# REGIONAL WORKFORCE ENGAGEMENT REPORT:

# WALES

The Faculty of
Intensive Care Medicine

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# 1 INTRODUCTION: THE CRITICAL CARE WORKFORCE

## 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, most Welsh units 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)

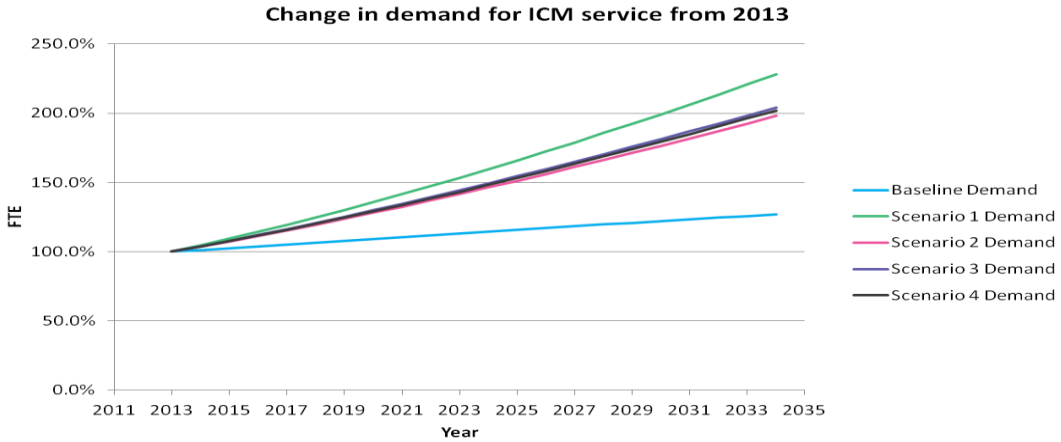
ICNARC is currently undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014.

"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.

In January 2015, the Faculty wrote to Professor Mark Drakeford, the Welsh Government Minister for Health and Social Services. We received a positive response, with Professor Drakeford noting that the Welsh Government would welcome any information which would help them decide on the best model for future critical care service provision in Wales.

Following extensive liaison with the Critical Care Networks and the Welsh Intensive Care Society (WICS), representatives (please see Appendix 1) were agreed with each Health Board, the Welsh Government, the Networks, WICS, the Wales Deanery and local training leads. We are grateful to the assistance given by Zoe Goodacre and Sue O'Keefe, respectively the South and the North Wales Critical Care and Trauma Network Managers.

### 2.1 Engagement aims

The engagements would be conducted with the aim of:

- Describing the current supply of ICM/critical care facilities in Wales 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 Wales, their distribution and demographic; and the workforce in training.
- Conducting network-based 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 Wales 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 Wales.

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 THE WORKFORCE IN WALES

## 3.1 Clinical Demand and Workforce in Wales

***This information was based on a presentation given by Dr Jack Parry Jones and reflects his opinion on the clinical demand and workforce situation in Wales. The presentation can be viewed in Appendix 4.***

The U.K. faces real difficulties staffing critical care units to generally agreed minimum levels. These difficulties will get worse, as the already real and further predicted demand for critical care increases. The Intensive Care National Audit and Research Centre (ICNARC) predict a 4% increase in critical care demand. Those delivering critical care know this only too well. The increasing expectations of our medical and surgical colleagues as to what critical care can achieve, married to a reluctance to accept death outside of all efforts mean workload is increasing alongside the intensity of that work.

The supply of junior medical staff delivering a service has diminished due to the European Working Time Directive, changes in anaesthesia training, inability to recruit staff from outside European boundaries, and Deaneries imposing well-meaning hours limits on junior's service. Each junior now delivers 50% fewer service hours than in the past. In the 2014 FICM workforce census the biggest source of stress to consultant intensivists was "Trainees – inadequate numbers, inadequate competencies." Critical Care consultants face increasing demands which impact on early retirement plans, movement into anaesthesia alone, and part time working.

Wales, with a population of 3 million, is no different from some other regions of the U.K and provides a microcosm to view difficulties and look towards solutions. If you were designing a health service with critical care support in the 21st century, and putting geographical and geopolitical limitations to one side, you might not choose to have 14 sites with critical care units providing care for a population of 3 million. Fewer but larger units from a medical workforce perspective have economies of scale. Each critical care unit requires 1 resident tier for advanced airway support but if additional medical staff is required e.g. if it is a larger unit with more than 8-10 patients, then the additional medical staff could be medical or surgical and not anaesthetic trained. Anaesthetists are having their critical care training increasingly restricted and are very unlikely to be the solution to critical care's staffing problems in the future. This arrangement of resident medical cover has considerable advantages in terms of availability since the number of possibly available medical staff is considerable larger - plus it is to all of our advantage, patients included, that medical and surgical trainees have a better understanding of critical care. In simplistic terms 14 units requires 14 x 8 (112) anaesthetists in a tier at any given time providing critical care cover. 8 being a minimum number in a tier although the deanery would rather 11 (154). If there fewer units e.g. 5 units you need 5x8 (40) or 5 x 11 (55) anaesthetists in a tier providing advanced airway cover with a second or even 3rd tier of medics/surgeons providing additional medical cover.

Wales could meet existing GPICS staffing standards within existing junior numbers if it had 5 big hospitals. As it is there is no way it can, as the NHS in Wales is currently structured, meet these standards in all units delivering critical care. There needs to be a realignment of resources to better match the demand and meet the necessary standards for patients. Solutions include more ACCPs and more non-anaesthetists doing critical care as part of their training requirements. National standards need to be met to improve training and to attract juniors and consultants into critical care. Finally to hold onto consultants there needs to be an agreed minimum number on on-call rotas, and national guidelines on on-call retirement age.

### 3.2 ICM and Critical Care Facilities in Wales

***This information was based on a presentation given by Dr Matt Dallison (Regional Advisor in ICM for Wales) and reflects his opinion on the current ICM and Critical Care facilities in Wales. The presentation can be viewed in Appendix 4.***

The following presentation attempts to give the reader an overview of critical care provision in Wales during 2015.

It summarises data obtained from the Critical Care Network here in Wales which of course was provided by the individual critical care sites.

It compares health boards and individual sites when considering some aspects of the GPICS document. This includes total Consultant number, whether there is a separate critical care commitment for on call for consultants and trainee staff, numbers and dependency of admissions, and average length of stay.

It reveals both similarities and differences between the various units within Wales.
It shows that there are similarities at most sites with the ratio of elective and emergency work. All sites had made provision for clinical governance with respect to critical care. All sites had education specific to critical care but formats varied somewhat. All units provided advanced respiratory, cardiovascular and renal support with some centres also using intra-aortic balloon pumps regularly.

