Miss Anna Ripley
Faculty of Intensive Care Medicine
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London, WC1R 4SG

Thursday 5 February 2015

Dear Anna,

RE: ACTA Response to Consultation Regarding Guidelines for Providers of Intensive Care Services

Thank you very much for the opportunity to read and respond to the 'Guidelines for Provision of Intensive Care Services' (referred to here as GPICS). We would like to set out below the considered response from the Association of Cardiothoracic Anaesthetists (ACTA) and the Cardiothoracic Intensivists in ACTA (CIA) following a wide ranging consultation with the membership.

Firstly may we offer our congratulations to all those involved in the production of this very comprehensive, well researched, well organised and well presented document. ACTA represents 500 clinicians in the UK and high quality critical care is a priority for our members, our stakeholders in related specialities and disciplines and most importantly our patients. Whereas we were disappointed that we were not invited to contribute as a stakeholder group, as our members oversee around 15% of UK critical care activity, we have had some interaction around potential difficulties with GPICS. In responding to this document, rather than review it line by line, we would like to make some broader points of critical clinical relevance to our services and our patients. Attention to these points will be crucial to maintain and improve the delivery of high quality cardiothoracic critical care medicine (CTICM).

Summary of ACTA response:

- ACTA is happy to endorse these Guidelines as we believe it promotes high quality care and will benefit cardiothoracic patients

- Cardiac ICM currently has inadequate capacity to deliver the required level of service to our stakeholder specialities

- Quality is already intensely monitored in cardiac ICM with work in place with ICNARC to develop this further. Big data research is needed to understand how best to deliver excellent cardiothoracic critical care for our patients

- The Standard in relation to Consultant rotas and continuity of care is expressed with different wording in the Core Standards document and the GPICS. We are specifically endorsing Standard 1.1.2 on page 30 of the GPICS

- In 2014 more than half of UK CT Units have combined Consultant on call rotas covering both cardiac anaesthesia and critical care. A defined and realistic transitional period will be needed to split these rotas

- Training numbers in cardiothoracic ICM currently are inadequate to realise the expansion of Consultant numbers required for universal compliance within 2 years

- Significant resources will need to be invested in training and Consultant workforce expansion for UK cardiothoracic units to achieve compliance with these Guidelines. We hope that FICM and NHS England will support this.

1. <u>Cardiothoracic Intensive Care</u>

As of 2014 there are currently 36 cardiothoracic intensive care units in England and Wales with a total of 660 beds (constituting approximately 15% of UK Intensive care beds according to the data contained within the GPICS). The majority of these beds serve post cardiac surgery patients, with an ever increasing number of beds devoted to acute cardiology (including out of hospital arrests), thoracic surgery, vascular surgery, trauma and tertiary respiratory patients including extracorporeal therapies. There is very little published evidence on the optimum way to deliver cardiothoracic ICM care and none is offered in this document. CTICM is a subspeciality emerging from the transition from surgeon led surgical ICM to intensivist led ICM over the last 20 years. This has been actively promoted by ACTA and we consider it has been one of our key achievements, although there is still plenty of work to do in this regard. Financial and capacity constraints are as prevalent within CTICM as other ICM disciplines. Bed occupancy rates are very high at over 90% in the majority of units with increasing cancellation rates for elective cardiac surgery and waiting lists and waiting times on the rise. An issue with deaths of patients on long waiting lists

for Wales has been flagged, this is unknown in the other nations where this data is not currently collected.

2. Quality Accounts

CTICM is probably the branch of ICM under most scrutiny. Although the surgical mortality figures are published with named surgical responsibility, the rigor of the data collection and the interventions triggered have had significant implications for CTICU quality improvement. In addition the National Cardiac Benchmarking Collaborative with leadership input from ACTA is a unique and highly successful multidisciplinary venture with a detailed annual report including many detailed CTICU quality accounts. Finally, ACTA has worked closely with ICNARC to initiate and promote ARCTIC (Assessment of Risk in Cardiothoracic Intensive Care) with an increasing membership of contributing CTICUs.

3. Consultant Workforce

Most of the above mentioned patient casemix is looked after by ACTA members in their cardiac intensive care roles, 95% of whom work flexibly to provide cardiac anaesthesia within their job plans. This has been a successful model of delivering cardiac intensive care as the skill set for cardiac surgical intensive care and cardiac anaesthesia are closely aligned. In larger centres and centres with more mixed patient populations, the non cardiac anaesthetist workforce make a small and vital contribution. We have significant evidence from our members around the country that recruitment of trained cardiac intensivists is becoming more difficult. It is our experience that general intensivists without cardiothoracic training do not apply to work on cardiothoracic units. These difficulties are most acute in smaller predominantly surgical CTICUs - permanent splitting of non compliant rotas between CTICU and cardiac anaesthesia will be difficult to achieve in a short time frame. This is not due to a lack of recognition of the need for continuity of care, rather the lack of an appropriately trained and interested pool of trainee recruits, an ageing consultant workforce together with current financial constraints in the employing trusts. In a survey conducted by the CIA one year ago, 20 out of 35 CTICUs had a rota whereby consultants were on call for both cardiac anaesthesia and CTICM. The majority of units had a plan to become compliant with Core Standards. We hope that there is a recognition that this will take some time to transition to compliance with the Core Standards as published and will also have a significant cost implication for Trusts. We trust that the FICM and ICS will support measures to increase placement of ICM trainees into CTICUs to facilitate these changes.

4. Training

Training in CTICM has mostly been through cardiac anaesthesia programmes which may be in programme, out of programme or post CCST. 18 months to two years total intermediate and advanced training is commonly accepted as the minimum training requirement due to the essential need to acquire skills and experience in cardiac anaesthesia, critical care and perioperative echocardiography. Thus far there have been a very limited number of advanced intensive care trainees who spend time on cardiothoracic units, this group of trainees have been centred in tertiary general

intensive care units. It is essential that this training pathway should expand and include CTICM in order to provide the required Consultant expansion to successfully implement these Guidelines in all units. Trainees will significantly benefit from the learning opportunities within cardiothoracic intensive care, not least the opportunities for echocardiography training and accreditation.

Trainee rotas vary widely across the UK. Very few ICM trainees are part of CTICM rotas and together with the reduction in anaesthetic trainees, this presents significant difficulties for many units. Smaller predominantly surgical CTICUs are frequently staffed by resident cardiothoracic surgical career grade trust doctors with an increasing complement of Advanced Practitioners. Larger and more metropolitan units make use of a migrant workforce of trained anaesthetists and intensivists from Europe and further afield as clinical fellows undergoing higher sub specialist training. Financial constraints in many Trusts make recruitment to these rotas problematic.

In conclusion, ACTA supports high quality cardiac intensive care and we are happy to endorse these Guidelines for the pursuit of excellence in the care of our patients. Whilst offering our endorsement, we hope there will be an understanding that these changes will be expensive for cardiac centres, will require time for appropriate recruitment and will carry a short term risk of reduced service delivery during transition. We hope that the Faculty of Intensive Care will support enhanced training in Cardiothoracic Intensive Care Medicine which will be necessary to facilitate the changes.

Yours sincerely,

Dr Noel Gavin, President Association of Cardiothoracic Anaesthetists

Dr Nick Fletcher, Chair Cardiac Intensivists in ACTA