REGIONAL WORKFORCE ENGAGEMENT REPORT:

WEST MIDLANDS

The Faculty of
Intensive Care Medicine

CONTENTS

1. INTRODUCTION: THE CRITICAL CARE WORKFORCE

This section is common to all FICM Workforce Engagement reports.

1.1 Critical care in the NHS

Historically there has been little or no workforce data published for Intensive Care Medicine (ICM) in the UK. With the birth of the Faculty of Intensive Care Medicine (2010), there has been the opportunity to begin generating crucial workforce data through a series of censuses (2012, 2014 and 2015), engagement with workforce modelling projects and drawing information from audit and research.

Hospitals are in need of consultants with general, acute clinical skills. The needs of patients and desire of central government for a 7 day, consultant-delivered hospital service has been made clear. Whilst funding is shifting towards supporting outpatient and community-based activity, increased longevity, the rising incidence of diseases such as diabetes and cognitive impairment, and the expectations of the public mean that demand for intensive care is rising.

ICM presents a unique challenge for workforce planners:

- The recognition by the General Medical Council (GMC) of intensive care medicine (ICM) as a specialty, some inevitable decoupling from its traditional base in anaesthesia and the evolution of training systems through joint, dual and single specialty programs, means workforce planning for ICM is multi-faceted.
- Training is based traditionally around teaching hospitals and in conurbations. Some 86% of trainees now end up as consultants working in the same area in which they trained. Arguably, areas that struggle to recruit trainees or have few allocated to them will struggle to fill additional consultant posts even if funding is available to create them.
- Joint Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) standards were published in 2015 (*Guidelines for the Provision of Intensive Care Services*). However, a number of units in England do not currently meet some of these standards, often through a lack of provision of separate ICM consultant rotas. Some critically ill patients are therefore being cared for overnight, over weekends and bank holidays by non-ICM trained consultants.

Whilst central government policy can set out to determine how many doctors are needed, the final number that can be employed in a particular geographical location is determined by the money available to employ them. In times of relative plenty (e.g. 1998-2008) expansion in consultant opportunities is rapid; more recently this has slowed significantly. Such swings are particularly apparent in specialist areas where significant capital investment is needed for optimal clinical practice, of which ICM may be the exemplar.

1.2 Projected demand

1.2.1 Census data

Between the 2014 and 2015 censuses, the figure for those intending to drop ICM sessions rose from 22% to 24%. The most common reasons across both censuses for wanting to leave ICM were all focussed on workforce issues:

- Work-life balance
- Work intensity / burnout
- Frequency of on call
- Lack of available beds?
- Lack of middle grade cover / nurses / consultants

In 2015, 47% of respondents felt that they found ICM stressful enough that it would influence their future career plans. Most respondents appeared to be working 12 PAs per week suggesting that they were taking on additional sessions.

The observation below acts as a summary of a number of similar comments submitted as part of the 2015 census:

'I have decided that regardless I will retire at 60 in order not to have to do ICM on call. The intensity of work is such that I cannot conceive of doing it up to the new retirement age.'

The censuses are revealing that, with increased work hours and increased stress, ICM consultants are already experiencing the difficulties associated with insufficient workforce.

1.2.2 Intensive Care National Audit and Research Centre (ICNARC)

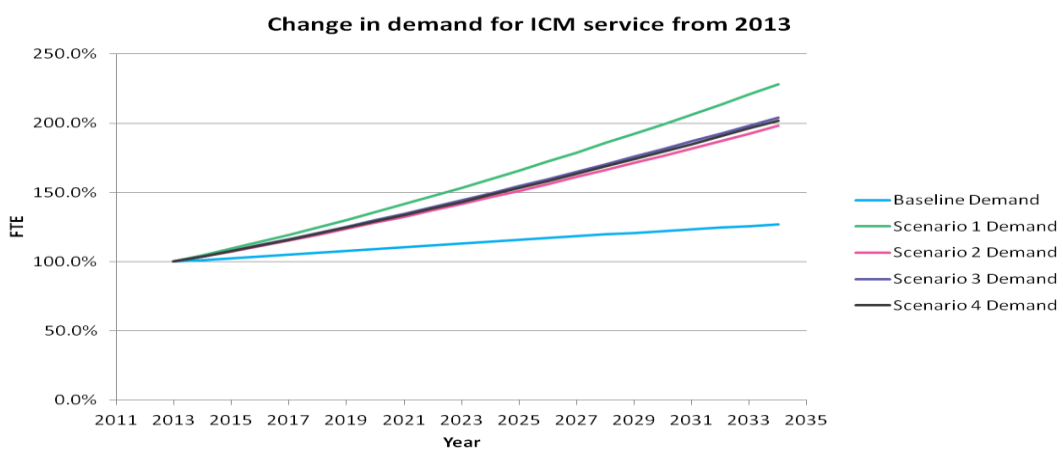
ICNARC is currently undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014.

"Modelling the trends in terms of age- and sex-specific bed utilisation rates and then projecting forward to 2033, if the observed trends continue, then an increase in overall bed days is estimated of approximately 4% per annum – comprising an approximate increase of 7% per annum for Level 2 bed-days and an approximate decrease of 2% per annum for Level 3 bed-days." (D Harrison, K Rowan)

1.2.3 Centre for Workforce Intelligence (CfWI)

The CfWI conducted an in-depth review of ICM during 2014. The review, which consisted of data sourcing, a Delphi process and scenario modelling, resulted in a final report in early 2015. The report recognised, in line with the ICNARC research covered in 1.2.2, that there is **likely to be a significant increase in need over the next 18 years up to 2033**, with most scenarios indicating that it is likely to double. Although the CfWI, as a partner of Health Education England, focussed entirely on England, the ICM clinicians taking part in the process agreed that the demand scenarios lines were applicable UK-wide.

Figure: *Change in demand for ICM workforce by scenario*



1.2.4 Workforce aims

All current national data sources suggest that, with an aging population with increasing co-morbidities, demand for critical care services will outstrip current supply levels. The censuses reveal that the current workforce is beginning to experience the added stresses and uncertainty of working in critical care at a time where demand is not being met with increased provision.

The last significant growth in ICM took place following the publication of Comprehensive Critical Care in 2000. This document grew out of the poor workforce climate of critical care in the nineties. The Faculty aims to ensure that the current workforce problems are addressed before the UK reaches a second state of emergency.

2. BACKGROUND TO THE ENGAGEMENT

In October 2014 the FICM Board accepted a position paper as a statement of current provision and UK-wide projected trends for ICU services. The Board recognised the need for modelling of workforce demand in the regions, requesting that two pilot studies be undertaken. Wales was chosen as the first region due to its relatively advanced state of workforce discussions, with the Critical Care Implementation Group considering the capacity gap in the specialty for Wales. This pilot engagement took place in November 2015 and we learned a few valuable lessons about the process for which are very thankful to the region.

