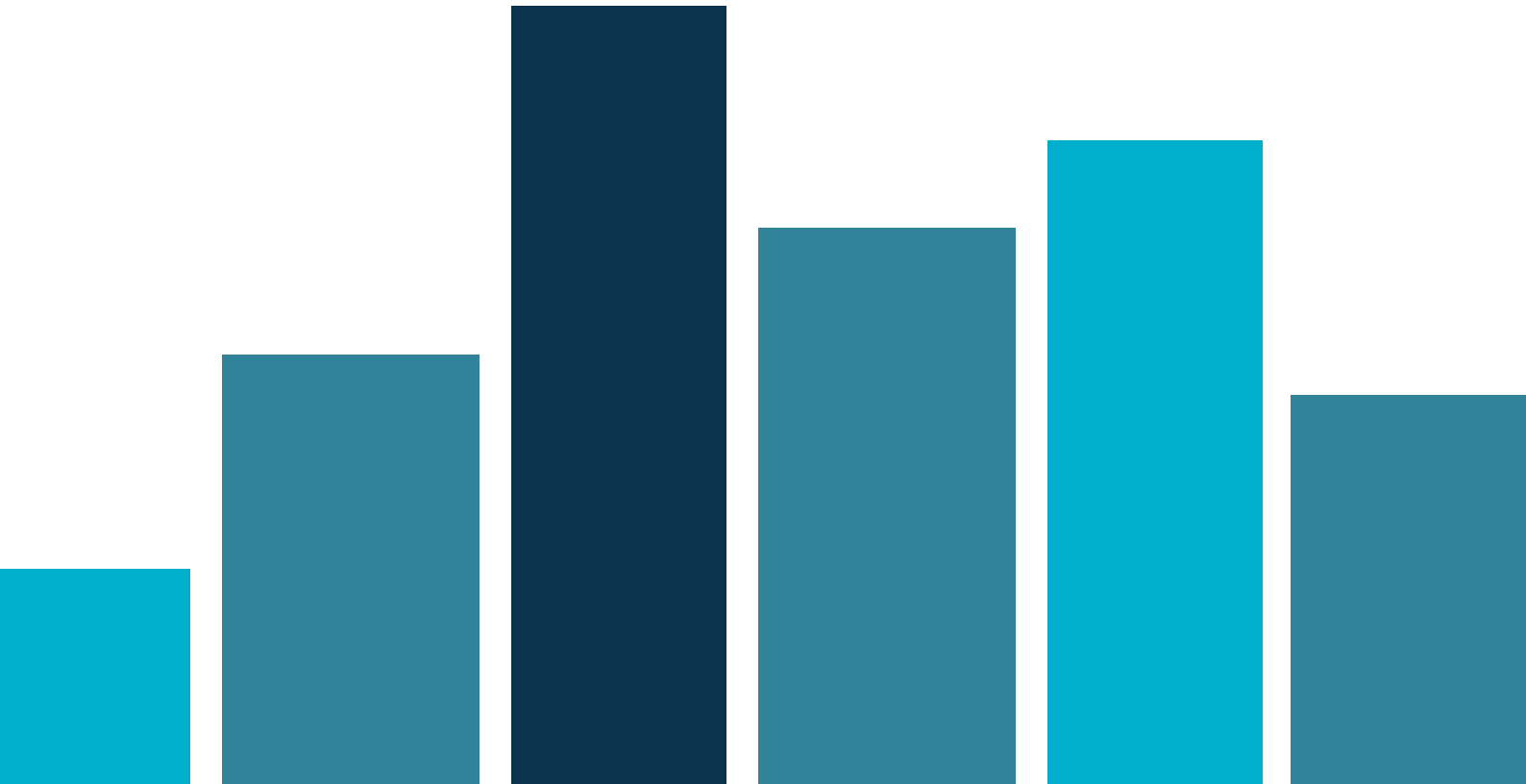
The Faculty of Intensive Care Medicine

CRITICAL STAFFING #1

A best practice framework for **SAFE AND EFFECTIVE CRITICAL CARE STAFFING**

June 2021



What is the Critical Staffing series and who are they for?

The Critical Staffing series brings together recognised and practical Best Practice Frameworks on staffing. The frameworks have been produced to guide commissioners, hospital management and Critical Care teams on how to ensure they have developed safe, effective and sustainable staffing in Critical Care.

The response of Critical Care services and staff to the public health threat of Covid has been exemplary but necessitated unprecedented changes to staff working.

See the Faculty's 2020 *Voices from the Frontline of Critical Care Medicine* report here.

The impact of short-term pandemic response working practice changes now need to be considered within the context of a service that needs to expand, and will continue to be subject to pressure. Retention of staff across all the Critical Care multidisciplinary team and for a lifelong career in ICM requires attention.

What is Critical Staffing #1 covering?

Critical Staffing #1: A best practice framework for safe and effective Critical Care staffing brings together best practice considerations to ensure you are recruiting, managing and developing a sustainable team, with particular reference to the intensive care medical workforce.

The aim is to ensure you are:

- Recruiting staff appropriately
- Proactively managing rotas, night work and on-call
- Working to improve job satisfaction
- Considering the implications for staff from diverse backgrounds and ages
- Planning for the future of your workforce

We have tried to provide key areas where you might like to concentrate your practical efforts.

Contents

INTRODUCTION: UNDERSTANDING THE RISKS

What is the current situation and why do we all need to act now?

Critical Care sits at the heart of all acute hospitals. It is not possible to run safe and effective acute care services without a fully functioning Critical Care service. Critical Care services that are not functioning well impact on other services e.g. Emergency Care, Anaesthesia and Acute Medicine departments. Critical Care departments cannot undertake their central work without an adequate and engaged workforce.

Critical Care is an acute environment, with multiple factors that risk the wellbeing of its staff, including fast-paced life and death decisions. Critical Staffing #2 covers staff wellbeing in further detail.

There are now a number of other stressors acting upon staff and wider Critical Care resources that are changing a stretched system to an overstretched system.