The second section of the presentation attempts to summarise the new CCT in Intensive Care Medicine. It gives an overview of the whole process from recruitment, the training scheme itself, the examination and how we are currently achieving all of this in Wales.

## 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 Wales. The attendees were divided into two groups, North and West Wales and South Wales. The groups were asked to discuss the following points:

- What current gaps in service provision (personnel or structural) are apparent in Wales?
- 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?

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

**BRONGLAIS HOSPITAL, ABERYSTWYTH: Hywel Dda University Health Board**

There are currently 11 consultants at the hospital but no trainees. It is the only hospital in Wales with purely consultant centred care. On call is mixed duty and resident. There are some staffing issues and all shifts between 9am and 8:30pm are ICM and Anaesthetics. There is an obstetrics unit which is also covered by ICU staff due to the location. There were 150 caesarean sections in 2014 which is 28% of all births in the hospital. The unit can cope with the serious cases. At the moment, the rota is sustainable but some colleagues are going part time.

**GLAN CLWYD HOSPITAL, DENBIGH, Betsi Cadwaladr University Health Board**

There are some gaps in staffing; there are 8 consultants and the hospital have recently tried to recruit for a consultant post however, this was unsuccessful on two occasions and the post remains unfilled. 3 of the consultants are over 50; after 55 consultants are taken off over-night on-call and placed on weekend trauma on-call instead. There is no dedicated ICM resident. Recruiting doctors with full ICM training remains difficult.

**GLANGWILI HOSPITAL, CARMARTHEN and PRINCE PHILIP HOSPITAL LLANELLI: Hywel Dda University Health Board**

There are 14 critical care beds in Glangwili and 5 in Prince Philip that are used flexibly for level 3 and 2 patients. There are 8 critical care consultants providing 24 hour cover to both units. All consultants work 12 session job plans with more than 50% commitment to critical care. Glangwili has a two tier resident on call in critical care with the senior tier dedicated to critical care. Prince Philip has a dedicated critical care resident. Neither Glangwili nor Prince Philip are recognised for ICU training and so the on call tiers are predominately composed of SAS doctors. We cannot use our anaesthetic trainees to fill the ICU resident rota and so we depend on both internal and external locums. There has been a decrease in the number of trainees placed in Carmarthenshire due to a central pull and this will undoubtedly lead to further recruitment problems. New appointments at both consultant

and middle grade level have either been from previous trainees or from abroad. We have had recent success by recruiting from both the Czech Republic and Hungary. There are 2 critical care consultant retirements in the next year, and we expect difficulties filling these posts with suitably qualified applicants.

**MORRISTON HOSPITAL, SWANSEA: Abertawe Bro Morgannwg University Hospital Health Board**

There are 26 critical care beds which are always over capacity. In theory, when the trainee: patient ration is 1:8 a locum can be requested but this doesn't happen very often. There is a separate anaesthetic and ITU rota so anaesthetic trainees are moved over to the ITU as locums. The senior tier is made of advanced trainees and there will be a shortfall at the end of the Joint trainees, this tier will also not be as experienced as it has previously been. There are 5 trainees in the top tier, 9 in the middle and 5 in the bottom tier along with lots of locums as not everyone does overnight on-call although this is not due to age. There are 14 consultants on the on-call rota doing varying amounts of critical care; no one is 100% critical care and 2 consultants do 50% job shares. The rota is 1:10 weekends at Morriston Hospital and 1:10 weekends at Singleton Hospital. The Singleton Hospital unit is barely level 2; the aim is to stabilise patients until they can be transferred. The demographic of consultants is fairly evenly split so there shouldn't be large gaps due to retirement.

**NEVILL HALL HOSPITAL, ABERGAVENNY: Aneurin Bevan University Health Board**

There are 8 ITU beds in the hospital; 6-2 flexibly split between level 3 and level 2 respectively. There is a 1:7 consultant rota: all consultants also work in anaesthetics but mainly ITU (60%-70%). The average age of consultants on the rota is over 40. There is a whole on-call tier missing; the junior tier is very junior and there are lots of calls to attend due to the lack of senior trainees and consultants. The hospital is however, in the process of training ACCPs.

**PRINCE CHARLES HOSPITAL, MERTHYR TYDFIL: Cwm Taf University Hospital Health Board**

There are 6 consultants working a 1:8 rota; there is no separate ITU on call rota. There are 2 tiers on site, 1 very junior trainee and 2 covering ITU and obstetrics. The hospital is in the process of trying to split the rotas and trying to recruit more senior trainees for a dedicated ITU on-call rota.

**PRINCESS OF WALES HOSPITAL, BRIDGEND: Abertawe Bro Morgannwg University Hospital Health Board**

Critical care at the hospital is very uncertain at the moment. There is currently a 1:6 consultant rota with one unfilled post. Three of the existing consultants anticipate leaving critical care in the next five years. CT1 and CT2 trainees cover both surgery and ITU out of hours, and although there are a number of SAS grades covering obstetrics, they refuse to cover critical care. Few operations (aside from emergencies) happen at night so anaesthetic trainees and consultants mainly cover ITU. There are lots of unplanned consultant resident on call which is causing major problems, and could lead to burnout. Locums are covering evening resident on calls and cost approximately £40k per month. There have been difficulties appointing consultants; at the last interview there were 2 un-appointable candidates and a previous post had been vacant for 2 years. There is huge competition with other units for candidates.

**ROYAL GLAMORGAN HOSPITAL, PONTYLCUN: Cwm Taf University Hospital Health Board**

There is a 1 in 8 rota, separate for ITU with 3 tiers. There are lots of non-training grade gaps and the hospital is currently liaising with the GMC about the recruitment of overseas doctors as well as looking into training ACCPs. Critical care at the hospital is very uncertain at the moment.

**ROYAL GWENT HOSPITAL, NEWPORT: Aneurin Bevan University Health Board**

There are 9 level 3 beds, 6 level 2 beds and 3 PACU beds. There are 9 consultant intensivists and 1 dedicated junior tier of mainly dual anaesthetic and ICM trainees working a dedicated critical care rota. The unit is in the process of trying to create a 2nd junior tier to include ACCPs due to the number of beds covered. The ideal number of consultants needed would be 12. Ideally there would be 2 consultants on call at the weekend to make it a 1 in 6 weekend rota. There is currently a 1 in 8 rota as two consultants are less than full time.