One of the many workforce metrics that the FICM has used to monitor the growth of training posts in the UK has been comparing the number of posts recruited each year for a region against the population of each region. The table below indicates the population per ICM training post recruited to in each year. As you can see, West Midlands has the highest population per post ratio of any region. Whilst some regions (for example KSS) may have a more reasonable post to population ratio due to parts of their population seeking treatment in another region (for example London), those present at the Engagement agreed that West Midlands was very unlikely to have a population that required critical care treatment beyond the boundaries of the region.

	2015 training post to population	**2016 training post to population**
1	West Midlands (1,134,942)	West Midlands (810,673)
2	East of England (992,362)	East of England (744,271)
3	East Midlands (919,746)	East Midlands (656,961)
4	Wales (770,603)	Northern Ireland (609,908)
5	KSS (745,578)	Scotland (591,967)
6	Northern Ireland (609,908)	KSS (559,184)
7	Wessex (394,978)	Wessex (394,978)
8	Scotland (355,180)	Wales (385,302)
9	Yorkshire & Humber (349,853)	South West (356,647)
10	London (339,747)	Yorkshire & Humber (349,853)
11	Thames Valley (330,900)	Thames Valley (330,900)
12	South West (329,213)	North Western (312,109)
13	North Western (326,971)	Northern (293,726)
14	Northern (293,726)	London (283,122)

West Midlands was chosen as the second region due to its low ratio of post to population, despite having a number of high quality training sites.
Following extensive liaison with the Critical Care Network, representatives (please see Appendix 1) were agreed with each Trust, the Network, HE West Midlands and local training leads. We are grateful to the assistance given by Angela Himsworth, Acting Midlands Critical Care and Trauma Network Manager, Network Nurse Lead and Chair of the Critical Care Networks National Nurse Leads (CC3N).

2.1 Engagement aims

The engagements would be conducted with the aim of:

- Describing the current supply of ICM/critical care facilities in the West Midlands and presenting an assessment of likely future (5-10 years) demand.
- Identifying the likely future location of critical care services based upon current provision and networks of clinical care surrounding regional centres.

- Presenting the best estimates that can be made of the current trained medical workforce in ICM in the West Midlands, their distribution and demographic; and the workforce in training.
- Conducting discussion sessions to reconcile supply and likely demand for ICM, with the current and projected workforce.
- Providing a data report that could be used by the region to exert professional pressure in order to address areas of workforce concern.

The engagements would not aim to:

- Use the visit to prioritise a particular workforce solution or to replace the local expertise in areas like the planning of training numbers (which is the responsibility of the Regional Advisor in conjunction with the Specialist Training Committee).
- Use this as an opportunity to police the uptake of GPICS. Recommendations and Standards in GPICS will be used as opportunities to model future potential future demands on the workforce in the West Midlands.

The engagement would result in this final report and its appendices which could be used by the local stakeholders (across the Health Boards, Networks, Deanery and Government) to manage workforce decisions in the specialty.

2.2 UK wide application

The Faculty's intention is to run further engagements across the UK. Information gathered from all these workforce engagements will aid the UK-wide workforce plans for the specialty.

3. ICM AND CRITICAL CARE FACILITIES IN THE WEST MIDLANDS

This information is based on a presentation given by Dr Zahid Khan and reflects his opinion on the clinical demand, workforce and critical care facilities in the West Midlands.

The West Midlands has a culturally and ethnically diverse population, 17.3% of whom are non-white. There are areas of severe deprivation. In Birmingham 29% children live in poverty, 23% of adults are obese and life expectancy is 7.6 years lower for men than UK average. Gap analysis of the D16 service specification demonstrated significant shortfalls particularly with regards to medical staffing. The West Midlands has 27 critical care units offering Level 3 care to a population of 6 million. There is a large variation in critical care beds to population served. The units range in size from 5 to 100+ beds with inequitable access to critical care.

The West Midlands has approximately 30 high calibre trainees in critical care medicine at any one time but expansion has been at the expense of Anaesthesia. The changes to the trainee contract and its effects on acute specialties have affected morale, with only 38% of trainees in a recent survey indicating that they would complete training.

There is an increase demand for critical care with ICNARC predicting a 4% annual increase. This is due to the change in patient demographics with more elderly patients with more chronic health problems, increase in inappropriate referrals. The public, political and professional expectations of the service are increasing. Meanwhile there is a reduced supply of medical manpower. This is multifactorial but is related to European working hour directives, changes in training, early retirement, return to anaesthesia, part time working with feminisation of the workforce, reduction in funding and changing priorities. The shortfall in other specialities impacts ICM. The demands on consultants are also increasing due to falling junior numbers with less experience. This leads to consultants picking up additional work with concern about personal and professional fallout, changing roles and poor job satisfaction.

There are too many hospitals trying to provide a full service specification of service with a political, public and professional reluctance to centralise. There is a target driven NHS with resource allocation and not a NHS driven by meeting agreed standards for patient care. We need a realignment of resources to better meet demand. Solutions to staffing standards include ACCPs, non-anaesthetists needed on rotas and for their training. We should meet agreed national standards in order to improve training and attraction to critical care. To maintain senior consultant workforce we need agreed minimum rotas and on-call age limits. There will be a requirement to make difficult decisions about how many units there should be in the West Midlands but we should not risk substandard critical care just to meet others specialities wishes.

4. ISSUES CURRENTLY FACING CRITICAL CARE

The information below was generated as part of the discussions regarding the issues currently facing critical care services in the West Midlands. The attendees were divided into two groups and were asked to discuss the following points:

- What current gaps in service provision (personnel or structural) are apparent in West Midlands?
- Are there any solutions, outside of increasing the workforce, that are being or could be introduced to address these?
- What is the current morale of the ICM workforce (consultant and the wider multi-professional team)?
- What is happening with regards to providing a dedicated junior tier in critical care and what issues does the group foresee with this?
- What is happening with regards to separating anaesthesia and critical care consultant rotas and what issues does the group foresee with this?
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The comments below are a reflection of these discussions and the opinions of those who took part.

GEORGE ELIOT HOSPITAL: George Eliot NHS Trust

The ICU has 8 beds plus 2 NIV beds on other wards. The unit currently has 7 ICU consultants working towards a whole week so 1:7. The consultants share on call with general consultants at night and during weekends. The Trust is trying to recruit an additional consultant, when this happens the on-call rotas could be separated. There is a 24 hour outreach service run by an ICU consultant. The unit does not have any ACCPs but does have a matron for the ICU.