Increasing stressors include:

- **Increasing demand for Critical Care.** Demand has increased year on year for Critical Care services. This has been for multiple reasons, including (a) a growing population, (b) an ageing population, (c) developments in surgery and medicine that allow for procedures to take place that previously would not have been impossible.
- **Resource management.** We have not seen a significant national growth in resources and workforce for Critical Care in 20 years. Increasing amounts of clinical time are spent on managing these limited resources (i.e. bed chasing) rather than in direct patient care.
- **Changing clinical demands.** Increasing numbers of clinical pathways now require involvement of Critical Care services and support. The benefits to patients are acknowledged and being realised eg the National Emergency Laparotomy Audit highlighted unmet need for Critical Care provision after emergency laparotomy, which is being addressed. Improvements in interventional care pathways for many acute medical conditions eg out of hospital cardiac arrest, acute stroke, CAR T therapy also require more involvement of Critical Care services to support improvements in patient outcome.
- **Separation of Covid and non-Covid care pathways.** Many Critical Care units have not been designed to provide a Covid secure environment in terms of cross infection. The impact of keeping 2 groups of patients separate, the infected from the non-infected can result in a 30% drop in capacity in some units.
- **Managing junior rota tiers.** Changes in other specialties' training programmes impact on trainee numbers and seniority (competencies). The addition of Intensive Care Medicine to Internal Medicine Training increases the number of medical trainees, but they arrive with fewer ICM competencies, whilst the impact of changes in Intensive Care Medicine training within Anaesthetics training potentially reduces the number of senior trainees with competencies. ICM CCT post numbers are still short of providing an ICM trainee tier in most hospitals. ACCPs have contributed enormously to patient care in some hospitals, but their numbers also need to be increased.
- **The pension framework.** Consultants in ICM disproportionately work contracts of 12 Programmed Activities or more. The implications of the pension framework has therefore meant that many consultants have dropped to 10 PAs to avoid financial penalties. Some consultants have retired earlier than initially planned, or retired and returned on fewer sessions.

- **Impact of Brexit.** Some parts of the UK are already feeling the impact of Brexit on staff recruitment and retention. Fears of increasing difficulty travelling between other EU countries and the UK add to the uncertainty of travel restrictions relating to Covid.

Evidence Based Work Planning, beyond a work diary

Sheffield Teaching Hospitals general Critical Care service consists of 34 beds across 2 floors on one site and 8 beds on a second site 4 miles away.

In 2014, we needed to critically appraise how we used our medical workforce for training and service needs and make a strong case for the benefit of the ACCP workforce within our service.

'Activity sampling' was used to record a number of data points illustrating the type of tasks medical staff were spending time on during any given shift. Volunteer nursing staff were trained in the use of a portable bar code scanning device. Overall, 134 hours of clinical time were monitored and over 7000 data points were collected.

Several changes were made:

- *3 new ICM consultants posts were created to support resident consultant working to 10pm each weekday evening at the larger unit.*
- *One ICM trainee was focused on advising on direct patient referrals only, which led to a timelier response for patients.*
- *Critical Care withdrew from attendance at trauma calls in favour of the Anaesthesia service, as this was consistent with the response needed for a major trauma centre.*
- *The ACCP workforce also had clearly identified roles in both units that supported Foundation doctor training as well as service delivery.*
- *All staff groups had new working patterns and rotas developed to allow for better matching of staffing to workload, reducing the burden of stress associated with twilight and weekend shifts.*

Dr Danny Bryden, Sheffield

What is the impact on patients and the wider NHS?

Due to Critical Care's pivotal role across the hospital, the implications of a depleted Critical Care workforce and resource are considerable.

Due to limited Critical Care resources, emergency cases need to be prioritised, and **elective operations are therefore cancelled or postponed,** leading to longer waiting times. The need for Covid secure pathways has exacerbated that. Due to the lack of staffed beds, it is not unusual for emergency cases to wait longer than is safe before being admitted to Critical Care; leading to **poor use of NHS resource and increasing patient safety risks.**

Implications for Critical Care include:

- **Reducing quality of patient care and poor patient experience.**
- **Increasing non-clinical transfers.** According to our *Critical Capacity report (2018),* 4/5 of units had to transfer patients due to lack of bed capacity.
- **Absenteeism, burnout and adverse health for Critical Care staff.**

- **Increasing reliance on locum medical cover and nursing bank shifts.** In addition to the associated expense, there is a risk of being unable to fill the shift requiring more senior staff to 'act down' eg consultants covering resident trainee shifts, the supernumerary nurse in charge taking care of a patient on a shift in addition to leadership duties, operating with reduced or absent staff increasing burdens on remaining staff eg pharmacy, physiotherapy.
- **Eventually, patient safety risks. As every option is used up to manage the current shortage, there is a risk that any further demand will compromise patient safety with the potential to increase episodes of error and/or harm.**

Key messages from the Critical Care workforce data

On the Faculty's workforce webpages we collect key data sources on adult Critical Care data. Here are some key messages from that data.

- **Demand.** Hospital Episodes Statistics (HES) data on adult Critical Care activity demonstrates an average of 4% increase in demand for Critical Care services per year. This is triangulated with work undertaken by both the Centre for Workforce Intelligence (CfWI) and the Intensive Care National Audit & Research Centre (ICNARC).
- **Bed occupancy.** Bed occupancy is a very blunt tool to measure patient flow to and from Critical Care. However, across the UK, most units are running pre covid at c.85-100% occupancy, which is considered above agreed safe levels.
- **Bed closures.** Two fifths of units have to close beds on at least a weekly basis due to workforce shortages (FICM Critical Capacity 2018).
- **ACCPs.** Two thirds of units have not yet been able to introduce an ACCP workforce to support patient care.
- **Doctors.** 15% of consultants in the 2019 Frontline Voices survey are considering giving up ICM before retirement. This is consistent with previous surveys and is not directly Covid related. Lack of workforce and resource are the primary quoted reasons for this decision, not the nature of ICM work as has historically been believed. However, applications for specialist training in Intensive Care Medicine have increased despite, or possibly because of the pandemic but the number of training posts remains lower than required. For consultants, Covid has not increased early retirement plans or dropping Critical Care in favour of a second specialty. In fact, more ICM consultants have expressed a desire to drop anaesthesia sessions than drop ICM sessions.
- **Nursing.** 62% of units do not have a full nursing complement [*FICM Critical Capacity 2018*], with just under 10% of positions in England and Wales empty [CC3N, 2016].
- **Pharmacy.** 11% of units still do not have a dedicated Critical Care Pharmacist (CC3N, 2016). Clinical pharmacists make important contributions to the safety and quality of care provided to Critical Care patients, leading to improved patient outcomes. Funding for most pharmacist posts comes from Pharmacy Departments, which contributes to potential for conflicting work pressures/ time prioritisation.
- **Allied Health Professionals.** The uptake of AHP services in Critical Care across the UK is very variable with many units struggling to develop business cases to develop this workforce eg psychology, speech and language, and rehabilitation services [FICM Workforce Engagement collated input, 2015-2019].