**UNIVERSITY HOSPITAL WALES, CARDIFF and LLANDOUGH HOSPITAL, PENARTH: Cardiff and Vale University Hospital Health Board**

There are 17 rota slots and 16 consultants with 14WTEs to cover the rota. 13 people do full time ITU with 5 working more than 10 sessions per week. Demographically, there are 2 big age groups, 1 group has an average age of 40 and the other group is mainly in their mid-50s. There is a 24/7 resident service which is not sustainable but there are currently no other alternatives. The resident rota is not attractive to the 2 trainee tiers; 1 tier is a 1:8 with the 8th slot being partly covered with advanced trainees. The advent of run through training means that as of next year these advance training slots will disappear. Therefore our tier 1 rota will become a 1:7. The junior tier is 1:12 but there has never been more than 1:10. At Llandough Hospital there is no trainee recognition and anaesthetic cover is vulnerable at night due to difficulties filling the rota. There are 41 bed spaces across the sites but only nursing staff for a maximum of 27 to be used; technically the units are always over capacity. The consultant staff will function as registrars rather than consultants; there is almost always an ST3 or ST4 on the unit however these trainees cannot run a unit so consultant support is needed. A 3rd tier of ST6 or ST7 trainees would be able to run the unit. The hospital has relied heavily on advanced trainees and the shortfall will make everything vulnerable. The unit is trying to create a 3rd tier but there is no extra money available. All trainees and consultants work nights, roughly every 1:5. PACU beds have increased out of hours commitment which were originally planned to be staffed by senior nurses. The unit has 2 funded ACCPs but expansion of this role has no secure funding. The only available funding at present would be from the medical staffing budget which is not viable. The entire junior tier cannot be replaced by 2 ACCPs although in theory this would be possible with 7 ACCPs. The unit is unable to attract clinical fellows and is reliant on individuals to take on extra work which could easily go wrong; the department is chronically fatigued. Llandough Hospital is at risk of not being fit for purpose; it has lost lots of services making it difficult to run a critical care service but 2/3 of the medical take go there so there has to be a service. The Health Board is aware of these issues.

**WITHYBUSH GENERAL HOSPITAL, HAVERFORDWESTL: Hywel Dda University Health Board**

WGH has 9 physical beds with nominal split of 3 ICU and 4 HDU beds. The rota is split between anaesthetics and intensive care; there are currently 4 intensivists who cover the working week. The

on-call rota is 1:10 with anaesthetists, without whom the service could not run. There is presently a dedicated middle grade doctor on the unit for the working day. The middle-grade staff who cover the unit out of hours are also very good and have worked on the unit for many years. The anaesthetic department and unit have benefited from a successful recruitment in Eastern Europe. The Health Board have removed anaesthesia CT trainees from Haverfordwest. Obstetric and inpatient paediatric services have recently been moved to the Glangwili site.

**WREXHAM MAELOR HOSPITAL: Betsi Cadwaladr University Health Board**

There are 6.5 consultants and 8 posts filled by locums. There are some concerns regarding the retirement of two consultants within the next 5 years. There is a mixture of middle-grades, non-trainee and trainee ACCPs, core and CCT trainees on the unit. Approximately 10-12 years ago the hospital recruited a large number of SAS doctors from North African countries but now there is an aging gap and the unit is having to rely more heavily on locums. The unit is struggling in general.

**YSBYTY GWYNEDD, BANGOR: Betsi Cadwaladr University Health Board**

There are 6 consultants who cover on-call with anaesthetics; this rota is sustainable at the moment. Currently ICM and obstetrics are both covered which is very common although they should ideally be separated. Ideally, the unit would like 3 tiers of on call however, there would need to be an increase in spending on locums as this would create more sessions which need to be covered. There are several staff grades; 8-10 have been recruited from Hungary. There is 1 ACCP in training. There are a selection of staff trainees working in dedicated blocks and some not in dedicated blocks. There is very much a team approach at the moment which seems to be working well. Trainees and consultants are attracted by the lifestyle offered by Bangor which helps to maintain the workforce; 3 ICM trainees have expressed an interest in returning to Bangor after completing their CCT.

**GENERAL DISCUSSION POINTS**

**Geographical differences**
It is difficult to recruit South Wales trainees to North Wales consultant posts; trainees are already settled in the area they train in and are reluctant to uproot. These trainees only stay in North Wales for short periods of training. Trainees are also reluctant to undertake the commute between North and South Wales for training. It requires people from outside the region to fill consultant posts. Trainees appear to be applying for consultant jobs in units which have trainees; if units create training posts, this might encourage consultant recruitment.

**Service reconfiguration**
The threat of service reconfiguration seems to be having a negative impact on junior doctors applying to train and consultants applying to work in affected areas; no decisions are being made which has created an atmosphere of uncertainty. Major Trauma Centres will also change the service dramatically.

**District General Hospitals**
Dual training tends not to be as good in DGHs; there may be a view that single CCT ICM consultants may be less keen to work in a DGH and that a relative lack of airway experience makes this individual more vulnerable in DGH than in teaching hospital. It is very common in Wales for DGHs to have staff grade cover. The political imperative to maintain A&E departments is a strong driver to maintain critical care services.

## 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 Wales. The attendees were asked to consider different models based on the short-term future (5-10 years):

- *What workforce would be required for each Heath Board in order to*
  - *maintain the current critical care service provision?*
  - *meet the Standards of GPICS?*
  - *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 of EMRTS and patient transfer and repatriation will be on units?*

*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. You should consider if there are any overall challenges or themes.*

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

**GLAN CLWYD HOSPITAL, DENBIGH: Betsi Cadwaladr University Health Board**

Glan Clwyd would need approximately 4-5 consultants to continue to the rota split of 1:8, this also takes into account potential retirees. We would also need 5-6 residents to have a dedicated on call resident rota.

**MORRISTON HOSPITAL, SWANSEA: Abertawe Bro Morgan UHB Abertawe Bro Morgannwg**

The hospital needs 40 critical care beds and currently only has 26. The unit was asked to design 3 models, one realistic, one plausible and one 'ideal world' and none were implemented. The service needs an additional 10 or 11 trainees to make up the numbers. Quicker discharge of patients and appropriate admissions to the ICU would make the workload easier. There is an issue with retaining nurses and junior staff; there is also an issue with senior staff moving up. The unit is good at retaining SAS grades and the majority would come from anaesthesia.

**PRINCE CHARLES HOSPITAL, MERTHYR TYDFIL: Cwm Taf University Health Board**

The hospital is highly reliant on Clinical Fellows. Until there is an agreement/plan for how critical care services will look in the future, there will be difficulty in recruiting staff at all levels. The Health Boards seem reluctant to make decisions on expanding some units and downgrading others all of which impacts on other hospitals in the area.