GOOD HOPE HOSPITAL & HEARTLANDS HOSPITAL: Heart of England NHS Foundation Trust

Heartlands Hospital has 11 ICU beds and Good Hope Hospital has 6 Level 3 beds. The ICU consultant rota is 1:9 at Heartlands Hospital and 1:8 at Good Hope Hospital. Consultants work a roughly 50-50 split between ICM and another specialty. The middle grade rota is at times unstable. A high proportion of capable and experienced middle grades tend to join training programmes which leave gaps. The Trust has practitioners, the more experienced of whom provide a lot of training to trainees. Junior doctors are used to fill gaps in night rotas, however fee caps on agency costs result in difficulty identifying competent individuals.

HEREFORD COUNTY HOSPITAL: Wye Valley NHS Trust

The unit has 6 level 3 beds. There are no other HDU beds in the hospital. There are currently four Intensive Care Consultants with one vacancy. The vacancy will be filled in February 17. All consultants are also anaesthetists. There is no separation of the rota so out of hours the on call consultant covers both theatres and ICU. We are moving towards increased cover at weekends so that there is a daily 'intensivist' led ward round including weekends and bank holidays. There are insufficient numbers of consultants on the on call rota to allow separation of the rotas so we are having to take a pragmatic approach to providing the best care. We are currently advertising for a 6th ICU consultant but past advertisements have not attracted candidates with joint or dual training in ICM. Two consultants are likely to retire within the next five years. The unit has dedicated middle grade cover at all times from experienced SAS doctors. We only use locums to cover ICU in exceptional circumstances.

KETTERING GENERAL HOSPITAL: Kettering General Hospital NHS Foundation Trust

The new ICU opened in 2012, before this the rota was combined with anaesthetics and was 1:16, it was then split and became 1:6. The unit has been able to recruit good quality candidates in the last year so the rota is now 1:8 for consultant cover. Due to the lack of airway competent middle grades, amongst other reasons, the unit is currently only employing consultant anaesthetic intensivists. Junior cover consists of a mixture of ACCS and ST3-5 level trainees, with up to four trust grade SHO/Registrar grade doctors. These posts have been easier to recruit to in recent months due to an increase in trainees wishing to take time out of programme to acquire FRCA.

NEW CROSS HOSPITAL, WOLVERHAMPTON: The Royal Wolverhampton NHS Trust

The unit has beds split 50:50 with cardiac services; cardiac beds are run separately by cardiac surgeons but the beds are physically in the same space. There should be 8 consultants but there are currently only 6 so the rota is 1:6. Ideally the unit would need 10 consultants which would enable 2 consultants to be working at the weekend. Most consultants work jointly in anaesthesia and ICM and there is 1 respiratory medicine and ICM consultant. There are currently 2 vacancies which means if someone is on leave, the rota becomes 1:5. The unit is losing staff to the Royal Stoke Hospital where the rota is more attractive with less on call; the trainees also see this which makes it a more attractive choice when they are looking for consultant posts. It took a year to replace the last consultant who left. It is mainly registrars on call and they deal with both medical and ICU referrals which means they are pulled in too many directions. A business case is being assembled to train ACCPs, although this is in the very early stages, which would assist in middle grade cover.

QUEEN ELIZABETH HOSPITAL: University Hospitals Birmingham NHS Foundation Trust

There are currently 36 consultants working 26 WTE and looking after 65 beds in total; this is across 4 units run as cardiac, neuro, surgery and general. The shifts run from 8am-6pm or 8pm. The weekend rota is 1:6 with 2 people working, one works a 24 shift, 1:4 rotas are hard as there is no-one to swap with. There is always an evening ward round. Trainee numbers vary but there are a large number of them so this does not usually cause problems; there are international trainees who get paid to train at the hospital as well as military, liver and respiratory trainees. Some might argue that the unit relies very heavily on trainees. Work intensity could be worse. There is a high calibre of trainees who can cover over night on call supported by a consultant on the phone. Consultants don't usually have to cover over night on-calls. There is a large divide between the training which is provided for/wanted by the trainees and the Trust's service requirements. The Trust trains Critical Care Practitioners but there have been problems with retention. These practitioners teach trainees to do all of the blocks (with consultant supervision) and it works well. Internal locums will be harder to get when the new contract comes in; internal locums have to be offered first refusal at 25% over the base rate however, this is not enough for most people to accept.

QUEEN'S HOSPITAL, BURTON: Burton Hospitals NHS Foundation Trust

This hospital is a smaller DGH with an increasing workload. The ICU is a 22 year old unit in a modern hospital currently with 6 Level 3 beds (although it needs an extra Level 3 bed) and 4 Level 2 beds. The unit has funding for 6 consultants all of whom need to work in ICM and anaesthesia. The hospital has never failed to recruit before as there have always been trainees to fill the consultant posts however, this year the unit has not recruited and so are advertising in Wessex. There is an 8am

handover with the person who worked the previous night, the shift is supposed to finish at 6pm although realistically it usually ends around 9pm. During this time there are lots of telephone calls. The weekends are 2 PAs as weekend days are treated the same as week days. The unit has 1 trainee at a time and this can be from any level (ACCS to ST7). There is an outreach service every morning which is not backfilled and has 2 consultants and 1 trainee. Sometimes there is only 1 consultant with an FY1 on call which is not good practice. Trainee networks are going to the Royal Stoke Hospital. Patients however, are coming to Burton as Stafford is closed. Burton is potentially merging with Derby which unpopular with patients as they do not want to travel greater distances.

ROYAL SHREWSBURY HOSPITAL & PRINCESS ROYAL HOSPITAL TELFORD: The Shrewsbury and Telford Hospital NHS Foundation Trust

The ITU rota has recently been split from general anaesthetists as there were not enough staff before to do so till recently; it has been mandated that the rota will be 1:8 rather than 1:6 to maintain attractiveness for recruitment. Consultant locums are filling two empty slots although we have a new appointment starting soon . Consultant weekends are three days. Trust Grades rather than trainees often cover the middle grade post at night on occasions. The Trust has made efforts to make the hospital more attractive (such as targeting a 1:8 rota), however the unit is understaffed. There are no ICM trainees and no plans to train ACCPs at present. The hospital has a sister site in Telford which is doing more medical work; this site is struggling with recruitment. The long term plan is a unified single ITU although the politics are not resolved yet. ICNARC and SMR figures support good clinical outcomes despite the problems of being a peripheral unit.

ROYAL STOKE UNIVERSITY HOSPITAL AND COUNTY HOSPITAL, STAFFORD: University Hospital North Midlands NHS Trust

The ICU has 34 beds and currently has 11 consultants working; the rota is 1:12 week nights and 1:6 weekends. One of the current consultants is due to retire in the next 2 years. There are no further retirements anticipated within the next 6 years. The predicted workforce requirements are for 3 additional consultants to increase the consultant body to 14. This cover also provides support during weekdays for the 4 bed high dependency unit at the County Hospital site. The PAs from the consultant body are predominantly in critical care. Job plans for the vacant posts encourage applicants from all base specialties. The unit has developed an ACCP programme to assist in middle tier medical cover for the critical care areas. The ACCPs provide a stable workforce, and there is an on-going plan for further recruitment/training to expand to the desired numbers. The ACCPs provide essential support to the medical staffing of the unit. The ICU runs well. Whilst the provision of supporting medical staff, including ACCPs is higher than comparable units to maintain these rotas the Trust relies upon recruitment/retention of trust doctors, international fellows, and MTI posts. There are gaps within these rotas and recruitment of suitable staff remains an issue for the foreseeable future.

