REGIONAL WORKFORCE ENGAGEMENT REPORT:

SOUTH WEST PENINSULA

The Faculty of
Intensive Care Medicine

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EXECUTIVE SUMMARY

The Faculty, represented by Dr Daniele Bryden and Dr Jack Parry-Jones (the current Lead for Workforce, reporting to the Careers, Recruitment and Workforce Committee (FICMCRW), and a Board Member) and Mr Daniel Waeland (Head of the Faculty), were welcomed to the South West Peninsula region by representatives from each Trust, the Network, the Specialist Training Committee and School. Dr Parry Jones writes:

What better way to warm up a cold, wet November day than a Faculty visit to a racetrack for the South West Workforce Engagement. There was no racing, or betting that I was aware of, despite the venue. Our needs for fodder however were very well catered for, and our sincere thanks must go to the region for your kind hospitality for what was the 7th Faculty Workforce Engagement. Our previous regional summaries are all on the Faculty website, with a summary report of the first six also available. I highly recommend them to you.

We started the day with two excellent presentations by Dr Sam Waddy (South West Critical Care Network Lead), and Dr Stuart Dickson (Regional Advisor). They clearly set out the scene and the regional challenges being faced. The region is geographically large, with relatively poor road services and is sparsely populated – except in summer when the annual tourist influx increases the population by a third. This makes the current provision of the seven acute hospitals and their critical care services, absolutely necessary but also correspondingly difficult to staff. Many common themes came through, as in previous engagements; difficulty staffing junior and consultant rotas, difficulty employing Allied Health Professionals(AHPs), and poor workforce morale, with critical care nurses back- filling a lack of nurses on general wards. There was a significant emphasis on the particular difficulties faced by the region. The following significant concerns are worth highlighting:

1. The out of hours advanced airway cover was recognised to be tenuous in some hospitals in the region following some incidents, with a requirement to mitigate the attendant risk. The General Provision for Intensive Care Services (GPICS) states that the critical care service resident junior should not also be providing cover external to critical care, and that there must be the on-site presence of someone with advanced airway skills. If the only anaesthetist out of hours is otherwise occupied (operating theatre, catheter laboratory, etc) and the junior doctor covering critical care does not have advanced airway skills then there is significant risk, as outlined in the RCoA's National Audit Project (NAP4) in March 2011, to critically ill patients requiring intubation/reintubation. The geography of the region means that the number of hospitals providing a 24/7 Percutaneous Coronary Intervention (PCI) service is more than expected for the population served, putting pressure out of hours on multiple sites.
2. There is a constant struggle first to recruit, and secondly to then retain critical care nursing staff. Units have to make a significant financial investment and make time to train nurses and it is a waste to then lose them to other services. This makes ensuring staff morale all the more important. The same also potentially applies to Advanced Critical Care Practitioners (ACCPs), which makes units wary of fully investing in them for fear that they may go elsewhere after completing their training. The region does have a well-developed ACCP training programme.
3. Units are being starved of investment despite the fact that they are running at a financial surplus. The money that units make through commissioning is being used to support other

hospital services that are running at a loss. If this investment was retained and used for critical care services, they would be able to provide a better and safer critical care service.

Since we were at a racetrack I couldn't but reflect on horses for courses. What is needed is a basic horse with four legs, ably trained to do the job, who can stay the course. For General Provision for Intensive Care Services (GPICS 2), the basic workhorse is defined as "*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 identified in their job plan. These programmed activities will be exclusively in ICM and the consultant will not be responsible for a second specialty at the same time."* Jump courses (eg an ECMO service) do require a specialist horse with specialist training – but it stills needs to be a horse.

The region has, with hard work and at some risk, increased the number of critical care trainees who are most likely to stay in region for consultant posts. These innovative solutions to training numbers need on-going support from trusts and deaneries to ensure the supply of critical care consultants for the future. It also ensures that senior ICM trainees can go into multiple hospital sites so they support the delivered critical care service, are well trained to the standards required, and can make better-informed choices about where they may want to become a consultant.

Lastly, it is understandable when you read these reports to feel dejected by the situation that units face and this report does contain situations that will clearly chime with others across the UK. However, the overwhelming feeling in the room was very upbeat and proactive and morale on the day was positive. The region has an active critical care network, significant numbers of consultants that trained in the region and excellent communication between units. Critical care in the South West has great potential for a vibrant future but it would hugely benefit from its difficulties being better recognised by the region's organisations, with investment particularly targeted to staff recruitment and retention in order to fully realise that potential.

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, and 2014 to 2018), 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 programmes, 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 known as GPICS*. 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. Furthermore, with the publication of GPICS2 in 2019, units will have to re-evaluate which standards they do and do not meet. 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 (eg 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 2016 censuses, the figure for those intending to drop ICM sessions rose from 22% to 38%. However, the most recent data from the 2017 and 2018 censuses show that this number has continued to drop from 16.6% to 16.07% respectively. The most common reasons across the 2014, 2015 and 2016 censuses for wanting to leave ICM were all focused on workforce issues:

- Work-life balance
- Work intensity / burnout
- Frequency of on call
- Lack of available beds/critical care facilities
- Lack of junior doctors

The 2018 census had a focus on gathering wellbeing data across the workforce. The issues that were leading to a decrease in ICM activities were: burnout, stress, retirement, family commitments and shifting to another specialty.

1.2.2 Expected increase in patient and NHS need for Critical Care

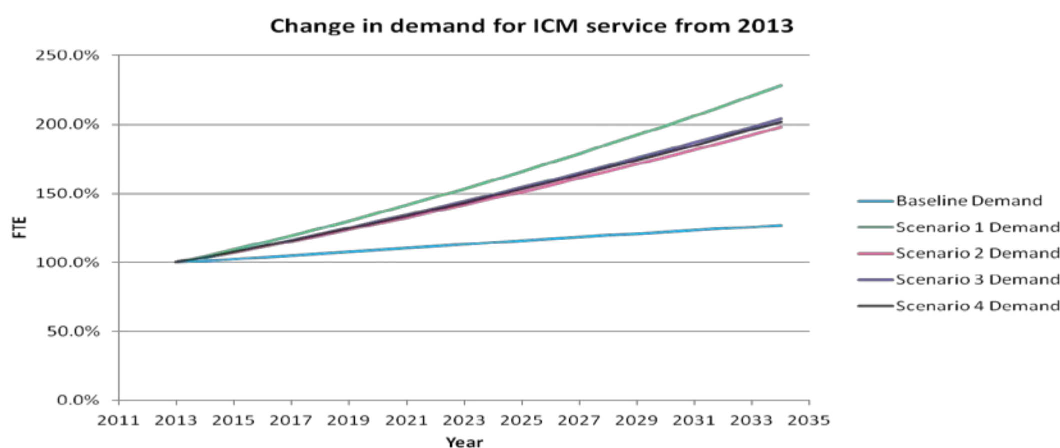
The **Intensive Care National Audit and Research Centre (ICNARC)** is undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014:

"*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)

The **Centre for Workforce Intelligence (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 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, focused entirely on England, the ICM clinicians taking part in the process agreed that the demand scenarios lines were applicable UK-wide.

This expected increase of circa 4-5%, is supported by **NHS Digital**'s own data. On their website, a summary of data is published from the Hospital Episodes Statistics (HES) warehouse on adult critical care activity, which increases by a little under 5% per year over the last five years.