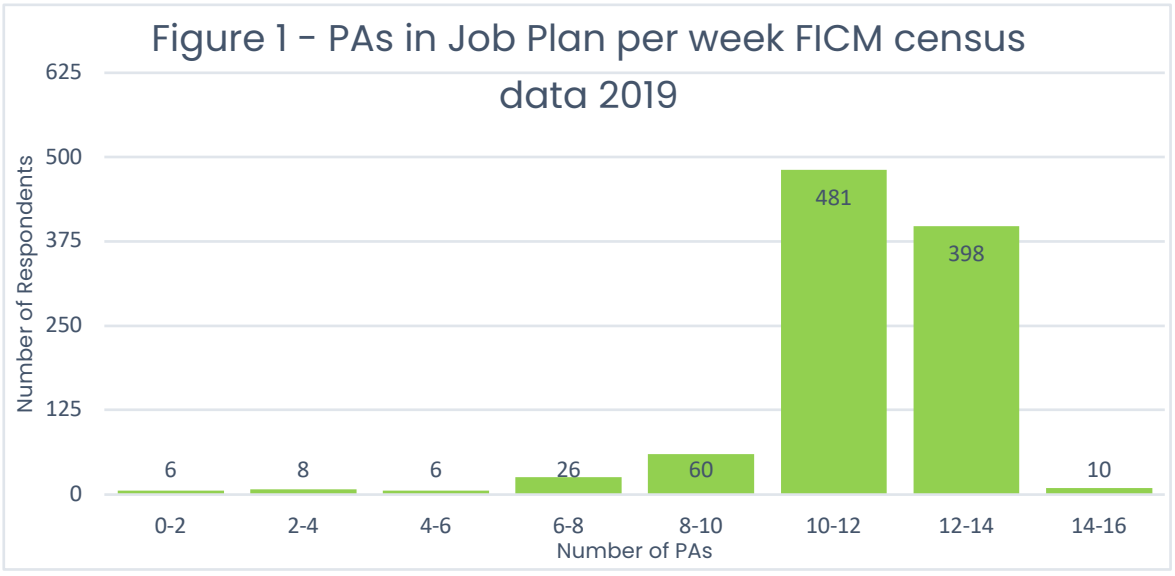
What does the future hold?

There is no sign that the 4% year-on-year increase is likely to trend downwards. Therefore, there will be increasing need for these services that must be proactively addressed. The Faculty is working to match solutions to these rising pressures, including:

- Development and promotion of Enhanced Care services to use NHS resource more effectively in the initial management of patients at risk of critical illness
- Better management of treatment escalation planning, including advanced care planning and end of life care.
- New workforce models, including expanding the ACCP workforce in conjunction with Health Education England (HEE) and promoting pharmacists' vital role in safety for critical and patient care activity.
- Working with NHS bodies across all 4 nations to establish better modelling of HDU and ICU facilities use and how this then links to Enhanced Care services. This includes developing relevant training standards and curricula.

The 'baby boomer' generation of healthcare professionals are getting towards the end of their careers or have already retired. Consultants and other established Critical Care team members will now increasingly be from the 'Millennial' generation. Indications show that Millennials and their Generation Z successors (now entering medical school), have different work-life balance expectations and job satisfaction.

Critical Care services rely heavily on current consultants working over the 10 session standard job plan (average is 11.5 sessions). As the pensionable age continues to rise, Critical Care team members are increasingly concerned about their ability to practice onerous on-call and night shift work into their mid to late 60s. Workforce leads for hospitals and departments risk ignoring a significant future issue if they presume that future generations of doctors will work the same rota patterns with the same job plans throughout their careers. Analysis of current working indicates that ICM consultants will vary their time commitment over their working lives (frequently increasing PA commitment to ICM services before sudden retirement from ICM work). Consideration must be given to the variability in sessional commitment provided by consultants over a career.



EXECUTIVE PROTOCOLS

What is an executive protocol?

The protocols frame the standards, recommendations, prevention techniques and interventions into a succinct checklist so you can evidence that you are undertaking due diligence to ensure you are managing related risks.

PROTOCOL FOR DIRECTORS, MANAGERS AND COMMISSIONERS OF CRITICAL CARE	
Consideration	**Management/Mitigation**
Make effective use of the multiprofessional team	Review of roles, numbers and flexibility of roles within the team
Support team recovery after Covid	Invest in training for peer-led first aid, access to psychology support for those needing it
Address hurdles to developing an ACCP workforce	Use schemes such as the apprenticeship levy to develop the ACCP workforce and remote learning courses from higher education institutions
Address consultant intensivist recruitment difficulties	Consult and work with the local Regional Advisor to review options and mitigations when consultant recruitment has been unsuccessful
Put patient safety and governance at the heart of ICM practice	Actively recruit and support training of critical care pharmacists using business cases to promote their role in safety and governance
Risk Register review	Should include multi-disciplinary staffing to meet GPICS vs 2 standards
Provide staff rest areas	Staff must be able to access, either in the unit or very close-by, break areas to eat, rest and recuperate
Maintain the physical health and safety of staff working at night	https://www.ficm.ac.uk/Fatigue Staff working resident medical type rotas overnight should have access to somewhere to sleep/rest. Other groups should have access to easily accessible rest facilities and quiet spaces during breaks

PROTOCOL FOR CRITICAL CARE TEAM MEMBERS	
Consideration	**Approach**
Put Equality, Diversity and Inclusivity at the heart of the ICM multidisciplinary team	Support those with different training or working patterns eg flexible working. International Medical Graduates (IMG) and international nurses may need support outside the work environment. https://www.ficm.ac.uk/careers-recruitment-workforce/IMGs
Departments without clinical psychologists should consider employing one, or as a minimum develop pathways for providing psychological support	Highlight the importance of psychological wellbeing to retention of staff in a highly pressurised environment
Conduct exit interviews for multidisciplinary staff leaving the department	Formalise the process for those leaving the department to learn lessons about why and what can be improved
Provide introduction packs for multidisciplinary team members starting in the department; to include who and how to access the directorate management team	Make clear the importance of how each individual can be listened to, and how individuals can improve the department
Mentoring scheme	All new consultant appointments should have access to a mentor

EXISTING STANDARDS AND BEST PRACTICE RECOMMENDATIONS

1. THE SAFE AND EFFECTIVE TEAM

1.1. Understanding the existing standards

Guidelines for the Provision of Intensive Care Services 2 (GPICS v2) includes staffing standards across the Critical Care team. The standards are contained in Section 2 (pg. 31) of GPICS v2 and cover the experience, training, support and (where appropriate) staffing numbers for each role within Critical Care. Section 2 of GPICS v2 also contains (on pg. 71) further standards and recommendations for managing staffing in remote and rural centres.