RUSSELLS HALL HOSPITAL: The Dudley Group NHS Foundation Trust

The ICU should have 9 Level 3 beds but is currently only staffed for 6 beds; there is also a HDU with 8 beds. There is a medical HDU which is run by a respiratory/ICM consultant who very helpfully keeps patients there. There are 9 consultants working 4.8 PAs in ICM from 6am-8pm Monday to Friday. Weekend on calls are for no specific time period; consultants are in for as long as they need to be. There are 2 consultant posts which have been vacant for 2 years; there has either been no interest

shown or no one was appointable. Of the current consultants, 2 would like to give up on-calls and 1 will be retiring soon; there are concerns about replacing them. This seems to be a problem across DGHs. There is a variation between the levels of trainees on call, they could be very junior or senior and there are usually 3 on call. The nature of on-call work in DGHs is different to those in larger hospitals as most of the work is outside of the ICU. Consultants are very 'hands on' and also cover the paediatric ICU. Staff work 2 theatre days per week which is not too onerous and there is a decent amount of time off between shifts which should be made clearer to prospective staff. The unit feels vulnerable because of GPICS and CQC inspections.

SANDWELL HOSPITAL AND CITY HOSPITAL: Sandwell and West Birmingham Hospitals NHS Trust

Each site has 14 beds 7 of which are Level 3. 90% of the work is medical not surgical. Within 2 years the units will be merging at a new hospital with 30 critical care beds however, the workforce will remain the same. Previously, there were 17 consultants however, this is now down to 13 (14 WTEs). The rota is currently 1:6.5 on call which is difficult to sustain as it poses problems with leave; Contracts are 12 PAs per week, a large portion of which is on call. 3 consultants will soon be retiring and 5 more will retire in the next 2 years. There are concerns about replacing them as 2 posts were advertised in 2015 and no one was appointed; these posts will be re-advertised later in 2016. The on-call rota is mainly made up of middle grade and FY2 trainees. There is funding available for more staff on the junior tier however, there seems to be a lack of suitable candidates. All trainees have to sign up to Trust bank but aren't paid enough to take on locum posts. The Trust has looked into recruiting overseas doctors however, there is little time to train them. There are 3 ACCPs being trained this year and 3 more are expected to be in training next year however, there have been problems with retaining them. The Trust needs more ACCPs and needs them to be confident in their role. Morale is currently very low as the frequency of on-call and intensity of the work is very high. The Trust rearranged its services so all cardiac cases now go to City Hospital; having a single unit should help with this. The direction of medicine in the region is unclear at the moment and there are concerns that the model of DGHs acting as single units is not working very well. Sandwell Hospital is able to accommodate a consultant working in just ICM however, it is possible that DGHs may not be able to maintain ICM services due to the demand for acute medicine.

UNIVERSITY HOSPITAL, COVENTRY: University Hospitals Coventry and Warwickshire NHS Trust

There are 10.5 WTE consultants working a 4:10 rota and also working one week in cardiac ICU. There is at least 1 trainee working a 'long day' every day and 2 FY2/CT1 equivalent on-call. The MDT handover each morning is very comprehensive. There are 3 consultants covering the 2 day weekend so there are at least 2 consultants on the unit at any time; 1 consultant covers 24 hours and 1 works 8am-6pm. The consultant who covered for 24 hours will then have 24 hours off. There is usually a telephone handover. 24 hours equals 3 paid sessions. The ICU nurses are working at band 8; over the last year £18million was spent on agency nursing staff. There are 2 PAAs in Anaesthesia.

Following the CQC visit the general intensive care medicine (FIM trained) consultants have taken on responsibility for the cardiothoracic intensive care unit with attending support from the cardiac surgeons. The team now manage a general critical care unit that has a capacity to manage 20 level 3 patients with a total of 28 beds. There are also 10 cardiac beds and the Trust hope to expand by an additional 4 beds. The hospital is a Major Trauma Centre supported by the cardiac service. Some physicians within the hospitals want to open up a medical HDU this is challenged as there is no resource to provide trainee or consultant ICM cover.

WALSALL MANOR HOSPITAL: Walsall Healthcare NHS Trust

The unit currently runs a 1:8 rota with 16 members. The unit has 2 trainees, 3 MTI trainees and 8 staff grades although there are 12 staff grade slots. The remaining gaps are filled by internal locums. On-call does not cover anaesthesia.

WARWICK HOSPITAL: South Warwickshire NHS Foundation Trust

The unit has 7 beds used for Level 2 and Level 3 patients; it is usually staffed for a dependence of 5 and there is no separate HDU. There are 8 consultants working a 1:8 rota covering ICU, Anaesthesia and Maternity. All of the consultants are also anaesthetists and all on-call duties are shared with the general anaesthetists. Discussions regarding a separate ICU rota are ongoing. There are 2 practitioners qualified and 1 in training. Residents are practitioners Monday to Friday plus CT1 Anaesthetic/ACCS trainees doing their ICU block. We are moving to weekend practitioner cover, but currently this is an anaesthetic/ACCS trainee who also has commitments to theatres. We have no ICM trainees and there are no anticipated retirements in the next 5-10 years.

WORCESTERSHIRE ROYAL HOSPITAL AND ALEXANDRA HOSPITAL: Worcestershire Acute Hospitals NHS Trust

The Trust runs 23 critical care beds split between Worcestershire Royal Hospital (WRH) which has 15 bed spaces and the Alexandra Hospital (ALX) which has 8 bed spaces. The nursing complement is staffed to cater for 13 Level 3 beds across the county at any one time, although the nursing resource is split to look after a mix of Level 3 and Level 2 patients. There are 18 consultants providing ICM sessions (8.7 WTE), working a 1:9 on call rota. On the Worcester site there are two consultants on for intensive care Monday-Friday 0800-1800, one principally looking after the unit, and the other performing outreach duties, including to the surgically run high dependency units. The medical and senior nurse workforce work across both sites on a rotational basis.

Junior doctor support is usually two FY1s seconded from surgery Monday to Friday, a CT2, and an ST3 or greater on the WRH unit, and a junior doctor of CT2 or greater on the smaller ALX unit. Out of hours, a resident junior doctor with no competing responsibilities covers each unit. Other junior anaesthetists (typically two to three on WRH site and one on ALX site) provide back up and surge capacity. Two non-resident consultants cover the units out of hours, one for each site.