Figure: *Change in demand for ICM workforce by scenario, CfWI Report*



1.2.3 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 FICM 2019 census will focus on the impact of ageing on those working in ICM to identify the impact on individual wellbeing.

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 home nations and regions, requesting that two pilot studies be undertaken. The first engagement was held in Wales in November 2015, followed by the West Midlands in May 2016, Scotland in September 2016, Yorkshire & Humber in November 2016, the North West in March 2017 and the East Midlands in November 2017.

The South West Peninsula was the seventh region to request an engagement with the Faculty, which we happily accepted. The South West Peninsula filled a quarter of their available posts in 2017; however, in 2018, the South West Peninsula had a 100% fill rate for the ICM training posts that they made available. Like many regions around the UK, they have concerns about the CCT output numbers in the intervening years between the Joint CCT finishers and the new ICM CCT trainees completing their training in sustainable numbers.

Following extensive discussion, representatives to attend the engagement meeting (please see Appendix 1) were agreed for each trust and included local training leads. We are grateful to the assistance given by the Network Medical Lead (Dr Sam Waddy), Regional Advisor (Dr Stuart Dickson) and the regional organiser (Dr Richard Gibbs), who all helped facilitate the event.

2.1 Engagement Aims

The engagement would be conducted with the aim of:

- Describing the current supply of ICM/critical care facilities in the South West Peninsula and presenting an assessment of likely future (5-10 years) demand.
- Identifying the likely future location of critical care services based upon the 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 South West Peninsula, their distribution and demography, 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 engagement 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 region.

The engagement would result in this final report and its appendices that could be used by the local stakeholders (across the Health Boards, Networks, School and Deanery) 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 THE SOUTH WEST PENINSULA

3.1 ICM Training, Clinical Demand and Workforce in the South West Peninsula Deanery Area

This information is based on the presentation given by Dr Stuart Dickson and Dr Sam Waddy and reflects their views on ICM training and workforce in the area of the South West Peninsula Deanery area. It reflects personal opinion where it is not clearly referenced to existing data from other sources.

The South West Peninsula area, in keeping with the rest of the UK, is facing increasing difficulties in adequately staffing Critical Care Units to minimum levels. The reasons for this in the South West are multiple and complex. Given current trends, the recruitment and retention of an adequate ICU workforce is likely to become increasingly challenging in the years ahead and will be compounded further by the increasing demand for critical care.

Measuring critical care demand and capacity gaps has proven difficult worldwide. Looking at surrogate markers such as, 'cancelled elective operations' we see increasing problems across the region. The pressures that the whole hospital system is under are also reflected in issues with flow and delays to ICU discharge of over 24 hours; however, these are being kept under control in the South and South West regions.

Historical predictions have suggested an ongoing 4% increase in critical care demand per year and whilst this was expected to be seen in increased Level 2 bed demand, many units are seeing rising Level 3 demand without an overall increase in capacity leading to a reduction in Level 2 bed usage. This has led to alternative pathways for Level 2 patients, particularly patients following elective major surgery. Whilst some of this movement out of intensive care is appropriate and represents evolving knowledge and case selection based on careful research, there is an increasing risk that it is occurring out of necessity and not design and represents an unmet need.

The South West Peninsula area delivers critical care in 7 intensive care units serving the populations of southern Somerset, Devon and Cornwall with a population at risk of approximately 1.9 million. This population increases substantially throughout the South West in the summer months, with Cornwall alone experiencing visitor numbers of up to 290,000 at any given time through the summer months. This represents an increase in the population at risk of up to 50% of Cornwall's normal resident population. Similar increases in population occur across Devon and Somerset. The South West Peninsula Deanery covers a geographical area of more than 11,000 km^2 and has the lowest population density in England, making the provision of all healthcare services including critical care particularly challenging. Furthermore, with the highest rate of inter-regional migration in England reflecting the area's attraction as a retirement destination, the area has the highest percentage of population over the age of 65 years in England, with projections that this age group will make up more than 22% of the resident population by 2022. The ageing population along with multi-morbidity, advances in therapies and differing expectations of patients, their relatives and parent teams, will continue to compound the demand on clinical services.

Across the 7 units in the South West Peninsula Deanery area, there are 102 critical care beds (Level 3 and Level 2) and all units manage these flexibly. The total medical workforce is currently 71 consultants, 70 of whom have weekly ICU day sessions, this equates to between 1 consultant per 7.5 to 16 beds in the daytime and 1 consultant per 8-26 beds at night. Several units are dependent on senior staff who have already retired and returned and it is predicted that up to 50% of the current consultant workforce will retire in the next 10 years. Many of the on-call rotas are not compatible with continued working post retirement due to their intensity and lack of middle grade cover.

At present, there are 23 trainees in the ICM training programme in the region, 18 of whom are dual trainees. Various stages of ICM training occur in 6 critical care units across the region, with trainees

travelling to Bristol Children's Hospital for Paediatric ICM / Paediatric Anaesthesia training in Stage 2. The projected output of 4 trainees per year from the ICM training programme will not be sufficient to match the number of senior clinicians retiring from clinical practice in the next 5-10 years. These shortages in the medical workforce will be felt particularly acutely, as regional units look to expand their consultant workforce in order to meet increasing clinical demand. Difficulty in achieving consultant recruitment is already a reality in the region. Many units in the region operate without an effective middle grade rota with consultants routinely 'acting down' to provide critical care services.

Whilst there is clearly unutilised training capacity within the region and a great appetite to provide high quality ICM training, there is no dedicated funding stream to facilitate this. Expansion in ICM training posts depends entirely upon trusts diverting funding from trust posts or unfilled consultant posts in order to generate funding for training. This funding model is clearly not sustainable and precludes effective workforce planning.

There are currently only 1-2.5 senior ICM trainees (years 6 and 7) across the whole region, and the intensive care units remain highly dependent on anaesthetic middle grade rotas particularly for out of hours cover. This struggle to find and fund sufficient trainees has driven innovation and 2 of the 7 units now have ACCPs included on their medical rotas with an active training programme continuing. However, there is a long lead-time for ACCP training, and it is not yet clear how effective ACCP retention will be, especially with the widespread development of Advanced Clinical Practitioner (ACP) roles in other areas of specialisation.

The nursing workforce is highly dependent on locally trained nurses and most of the 7 units recruit preceptees. There is minimal movement of nurses from unit to unit due to the remote geography, which results in a loss of nurses from ICU as they seek career progression outside of the ICU within their current hospital or community. The net result is a relatively 'junior' nursing workforce and a constant struggle to achieve national standards in numbers of staff with an ICU qualification. The need to continue to invest in dedicated ICU Nurse Educators and ring-fence training and induction time is clear.

Allied Health Professional (AHP) staffing across the units is highly variable in design and time dedicated to critical care.

In the South West Peninsula, we continue to recruit motivated trainees who want to pursue a career in ICM. It is vital that we ensure the training, working patterns, AHP and nurse staffing are maintained and improved such that the specialty can continue to deliver the highest standards across a demographically and geographically challenging region and that we can keep these trainees as they become consultants.

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 South West Peninsula. 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 your unit specifically and the region in general?
- 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 attendees were also 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?