**PRINCESS OF WALES HOSPITAL, BRIDGEND: Abertawe Bro Morgannwg**

Three out of six consultants are in their early fifties and so we will need 3 replacements in 5-10 years, plus an additional 2 if we are to run a 1:8 on call. All consultants have a 50 percent

commitment to ITU. To make our resident tier for the ITU compliant with GPICS, we would need an additional seven doctors to the one we currently have. We are in the process of recruiting 2 ACCS and 3 SAS doctors. If we are able to recruit we should be well on the way. Local reconfiguration is at the whim of local politics. If the Royal Glamorgan ceases acute care, then our workload could increase.

**ROYAL GLAMORGAN HOSPITAL, PONTYCLUN: Cwm Taf University Health Board**

The hospital hasn't modelled patient flow or bed use due to uncertainty; any modelling done would impact on Prince Charles Hospital.

**ROYAL GWENT HOSPITAL and NEVILL HALL HOSPITAL, NEWPORT: Aneurin Bevan University Health Board**

If a new hospital is built (Specialist Critical Care Centre) merging the critical care services of Nevill Hall and Royal Gwent onto one new site then 15-20 consultants would be required. This would simply merge the existing consultant workforce of the 2 hospitals. Without the new hospital the number of consultants needed would be 12 on the RGH site (an increase of 3), with 7 on the Nevill Hall site. Due to an ageing consultant workforce in the next 5 years we will need 4-5 consultant replacement posts. For junior staffing we need across the 2 sites a full tier of 10-11 depending on what the deanery considers an acceptable rota. The ACCPs in training will be used as part of the junior tier on each site.

**UNIVERSITY HOSPITAL WALES, CARDIFF and LLANDOUGH HOSPITAL, PENARTH: Cardiff and Vale University Hospital Health Board**

The hospital has undertaken bed modelling; for supply to meet demand, the Trust would need 45 fully staffed beds (40 at level 3). This would require massive recruitment as for every 10 beds there would need to be a consultant lead team; this would require at least 20 consultants, more if resident service was required so an increase of at least 7 consultants. There would need to be a new tier of senior and junior trainees and at least 6-7 clinical fellow type roles. There would also need to be a tier of ACCPs. There are currently issues with nurse staffing; the unit is supposed to have 204 WTE but runs at around 170 WTE. There needs to be 7 nurses per bed however this is unlikely to improve due to funding cuts. The ideal would be a service that doesn't rely on full training posts.
A meeting was arranged for mid-November to develop the Cardiff workforce strategy; attendees would include head of finance, board members and directorate manager. There was a request that the FICM put more pressure on other specialties to consider ICU a mandatory part of training. The PACU unit is currently being run by the critical care service rather than anaesthetics however this will eventually change. Llandough Hospital is running as a level 2 unit as there is no guarantee that there will be space to transfer patients; ideally it would be run at a level 1.

**WREXHAM MAELOR HOSPITAL: Betsi Cadwaladr University Health Board**

Wrexham would need approximately 4-5 consultants to continue to the rota split of 1:8, this also takes into account potential retirees. We would also need 5-6 residents to have a dedicated on call resident rota.

| GENERAL DISCUSSION POINTS |
| --- |
| There is an increasing trend of separating elective and emergency surgery.<br><br>Dual trainees with a non-anaesthetic background have an effect on on-call rotas; there needs to be an anaesthetist on call to ensure airways etc. are covered. |

# 6 PROBLEMS AND SOLUTIONS

## 6.1 Problems

Sections 3 and 4 of this report detail the many problems currently facing the ICM workforce in Wales. These can be summarised into four global 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.

### 6.1.1 Staffing: current or imminent gaps

There are concerns regarding gaps in staffing levels in the immediate future at all sites. This includes people working part-time or dropping ICU sessions from job plans. A number of sites have had semi-permanent gaps that they have to fill using either expensive locum workforce or by advertising for applicants abroad.

### 6.1.2 Staffing: long-term gaps

Due to the comparatively low levels of training posts available, the number of applicants for future consultant posts will also be lower. However, the number of consultants aged 55 or over is increasing and with this the number of retirements. The flexibility of junior training programmes means it is difficult to predict if trainees will choose to train in ICM at ST3.

The IASP language exam standards are being tightened with doctors now required to obtain a score of 7.5 by the GMC for European recruitment. This may affect the recruitment of European doctors.

### 6.1.3 Work intensity: workload

Consultant workloads are being stretched. There are not enough consultants or sessions to cover what is needed and the lack of medical resident for ICUs is increasing consultant workloads out of hours. It is clear that there is an increasing need among the population for critical care services, but the number of beds could not be expanded without the workforce to manage them.

### 6.1.4 Work intensity: on-call

The intensity of on-call commitments is impacting on services:

- There are instances of theatre lists being cancelled if a consultant has been on-call the night before.
- Resident on call becomes increasingly difficult with age as recovery times increase.
- Some consultants have given up other roles, such as educational supervisors, in order to aid this.
- Anaesthetic trainees are already committing beyond their curriculum requirements to cover ICU on call; this may lead to concerns within the Deanery regarding the quality of training.

## 6.2 Solutions

The discussions covered in Section 5 indicated a number of solutions to the current workforce situation, which are summarised below. Most importantly, these are solutions to deal with the impending problems facing Welsh Health Boards and do not build in the potential for the likely substantial growth in patient need expected (as with Sections 1 and 2 above).

### 6.2.1 Increasing the medical workforce: trainee doctors

Wales has fewer posts per population recruited annually than for most of the rest of the UK. The lack of middle grade support on units was raised multiple times during the engagement. 47% of CMT posts will be unfilled for 2016; Health Boards have been informed and told to find uses for the posts. During the discussions, it was reported that Emergency Medicine in Wales has more trainees than posts and it was suggested a possible solution (at a more junior level) could be to 'borrow' some of these trainees.

### 6.2.2 Increasing the medical workforce: consultants

Following on from the trainee increase, there needs to be an increase in consultant time dedicated to ICM. Although in the medium to long-term, this should be sourced from proper levels of UK workforce, in the short-term there may need to be further European recruitment to get resident cover to aid the consultant workforce. This would include a 6-9 month lead in time with the doctor being treated as a novice trainee before being 'signed off' for the on call rota.

### 6.2.3 Advanced Critical Care Practitioners (ACCP)

Wales has historically trained only small numbers of ACCPs, but those present at the engagement felt that more practitioners would provide much needed support on the unit at the middle grade level. With the new FICM ACCP Curriculum, there is the opportunity to train practitioners to a single standard and avoid the variation of remit of ACCPs between units that currently exists.