We have had no particular problems recruiting consultants to our team to replace vacancies, but we have received notice from the Deanery that the number of trainees provided to the ALX site is to change from 2017, which will threaten our ability to keep a full service staffed by trainee doctors running. Our service is currently investigating training ACCPs to bridge this gap. Morale amongst the consultant body is generally good.

GENERAL DISCUSSION POINTS

For some sites, working in ICM and anaesthesia remains attractive as working in theatre adds a varied and less stressful aspect to the job. There are also concerns that working too much in the ICU will reduce skills in anaesthesia. This differs from some regions which have greater numbers of non-anaesthetic intensivists.

Some DGHs are not appealing for consultant recruitment due to uncertainty caused by the possibility of imminent service configuration.

Investment in ICM

The specialty is not on the general public's radar which means it does not have as much of a voice and the consequent ability to encourage government investment in a stretched specialty.

More units are being created but there are still the same number of foundation posts.

Training and Trainees

There are too many trainees in big teaching hospitals; if they rotated to the smaller DGHs more, this may help with recruitment at these hospitals. DGHs can also provide more management skills and self-development for trainees than larger teaching hospitals. However, specialist areas of the curriculum make it difficult to teach some aspects in DGHs and some trainees will prefer larger DGH or teaching hospital so they can be purely on the ICM rota.

Larger hospitals can discourage trainees from training in ICM as they can be used as 'service fodder'. However, trainees are more able to specialise in larger hospitals rather than be placed where the service needs demand.

Deaneries do not allow trainees to train in 2 specialties in 2 regions as it creates complications with funding and gaps in training posts. Across the country as a whole, there are enough trainees to fill all available posts however, these restrictions prevent a 100% fill rate. It is also recognised that trainees usually prefer to work where they train as they establish roots and are then reluctant to move. It is possible for dual trainees to train other hospitals within the region. There is less scope for single trainees but this could be done during their Special Skills Year

There needs to be an increase in posts available in the region; historically there have been more appointable candidates than posts available which suggests the region is significantly under-training. The number of Foundation and Core trainees has also decreased; trainees appear to be either moving abroad or taking up locum posts.

A trainee survey done by the region's Trainee Representatives at the height of the Junior Doctor contract negotiations looked at the new NHS rota and compared it to the current rota. 60% responded and of those, most respondents had 3 or 4 years left and were Dual trainees. 35% would quit ICM to finish earlier, only 5% would quit their other specialty. The morale score was extremely low. The comments regarding the new rota demonstrated that trainees were worried there would be more service provision cover, that they would not be able to attend mandatory training, that they would not be supervised appropriately, that their work life balance would suffer and that there was a move towards privatisation.

Clinical Fellows can be kept for unlimited period but MTI trainees are limited to 2 years. These trainees usually have an anaesthesia background and are tested on theatre rotas before moving to daytime on-call. Trainees without anaesthetics experience are more challenging as they require additional training and supervision, often with limited time and resources being available.

Undergraduate exposure

There is a lack of exposure to ICM at undergraduate level. In Warwick, ICM exposure is 2 days in the final year whereas in Birmingham it is a 2 week block and this can really influence a career choice. For example, Walsall and Kettering take undergraduate students for 2 weeks and many return in their Foundation years if they do not get a CMT post.

Challenges faced when working in ICU

The main concerns from ICM consultants are onerous rotas, work/life balance, quality of work, burn out and stress. The role of an ICM consultant has changed and this is discouraging people from pursuing the specialty. The lack of workforce and investment makes attempting to meet standards (such as GPICS) increasingly stressful.

ACCPs and Nursing Staff

There can be tensions between ACCPs and trainees. Most senior trainees feel ACCPs are very useful but some of the more junior trainees are worried that ACCPs are detracting from their training. Senior trainees are more confident in being able to manage ACCPs rather than becoming intimidated. Consultants need to be able to allocate jobs effectively to make sure these risks are minimised.

ACCPs can be a solution for bigger hospitals however, not all hospitals are able to implement an ACCP programme due to a lack of middle-grade cover and consultant resources.

Training ACCPs often leaves gaps in the senior and experienced nursing staff which creates additional issues for units without ACCPs and when senior nurses retire. There has been an issue with retaining practitioners after they are trained.

Band 5 nurse training appears to be varied; this can make things more difficult for the trainees and consultants.

External Factors

ICM is now working in competition with everyone else in other hospitals and the service is becoming more fragmented.

Shortfalls in other specialities are beginning to affect ICM. Due to the lack of availability of medical consultant colleagues, due in turn to their busy workload, many medical trainees were relying on ICM consultant for advice, further decreasing their day to day capacity.

Some physicians who do not have much experience of ICM and what the specialty is able and not able to do often make inappropriate referrals which are difficult to refuse. ICU consultants are increasingly being asked for input in other areas which has changed the nature of ICM on-call.

There are ever growing expectations from the relatives of patients, an increasing number of whom will never agree to stop treatment, even when it has been carefully explained as futile. For the West Midlands, which has huge ethnic diversity, the question of ethics and religious sensitivities can cause significant problems.

5. MAPPING THE FUTURE

As with section 4, the information below was generated as part of the discussions regarding the future of critical care services in the West Midlands. The attendees were asked to consider different models based on the short-term future (5-10 years):

- What workforce would be required for each Trust in order to
  - to maintain the current critical care service provision?
  - to meet the Standards of GPICS?
  - to meet both the Standards and Recommendations of GPICS?
- Will local reconfiguration plans have an effect on the above workforce models?
- What does the group foresee the effect could be of the introduction of an Emergency Medical Retrieval and Travel Service such as that in Wales and how might that affect patient transfer and repatriations?

For each model, please include the approximate number of WTE consultants, trainees, ACCPs and nurses and any other specific relevant detail (i.e. the number and level of beds). You may want to use the TOTALS page from the Information Request template for your modelling.

The comments below are a reflection of these discussions and the opinions of those who took part.

GOOD HOPE HOSPITAL & HEARTLANDS HOSPITAL: Heart of England NHS Foundation Trust

The Trust is struggling to recruit band 5 nurses and needs to recruit more mid-grade doctors just to maintain the service. Heartlands Hospital is in a deprived area so there is a higher than average use of emergency admissions and services. There is a tier of 24 Practitioners however, more are needed to go to Good Hope Hospital. Ideally a new unit is needed but this is not expected for 4 or 5 years. Good Hope Hospital would struggle with more than 6 Level 3 beds and the GPICS standard which requires a nurse in charge plus another supernumerary nurse. It would require an additional 5 WTEs to meet the standard and it is unlikely there will be funding available. The service cannot offer a follow up clinic as, although there could be psychologist involvement, finding nurses would be a problem.