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

<u>Derriford Hospital, University Hospitals Plymouth NHS Trust</u>

- 26 bed unit 15 Level 3 and 11 Level 2 currently.
- 14 consultants in total (including 2 military consultants, 1 retired consultant for daytime sessions).
- 3 consultants work during the day from Monday – Friday until 6pm.
- 2 consultants are on call at weekends.
- 2 residents and 1 registrar provide cover 24/7 usually there are additional residents in the daytime.
- 15 trainees in total (Foundation: 3 Core: 9 Higher: 2 Non-training post: 1).
- 1 higher trainee can also provide on-call cover but this is variable.
- They have 6 ACCPs.
- There are workforce gaps across the unit with respect to nursing staff, especially with specialist nurses working at Band 6 and the unit currently has vacancies.
- The unit is reliant on anaesthetic registrar cover as there is constant pressure to be seeing patients in the Emergency Department, they do not have separate cover for major trauma and accompany patients to the Catheter Laboratory. Support cannot be guaranteed.
- The site does not have a Post-Anaesthesia Care Unit (PACU) however, when planned extended recovery is used there are supposed to be additional staff, this is not always possible to facilitate.
- A lot of patients after surgery go directly to Level 1.
- The concept of the 'extended recovery patient' risks limiting the capacity of a key area of escalation for ICU should it be required for a large-scale disaster.

North Devon District Hospital (Barnstaple)

- 8 bed unit predominantly Level 3 beds.
- 8 consultants in total. 9 starting in July 2019. Permission to recruit to 10.
- From April 2019, there will be 1 consultant working during the day from Monday – Sunday until 6pm, completing the ward round with night staff.
- 1 consultant on call at weekends.
- Resident cover is provided by ACCS/CAT trainees daytime and night time, who are predominantly year 1 trainees. Consultants attend for most non-theatre admissions and intubations.
- 9 core trainees.
- 9 trainees on a full shift covering out of hours and weekends. Daytime 1-3 trainees with a mixture of long (0800-2100) and short days (0800-1700). There is a consultant-led handover morning and evening.
- The current nursing establishment is based on 4 Level 3 patients and 4 Level 2 patients. Moving forward they are working towards increasing the nursing establishment to cover 6 Level 3 beds which equates to 52 WTE.
- The trust is committed to a 3-year review of critical care capacity, with potential expansion. This review is at a very early stage.
- The hospital has been given permission to increase the anaesthetic consultant body, there is funding for 10 more anaesthetic consultants in the next 5 years. If a suitable candidate arises, then one of these posts could be converted to an ICM consultant post. The unit would be open to appointing either a physician intensivist or emergency medicine intensivist if a suitable candidate presented.
- The unit is having difficulty with predicting and measuring their workforce need as they are in a state of flux.
- The unit is getting busier and busier and is having issues as a result but is presently coping. The unit would struggle if the situation worsened but plans to reduce the elective anaesthesia commitment for intensivists if required.
- Redeployment of staff within critical care to support other departments is problematic at times. However, there are more robust systems in place to prevent deployment through trust-wide staffing review meetings, accurate logs of activity; actual and predicted, skill mix and training needs analysis.
- 10 nurses with English National Board 100 (an older critical care course that was available a few years previously, equivalent to 60 credits), 2 nurses with 60 credit module with another about to complete, and 3 nurses with 40 credits critical care module. Course availability, length and ability to support educational courses all impact on our ability to meet the requirements recommended in GPICS.
- Whilst North Devon has senior sisters interested in the ACCP course, the role has not been supported within the unit amongst the intensivists as they feel there are too many core trainees needing support. If there were a reduction in core trainees then the unit would be very interested in it.
- The unit also handles many transfers, and due to its geographical isolation the average transfer takes 6 hours.

Musgrove Park (Taunton)

- 12 bed unit with a mixture of Level 2 and 3 beds.
- 8 consultants with a plan to increase to 9.
- 7 trainees in total (Foundation: 2, Core :3, Higher: 2)
- 2 SAS Grade doctors.
- 3 ACCS trainees.
- 2 consultants working during each morning from Monday – Friday until 1pm.
- 1 consultant on call at weekends.

- The unit has funding for 2 ACCP posts.
- A two bedded Level 2 unit opened in February for low risk elective cases, staffed from the Critical Care Unit.
- There is a good working relationship between the intensivists and anaesthetists at the trust. Anaesthetists go with ICU patients that are sent to the Catheter Laboratory, or if they need Interventional Radiology (IR) and for transfers. There is an internal agreement with the anaesthetists for them to cover these procedures. They are also happy to go down to the Emergency Department if the ICM team are overstretched.
- The lack of dedicated registrar/middle grade cover for ICU has been put on the trust's risk register. The registrar currently covers both ICU and obstetrics. However, this is likely to change.
- The main problem experienced at the trust has been with nursing recruitment. There is a high succession rate – 5-9% and a chronic recruitment problem as 10-20% of the posts remain unfilled.
- Taunton has done intensive recruitment for nursing staff over the past year and is now fully staffed for 90% occupancy. There is a healthy bank of staff that provides flexibility. Currently an establishment review is in progress to take the unit staffing to 100% occupancy and to provide predicted staffing for the planned new 22 bedded unit.
- GPICS has been a very useful way to combat questions from trusts and commissioners over why it takes so long to bring nurses up to speed on the ICU.
- Taunton have been trialling 1 WTE rotation Practice Facilitator post to work with the unit Practice Educator to support the new staff clinically, which has reduced the turnover in the < 1 year staff group.
- They are looking at employing clinical fellows or post CCT fellows to fill the gaps as they cannot employ enough middle grade doctors.
- Extended recovery is available for emergency cases.
- There is a fully established 24/7 Critical Care Outreach team in place

Royal Cornwall Hospital, Royal Cornwall Hospitals NHS Trust

- 11 consultants – the 12th covers the on call (via an old style caretaker system).
- 19 physical bed spaces of which 15 are open with an acuity of 6 Level 3 & 9 at Level 2.
- The unit has gone through a dramatic increase in activity. Level 3 beds are running at 105%-120% capacity and Level 2 at 100%.
- 15 trainees (Foundation: 6, Core: 7, Higher: 1, Non-training post: 1).
- There are two junior doctor rotas in operation - both are Band 1A & 2016 compliant rolling rotas.
  - Rota for Foundation doctors with 6 people - 3FY1 and 2FY2 doctors covering 24hrs.
  - Mixed rota for CT and ST doctors with 7-9 people including: 2 medical trainees, a selection of ACCS trainees, a fellow post and 2 anaesthetic trainees.
- For periods of time, there is no airway cover by trainees. Out of hours (after 8pm) a session anaesthetist covers trauma calls, paediatrics, ED and acts as a backstop for obstetric emergencies.
- Due to the geography, inter-hospital transfers have made a big difference to the way they operate. As consultants and senior trainees can be lost for a whole day when required to accompany patients on transfers.
- The Safer Care Initiative does not work for ICU as it takes nurses away from the service. The national Critical Care Networks have written to NHS Improvement regarding this saying it is unacceptable for Intensive Care. A different model must be found or ICUs should be removed from participating.
- In terms of their outreach provision, they have a 24/7 outreach service of band 7 nursing staff who support all admissions and discharges from a hospital-wide perspective and also

manage the Noninvasive Ventilation (NIV) service for patients in A&E or Medical Assessment Unit (MAU).
- Nursing is a big problem in the South West, when staff leave there is no one there to fill the gaps.
- They have enjoyed success with their national recruitment campaign and stress the importance of recruitment team and board involvement to gain approval for advertisement and attendance at events around the country. The international recruitment campaign has not been as successful as hoped due to many reasons including accrued hidden costs, funding and support for nurses to gain access to register and the inability to retain them long term.
- They have been working hard to develop a rotational preceptee post within critical care, recovery and anaesthetics, and if successful, this could address future vacancies in several areas. This proposal is only possible with dedicated practice education support in all areas and a promise to keep these nurses in training, rather than move to other areas if short staffed. They are hoping to implement this in September 2019