There were suggestions for units to collaborate regarding the training and employment of ACCPs, although issues of salary, training funding and back-fill would need to be considered.

### 6.2.4 Reorganisation and adaptation

The group discussed a number of possible reorganised structures that would aid with fill rates and recruitment.

**Rotating consultant posts**: There was discussion about amalgamating units to ease the burden and cross-cover. This could be a possible solution; however there needs to awareness of issues with SPAs and split job contracts. There would be benefits, for example most consultants in Bridgend live in Cardiff but commute in and there could be an option to do on-call in Cardiff. Agreed it would be useful to do a man-power model for this.

**Perioperative Medicine:** Develop post-operative units throughout Wales similar to those in Cardiff which have ICU nurses and a new 4 bed post theatre suite.

**North Wales training:** There are currently no trainees permanently based in North Wales; trainees only work in North Wales for blocks of training from areas such as Manchester and Liverpool. The links with the North West are not formalised but this could be done. It would be beneficial to offer particular modules in North Wales (e.g. an ICU ECHO Fellowship) which would appeal to senior trainees.

**Emergency Medical Retrieval and Transfer Service**: There are plans for the service to go 24/7 and it might be more efficient to centralise transports rather than sort out each separate service. If centralisation occurs, transport will become a significant issue across the country. It would have 3 bases in North, Central and South Wales. It was modelled in South Wales but would have limitations

such as being geographically dependent. There were concerns regarding retaining staff; Scottish service has no trouble attracting staff for shorter contracts but staffing could become an issue long term.

### 6.2.5 E-ICU

The premise is for a consultant to be sitting in a central hub receiving information and advising on multiple cases and making decisions on treatment across a network or group of hospitals. This is done by radiologists in Australia. There are concerns that a consultant would still be needed on site as success depends massively on the assessment of the admitting team and the skills of the junior doctor. It would also be dependent on local sensitivities/knowledge and the consultants' ability to deal with different personalities. This would be an option if the team was reliable and skilled. However, a looser decentralised structure is under discussion in Hywel Dda which reflects the experience and knowledge and availability of the medical staff involved.

There are lots of issues to consider and be resolved if this were to be implemented. Difficulties would include the loss of continuity of care and failure to appreciate local variations in process and practice. It does not solve the current or predicted future lack of medical resident cover or the predicted shortfall in consultants. There is a lack of medical workforce on the development group. Although North and South Wales share a lot of data, a lot of pathways would need to be built/standardised in order for it to work. However, the Welsh Government is keen on implementing a Clinical Information System (CIS) and has committed to spending £3.35 million over the next 3 years.

# 7 SUMMARY

Critical care is a key service for an acute hospital without which many dependent specialities would be unable to safely function. This has been recognized by the Care Quality Commission which assesses critical care services in every hospital inspection, recognizing 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 Wales is very different between the North and South of the country. Partly this relates to geography with the Northern hospitals being sited around the mountainous interior, but also relates to the population base being mainly in the South. This has profound implications for the delivery of critical care across the region with very different solutions having developed in the two areas and by necessity future solutions will have to be different.

The main tertiary referral hospitals in Wales are situated in the South of the country. This means that patients requiring specialist care need to be transferred large distances. In the North of the country, patients would either have to be transferred to the South or transferred to the cities of Liverpool / Manchester in England.

When the Welsh critical care units are compared against national GPICS standards it is clear that there is a significant shortfall in place already. This shortfall manifests in both junior and senior rotas. There is a shortfall in trainees (mostly in the North) and a deficit in consultant numbers throughout. This deficit is significant. In order to meet the demand placed upon them a number of hospitals have developed rotas of non-training grade doctors from the European Union. Of concern, a number of these rotas are now untenable with an ageing workforce that is becoming difficult to replace.

Current standards suggest that the consultant workforce should only cover Intensive care out of hours and not also be called to provide care in other areas of the hospital such as the operating theatre or delivery suite. Very few hospitals in Wales are able to meet this standard and there is a realization that this is unlikely to change.

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 Wales as due to the geographic isolation they are also expected to provide a level of specialist care that other similar district general hospitals do not. There does not seem to be any easy solution to this increased requirement for trained intensivists and the current shortfall is likely to significantly increase in the near future.

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

## APPENDIX 1: LIST OF ATTENDEES

| | | |
|---|---|---|
| Alan Lewis | Associate Medical Director | Cwm Taf University Health Board |
| Ami Jones | Clinical Lead (Critical Care) | Nevill Hall Hospital, Aneurin Bevan UHB |
| Andrew Hermon | ICU Manager | Cwm Taf University Health Board |
| Caroline Lewis | Major Health Conditions Policy Officer | Welsh Government |
| Chris Littler | Clinical Direct (Anaesthetics) | Wrexham Maelor Hospital - BCUHB |
| Chris Thorpe | Consultant (ICM) & Former Lead for STA in Wales | Ysbyty Gwynedd - BCUHB |
| Dave Hope | Clinical Lead (South Wales CC Network) | ABMUHB |
| Dena Jones | Senior HR Business Partner | Cwm Taf University Health Board |
| Ed Farley-Hills | Clinical Director (Critical Care) & Clinical Lead | BCUHB & North Wales Critical Care Network |
| Eluned Wright | Regional Advisor (Anaesthetics) | All Wales |
| Gareth Scholey | Clinical Director (Critical Care) | Cardiff & Vale University Health Board |
| Hywel Roberts | Chair | Welsh Intensive Care Society |
| Jack Parry-Jones | Clinical Lead (Critical Care) | Royal Gwent Hospital, Aneurin Bevan UHB |
| Lisa Bassett | Specialty Training Manager | Wales Deanery |
| Maria Hobrok | Clinical Lead - Critical Care | Hywel Dda University Health Board |
| Matt Dallison | Regional Advisor (ICM) | All Wales |
| Piroska Toth-Tarsoly | Clinical Lead - Critical Care | Cwm Taf University Health Board |
| Richard Pugh | Clinical Lead (Critical Care) | Glan Clwyd Hospital - BCUHB |
| Richard Self | Clinical Lead (Anaesthetics Critical Care & Theatres) | Princess of Wales Hospital, ABMUHB |
| Sam Sandow | Clinical Lead (Critical Care) | Wrexham Maelor Hospital - BCUHB |
| Sarah Harries | TPD (Anaesthetics) | All Wales |
| Sue O'Keeffe | Network Manager | North Wales |
| Tamas Szakmany | Clinical Lead (South Wales CC Network) | Aneurin Bevan University Health Board |
| Teresea Evans | TPD (ICM) | Aneurin Bevan University Health Board |
| Vincent O'Keeffe | Clinical Direct (Anaesthetics) | Glan Clwyd Hospital - BCUHB |
| Zoe Goodacre | Network Manager | South Wales |