KETTERING GENERAL HOSPITAL: Kettering General Hospital NHS Foundation Trust

The unit has 12 beds generally open, but a maximum of 14 in current configuration (there are a further 2 which are used for inpatient dialysis). The unit is able to meet the 'seen by a Consultant' standards and 1:8 trainee to patient ratio only during normal working hours, and 'get by' at night because the theatre trainee usually helps out as out of hours theatre activity is relatively low. It is unclear whether this ratio will make care any better and it is possible that there could be too many trainees to supervise. The unit is able to meet the follow up clinic standard but this is only because of one enthusiastic nurse running it in their own time. The clinic has psychologist input but few people have wanted the service. Most rehabilitation services should be provided in a community setting.

QUEEN ELIZABETH HOSPITAL: University Hospitals Birmingham NHS Foundation Trust

The main issues with meeting the GPICS standards are seeing patients within 12 hours and ensuring there is a ratio of 1 trainee to 8 patients; it is unlikely the Trust will recruit more trainees to meet this

standard. An increase in senior trainees would mean consultants do not have to do procedures and means they could supervise more patients. The nursing standards and recommendations will be the most difficult to implement as there is unlikely to be funding for the number required. The Trust does have a follow up clinic and this runs well. The new unit Sandwell and West Birmingham Unit will mean more work and the QEH will need to expand the mid-grade tier to accommodate this; the Trust could potentially utilise ACCPs. Any reconfiguration of services will have unintended consequences and will require the service to expand.

ROYAL SHREWSBURY HOSPITAL & PRINCESS ROYAL HOSPITAL TELFORD: The Shrewsbury and Telford Hospital NHS Foundation Trust

Consultant provision has been improved at the Royal Shrewsbury Hospital site and we are looking to use this model to separate the ITU rota in Telford; this will require Trust support and finance and is in the very early stages. In Telford, a rota comprised of 8 ITU consultants working 1:8 would require recruitment of 4 consultants in the short term, an extra consultation in the medium term (approximately 2-3 years due to retirement) and possibly an additional 2 consultation in the longer term to allow for potential 'ICU burnout'. More trainees are needed across the board. The unit would strongly support training ACCPs and suggest that this be a national process rather than on a hospital by hospital basis. Physicians should spend time on the ICU in order for there to be better co-ordination and prevent inappropriate referrals. Shrewsbury is a DGH located 30 miles from the nearest teaching centre so centralisation would be difficult however, numbers within the Trust are dependent upon the 'Future Fit' programme which we are led to believe may deliver a single site 30 bed ITU. If this goes ahead there will be no immediate increase in combined nurse staffing and dependency levels. If this unit opens, it would require 16 consultants providing cover on the main site and possibly also to an alternative site (for medical patients although no planned critical care facilities). The consultants would be working on two 1:16 rotas equating to a 1:8 on-call.

ROYAL STOKE UNIVERSITY HOSPITAL AND COUNTY HOSPITAL, STAFFORD: University Hospital North Midlands NHS Trust

The unit needs to provide 1000 bed days over the next 3-5 years. It is under capacity at the moment but there will be no increase in service provision. The rest of the hospital needs to have better systems for taking patients when they are discharged from the ICU. The Trust is currently trying to recruit more nurses from Europe. Ideally the unit needs 3 extra consultants, 4 more trainees and potentially 9 ACCPs. There is pressure to take over surgical special care currently run by surgeons; the service is Level 2 and the average length of stay is 5 or 6 days. Some people in both the surgical and ICM teams are unhappy with this.

SANDWELL HOSPITAL AND CITY HOSPITAL: Sandwell and West Birmingham Hospitals NHS Trust

The hospitals within the Trust will be merging their ICUs. The unit is mostly compliant with GPICs with the exception of providing a rehabilitation clinic. There should be more emphasis on Level 1 patients and preventing deterioration. The critical care outreach service needs to be expanded which will require an additional acute physician. ACCPs may be part of the solution as well as recruiting more SAS doctors from overseas via the MTI scheme.

UNIVERSITY HOSPITAL, COVENTRY: University Hospitals Coventry and Warwickshire NHS Trust

The unit is operating at 94% capacity; more is needed, ideally 6 -8 additional beds. There are not enough resources or consultants. The main problem is that there are 11 consultants and this is not enough especially after the CQC decision that the cardiac unit should be taken over. Ideally, the hospital would need 16 consultants so an increase of 5 is needed. ACCPs and Physician Assistant roles need to be developed. Annualised hours outside of the ICU work well for the work/life balance and allows flexibility; 42 weeks is standard and there is lots of downtime which will reduce burnout.

WALSALL MANOR HOSPITAL: Walsall Healthcare NHS Trust

The Trust are building a new ICU; bed space will increase from 14 to 16 so additional consultants will be needed and the unit will need to change the way it is run. The unit is not able to meet the follow up clinic standard in GPICS; they have been able to recruit nurses but do not have a physiotherapist or psychiatrist input.

WARWICK HOSPITAL: South Warwickshire NHS Foundation Trust

It is unclear if the Trust will be able to recruit more trainees to meet the GPICS standards. The unit has a follow up clinic run by nurses where there is no consultant input. However, the nurses are able to refer patients to psychologists when necessary.

GENERAL DISCUSSION POINTS

Reconfiguration & potential centralisation

The region is not expecting any major service reconfiguration in the near future although there are local reconfigurations being discussed.

Centralisation could be possible in certain cases, for example, post-surgery patients could be stabilised and transferred which would put all trainees in the same centre. It is unlikely that this would be popular. It is sometimes difficult to transfer patients and would require a similar number of nurses etc. to transfer a large number of patients safely. This also would not help the problem with junior staffing levels as a similar number would still be required to meet the ratio. There are patient transfer models that work, e.g. paediatrics. The problem would come when the patient was not stable enough to transfer. The region would also need to take into account population; increasingly older population may not want to go too far from home and relatives may not be able to visit.

Overall Summary

The region needs to increase its staffing numbers, particularly middle-grades and nurses.

It is difficult to meet GPICSs standards regarding supernumerary nursing and ensure there is 1 trainee: 8 patients.

The region needs to train more ACCPs and find a way to keep them at the hospital they train in. Ideally a salary agreed across the region would lessen the appeal to move.

There will be increased demands and ethical concerns regarding an increasingly aging population

and whether they should be admitted to the ICU.

Community care for long-term patients with degenerative conditions needs to improve. Home care packages could be set up to prevent their admission to the ICU. It is difficult to turn patients away in these cases. It is also difficult to refuse inappropriate referrals from other departments due to increased pressure from relatives, colleagues and managers.

6. PROBLEMS AND SOLUTIONS

Sections 4 and 5 of this report detail the many problems currently facing the ICM workforce in the West Midlands. These can be summarised into the areas below. It is notable that when compared to information from the annual ICM workforce census, all of these areas are common across the entire UK.