Royal Devon and Exeter Hospital

- 15 bed unit (currently funded for 13 Level 3 beds).
- 9 consultants.
- 3 ACCPs (2 full time and 1 0.7 WTE).
- 4 Trainees 'on block' at any one time and are a mix of ICM specialist trainees and anaesthetists on their 3 month blocks.
- 2 Locum Appointment for Service (LAS) posts, an F1 for 2/3 of the year, and occasionally an advanced trainee.
- Anaesthetic trainees fill gaps in the rota ad hoc.
- Monday to Friday from 08:30 – 17:00 there are two consultants on call.
- Out of hours and at weekends 1 consultant is on call (no sessions).
- The unit has no current expansion plans.
- There is funding for 13 Level 3 patients which is used flexibly to accommodate 14/15 patients at times.
- 2 resident roles (LAS) have recently been recruited.
- A Post-Operative Surgical Unit (POSU) is run jointly by surgeons and anaesthetists 2-3 nights per week for patients that wouldn't normally come to the ICU.
- It is becoming increasingly difficult to find airway competent cover at night and weekend days.
- Fantastic culture and static workforce are the hospital's great strengths.
- Hybrid model: responsibilities being shared among anaesthetic and ICM trainees, ACCPs and LAS posts. The majority do not possess advanced airway skills, so it is very variable what they can do.
- At night, there are now 2 medics on call. Senior/advanced airway cover is provided by a 4th on call who cross-covers the rota and helps for example, to intubate patients in the Emergency Department, with obstetric emergencies and with aneurysms in theatres etc. Trainees now feel much more supported.
- However, the unit is still struggling to find a registrar after midnight and the trainees require significant support, adding to the pressure on the consultants.
- Core Medical Training is funded by the ICM training programme as the medics cannot afford to send their trainees to ICU. There is a plan in place to allow the medics to come into ICU in place of the LAS posts that are often difficult to fill.
- ACCPs at Royal Devon and Exeter understand the unit and have many additional skills that are very helpful for ICM. However, the ACCPs would not intubate a patient or administer drugs on their own and though one ACCP has extended skills that allows them to do inter-hospital transfers, the 2 more recent appointments do not.

- The hospital are cognisant of the fact that training ACCPs to do practical skills (eg how to put a line in) is relatively easy, the difficulty comes in training ACCPs for patient assessment, diagnosing and complex problem solving.
- The assessment of patients is what sets ACCPs apart from ACPs. The ability to problem solve is key. It is important to highlight this to commissioners and trusts.
- For the transfer of neuro or trauma patients, the 4th person on call is contacted, who will usually go. The ICU consultant would then come in to cover the ICU (acting down). A consultant delivers out of hours Anaesthesia. The POSU (pilot now finished) is supported by the 4th trainee.
- ACCPs are part of the junior medical rota.
- 2 newly recruited resident roles are not currently airway trained but in time it is hoped they will be able to assist with patient transfers. They rotate every 6 months, so repeated training of very junior staff is necessary.
- The maximum period spent on duty/on call, is 58 hours. Remunerated as a mixture of predictable and unpredictable on call.
- Weekend shifts start on Friday morning and finish at 6pm on the Sunday. During this time, a solo consultant carries responsibility for the ICU, whereas during the week, that responsibility is shared between 2 (in hours)

Torbay

- 10 bed unit. Currently providing 6 beds at Level 3 and 4 at Level 2, a strategy is in place to provide 14 beds.
- The ICU doctors also manage 2 Level 1.5 "Higher Care" beds on an orthopaedic ward for high-risk post-op orthopaedic admissions.
- 10 consultants are on the rota.
- ICM Consultant A does Mon-Weds 8am-6pm. Mon – Fri nights are covered as single on-calls by the other ICM consultants.
- ICM Consultant B does Thurs-Sun 8am-6pm, and continues as on-call Saturday and Sunday night.
- 9 Trainees in total (Foundation: 3, Core: 2, Higher: 1, Non-training post: 3).
- ICM specialty trainee rotas are negotiated individually according to working hours and training needs.
- 5 or 6 Core Trainee junior doctors provide 24/7 trainee cover for the unit on a full shift rota (0800 – 2030, 2000 – 0830 shifts).
- Airway and procedures hands-on support is provided by anaesthetists when consultants and ICM trainees are unable.
- Anaesthetic specialty trainees do a minimum of 3 month blocks.
- The team includes ICU funded occupational therapy, physiotherapy, dietician, pharmacy and psychology support staff.
- The nursing team is led 24/7 by senior experienced nurses with the nurse in charge not being allocated to individual patient care to ensure safe oversight and to support the nursing team.
- The critical care outreach service is delivered 24/7 by senior experienced nurses with sessional support from ICM consultants (currently Monday to Friday, 1 session per day).
- While nursing staff levels are currently stable, this has been the result of a significant ongoing recruitment drive. Alongside this, strenuous efforts to retain staff have proved successful. They have adopted a flexible model of working to sustain the critical care service on a day to day basis. This is team led and reflects a strong team culture.
- They have frequent gaps at ICM ST3 level.

- Out of hours advanced airway management and hands-on support for the ICM core trainee level doctors is provided by the anaesthetic registrar, who also covers obstetrics, wards, theatres and the Emergency Department.

Yeovil District Hospital

- 10 bed unit, mixture of Level 2 and Level 3 beds.
- 14 WTE Anaesthetic Consultants in total (7 specifically with daytime ICU).
- Roughly 1 week in 7 dedicated to ICU.
- 0 ICM Trainees (no training recognition) Other juniors: F1: 1, Anaesthesia CT1: 5, Higher: 0, Non-training CT equivalent post: 1 WTE).
- Middle grade SAS anaesthetists work flexibly in both anaesthetics and ICU.
- 1 dedicated consultant covers the unit Monday to Friday 0800-1800.
- 1 consultant covers the unit out of hours Monday to Friday 1800-0800 (cross covers anaesthesia).
- 1 consultant covers the unit during the day at weekends (cross covers anaesthesia).
- 1 consultant covers the unit overnight at weekends (cross covers anaesthesia).
- Additional weekend intensivist DCC PAs to achieve 7 day working.
- The unit is endeavouring to move from an open model to a closed model (the responsibility for the patient and their treatment is transferred to the Intensivist) during 2019, and a funded scheme is being rolled out.
- A single joint overnight on call for anaesthesia and ICU operates. Plans for a hybrid rota or two separate ICU and anaesthesia rotas, are being considered.
- There are currently insufficient junior doctors to run a closed model, utilising training or non-training doctors. Funding has enabled additional recruitment rounds, but these were unsuccessful. All other options, such as locum staff, new rotational posts and non-medical practitioners are all being considered.
- Overall nursing retention and recruitment is break even in critical care, and there are robust international, national and internal recruitment programmes. There is no clinical educator in post, but a strong commitment to teaching and training exists coordinated by the ICU sisters.
- There is a 24/7 critical care outreach team that is supported by the ICU sisters who rotate to support the management of the deteriorating patient in the ward areas.
- Yeovil assess and follow up critical care patients in line with National Institute for Health and Care Excellence (NICE) guidance through a nurse and physiotherapy led clinic and rehabilitation service with regular gym sessions, supported by consultants.