## APPENDIX 2: MAP OF WALES – HOSPITALS AND HEALTH BOARDS

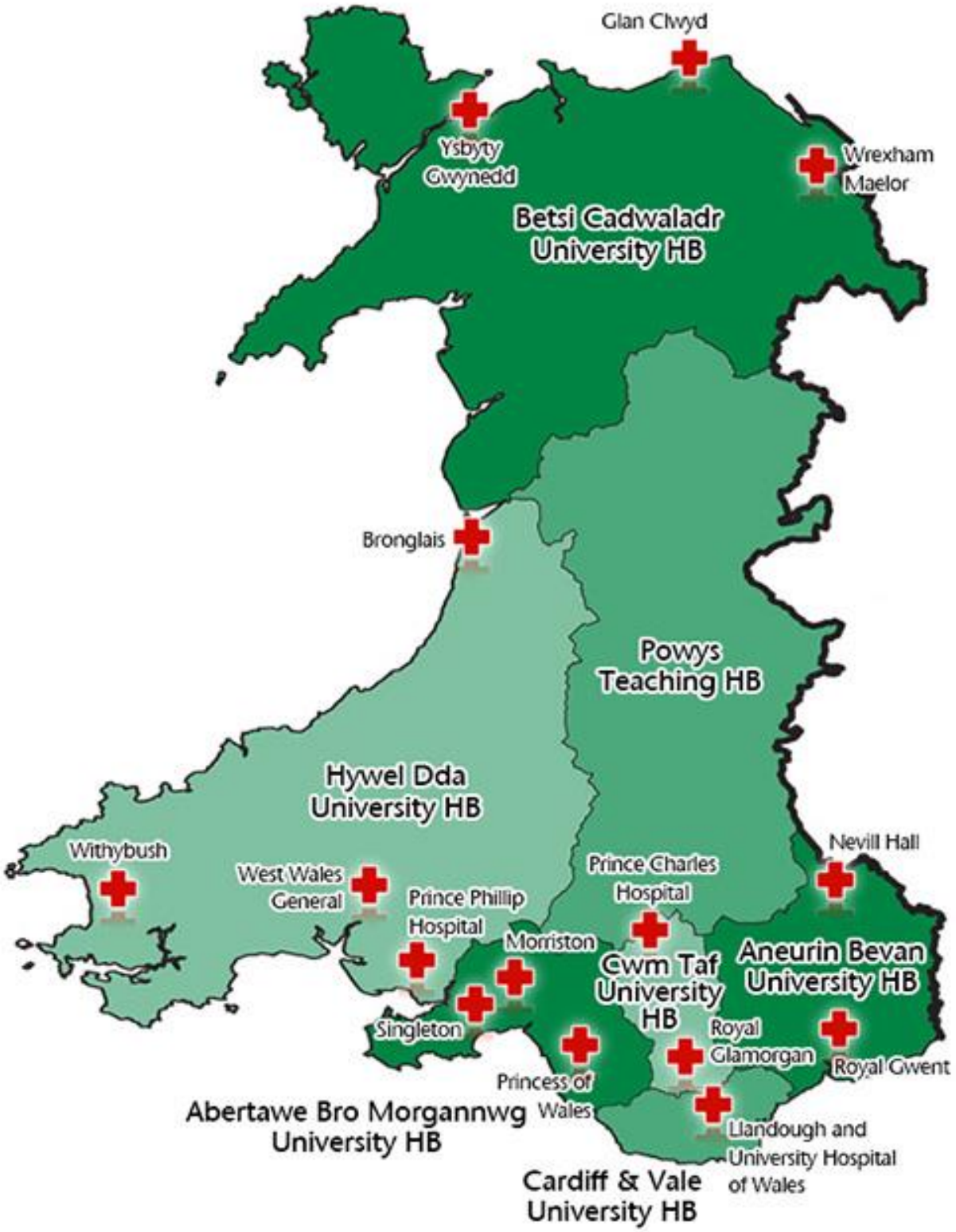



Image from Wales Deanery

## APPENDIX 3: AUDIT OF CRITICAL CARE CONSULTANT AND JUNIOR STAFFING AGAINST WELSH AND UK-WIDE CORE STANDARDS (APRIL 2014)

**Key Findings:**

1. 50% of Welsh Critical Care units do not currently meet Intensive Care Medicine (ICM) consultant staffing standards
2. Little progress has been made in meeting ICM consultant staffing requirements in the 8 years since Welsh critical care standards for consultant staffing were originally published
3. Largest cause of failure to meet standards is Tier 3 units being staffed out of hours and weekends by non ICM trained consultants
4. 50% of units share their out of hours resident (junior) cover with theatres or obstetrics
5. 80% of units do not meet all the standards for junior staffing – either shared cover 6/14 or covering too many patients out of hours 3/14
6. Too many units across Wales are reliant on anaesthetic junior cover with a dwindling work force due to the EWTD, a reduction in the stipulated critical care commitment by trainee anaesthetists by the Royal College of Anaesthetists and an inability to recruit non-training grade staff to cover critical care
7. At current trainee staffing there are too many Tier 3 critical care units in Wales

**Key Recommendations:**

A full medical staffing workforce review has already been recommended in the Delivery Plan for the Critically Ill (2013). This is paramount. A timeline needs to be agreed, along with appropriate composition of the group carrying out the workforce review. This should include a gap analysis of consultant and junior staffing levels between what is deliverable now, what is required to meet standards now, and what is required to meet requirements following reconfiguration of services. Units not meeting consultant staffing requirements should either split consultant rotas from anaesthesia or drop the tier of care within an agreed timeframe by the implementation group. This may require the employment of additional ICM consultants in some Health Boards to make rotas sustainable

**Introduction:**

In June 2013 the Welsh Government published "Together for Health – A Delivery Plan for the Critically Ill". The medical staffing in the Delivery Plan was based on a "Strategic Vision for Critical Care Services in Wales" which was endorsed by the Welsh Intensive Care Society, the National Specialist Advisory Group for Anaesthesia and Critical Care, and the Welsh Critical Care Networks. An Implementation group was set up by the Welsh Government (chaired by Andrew Goodall, CEO Aneurin Bevan University Health Board) to oversee the Delivery Plan, and this met in January and March 2014.

