHS Wales response, demonstrating its true value and positive impact upon outcomes within Wales, the UK and worldwide. These successes need to be built upon, resourced and supported within NHS Wales in future.