General Service level

Service levels vary generally across the units and at different times of the year. The influx of tourists over the summer months means a higher workload and this is of course coupled with the usual winter pressures faced by a region with an increasingly ageing population, especially for those over 80.

One of the largest areas of concern was sufficient out of hours airway cover on units. All units mentioned there was at least some period where there was very little or no airway cover. While units are recruiting to combat workload pressures, there is a gap in the provision of airway skills and senior ICU skills. There are numerous junior medical trainees but they are not yet airway competent. Having many junior hands helping is not a comprehensive solution for cover. Units reported it was easier for a consultant to work harder and take on more patients with fewer junior staff to supervise, than to have lots of inexperienced doctors present. Crucially, what is needed is airway competent middle grade doctors that can intubate in the emergency department, manage the patient and bring them to the ICU without having the consultant there.

There is a will to change this and to find middle grade doctors to address the issue but it is difficult to find doctors from within the region (or indeed anywhere) and there is a lack of funding.

Follow-up clinics

Whilst provision of Rehabilitation and Allied Health Professions (AHPs) (eg: Physiotherapy, Pharmacy, Dietetics, Speech and Language Therapy and Psychological Support), is largely woeful in terms of meeting the GPICS standards in this region; Torbay has a good provision of Occupational Therapy, Physiotherapy, Dieticians, Pharmacy, Speech and Language Therapy and Psychology input. Torbay's rehab service is excellent and they are frequently approached by other centres for advice on developing this aspect of the critical care service. While Torbay may be exemplary, the region still needs investment and support in this area. Often units ask for these services and do not get them so end up funding them from their critical care budget.

For weaning and Long Term Ventilation (LTV) ICM Consultants often run these services themselves. Lane Fox Weaning, Rehabilitation and Home Mechanical Ventilation Services are very rarely offered. Derriford hospital hosts a home ventilation service run by the respiratory physicians rather than the ICM Consultants. Patients with Motor Neurone Disease are often referred down that route. The home ventilation service Derriford offers also covers Devon and Cornwall in the region.

Derriford hospital has 2.2WTE pharmacists, which for its size is not sufficient. They do not have any dieticians on the ICU (no daily visits) but there is a service they can refer patients to.

Royal Cornwall has a critical care follow-up clinic but it has been unfunded and uncommissioned for 16 years.

Royal Devon and Exeter have just set up a critical care follow-up clinic using the Glasgow Inspire model. It has Psychology, dietetic and Physiotherapy support etc. Patients and their caregivers attend 1 morning per week for 5 weeks where they get to see all of the professionals both in a group and on a 1:1 basis as required. They had a GP liaison that helped with its development. The clinic has only been in place for a few months however, initial feedback is excellent, and the data supports its effectiveness in reducing hospital attendances.

At North Devon, 0-5 patients are referred for clinical psychology after discharge from the ICU per year.

Trainees

The region has had a deliberate increase in the number of trainees in the past year compared with 2017 but there is no central funding for them. Ideally, trainees would be spread around the region but as funding varies from trust to trust, there is a disproportionate spread. Trainees are increasingly junior when they come to work in critical care in the region, which means gaps in skills and service provision potentially develop. Being able to introduce Core Medical Trainees (CMTs) to ICM at an early stage is very positive for the specialty however, there are practical issues with implementing the on call aspects of their training at some units due to funding. The CMTs must do on call in ICU, some of it can be medical on call but it has to include critical care. Units may not be able to afford to fund this if medical teams do not release Acute Internal Medicine trainees to undertake critical care on call. Although there is critical care funding for this development, the core medical rotas are often underfilled which makes releasing them from medical on call to ICU on call often not possible.

There is concern among some units that the lack of middle grade doctors and the increasing workload is leading to a drop in training levels and opportunities to learn in an appropriately

supported environment. The groups are concerned this is starting to have a negative impact on training and this may well contribute to the feeling that there is a higher-level of attrition for trainees in the South West. ICM trainees also understandably want some work-life balance but with current constraints and pressures on senior intensivists and their numbers, ICM trainees are often covering far more weekends for ICM than they would in their partner specialty. For dual trainees, when they see less of a burden in their other specialty, there is the temptation to pursue that instead. Historically, advanced trainees have only been sent to Derriford, Truro and Exeter. Torbay have asked the Training Programme Director to consider sending advanced trainees to Torbay and Taunton so that they are exposed to the full spectrum of critical care units in the region.

ACCPs

ACCPs, whilst still a small portion of the workforce across critical care units, have become a crucial part of it. The chance to train to be an ACCP is helping units hold on to nurses, helping them 'stick it out' for trainee ACCP posts. It is an especially attractive role for nurses who do not want to enter managerial roles (Band 7) but would like further seniority that keeps them by the bedside. However, there are issues with banding compared to ACPs. Units may lose nurses and physios to ACP roles if the ACCP banding cannot be matched locally within the trust.

ACCPs are seen favourably; as they have much a better structured and regulated curriculum, more experience and a full qualification at the end of their training period. There are concerns about the variety of ACP roles and how the standards and competencies of the ACP role are measured. There is some apprehension over the robustness of training for ACP roles; this varies from trust to trust. Currently ACCPs, once trained, stay with their unit; this is largely due to the small numbers of ACCPs in the region and its geography. It is becoming increasingly difficult to obtain funding for ACCPs and the Medical Associate Professions (MAPs) decision not to regulate the role may have negatively influenced commissioners and trusts' opinion of the ACCP role.

There has been some tension reported between ACCPs and trainees as they compete for the same training; this can be exacerbated by lower numbers of consultants able to offer support.

Recruitment

Recruitment and retention of staff is a universal problem. All units reported medium to high nursing vacancies. Part of this happens structurally. When nurses are recruited, there is a 3-month period between nurses being hired and them being able to complete all the competencies necessary to work on the unit at a Band 5 level. The barriers in providing career progression for nurses also causes gaps across the region. To achieve seniority as a nurse, it is felt nurses must 'hop' from unit to unit. Because the South West is geographically limited, there is less scope to do this, so nurses move out of ICM to seek opportunities where they can obtain seniority in other specialties. There is also pushback from trusts as it takes time to get nurses 'up to speed'.

Commissioners need to be persuaded to fund a higher band for the specialist nurses and to be convinced of the specialism of ICM and why they need to be paid more for this expertise. Many units have a number of consultants planning to retire in the next five years and have difficulty holding on to middle grade doctors to keep up the flow of experienced staff. There is a fair amount of recruitment being sourced from outside the region and many units are concerned about the further effect Brexit will have, given the high numbers of staff that currently come from Spain and Greece.

Morale

Morale varies across the region but all units are feeling under pressure and understaffed. In particular, this pressure comes from the lack of middle grade doctors. The lack of sufficiently

skilled trainees/junior staff has placed an enormous burden on the consultants, who often find themselves doing this work in addition to maintain their responsibilities. Skill deficits are filled by consultant presence.

Nurses are frustrated because there are few opportunities to progress. Even though nurses report that they enjoy working in critical care, they feel they have no choice but to leave in order to continue developing their careers. Some nurses have reported feeling that patients are getting suboptimal care while the unit tries to cope. There are difficulties getting on courses to train due to local rules about Band 6s and this varies across the region.

The workforce is getting older and are also fatigued due to the lack of middle grade doctors. One unit reported finding it difficult to find a registrar after midnight. The morale of the trainees seems to be affected, as some sites reported trainees seeming insufficiently confident and less well prepared to start on the unit. Some units question if this is due to a lack of support from senior staff during busy periods. The majority of units reported that the staff were fatigued and stressed.