1.2. Making effective use of the multi-professional team

Critical Care works most effectively when consideration is given to all parts of the multi-professional team. There are staffing standards and recommendations for each role within critical care. The sections below give examples of opportunities and risks of failing to proactively manage the workforce for each role. Key to these discussions and recommendations are real-life examples of diary exercises to fully map out the workload of Critical Care team members and how these can be used to enhance patient safety, improve morale and work satisfaction, and allow robust data to be used in job planning, business cases etc.

1.2.1. Doctors (Consultants, Doctors in Training, Staff & Associate Specialists)

Opportunities
Working in a multidisciplinary team is one of the real strengths and benefits of Critical Care. Doctors and others talk of their #workfamily. The benefits of delegation and team working are multiple and greatly enhance the working atmosphere. FICM survey data frequently reports the opportunity to work in an MDT as one of the highlights of Critical Care working.

Recruitment of alternatives to the standard trainee-consultant model in the form of MTIs, ACCPs, pharmacists has been shown to be an effective way to manage the workforce as well as bringing in a diversity of experience.

Risks
Non-standard routes to recruitment can be challenging both for trainers and human resource departments. Recruitment to national training schemes has been centralised over recent years and hospitals may lack the experience/confidence to recruit. Variable recruitment and allocation may result in rota gaps. We anticipate this document will help Critical Care departments navigate recruitment outside of traditional routes.

Employing doctors from outside the UK:

Flexible workforce options:
Dr Shashi Chandrashekaraiah, Lancashire

The Medical Training Initiative (MTI) is a national scheme designed to allow a limited number of International medical graduates (IMGs) to work in the NHS for a maximum period of 2 years before returning to their home countries. The Royal College of Anaesthetists (RCoA) manages the MTI scheme for Anaesthesia, Intensive Care and Pain Medicine through their Global Partnerships team.

Attractions	***Difficulties***
PLAB exemption only needs the language test (OET or IELTS). Huge financial savings for some IMGs along with time/effort.	*Requires a supernumerary period to integrate into the NHS and initial pastoral support. Also issues with individuals/families adapting to UK society/culture.*
Experienced/skilled doctors with postgraduate training from medical training similar to the UK.	*Wide variation in skills/competencies for the same qualification, which UK clinicians are not familiar.*
Huge financial savings compared to locum costs.	*Number of posts limited to 30% of total trainee numbers.*
Regular workforce if able to develop overseas contacts/work closely with overseas universities. The RCoA also has a pool of interested candidates.	*Initial set up takes some time/effort and needs good HR support but once approved it is a continuous process. A 6 monthly report must be provided to the RCoA.*

Useful Tips:

- *Speak to hospitals/individuals with experience in setting up an MTI programme.*
- *Don't conduct interviews before language test completion*
- *Identify candidates with an ICM interest and be clear at the time of appointment that ICM is included (IMGs can use this route for GMC registration and move hospitals later)*
- *1 year each of ICM/Anaesthesia might make the posts attractive*
- *Good support is vital to the success of the programme especially in cross cultural areas like human factors, communications & inter personal skills, MDT working*
- *It takes on average 6 months from appointment to the individual starting the post.*

See the RCoA's MTI webpage for further information: https://rcoa.ac.uk/medical-training-initiative

1.2.2. Advanced Critical Care Practitioners

Opportunities

ACCPs have been introduced in numerous trusts/hospitals across the UK to improve patient care. Once introduced they provide a stable workforce and have allowed changes to medical working patterns.

Risks

Initial costs of funding and training are borne by the employing trust/hospital, though recent developments have enabled employers to utilise the Apprenticeship levy and train ACCPs as apprentices, whilst embedding the paid Trainee ACCP in the unit workforce.

Concerns around individual hospitals investing in training for people who then leave when qualified is becoming less relevant as the ACCP workforce becomes more widespread across more units.

How you implemented the ACCP role within your trust, what fears did people have and were they proven wrong?

Ms Carole Boulanger, Exeter

As one of the original pilot sites for the ACCP role this was new territory for the unit and there was a healthy mix of anxiety and excitement setting up what the role might look like in clinical practice and the knowledge, skills and competencies required to achieve this. Whilst the role has clearly moved on significantly since that point, the fears/anxieties around this may still exist in units new to the role today. These are addressed below;

1) *Negative impact on medical/anaesthetic trainees with competition for skills practice. This is carefully managed in terms of timing and does still require planning as a unit. Having FICM trained ACCPs in the unit brings significant pay back in that we can take on some of the skills training and competency sign off for medical trainees. This releases not only time for the ICU consultant body but also provides an additional level of trainer/assessor to maximise use of training opportunities. This not only embeds the role into clinical practice but also offers "payback" for the not insignificant amount of teaching/support during the training period.*
2) *"Fit" - how the role fits into the clinical team was an initial concern, which still holds true with a unit setting up the role de novo. Careful preparation of the whole clinical team around the scope and expectations of the role is key. Our logistical clinical "home" on the medical rota provides not only context and structure but also financial sense; additional roles cannot be introduced without resource implications. This also ensures a bridge between professional groups within the team. A significant advantage of the ACCP role for the intensive care unit is that it can improve the sometimes-elusive goal of maintaining continuity of care.*
3) *Damage to the image of Critical Care nursing plus depletion of ICU nursing numbers - There was a small amount of historical rhetoric suggesting that the image of Critical Care nursing has been blurred, blended or is disappearing due to the development of ACCP roles. In reality, this role offers not only experienced Critical Care nurses but also Allied Health Professionals an additional career progression opportunity, which is clinically based rather than education or management. Moreover, this keeps more Critical Care nurses at the bedside and reduces the risk that some may leave ICU and move into specialist nurse roles, resulting in a loss to the critical care workforce. This concern is also mitigated with the expanding numbers of ACCPs who are physiotherapists or paramedics by background. The ACCP role enables patient-based rather than occupational boundary-based care. Moreover, improved communication with the ACCP acting as an interface between medical and nursing and AHP staff, only serves to improve patient care and develop awareness of the unique contribution of each role as they come together as a Critical Care team.*
4) *Consultant concerns about being on call with an ACCP rather than a doctor and the potential impact this may have. These were early and valid fears and largely for those who held these, experience of the role has meant this fear has been proved wrong. The incremental value of a permanent team member supporting increasingly junior medical staff has helped to alter this perspective. There is an element of proving your worth as an ACCP in practice, which builds the confidence and assurance that the scope of practice is clear along with that relationship of trust.*

FICM provides national clear standards for training and practice for the growing ACCP family.