6.1 Problems

6.1.1 Staffing

There are concerns regarding the staffing levels in many units; there are difficulties in filling vacant posts which are expected to increase due to consultants approaching retirement. As most of the rotas in the region are still combined, it is difficult to recruit from overseas as doctors need to have adequate airway skills before they are appointed; there is very little time to train them otherwise.

Practitioners have an important role within the region however, recruiting them does leave a gap in the senior nursing rota. There seems to be an issue with retaining these practitioners in some hospitals once they have qualified.

There is a lack of stability in the middle-grade rota in many units and it is becoming increasingly difficult to employ internal locums due to Trust policies and a cap on pay.

The region as a whole needs to increase the number of training posts available. As with other parts of the UK, trainees tend to take up consultant posts in the region in which they trained, the West Midlands is no different. However, the West Midlands has the lowest trainee to population ratio in the UK which makes the problem more acute. There are very few trainees in the smaller DGHs within the region; those trainees who are based in these hospitals vary significantly in their stage of training and ability.

6.1.2 Workload

The frequency of the on-call rota in some hospitals, particularly some of the DGHs, is quite onerous. This is compounded when people are on annual leave or sick leave. Most hospitals within the region have found an increase in the number of inappropriate referrals to the ICU and, particularly when on call, most of their work was done outside of the ICU.

6.1.3 Service Reconfiguration

During the discussions there seemed to be a lot of uncertainty about the direction of services within the region. In some Trusts, ICUs were merging without an increase in staffing numbers. This uncertainty was also thought to be impacting on the ability to recruit for vacant posts.

6.2 Solutions

6.2.1 ACCPs

Recruiting and training more ACCPs would help fill gaps in the rota and also assist consultants in training junior trainees. Many of the attendees felt ACCP training and pay should be funded centrally, either nationally or by region, in an effort to standardise both training and pay; this would hopefully lead to an increase in retention.

6.2.2 Trainees

There was unanimous agreement that more trainee posts were required across the region. DGHs within the region needed to be more attractive to trainees and there was a suggestion to create a specialist rotation in DGHs to encourage trainees to go there to train in a particular area of the curriculum. An increase in trainees in DGHs would also help fill gaps in the rota. There was also a suggestion to engage with undergraduate medical students much earlier in their careers; historically students are not exposed to ICU until quite late in training and get very little experience in an ICU before this. However, there would be little point in encouraging more trainees if there were not the posts for them to fill.

6.2.3 Workload

Rotas: The region could benefit from improving the morale of consultants and making the specialty more attractive to encourage established consultants to keep working in ICM. There was a suggestion to standardise changing rotas as people move through their career in order to reduce burnout; for example weekend on-calls only after the age of 55.

Community Care: Improving the community care packages for patients with long-term or degenerative conditions might reduce the number of admissions to the ICU.

Level 1 Care: There were discussions around improving Level 1 care and preventing deterioration of patients. There was also agreement that not all ventilated patients needed 1:1 care. Establishing different types of units, such as nurse-lead weaning unit, could help to reduce this burden.

Physician attachments: Several of the attendees voiced concerns that their physician colleagues did not have enough awareness of the role and limitations of intensive care medicine. There was a suggestion that newly qualified consultants who would be expected to refer patients to an ICU should spend some time on a unit to help avoid inappropriate referrals and future conflict when these referrals were refused.

Technology: There were suggestions to increase the use of technology during consultations either with trainees or other wards. Establishing a telemedicine system or utilising FaceTime or Skype would allow a consultant to ensure a referral was appropriate before accepting it and meant they could supervise trainees at other sites and subsequently fill rota gaps.

7. DATA

All attendees at the Regional Engagement Meeting were asked to provide information on their current workforce and what they expected their workforce need to be approximately 5 to 10 years in the future. Those with question marks either failed to provide any information or could not give an estimate.

7.1 Headcount

All attendees were asked to provide a headcount of all consultants, ACCPs and nurses working on their unit both now and in the future. The question marks within in the tables indicate that the information was not available or not provided.

HOSPITAL	CONSULTANTS		ACCPs		NURSES	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Burton Hospital	6	8	0	2	50	50
Heart of England NHS Foundation Trust	17	20	8	16	145	145
Hereford County Hospital	4	8	0	0	57	50
Kettering General Hospital	8	8	0	0	69	74
New Cross Hospital, Wolverhampton	6	10	0	6	150	150
Princess Royal Hospital, Telford	4	8	0	?	49	49
Royal Shrewsbury Hospital	7	?	0	?	?	?
Russells Hall Hospital	9	?	0	?	66	?
Sandwell and West Birmingham Hospital	13	15	0	6	114	114
University Hospital Coventry	11	16	0	6	128	146
University Hospital North Midlands NHS Trust	11	14	9	10	171	?
Walsall Manor Hospital	8	8	0	0	?	?
Warwick Hospital	8	8	2	8	38	38

7.2 Whole time equivalents (WTEs)

All attendees were asked to provide the whole time equivalent (WTE) of all consultants, ACCPs and nurses working on their unit both now and in the future. The question marks within in the tables indicate that the information was not available or not provided.

HOSPITAL	CONSULTANTS		ACCPs		NURSES	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Burton Hospital	6	8	0	2	36	40
Heart of England NHS Foundation Trust	8.5	10	7.5	16	123.6	140
Hereford County Hospital	4	8	0	0	48.6	44.8
Kettering General Hospital	2.5	3	0	0	63.55	68.55
New Cross Hospital, Wolverhampton	6	10	0	6	148.72	142.12
Princess Royal Hospital, Telford	3.7	8	0	?	42.95	42.95
Royal Shrewsbury Hospital	7	?	0	?	54	?
Russells Hall Hospital	8.8	?	0	?	66.07	?
Sandwell and West Birmingham Hospital	16	15	0	6	125.37	127.79
University Hospital Coventry	10	16	0	6	106.57	145.5
University Hospital North Midlands NHS Trust	11	11	?	?	184.5	200.5
Walsall Manor Hospital	10	10	0	0	67	67
Warwick Hospital	8	8	2	8	31.7	?

7.3 Trainees

All attendees were asked to provide a headcount of all trainees working on their unit both now and in the future; these were broken down into those in their Foundation, Core and Higher training posts along with those trainees not in a recognised training post. The question marks within in the tables indicate that the information was not available or not provided.