Medical staffing is very high up on clinicians concerns about delivering good safe critical care now and in the future. It has been clear since 2006 and the publication of "Designed for life: Quality Requirements for Adult Critical Care in Wales", that critical care medical staffing is compromised in Wales and frequently has not been sufficient to meet recommended critical care professional standards. In 2009 more than 50% of critical care units in Wales were not compliant with consultant and junior staffing when audited against the standards agreed in the "Designed for Life: Quality Requirements for Adult Critical Care in Wales". The decision was made by the Implementation group to audit the standards.

**Method:**
An audit form was emailed out to all identified clinical leads for each Intensive Care unit. This was followed up by email and through the Critical Care networks on 4 further occasions to get more than 90% compliance (missing data from cardiac and burns critical care ABMUHB). 2 general adult units – Prince Phillip Hospital (Llanelli) and Princess of Wales Hospital (Bridgend) did not supply data. Standards audited against were the recommended professional standards for Medical Staffing from the Intensive Care Society and from the Welsh standards outlined in "Together for Health – A Delivery Plan for the Critically Ill". These do not differ to any degree from either each other, or from the European Standards outlined by the European Society of Intensive Care Medicine (ESICM):

**Standards audited against:**
*Core Standards for Intensive Care Units (2013, The Faculty of Intensive Care Medicine and the Intensive Care Society).*

1. Care must be led by a consultant in Intensive care medicine.
   A consultant in Intensive care medicine is a consultant who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine. A consultant in Intensive Care Medicine will have Daytime Direct Clinical Care Programmed Activities in Intensive Care Medicine written into their job plan. These programmed activities will be exclusively in ICM and the Consultant may not cover a second speciality at the same time.
2. Consultant work patterns should deliver continuity of care.
   Blocks of care are commended for providing continuity of care.
3. In general the consultant/patient ratio should not exceed a range between 1:8 – 1:15, and the ICU resident/patient ratio 1:8.
4. A consultant in ICM must be immediately available 24/7, be able to attend within 30 minutes and must undertake twice daily ward rounds.
5. Consultant Intensivist led multi-disciplinary clinical ward rounds within Intensive Care must occur every day (including weekends and national holidays).

Welsh Standards: **"Together for Health – A delivery Plan for the Critically Ill". June 2013**

| Unit Tier | Level 3 care | Critical Care Consultant Staffing | Anaesthesia Consultant | Dedicated Critical Care junior | Level of patient care provided |
|---|---|---|---|---|---|
| Tier 1 | Ability to intubate/ventilate/transfer level 3 patients | 7 sessions/week | Yes, in emergencies | 0 | Level 2 care only |
| Tier 2 | Level 3 care < 48hrs | 14 session weekly commitment by a critical care consultant | Overnight out of hours cover acceptable within the 12 hourly review by a critical care consultant | Dedicated | Level 2 and short term level 3 |
| Tier 3 | Prolonged level 3 care | Dedicated Critical Care Consultant rota, >14 sessions/wk | Emergency unpredictable only | Dedicated | Level 2 and prolonged Level 3 |
| Tier 3T | Prolonged level 3 care and specialist care | Dedicated Critical Care Consultant rota | Emergency unpredictable only | Dedicated | Level 2, 3 and specialist care |

**Results:**

Intensive Care Medicine (ICM) Consultant staffing of Critical Care Units in Wales. April 2014

| Hospital | Tier of critical care delivered | Is patient care led by an ICM consultant 24/7 | Does the critical care consultant provide blocks of care | Are non ICM consultants providing out of hours cover | Does the ICM consultant to patient ratio exceed 1:15 | Is an ICM consultant immediately available 24/7 within 30 minutes | Are level 3 patients seen x2/daily by an ICM consultant | Are level 2 patients seen x1/daily by an ICM consultant | Do ICM led MDT ward rounds occur daily | Meets consultants standards appropriate for Tier |
|---|---|---|---|---|---|---|---|---|---|---|
| CTUHB PCH | 3 | N | Y | Y | N | N | N | N | N | N |
| CTUHB RG | 3 | N | Y | Y | N | N | N | N | N | N |
| CVVUHB UHW | 3T | Y | Y | N | N | Y | Y | Y | Y | Y |
| CVVUHB LUH | 2 | Y | Y | N | N | Y | N | Y | Y | N |
| CVUHB cardiac | 3T | Y | Y | N | N | Y | Y | Y | Y | Y |
| ABMUHB Morriston | 3T | Y | Y | N | N | Y | Y | Y | Y | Y |
| HDUHB Withybush | 3 | N | Y | Y | N | N | N | N | N | N |
| HDUHB Glangwili | 3 | Y | Y | Y | Y | Y | Y | Y | Y | N |
| HDUHB Bronglais | 3 | Y | N | N | N | Y | Y | Y | Y | N |
| ABUHB NHH | 3 | Y | Y | N | N | Y | Y | Y | Y | Y |
| ABHB RGH | 3 | Y | Y | N | N | Y | Y | Y | Y | Y |
| BCUHB YGC | 3 | Y | Y | N | N | Y | Y | Y | Y | Y |
| BCUHB YG | 3 | N | N | Y | N | N | N | N | N | N |
| BCUHB WM | 3 | Y | Y | N | N | Y | Y | Y | Y | Y |

ICUs highlighted in red do not meet standards. 50% of critical care units do not meet consultant staffing standards.

Junior Staffing of critical care units.

| Hospital | Tier of critical care delivered | Is there a dedicated ICM resident for critical care only 24/7 and weekend | Is the junior covering critical care also covering theatres/obstetric | Does the ICM resident(s) have to cover >10 patients at night and weekends | Is the critical care unit recognised for ICM training | Number of resident staffing tiers | Is the junior tier reliant on trainees | Is the unit compliant with consultant staffing standards | Is the unit compliant with ICM resident standards |
|---|---|---|---|---|---|---|---|---|---|
| CTUHB PCH | 3 | N | Y | N | N | 1shared | Y | N | N |
| CTUHB RG | 3 | Y | N | N | Y | 1 | Y | N | Y |
| CVVUHB UHW | 3T | Y | N | N | Y | 3 | Y | Y | Y |
| CVVUHB LUH | 2 | N | Y | N | N | 1shared | N | N | N |
| CVUHB cardiac | 3T | N | Y | N | Y CARDIAC | 1shared | Y | Y | N |
| ABMUHB Morriston | 3T | Y | N | Y | Y | 3 | Y | Y | N |
| HDUHB Withybush | 3 | N | Y | N | Y | 1shared | Y | N | N |
| HDUHB Glangwili | 3 | Y | N | Y | Not answered | 1 | Y locums required weekly | N | N |
| HDUHB Bronglais | 3 | N | Y | N | N | 1shared | N | N | N |
| ABUHB NHH | 3 | N | Y | N | Y | 1shared | Y | Y | N |
| ABHB RGH | 3 | Y | N | Y | Y | 1 | Y | Y | N |
| BCUHB YGC | 3 | N | Y | N | Y | 1 | Not answered | Y | N |
| BCUHB YG | 3 | N | Y | N | Y | 1(shared) | Not answered | N | N |
| BCUHB WM | 3 | Y | N | N(Y) | Y | 1 | Not answered | Y | N |

80% of units do not meet the standards for the resident tier. In most cases this is because the junior is also covering out of hours and weekend either theatres or obstetrics. In 3 units the junior is covering more than the recommended number of patients.