Torbay Hospital have funded support from a senior psychologist who supports and delivers staff wellbeing workshops, which are very well received.

Communication within units

WhatsApp groups are being used to notify unit staff when there are gaps in rotas that need filling. This was across the whole workforce. This leads to several questions. If gaps in the rotas are filled ad-hoc via WhatsApp then is this being officially reported back to trusts to note the gaps? Are these numbers being collated and thus being used to demonstrate how overstretched units are? Is WhatsApp the most appropriate platform to facilitate this and is it secure enough to meet GDPR standards? However, it is felt that if units were to stop using WhatsApp this would be disastrous in terms of filling last minute rota gaps.

Funding

Units reported that surplus funding for ICM is often being funnelled to non-ICM related activities. This creates frustration among the ICM workforce, as those funds are needed within ICM. Funding is convoluted and it is felt that trust finance teams do not understand it within the context of ICM. Units are told to hit targets but then that results in less money being available the next year when really the whole region needs considerable investment. While units understand the need to save for the health economy as whole, having Financial Improvement Programme (FIP) targets for intensive care seems inappropriate given the nature of the specialty and what they do to the flow of funds.

There are quirks of funding such as the Air Ambulance. While very important and a necessity, it generates more work for the units and the ambulance gets paid more the further the ambulance travels, meaning there is a financial benefit to taking a patient to a unit further away. Helipads at some units have been out of action, which has meant that the air ambulances have had no choice but to put more pressure on a smaller number of units (with active helipads) and that patients have been taken further than they should have been, leading to higher costs.

Units reported a top slice being taken from ICU income. ICUs make more money as a department but the surplus is not put back into the service, the rest of the hospital absorbs it.
Taunton – top slice is 50%
Torbay – top slice is 40%

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

- Will local reconfiguration plans have an effect on the above workforce models?
- Are there any other factors that may have an effect on future workforce models?

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

Expansions
All units feel there is more and more work but not enough space. Over the next 5-10 years, all units will need more space. There are expansions planned for Musgrove Park and an expansion is being considered at North Devon. As a geographically isolated unit, North Devon are having more issues with surges in demands both in winter and summer (the tourist season). The NHS England Sustainability and Transformation Plan reaffirmed the future of North Devon. Taunton are concerned about having the funding to expand the staffing for the new unit.

Previously, units have ended up with a nicer and newer environment but no more people to deal with the workload that increases with the expansion.

The Royal Devon and Exeter's Emergency Department workload has expanded but critical care's resources have not, meaning more work but no more space. In addition, the shifting of services such as inpatient cardiology from North Devon District Hospital to Royal Devon and Exeter has resulted in an increased demand for example for patients who have suffered an out of hospital cardiac arrest. At the time of the South West Engagement event, they had a POSU pilot project in place. It ran for 6 months and took elective high-risk patients having joint replacements. The pilot finished in March 2019 and a business case is currently being made to support a more permanent model.

Derriford reported that a high proportion of their surgical patients go directly to Level 1 beds. Sometimes this occurs by a patient being established as an extended recovery patient to guarantee them a certain bed space but this leads to concerns that a crucial area for escalation may already be filled. Derriford are pushing to have recovery occupancy vs staffing levels regularly reported to measure this. There has not been a problem as a result of the system yet. However, they are unsure if this means the system is working at a comfortable and maintainable level or if this is only because they have not had to deal with a large escalation need with this system in place at the same time.

Retirement
One unit reported that it was predicted that 40% of their nursing staff would have retired in the next 5 years. Essentially, 6 more consultants are needed for each unit over the next 5 years, just to cope with the mounting workload and to cover retirements. There is a need to expand the consultant workforce by 30-40%.

Many consultants are working far more than their job plans allow for and it is not surprising that older members of the workforce may see this as a reason to retire earlier.

Patient transfers and bed spaces
Transfer procedures may need alteration to better suit the geography and staffing of the region. Dedicated transfer teams are possibly needed. Often there may be bed spaces available at a unit

when another unit is at capacity but transferring a patient may mean losing the only registrar or consultant on site in order to complete the transfer.

Units agreed there is an inefficient use of beds. Often there is a lack of communication as to where the available beds are. The Bed Bureau System used to be an effective tool for this; there were regular updates on the locations of beds across the region but this no longer seems to be used. Units asked if it would be possible to reinstate the system as a way to alleviate pressure when others are less stretched.

Trainees

Taking on more trainees does not necessarily help with gaps in rotas and there are issues with funding trainees in the first place. Half of the medical jobs are funded by the Deanery and the other half is funded by trusts. They are not always fully funded posts so hospitals end up supplying the shortfall. The gaps of one central funding stream result in a disproportionate spread of trainees, so the relief provided by extra trainees is not necessarily in the right areas.

There is currently a massive gulf in understanding between medical colleagues and ICM Consultants regarding the training of Core Medical Trainees (CMTs). The CMTs must do some on call in the ICU, some of it can be medical on call but it has to include critical care. It is difficult to provide meaningful ICU training in less than 3-4 months. Short attachments further stress the system, as more time needs to be found for frequent inductions.

GPICS standards and pressures

GPICS is a very helpful tool for helping trusts and commissioners understand the complexities of the specialty and why it takes more time to bring staff up to speed on the competencies required for the ICUs. It does however add to the pressures felt on the units because of the hard work needed to meet the standards.

Many units reported that they felt they hit most of the GPICS standards but due to a lack of funding and understaffing, they are not able to perfectly execute them. This gives cause for concern for patients obviously but it also means more pressure is internalised by staff as they feel they miss the mark but cannot change this given how much is supplied to do the job. To meet the GPICS standards, more senior and advanced trainees are needed.

Units reported that they were not meeting the GPICS standards in terms of their rehabilitation teams and AHPs. They often have to fund these services from the critical care budget, as the trusts will not provide funding from other streams. Most units reported a gap in being able to provide a doctor with advanced airway and resuscitation skills 24/7.

6. PROBLEMS AND SOLUTIONS

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

6.1 PROBLEMS

6.1.1 Staffing shortages

All units present on the day expressed current and future concerns surrounding staffing numbers. While some units were only experiencing current recruitment issues for one particular role or group, be it nurses, junior tier staff or consultants, many were highlighting recruitment concerns for a combination of these roles. As these problems rarely occur in isolation, concerns were raised about the knock-on effect that would be felt by remaining staff after repeated failed attempts to recruit and retain adequate staffing numbers.

6.1.2 Doctors in training

Whilst units feel that they could handle more trainees, the lack of funding and the knock-on effect from the lack of middle grade doctors means that units feel they are not able to provide the support the trainees need. There are also concerns that during intense periods on the ICU, consultants have to take the strain of solving problems rather than teaching the trainee what to do, as ultimately patient care is the highest priority. Consequently, trainees may miss teaching opportunities and consultants are sometimes doing too much at once, leading to further fatigue and stress.

At the time of the meeting, 2 of the 7 units represented did not have any ST3+ ICM trainees in post and across a region that is about to undergo expansion there are only eight ST3+ trainees.

6.1.3 Middle Grade Doctors (advanced airway trained)

The region has a severe lack of middle grade doctors. Throughout the conversations the groups had, it was clear that this was one of the lynchpin issues. A lack of middle grade doctors means less trainee support, less consultant support and it means there will be a gap in the flow of doctors becoming consultants in the region.