1.2.3. Nurses

Opportunities
This document is largely aimed at medical staffing, but doctors in Critical Care work as part of a MDT and without highly trained nursing staff the care we deliver would be impossible. The Critical Care competency programme and the ability for nursing staff to progress their careers with nursing roles on the ICU, outreach, education, post ICU recovery clinic, and organ donation can all enhance the profile of ICU nursing, increase recruitment and just as important also retention of a highly skilled and specialised nursing workforce.

Likewise, the enhanced training of Health Care Assistants within ICM will enhance their recruitment and retention.

Risks
Critical Care nursing is impacted by national issues of nursing recruitment and low numbers. Issues of nursing staff morale and retention must be considered alongside those of medical recruitment and retention. Bed closures due to lack of nursing staff will have inevitable knock-on effects on patient safety.

1.2.4. Pharmacists

Critical Care Pharmacists are essential to the safe and effective running of Critical Care services, supporting patients and improving outcomes. They form a central part of the multi-professional team, optimising medication therapy, improving quality and safety by resolving errors and undertaking wider professional support and education.

Pharmacist members now form an additional membership category of FICM. FICM provides support to Critical Care Pharmacists, including delivery of educational and training tools such as the curriculum and supporting materials, developing a workforce strategy, and reviewing and considering national initiatives as appropriate. Embedding pharmacists within the Critical Care team can reduce nursing and medical workload as well as improving patient safety and governance.

2. CRITICAL RECRUITMENT: HOW TO RECRUIT DOCTORS SAFELY AND EFFECTIVELY

2.1. Setting job descriptions and person specifications

Recruitment to ICM consultant posts has undergone a series of changes from a situation of no formal training scheme to a fully-fledged specialty. The transition to training enough doctors in the CCT programme to fulfil UK demand still poses challenges to many departments.

Opportunities

- The advent since 2010 of the CCT programme in ICM allows for the first time the recruitment of fully trained intensivists within the UK.
- Different dual specialties allow flexibility and opportunities for departments to enhance their workforce and standards of care.

Risks

- Recruitment requires an attractive person specification and job plan.
- There are risks associated with departments recruiting those not fully trained in ICM. Patient safety may be compromised and future difficulty may arise recruiting fully trained intensivists to departments where more senior consultants are not ICM trained.
- Only advertising for an individual with a dual ICM CCT with Anaesthetics for a post will increasingly reduce the potential pool of applicants from single ICM CCT, and those with dual ICM and medical specialties e.g Respiratory, Acute Internal, Renal & Emergency Medicine. At present, approximately 60% of doctors in the ICM training programme intend to dual train with Anaesthetics. A broad range of ICM plus another CCT enhances a unit's skills base and attractiveness to others with the same ICM training background.

Mentoring for Consultants:

Mentoring is recognised to be valuable to staff development and welfare, in both professional and personal areas of a doctor's life. FICM have launched a mentoring programme - FICM Thrive.

This was launched in May 2021 and is initially offering mentoring for consultants during the first 5 years of their consultant appointment.

FICM Thrive matches people seeking mentoring with mentors. A module on E-learning by those wishing to be a mentor needs to be completed and the Faculty have produced a guideline about how the mentoring relationship should proceed.

Doctors who are mentored reap many benefits, including help with decision making and career development, assistance in developing strategies to assist with a difficult work situation or relationship, improved inter-personal and professional skills, improved reflective practice and understanding of what is right for you, increased self-confidence and wider benefits such as better balancing of work, enhanced career opportunities and positives in other aspects of their life.

Doctors who mentor others also gain many benefits, increased communication and listening skills, further self-reflection and understanding, leadership and management experience and the ability to grow and develop the wider specialty.

FICM believes all new consultants should have access to a mentor.

2.2. Consultant job descriptions: Approval and best practice

2.2.1. Approval process

Royal Colleges and Faculties approve consultant job descriptions in order to provide Health Boards / Trusts with professional guidance and quality assurance for consultant appointments, focused on maximising quality of care for patients and their families, providing organisational leadership, and education and training through role modelling. Currently this process does not apply in Scotland.

The Faculty of Intensive Care Medicine is the professional body responsible for providing this guidance on consultant posts with sessions in Intensive Care Medicine, whether these are full-time ICM, or linked through dual certification programmes with the specialties of Anaesthetics, Acute Internal, Renal, Respiratory and Emergency Medicine. The Faculty represents eight Trustee Royal Colleges, with governance through the Royal College of Anaesthetists (RCoA). The Faculty uses the same principles as the RCoA for approval of consultant appointments.

Approval of ICM consultant post job descriptions will usually be provided by the FICM Regional Advisor provided that certain minimum standards are met. For the purposes of approval, a post is defined as needing ICM approval if it has a minimum of 1 daytime DCC PA in ICM. This includes neuro and cardiac anaesthesia posts where the post holder is required to provide cover to a standalone neuro or cardiac intensive care unit.

To note:

- **AAC representatives:** The Faculty will also provide representatives to join appointments committees if this is desired by Health Boards /Trusts, given sufficient warning and availability. The availability of AAC representation may be more forthcoming with the increased use of online platforms to facilitate meetings.
- **Locums:** Although approval of locum consultant posts is not undertaken by the FICM and FICM RA, it would be anticipated that trusts wishing to appoint to locum consultant posts would be mindful of this guidance in making such appointments.

2.2.2. Job description principles

In addition to the generic guidance provided by the RCoA, the following principles should be observed in providing a job description for a consultant post in ICM. Person specification requirements are covered in Section 2.3 immediately below.

1. **Clinical Duties**: A description of the clinical workload and work pattern in intensive care (and linked specialties as appropriate), and an indication of the new post's relationship to existing posts.
    a. A minimum of 1 DCC per week in ICM is required, to be delivered during daytime hours. It would be expected that job descriptions will contain more than one DCC in ICM in order to attract a suitably qualified candidate.
    b. Duties delivered in blocks of time over several contiguous days to optimise continuity of care; according to the national service specification for ICM would be the most frequently encountered pattern of working.
    c. Nighttime duties are limited to intensive care medicine and associated work (resuscitation, ward and ED referrals), without concurrent cover for other disciplines e.g. general theatre work, acute medical take, obstetric anaesthetics.