HOSPITAL	FOUNDATION		CORE		HIGHER		NON-TRAINING		TOTAL	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Burton Hospital	1	2	6	6	4	6	13	12	24-26	26
Heart of England NHS Foundation Trust	2	2	9	9	14	14	0	0	27	27
Hereford County Hospital	1	0	1	?	1	?	0	?	3	?
Kettering General Hospital	1	1	3	2	1	1	2	4	7	8
New Cross Hospital, Wolverhampton	2	2	13	13	11	11	0	0	26	26
Princess Royal Hospital, Telford	0	?	0	?	0	?	2	?	2	?
Royal Shrewsbury Hospital	3	?	1	?	1	?	0	?	4	?
Russells Hall Hospital	0	?	12	?	8	?	3	?	23	?
Sandwell and West Birmingham Hospital	?	?	?	?	?	?	?	?	?	?
University Hospital Coventry	4	4	6	6	6	8	0	0	16	18
University Hospital North Midlands NHS Trust	2	2	4	4	5	4	4	8	15	18
Walsall Manor Hospital	2	2	8	8	2	2	0	0	12	12
Warwick Hospital	1	1	9	9	4	4	2	2	16	16

7.4 Summary

The table below provides a summary of all of the tables found earlier in this section and indicates whether units expect their need for workforce to increase, decrease or remain the same in the future. The question marks within in the tables indicate that the information was not available or not provided.

HOSPITAL	NOW	FUTURE	% INCREASE OR DECREASE
Burton Hospital			
WTE for Consultants	6	8	33% increase
WTE for ACCPs	0	2	200% increase
WTE for Nurses	36	40	11% increase
Number of Trainees	26	26	remains the same
Heart of England NHS Foundation Trust			
WTE for Consultants	8.5	10	18% increase
WTE for ACCPs	7.5	16	113% increase
WTE for Nurses	123.6	140	13% increase
Number of Trainees	27	27	remains the same
Hereford County Hospital			
WTE for Consultants	4	8	100% increase
WTE for ACCPs	0	0	remains the same
WTE for Nurses	48.6	44.8	8% decrease
Number of Trainees	3	?	unknown
Kettering General Hospital			
WTE for Consultants	2.5	3	20% increase
WTE for ACCPs	0	0	remains the same
WTE for Nurses	63.55	68.55	9% increase
Number of Trainees	7	8	14% increase
New Cross Hospital, Wolverhampton			
WTE for Consultants	6	10	67% increase
WTE for ACCPs	0	6	600% increase
WTE for Nurses	148.72	142.12	4.4% decrease
Number of Trainees	26	26	remains the same
Princess Royal Hospital, Telford			
WTE for Consultants	3.7	8	116% increase
WTE for ACCPs	0	0	remains the same
WTE for Nurses	42.95	42.95	remains the same
Number of Trainees	2	?	unknown
Royal Shrewsbury Hospital			
WTE for Consultants	7	?	unknown
WTE for ACCPs	0	?	unknown
WTE for Nurses	54	?	unknown
Number of Trainees	4	?	unknown
Russells Hall Hospital			

WTE for Consultants	8.8	?	unknown
WTE for ACCPs	0	?	unknown
WTE for Nurses	66.07	?	unknown
Number of Trainees	23	?	unknown
Sandwell and West Birmingham Hospital			
WTE for Consultants	16	15	6.25% decrease
WTE for ACCPs	0	6	600% increase
WTE for Nurses	125.37	127.79	2% increase
Number of Trainees	?	?	unknown
University Hospital Coventry			
WTE for Consultants	10	16	60% increase
WTE for ACCPs	0	6	600% increase
WTE for Nurses	106.57	145.5	36.5% increase
Number of Trainees	16	18	12.5% increase
University Hospital North Midlands NHS Trust			
WTE for Consultants	11	11	remains the same
WTE for ACCPs	?	?	unknown
WTE for Nurses	184.5	200.5	9% increase
Number of Trainees	15	18	20% increase
Walsall Manor Hospital			
WTE for Consultants	10	10	remains the same
WTE for ACCPs	0	0	remains the same
WTE for Nurses	67	67	remains the same
Number of Trainees	12	12	remains the same
Warwick Hospital			
WTE for Consultants	8	8	remains the same
WTE for ACCPs	2	8	300% increase
WTE for Nurses	31.7	?	unknown
Number of Trainees	16	16	remains the same

8. SUMMARY

Critical care is a key service for an acute hospital without which many dependent specialities are unable to safely function. This is recognised by the Care Quality Commission which always assesses critical care services in every hospital inspection, recognising that a functioning service both provides a safety net for other failing areas but also acts as a bellwether for the whole system.

Critical care provision in the West Midlands is challenging when compared to other parts of the country. Most hospitals have now split the ICM on call rotas from base specialties, but have not been able to complete this process and for some it seems unlikely this will happen in the near future.

Employing a sustainable workforce in this region is a considerable challenge for this region. The UK as a whole is expecting a 4% year on year increase in the need for critical care services. If anything, this may be an underestimate for some hospitals in the West Midlands. Many hospitals are reporting increasing requirements for critical care input and this is translating through to consultant on call rotas becoming both more frequent and more onerous. This in turn may lead to recruitment and retention issues for the specialty.

Most hospitals in this region have a number of vacant posts at the consultant level which they are struggling to fill and many are anticipating the need for a significant further increase in consultant numbers in the future to be able to cope with demand. It is difficult to see where or how this shortfall will be breached unless something changes.

Trainee numbers in many hospitals are limited and the consultant body is therefore under considerable stress. Due to how the original training programme was set up, trainees in the West Midlands are predominantly placed into just a few centralised tertiary centres leaving other hospitals struggling to cover the middle grade positions. Morale amongst the current trainees in the region is low and this has significant implications on the future of the workforce for this area, recognising that the future consultant appointments tend to come from locally trained junior doctors.

The Faculty hopes the proposed solutions discussed in Section 6.2 offer a framework for the Critical Care Network, the Deanery and the Department of Health, to develop a strategy to begin to address the problems outlined.

APPENDIX 1: LIST OF ATTENDEES

Amanda Barber	West Midlands Deanery
Ranjna Basra	Trainee Representative
Tom Billyard	University Hospitals Coventry & Warwickshire
Tom Gallacher	Queen Elizabeth Hospital, Birmingham
Shameer Gopal	Royal Wolverhampton NHS Trust
Angela Himsworth	West Midlands Network Lead
Paul Jefferson	South Warwickshire NHS Foundation Trust
Zahid Khan	Queen Elizabeth Hospital, Birmingham
Laura Kocierz	Trainee Representative
Aditya Kurvai	Walsall Healthcare NHS Trust
Robert O'Brien	Heart of England NHS Foundation Trust
Mamta Patel	TPD & Sandwell and West Birmingham Hospitals
Nehal Patel	North Staffordshire Royal Infirmary, Stoke
Mike Reay	Russells Hall Hospital, Dudley
Nick Sherwood	City Hospital, Birmingham
Paul Smith	Queens Hospital, Burton on Trent
David Stanley	Russells Hall Hospital, Dudley
Duncan Watson	University Hospitals Coventry & Warwickshire
Phil Watt	Kettering Hospital
Carole Webb	Queens Hospital, Burton on Trent
Alistair Windsor	Royal Shrewsbury Hospital