6.1.4 Consultants

Many of the units are attempting to recruit new consultants, however this process can take several months and even after accepting a job there will a be further wait while the consultant makes the move to the region. A serious consideration needs to be given to the manageability of careers for older intensivists, as a growing group of individuals, not quite ready to retire, are instead opting to pare back their roles to just their partner specialty for the later stages of their career.

6.1.5 Nurses

Concern over nursing numbers was also a common theme for the units across the region, with low numbers resulting in some units feeling that patient care may be at risk of falling below the appropriate standard. Units also mentioned that nurses are often ‘poached’ from the ICU to cover a lack of nurses on general wards. Whilst it is understandable that sometimes this may be unavoidable, it needs to be understood by wards that critical care nurses are not a backup option and that they are needed on the ICU. It can have a significant negative effect on morale.

Recruitment, retention issues, ageing staff and impending retirements were all raised as concerns. There was real concern that nursing staff were leaving units due to a lack of career development for them. While the ACCP route offers significant career development, it is not sustainable, financially viable or appropriate to offer the ACCP route as a method of keeping nurses.

6.1.6 Workforce Wellbeing

All of the above staffing issues and periods of change associated with training changes and expansions can easily contribute to the current and remaining staff struggling. Staff retention and motivation are fragile.

Low staffing numbers require the existing workforce to have large periods of coping rather than functioning. While there is a great deal of praise to be given to those who are holding things together, the message that can sometimes be picked up from HR and trusts, is that more staff are not urgently needed for the units to run. This was highlighted in one group through the use of a WhatsApp style notice board for gaps in rotas as mentioned previously.

At one unit for example, they are filling the skills shortage out of hours by the consultants staying in – often in the twilight shifts, and weekend days. This is being remunerated in time or money, but there is a general feeling that therefore the trust does not see the problem, because it is being patched up day by day.

Burnout can and does affect all levels of staff and is often hard to identify before crisis point. Work needs to be done on addressing staff morale and having an open culture of acknowledgement and support for staff going through this challenging time.

6.1.7 Guidelines for the Provision of Intensive Care Services (GPICS)

GPICS and standards invariably appear on both the problems and solutions sections of our regional reports. GPICS is greatly positive in that it shows trusts and commissioners the bar that needs to be reached but it becomes harder to meet the standards when units expand without proper support. Torbay reported that they were able to deliver many of the standards, but they felt that as they are a smaller hospital with progressive and senior nurses, they are perhaps able to manage the flow of patients more easily than those with more beds and fewer staff. The region wants to meet the standards but the means by which they can do so are limited. GPICS is seen as helpful but very hard work to attain.

6.2 SOLUTIONS

6.2.1 Staffing solutions

Serious focus is needed on the recruitment and retention of nurses, the recruitment of middle grade doctors, or an expansion of ACCPs with advanced airway skills. It would be beneficial for all units (which must include the managerial and clinical directors empowered to enact change) to undertake a region-wide review of the need for further expansion of resources and workforce.

Taunton recently did a huge drive in recruiting nurses to produce a healthy bank of staff, however further work needs to be done to train the new staff in ICM competencies. Taunton and Royal Devon and Exeter and Torbay have onsite practice facilitators to help aid the period of ICM competency training. It may be worth other units investing in training their current staff as trainers so they can help with new staff inductions. Units need to make it an aim in order to make it a reality. Trusts need to look at the standards by which nurses can achieve Band 6, as this is not uniform across the region. It leads to some areas struggling far more to retain or even train Band 6 nurses. It also leads to a feeling of double standards if some nurses are expected to have completed certain courses before

applying for Band 6 roles and others are not, purely based on a trust's inclination. Units mentioned that fostering an environment of open discussion about career progression would help aid them in supporting nurses with their long-term career goals. If units were able to have a spreadsheet or database, containing information on what the nurses' career goals are and where they currently sat, it would allow for forward planning of the nursing workforce.

Where middle grade doctors are concerned, appointing Medical Training Initiative (MTI) doctors to the trust might help to address the problem, although MTIs can only stay in post, up to a maximum of 24 months. Similarly, increasing the number of Fellowships (eg trauma), may offer some relief to the overstretched workforce.

6.2.2 ACCPs

Competition between ACCPs and more junior trainees for the same training experiences needs to be resolved on some units to get the best out of both workforce groups. Using more senior ACCPs to help new trainees on the unit to build better working relationships and increase clinical experience may be a way forward. There is interest in developing the ACCP role in units that do not currently have ACCPs, but there are concerns about how feasible this would be for smaller and more remote units to provide the training: ACCPs also need to be able to complete their competencies in order complete training.

The benefit of an established ACCP workforce is the continuity of knowledge for patients, relatives and clinical staff. They can augment the training of doctors rather than detract from it and help resolve the middle grade staffing problems.

6.2.3 Ways of working

Through their discussion of consultant recruitment and retention, the group raised some possible solutions that warrant further exploration. A key benefit in the region is how, despite the geography involved, the units are able to stay in good contact – sharing solutions and pooling ideas can only increase this benefit.

For example, at the Royal Devon and Exeter Hospital, they split weekend shifts. At night there are now two medics on call supported by a 4th on-call anaesthetic type rota, this provides cover across ICU and anaesthesia. They fulfil roles such as intubating patients in the Emergency Department, helping with obstetric emergencies and with aneurysms in theatres etc. Trainees now feel much more supported but this kind of rota can be difficult to staff and sometimes relies on consultants acting down.

Furthermore, the Royal Devon and Exeter hospital is happy to share the business case for its follow-up clinic. Though it is in its infancy, the feedback so far has been superb, and patients have had ready access to advice and support services. It strives towards understanding the trauma the patients and their families may have gone through while in intensive care. In addition, it provides a unique insight for the ICU team to learn from the patients and address issues brought up by them eg noise, overhearing conversations about other patients, being in an isolation room etc.

Some units have access to a psychologist to support staff in dealing with the general stress of the ICU; this has been a real positive for staff. If trusts are able to find funding (though it is accepted this may be difficult) this may well be a worthwhile pursuit.

6.2.4 Transfer and geography

As part of the review of resources recommended in 6.2.1, it would beneficial to consider who would be best placed to oversee patient transfers, including the development of transfer teams and a database of beds. These may better utilise current resources across the disparate geography of the region.

7. DATA

All attendees at the Regional Workforce Engagement Meeting were asked to provide information on their current workforce and what they expected their workforce needs to be, approximately 5 to 10 years in the future.

7.1 Headcount

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

HOSPITAL	CONSULTANTS		SAS Grades		ACCPs		NURSES	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Derriford Hospital, University Hospitals Plymouth	14	16	0	0	6	8	141.27	165
North Devon District (Barnstaple)*	8	?	0	?	0	?	44	?
Musgrove Park (Taunton)	8	14	2	1	0	2	68	?
Royal Cornwall Hospital	11	14	0	0	0	5	65.17	83.49
Royal Devon and Exeter Hospital	9	12	0	0	3	5	120	150
Torbay	9	10	1	0	0	0	50	50
Yeovil	7	7	5~	6~	0	0	53	53

~ The conjoined status at Yeovil Hospital with anaesthetics makes ICU numbers difficult to predict.

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 now and estimate what they might need in the future. The question marks within the tables indicate that the information was not available or not provided.