2. **Support:** Adequate provision for continuing professional development, audit, teaching, training and research and office space.
    a. The minimum number of SPAs considered adequate for continuing professional development, appraisal and revalidation in ICM is 1.5 per week. It is expected that high quality organisations will offer more than 1.5 SPAs, and that the post holder will provide evidence of delivery through appraisal.
    b. Additional SPA time will be required for consultant involvement in formal teaching, or specific tasks and duties, for example in management. The job description should explain how this support will be accessed.
    c. A statement about the Health Board/Trust's approach to supporting consultant involvement in quality improvement and national activities.

2.3. The consultant person specification: Standards for essential and desirable criteria

The table below indicates the standards for person specifications for substantive consultant posts in ICM. This aligns with GPICS v2, and Trusts/Health Boards should remain cognisant of this when seeking to make appointments.

Where at all possible, for the credibility and future of the specialty, it is preferable to appoint CCT holders in ICM as a priority and on merit. Over 100 Intensivists now gain their CCTs/CESRs each year and this is increasing. Trusts and Health Boards should not seek to appoint an individual without a CCT in ICM where the option of appointing an ICM CCT holder exists. The Table below is a suggestive example of an appropriate Person Specification, which a Regional Advisor would be seeking to approve as a minimum.

FACTORS	ESSENTIAL	DESIRABLE	HOW IDENTIFIED
Qualifications / clinical skills	• MB ChB, MBBS or equivalent Primary Medical Qualification • Registration with the GMC, with a full licence to practise **OR** eligible for registration within six months of interview. • Eligible to be included on the GMC Specialist Register with a Certificate of Completion of Training (CCT) or equivalent Certificate of Eligibility for Specialist Registration (CESR) in ICM (*or where not possible in a complementary specialty to ICM) **OR** be within six months of achieving CCT in ICM (*or where not possible in a complementary specialty to ICM) at the time of interview.	• Hold the FFICM or EDIC • MD or PhD (for applicants to research posts) • Extended complementary skills e.g. Echo, USS accreditation	CV/ Interview

Special knowledge / abilities / experience	• Evidence of equivalent levels of experience (e.g. Consultants pre-dating the CCT programme) **OR** • Clinical training and experience equivalent to ICBTICM Intermediate/Stage 1 ICM training • Extensive relevant experience for the post	• Interest in developing subspecialist areas of Critical Care	CV Interview References
Personal skills / qualities	• Able to communicate effectively and appropriately with patients, their families and other health professionals. • Leadership skills appropriate to participating in and leading a multidisciplinary Critical Care team. • Able to delegate appropriately. • Maintains good working relationships with patients and colleagues. • Able to work with colleagues in a team. • Proven commitment to personal professional development.	• Able to develop, present and implement coherent ideas for service development / delivery.	CV Interview References
Audit & research	• Evidence of participation in clinical audit and Quality Improvement • Able to teach and support staff effectively. • Commitment to continuing professional development and medical education.	• Published research. • Relevant Critical Care presentations /publications.	CV Interview References
Teaching & training	• Experience in teaching, training and supervising medical students, doctors and the wider MDT	• Membership of Academy of Medical Educators/GMC Educational Supervisor status/or equivalent. • Formal teaching qualification or instructor status for a relevant course on acute care or the deteriorating patient eg. ALS/ATLS.	CV Interview References

*It is understood that whilst the ICM training workforce goes through an extensive period of transition and growth, some units (e.g. smaller, remote and rural - see vignette below) may be unable to recruit in line with the essential criteria listed above. In these circumstances, the involvement of the local RA is strongly recommended before adjusting the person specification. Efforts need to be made to ensure that the post advertised meets service needs and upholds standards of patient safety, as per GPICS vs 2. This may include amending some of the essential criteria; however, this should be the

fallback option when recruitment using essential criteria has been explored. There would then be a need for a mitigation plan to ensure the safe transition of a doctor without a full ICM CCT to solo working (see below) in the appointing unit. Again, the RA should be involved.

2.4. Adapting to different situations and different units

Small, remote and rural units

Dr Chris Thorpe, Bangor

Small units run different staffing structures but still manage to obtain the similar outcomes as larger UK units. GPICS v2 has a specific chapter on small remote and rural units *that outlines the sort of staffing structures that need to be considered.*

Currently for the majority of smaller units in the UK, cover is provided by a combination of Intensivists and Anaesthetists with physician input when required. The combined Anaesthetic/ Intensive care department shares administrative support, which allows smaller consultant numbers to be economically viable, and crucially ensures the two work closely together so skills are kept up in all areas. CPD is an essential part of this: educational and mortality meetings are department wide, so all consultants are skilled in looking after critically ill patients.

A core of consultants provides daytime cover with DCCs in ICM. Anaesthetists supplement the nighttime cover and the consultant would cover both Intensive Care and theatres. If there were specific problems that needed further discussion, Intensive Care expertise should be available either locally or through the network. On site would be anaesthetic airway cover and a separate resident for the ICU that would be non-airway trained such as an ACCP, medical or foundation trainee. On-call residents would work in tandem, so airway cover forms part of the team looking after the unit.

3. CRITICAL ROTAS: MAKE JOB PLANNING EFFECTIVE

3.1. The variables of job planning

Job planning is a vital part of ensuring the delivery of effective Critical Care. Earlier attempts to classify job plans and distribute example job plans were thwarted by the realisation that there are nearly as many job plans as intensive care units. Increasing flexibility to allow better work-work and work-life balance have made the 'one size fits all' job plan a thing of the past. In this section, examples of annualisation, flexibility, supporting trainees with on-site working, simple measures with large impact, and ways of sustaining the workforce through relatively simple changes are described in a series of vignettes.

3.2. The Consultant without an ICM CCT

The Faculty Careers, Recruitment and Workforce (CRW) Committee have received requests for advice from some Critical Care clinical directors and lead clinicians about what should be stipulated as reasonable standards required of consultants without an ICM CCT who are working in Critical Care; including out of hours cover.

The guidance below needs to be cognisant of an individual's background competencies and training, which may be very variable. Interpretation of the guidelines should therefore be tailored to an individual's needs. These needs should be explored with the individual's clinical lead and directorate manager. These suggestions do not form a credential in ICM or can in any way be considered as forming an alternative standard to a CCT in ICM, but are a pragmatic recognition of a need to provide an ICM service whilst also upholding standards for patients.