**Conclusions:**

**ICM consultant staffing:**

Most units failing to meet standards do so because they remain at Tier 3 but without the provision of a separate ICM consultant rota. Critically ill patients are therefore being cared for overnight, over weekends and bank holidays by non ICM trained consultants. These units need to consider whether to provide consultant ICM staffing standards or to become tier 1 or 2 units. This may require the employment of additional ICM consultants to make rotas sustainable. An appropriate timeframe therefore needs to be agreed for implementation.

**ICM junior staffing:**

The majority of units are failing to meet standards for the resident tier, due mainly to shared cover with other specialties. There remains a dangerous reliance on anaesthetic junior staffing, whose numbers are falling whilst the number of critical care units has remained largely the same. There are very few critical care trainees in Wales (less than 20 advanced critical care and Faculty of Intensive Care Medicine trainees). Critical care trainees themselves, in their present number would only be able to staff one large critical care unit (> 10beds). As such, critical care in Wales remains completely reliant on anaesthesia to provide resident staffing rotas.

The following is an extract from the Delivery plan for critical care:

"There are significant factors impinging on how a critical care service is going to be delivered over the short, medium and long term across Wales. These include:

1. A reduction in training hours brought about by the European Working Time Directive (EWTD).
2. A call by the Royal College of Anaesthetists for a reduction in service delivery to critical care. A training commitment in critical care for Anaesthetists remains due to competencies being best met by some competency assessed training in critical care medicine.
3. A deanery recommended increase in the number of trainees per rota from 1:8 to 1:10 (11).
4. The Faculty of Intensive Care Medicine (FICM) has from 2012 dedicated critical care medicine trainees but the numbers are very small (8-12 posts in Wales 2014)."

In view of the above, alternative staffing utilising Advanced Critical Care Practitioners (ACCPs), Staff Grade and Associate Specialists (SAS), and post Completion of Certified Training (CCT) doctors need to be further explored and initial investment made in the medium to long term to create a team to provide the necessary service in Health Boards across Wales.

Medical staffing as a whole needs to be jointly addressed by Health Boards, the Welsh Deanery, and the Critical Care professional bodies – Welsh Intensive Care Society (WICS), the Critical Care Networks and the National Specialist Advisory Group (NSAG) for anaesthesia and critical care."

A critical care workforce review is of paramount importance. There is a significant risk is that a unit will be forced to close for resident staffing reasons and this will then impact on all the acute services using that site. This will lead to a collapse of services on that site and a destabilising impact on other hospital sites.

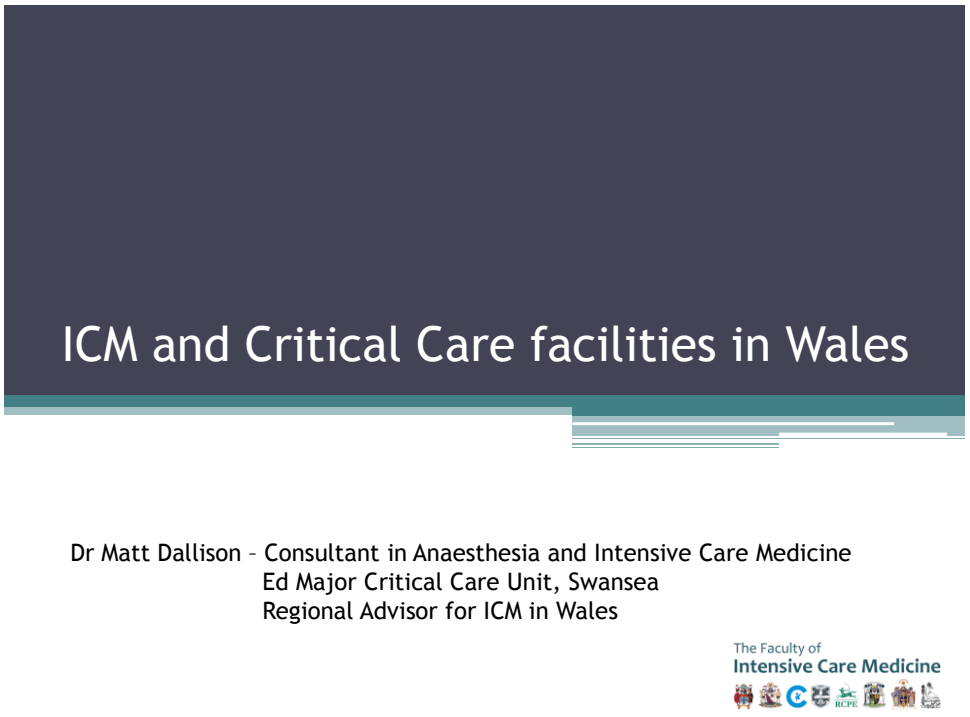
This workforce review should include a gap analysis of what is achievable now, against what ICM consultant and resident staffing is necessary with the present configuration of Welsh hospitals, and lastly what consultant and resident staffing is necessary with various permutations of reconfiguration plans.

The composition of the workforce team needs to be agreed with a timeline to report back to the Implementation Group.

1. "Together for Health – A delivery Plan for the Critically Ill" http://wales.gov.uk/docs/dhss/publications/130611deliveryen.pdf
2. "Core standards for Intensive Care units. 2013". The Faculty of Intensive Care Medicine and the Intensive Care Society.

Author: Jack Parry-Jones FRCP FRCA FFICM
Agreed by the Critical Care Implementation Group 13th June 2014.
Issues related to critical care junior training have been omitted

## APPENDIX 4: Presentations given by Dr Jack Parry Jones and Dr Matt Dallison


The presentations can be found on the FICM website: https://ficm.ac.uk/workforce/local-engagements