HOSPITAL	CONSULTANTS		SAS Grades		ACCPs		NURSES	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Derriford Hospital, University Hospitals Plymouth	12	16	0	0	6	8	141.27	165
North Devon District (Barnstaple)*	5.3	?	0	?	0	?	37	52
Musgrove Park (Taunton)	5	8	0	1	0	3	58	?
Royal Cornwall Hospital	11.3	14	0	0	0	5	74.18	83.49
Royal Devon and Exeter Hospital	6.5	9	0	0	2.3	3.5	85	100
Torbay	9	10	1	0	0	0	48.3	48.3
Yeovil	2	2	5	5	0	0	46.59	46.59

*Unit is about to undergo a large expansion estimating the future workforce is therefore difficult due to state of flux.

7.3 Trainees

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

HOSPITAL	Foundation		Core		Higher		Non Training Posts		TOTALS	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Derriford Hospital, University Hospitals Plymouth	3	3	9	9	2	2	1	0	**15**	**14**
North Devon District (Barnstaple)*	0	?	9	?	0	?	0	?	**9**	**0**
Musgrove Park (Taunton)	7	2	3	3	2	3	0	1	**7**	**8/9**
Royal Cornwall Hospital	6	6	6	7	2	3	1	4	**15**	**19**
Royal Devon and Exeter Hospital	1	1	2	2	1	2	3	3	**7**	**8**
Torbay	3	3	2	2	1	1	3	3	**9**	**9**
Yeovil	0.8	0.8	0	0	0	0	1	3	**2~**	**4~**

*Unit is about to undergo a large expansion therefore estimating the future workforce is difficult due to state of flux.
~ Yeovil Hospital, for Training purposes, is currently aligned with Severn Deanery for Core Training.

7.4 Data 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 the tables indicate that the information was not available or not provided.

HOSPITAL	NOW	FUTURE	INCREASE OR DECREASE
Derriford Hospital, University Hospitals Plymouth			
WTE for Consultants	12	16	Increase
WTE for SAS Doctors	0	0	Increase
WTE for ACCPs	6	8	Increase
WTE for Nurses	141.27	165	Increase
Number of Trainees	15	14	Increase
North Devon District (Barnstaple)			
WTE for Consultants	5.3	?	
WTE for SAS Doctors	0	?	
WTE for ACCPs	0	?	
WTE for Nurses	37	52	Increase
Number of Trainees	8	?	
Musgrove Park (Taunton)			
WTE for Consultants	5	8	Increase
WTE for SAS Doctors	0	1	Increase
WTE for ACCPs	0	3	Increase
WTE for Nurses	58	?	?
Number of Trainees	7	8/9	Increase
Royal Cornwall Hospital			
WTE for Consultants	11.3	14	Increase
WTE for SAS Doctors	0	0	Remains the same
WTE for ACCPs	0	5	Increase
WTE for Nurses	74.18	83.49	Increase
Number of Trainees	15	19	Increase
Royal Devon and Exeter Hospital			
WTE for Consultants	6.5	9	Increase
WTE for SAS Doctors	0	0	Remains the same
WTE for ACCPs	2.3	3.5	Increase
WTE for Nurses	85	100	Increase
Number of Trainees	7	8	Increase
Torbay			
WTE for Consultants	9	10	Increase
WTE for SAS Doctors	1	0	Decrease
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	48.3	48.3	Remains the same
Number of Trainees	9	9	Remains the same
Yeovil			
WTE for Consultants	4	4	Remains the same
WTE for SAS Doctors	5	5	Remains the same
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	46.59	46.59	Remains the same
Number of Trainees	9	11	Increase

7.4 Training Posts

One of the many workforce metrics that 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 or home nation against the population of each region or home nation. The table below indicates the population serviced per training post recruited to in each year. The South West Peninsula has improved its training to population number in 2018, offering and filling 8 posts at National Recruitment. As trainees are increasingly unlikely to seek employment beyond the vicinity of where they are trained (having established mortgages and families there), continuing to grow and support training posts in the region was supported by the intensivists present at the engagement.

	2017 training post to population*	**2018 training post to population***
1	West Midlands (1,418,678)	KSS (879,262)
2	North Western (1,144,398)	East of England (850,595)
3	KSS (879,263)	West Midlands (810,673)
4	East of England (744,271)	East Midlands (656,961)
5	Wessex (631,964)	Scotland (443,975)
6	**South West (611,395)****	Wales (440,344)
7	Northern Ireland (609,908)	Northern (419,609)
8	East Midlands (574,841)	Wessex (394,977)
9	Scotland (532,770)	Severn (389,751)**
10	Northern (367,158)	Yorkshire & Humber (374,842)
11	Yorkshire & Humber (349,853)	Northern Ireland (365,945)
12	Wales (280,219)	North Western (264,091)
13	London (249,814)	London (242,676)
14	Thames Valley (231,630)	Thames Valley (231,630)
15		**South West Peninsula (225,623)****

*These calculations are based on the 2013 RCP census data report

** For the purposes of this report we have divided the South West information into the Severn and South West Peninsular regions. In previous years, they have been calculated together.

APPENDIX 1: LIST OF ATTENDEES

ICU/Organisation	Name
Royal Devon & Exeter	Dr Rebecca Appelboam
Network Nursing Lead	Graham Brant
North Devon District Hospital	Dr Timothy Cobby
Royal Devon & Exeter	Dr Mark Davidson
Musgrove Park	Dr Fiona Dempsey
Regional Advisor for South West Peninsula	Dr Stuart Dickson
Derriford Hospital, Plymouth	Dr Craig Dulop
Regional organiser for the day	Dr Richard Gibbs
Network Medical Lead (Did not attend groups)	Dr Tim Gould
Torbay Hospital	Dr Tod Guest
Training Programme Director for South West Peninsula	Dr Robert Jackson
Associate Postgraduate Dean and Deputy Dean	Dr Jeremy Langton
North Devon District Hospital	Dr Nick Love
Derriford Hospital, Plymouth	Dr Paul Margetts
Taunton	Kath Robinson
Yeovil	Mark Robinson
Royal Devon & Exeter	Dr Will Rutherford
Severn Representative	Dr Sarah Sanders
Royal Cornwall Hospital	Dr Michael Spivey
Derriford Hospital, Plymouth	Dr Sam Waddy

APPENDIX 2: 2018 CENSUS DATA

COUNT: 70 consultants that stated they were from the South West and Severn (out of 877 complete responses) completed the census.
84% of these consultants are practicing in both Anaesthetics and ICM. This compares to 82.9% in Scotland, 87.1% in West Midlands, 96.7% in Yorkshire and Humber, 76.3% in the North West and 82.2% in East Midlands.

Do you plan to alter your ICM commitment in the next 2 years?

	South West
Increase	6
Decrease	16
Neither	48

Do you intend to practice ICM for the remainder of your career?

ANSWER	South West
Yes	47
No	23

7 units were represented in the Clinical Leads section from the South West

Do you have ACCPs on the unit	South West
Yes	2 Units

PA AND SERVICE TIME DATA
Over a 12-month period, what percentage of clinical time (DCC) is spent in Intensive Care?

%	South West
0-25%	10
25-50%	19
50-75%	22
75-100%	19

Over a 12-month period, what percentage of non-clinical time/SPA is spent in Intensive Care?

%	South West
0-25%	26
25-50%	13
50-75%	15
75-100%	15

*One respondent did not answer this question

NB: Per week PA data across the region

	Total PAs number in your Job plan	All SPAs (ICM and non-ICM)
RANGE	0-14.55	0.87-5.5
MEAN	11.04	2.25
MEDIAN	11.75	2.57
MODE	11	2.5

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