1. Commitment: the individual must demonstrate a commitment to ICM with on-going learning in it (documented within their job plan, annual appraisal, and Personal Development Plan).
2. The individual should demonstrate adequate experience in ICM with direct supervision from an ICM consultant for 12 months (mentorship), with local formalised access to a second opinion/reassurance through local ICM consultant colleagues, as well as to the local ICM Network.
3. Fairness to those in the ICM training programme: The preference is always for the ICM CCT route (CESR is aligned to equivalent training and experience) either as single or dual programme. Review of the ICM curriculum and the CESR process to identify and rectify areas of possible weakness in the individual's training and experience to date is needed. This would include Medicine for an Anaesthetic trained individual, and vice versa Anaesthetics for Medical CCT/CESR holders. Until these are addressed, the consultant should not supervise a stage 3 ICM doctor in training.
4. Active participation in the ICM directorate is required: Morbidity and Mortality, Clinical Governance, Quality Improvement and Safety, Journal Club meetings etc.
5. Medico-legal considerations must be risk assessed: reassurance is required for the individual clinician and for their employing organisation that suitable clinical knowledge and competency in the specialty of Intensive Care Medicine has been demonstrated. The Medical Director, and or the individual's senior responsible officer (SRO) should be aware of the structures and processes put in place to safeguard the individual, patients and the integrity of the ICU, by demonstrating their commitment, additional training, supervision and experience.

There is, in addition the option of sitting an examination in ICM e.g. FFICM, or European Diploma in Intensive Care Medicine. An examination demonstrates a suitable knowledge base at a given point in time, which may provide reassurance for the individual and employer.

3.3. Alternative Working Patterns

Cross-site working
Dr Jack Parry-Jones, Cardiff

Small district general hospitals find it particularly difficult to recruit ICM CCT consultants, many of whom want to work in larger units with similarly trained consultant colleagues. Larger units however can also struggle to meet staffing requirements particularly in those regions where there are historically fewer ICM trainees.

Drivers for cross-site employment:

1. *In Cardiff, despite having 22 ICM trained consultants participating on the rota many have other commitments, reducing their direct clinical commitment (PAs) to the rota. (Many have external roles in management, research, postgraduate and undergraduate teaching, Emergency Medicine Retrieval and Transfer Service, Long Term Ventilation, and Anaesthesia). We were relatively short of PAs, with an on-going requirement for consultant locum cover. Locums were increasingly difficult to find due to the tax/pension situation.*
2. *Improving Critical Care Network relationships and direct communications by cross-site working. This would improve communication particularly around transfers in from DGHs and repatriations once tertiary care completed.*
3. *Improving the perception amongst ICM trainees of the Cardiff Critical Care directorate as a place to work as a consultant. Improving the flexibility and attractiveness of job plans would pay dividends in future.*
4. *A consultant wanting to live and work in a rural setting in a small and potentially remote DGH can more readily access the clinical experience of a large busy unit with a broad case mix. They can also utilise/access the Quality Improvement Programmes, Morbidity and Mortality meetings, Quality and Safety meetings and education including Simulation. This can be very rewarding for the individual and useful to the small DGH when these lessons and skills are brought back.*

Top tips:

The possible ways of consultants working across different hospitals that we have used are:

1. *The consultant has 2 entirely separate contracts with their employers - with a less than full time contract in each. The advantage of this arrangement is more flexibility in increasing or decreasing DCCs by the consultant between the two organisations.*
2. *The consultant has one employing organisation. The second organisation then has a service level agreement and "buys" a pre-agreed number of DCCs per annum for the employing organisation. This requires close liaison between management in the 2 organisations at the outset. Once set up however the onus then is on the consultant, their directorates, and the rota to ensure it functions well. The advantage of this arrangement is having a single employer is easier for an individual's Income Tax and National Insurance contributions. In theory, there may be a difficulty with supporting professional activities (SPAs) and who pays for what. In practice, we had no difficulty with this.*
3. *The most important aspect of trying to set these jobs up is "where there is a will, there is a way." Providing the individual wants this arrangement, and the directorates in each hospital*

want it as well, we have not found this difficult. There is mutual benefit to both organisations and to the individual.

4. *These jobs will not suit everyone but for some people they provide an attractive, flexible job plan that suits their lifestyle, and in so doing, supports their wellbeing. They may facilitate small DGH hospitals attracting trained intensivists, which might otherwise prove very difficult and also benefits the teaching hospital workforce. How that individual works long term may change; an individual may choose to move full-time into one or other organisation, but the organisation they leave will still have benefitted from the arrangement for the time they worked there.*

'Last of the Summer Wine' Rota

Dr Pete MacNaughton, Plymouth

As an aging intensivist (I am in my 26th year as an ICU consultant), I still loved the clinical interest, challenges and rewards of my job but found the prolonged periods of duty an increasing struggle. I could perfectly well cope with a 13 hour shift but did not relish then being on call with a high chance of having to stay on late with subsequent disturbed sleep.

Two years ago, together with two of my other most senior colleagues, we decided to share 2 full time ICU rota slots between the three of us to allow a full separation of day-time and night-time duties throughout the week. Locally, we had already separated out evening/on call sessions from daytime sessions between Monday and Thursday for all of the ICU consultants but weekends remained a more traditional 30 hour plus period of duty.

With 3 people sharing 2 slots on the rota, we were able to keep the weekend frequency the same but ensure day-time shifts and nighttime on call were separated. We now work hours, which match the shift patterns/handovers of the trainees, although not resident on call. This change has had an enormous impact on our well-being and feeling of sustainability.

My colleagues nicknamed the rota the 'last of the summer wine' as we were all male and physically, at least, beyond our prime. It is of note that after 2 years of the three 'oldies' working this rota, my younger colleagues have seen the benefits and have decided to work towards establishing the same working pattern for all.

It is becoming increasingly important, as retirement age increases to keep job plans flexible enough to enable 'ageing' intensivists to continue to work in ICM up to retirement age. These experienced clinicians' skills may address particular areas of service provision e.g. Critical Care follow up, addressing complaints and concerns from patients, relatives and Coroner/Procurator Fiscal reports. Stopping or reducing overnight sessional commitment may increase daytime weekend cover, which may benefit consultants with a young family or other commitments.

Diary exercise, small change but significant quality of life improvement.

Dr Mark Carpenter, Sunderland

In a large general hospital, 11 consultants cover an 18-bedded combined Level 2/3 general Critical Care unit. Off-unit roles within the hospital also includes cover of Critical Care needs of a large emergency department, paediatric emergency stabilisation and Critical Care support for a 24 hours PCI service.

Thoughts that on-call was becoming more onerous led to a 7-week on-call diary exercise being completed by all 11 consultants using the BMA diary spreadsheet. Out of hours work was found to be onerous, but the most important finding was regarding lack of continuous rest. On only 15 out of 36 nights on-call did the consultant get more than 6 hours continuous rest without interruption. It was felt that this was unlikely to be sustainable and so a decision was made to stop doing clinical work on the morning following night's on-call. Prior to that, an ad hoc informal arrangement was in place if colleagues were not able to work post-call.

Definite diary evidence showed that not only was this an improvement in patient safety but a significant improvement in quality of life for consultant staff. This was accompanied by a reduction in DCC PA allocation, although the diary exercise revealed the intensity of workload was not being recognised and so total PA allocation was unchanged.

Annualised working

Dr Jonathan Goodall, Manchester

Consultants on our unit have always worked flexibly but individual job plans diversified over time: the total number of ICM PAs worked by colleagues now varies between 3 and 8.5 each week. To ensure equity we decided to move to an annualised job plan.

We agreed and allocated a number of PAs for each part of the ICM rota. In our service, a typical day shift (from 08:00 to 17:00) attracts 2.25 PAs, a long day (08:00 to 20:30) 3.25 PAs, an overnight on-call (from 16:00 to 10:00 the next morning) 5 PAs.

Having established these rules, making them work was relatively easy. A consultant who is contracted for 7 DCC PAs to ICM is expected to work 7 x 42 PAs to ICM, ie 294 PAs in the year; this becomes their 'target' for the year (42 weeks of work rather than 52 due to annual leave, bank holidays, and professional and study leave).

We have agreed SPA tariffs for educational supervision, governance lead, audit lead and other essential roles, which ensure equity within the group.

All feel that their contributions to the shared workload is recognised and is reflected by appropriate renumeration. It allows a huge degree of flexibility – one colleague works his clinical PAs in 6-week blocks and has the alternating 6 weeks entirely off. It allows those of us with regional and national roles to attend meetings without colleagues complaining they are having to 'cover for them whilst they're away'. It promotes a work-life balance whilst ensuring that the Trust gets every session it pays for.

24 hours resident on call. Flexibility to advance patient safety

Dr Matt Williams, Portsmouth

In 2015, we had a period where we found ourselves having to "act down" to cover a sustained 6-month significant drop in middle grade cover.

The option of changing to a resident on call system was identified as meeting our agreed aim of having two experienced practitioners on site overnight. This was facilitated by:

- *A dedicated on call room*
- *The nights were considered resident "on call" as opposed to a shift*
- *An overall uplift in overall PAs for all consultants.*

- *An agreed review date of 12 months,*
- *2 locum consultant colleagues were appointed to make the frequency acceptable*

We worked the resident rota for 12 months, when we were able to change to a hybrid system where we are only resident on call Friday, Saturday and Sunday.

Advantages:

- *Separating out nights at the weekend has helped our own fatigue and therefore, we hope, the safety of our patients.*
- *The trainees and nursing colleagues have felt reassured having us on site.*
- *The wider hospital also seemed to be reassured to know there was a Critical Care consultant on site.*

Negatives:

- *Nobody sleeps that well on site.*
- *Care has to be taken not to stop the enablement of trainee development.*
- *Cost in terms of increased consultant PAs.*

3.4. Managing the complexities and conflicts within job planning

Different ICM working patterns, different ICM consultants, different staffing of unit (s) all play a part in job planning. Effective recognition and management of these conflicts is essential to effectively manage a service's requirements. Doing this well will be good for patients, intensivists and other staff members.

- Workload is more than just beds covered. Different hospital and unit work patterns will vary in terms of the roles that the intensive care doctors fulfil (trauma, cardiac arrest, paediatric stabilisation etc). Workload throughout the 24-hour period should be matched to staffing, and staffing needs to be consistent with GPICS v2 guidance.
- Different levels of support from trainee and career grade doctors, nurses, ACCPs can have effects on the workload and therefore job planning of intensivists and should be factored in.
- The geography of the service, both within one site with different non co-located units, and hospitals where Critical Care services are delivered across sites must be taken in to account. The effect of remote and rural working may create challenges for job planning where creative solutions may be required in both job planning and recruitment.
- Intensive Care consultants may well have other clinical commitments in the Trust/Health Board (EM/Medicine/Anaesthesia/Home ventilation service) that will impact on job planning. The flexibility (or lack of) with which these can be accommodated may have effects on job planning and recruitment. Annualisation is one way of dealing with this, or adding specific rest after on-call may allow better planning of non-ICU work. Sessional commitment to Critical Care Follow Up should be agreed as part of job planning.
- Non-clinical work such as management, work for other organisations or for the wider NHS structures may take up a considerable amount of time and should be factored into any job planning discussions to allow flexibility whilst continuing to maintain the Critical Care service.
- Private work and other secondary employment should be factored within job planning to ensure there is no conflict in terms of timings including on-call and emergency cover.
- Lifelong Critical Care: With the advent of the single CCT and the increasing number of intensivists doing nearly full-time intensive care, the need to ensure that a career in intensive care is sustainable for the lifelong career has never been more important. Making shifts and

work patterns manageable in the long term should be a priority for any unit. Annualisation, changes to working patterns, and most importantly robust data on work patterns through diary and/or more sophisticated means can and should inform the job planning process.

Attributes

Authors: Dr Mark Carpenter, Dr Ken McGrattan, Dr Richard Porter, Dr Sarah Clarke, Dr Liz Thomas

Vignettes: Dr Danny Bryden, Dr Shashi Chandrashekaraiah, Ms Carole Boulanger, Dr Chris Thorpe, Dr Jack Parry-Jones, Dr Peter Macnaughton, Dr Mark Carpenter, Dr Jonathan Goodall, Dr Matt Williams

Editors: Dr Daniele Bryden, Dr Jack Parry-Jones, Mr Daniel Waeland, Ms Natalie Bell

Designer: Mrs Dawn Tillbrook-Evans

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The Faculty of
Intensive
Care Medicine™

Churchill House | 35 Red Lion Square | London | WC1R 4SG
tel 020 7092 1688 | email contact@ficm.ac.uk

www.ficm.ac.uk

@FICMNews