# REGIONAL WORKFORCE ENGAGEMENT REPORT:

# THAMES VALLEY

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 Ms Natalie Bell (Board and Training Projects Manager), were welcomed to the Thames Valley region by representatives from each Trust, the Network, the Specialist Training Committee and School. Dr Parry Jones writes:*

*May's long awaited resignation finally comes whilst we are sitting in a lovely venue in Reading reviewing the workforce data in Thames Valley. The country has slipped, straddled, and is in the process of toppling out of the frying pan into what has now become Johnson's fire. There is barely a sizzle of excitement over her going; all focus is concentrated on the local critical care workforce, service, and provision. You do not need to have an intensivist's understanding of triage to realise that May is well beyond saving. Critical Care however, is worth fighting for.*

*The Faculty has been doing these in-depth workforce reviews for 5 years now and much has changed around us. It has become more apparent that the majority of services provided by the 'National Health Service' are far from uniform, and critical care is no different in this regard. Working towards services being more standardised, as envisaged for us by the General Provision of Intensive Care Services (GPICS 1 and now 2) should benefit all of our patients, those training in the specialty, and the multidisciplinary team that constitutes 21st century critical care. Critical Care services have commonly developed reactively in a piecemeal fashion according to local perceived needs, and not in a planned, regionalised and organised way. 'Getting It Right First Time' (GIRFT) and GPICS are there in an attempt to reduce this variation. We do need critical care services nationally to have structures and processes that are recognisable to each other. To do this we do need the workforce.*

*As in all the workforce reviews that I have been involved with, the people with the ability, and energy are there. There were excellent presentations to set the scene and really good engagement from the units. Much has already been done in Thames Valley to improve things, and the region as a whole appeared strong, stable and well led. Yes, it does seem possible. There are issues peculiar to the region. The number of critical care trainees is high in comparison to many other regions partly because of the number linked with academia. Other regions might see this as a surfeit, but the need to provide flexibility in job plans and training, does make this very complex to run well. Without flexibility, the risk is losing that trainee. The feedback was good.*

*There are also generic issues. The number of consultant intensivists in some hospitals is low, and it can be very difficult to recruit and retain consultants. This remains a familiar issue to many of us and certainly not one unique to Thames Valley. Making a hospital attractive enough to recruit to, in a very competitive market place, requires a lot of time and effort. There is a critical mass to the consultant body and if it drops below this, then a spiral can be entered from which it can be very difficult to escape. These units may require nurturing and support. Difficulties with the recruitment and retention of nursing staff is also familiar to many of us. Thames Valley has fewer ACCPs than many other regions, and this may be an area to focus attention as a means of retaining nurses in the clinical arena by giving new exciting career opportunities.*

*The Faculty were given a very warm reception and an excellent lunch. Thank you. As for parallels; forget about the moon landing. Where were you when May resigned?*

# 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 2019), 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 seven-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 June 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, data from the 2017 and 2018 censuses showed that this number dropped from 16.6% to 16.07% respectively. The most recent census in 2019 showed the figure for those intending to drop ICM sessions nationally rose again to 23%. The most common reasons across the censuses for wanting to leave ICM are 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 moving to another specialty.

### 1.2.2 Expected increase in patient and NHS need for Critical Care

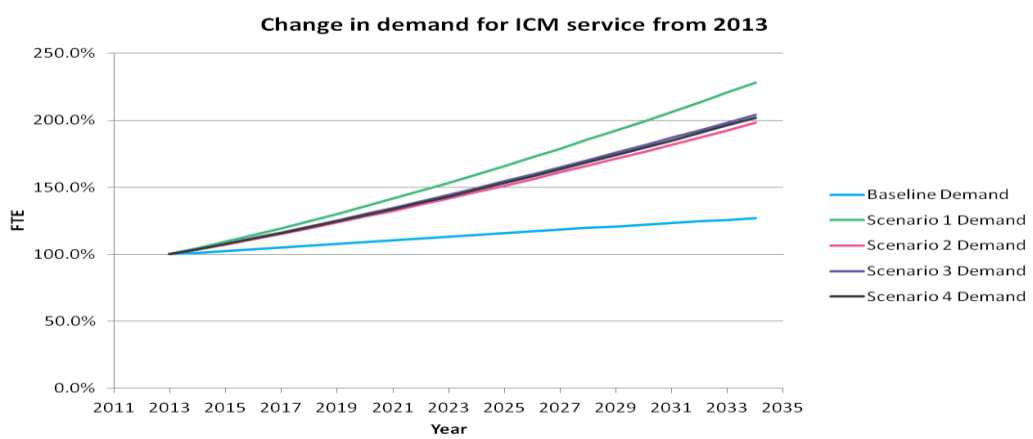
The **Intensive Care National Audit and Research Centre (ICNARC)** is undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014:

"*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 that 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, the East Midlands in November 2017 and the South West Peninsula in November 2018.

Thames Valley was the eighth region to request an engagement with the Faculty, which we happily accepted. Thames Valley filled seven of their ten available posts in 2018; however, in 2019, Thames Valley had a 100% fill rate, filling all ten ICM training posts that they made available.

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 Kathy Nolan), Regional Advisor at the time of the meeting (Dr Ian Rechner) and the regional organiser and Training Programme Director (Dr Liza Keating), 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 Thames Valley 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 Thames Valley, 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 THAMES VALLEY

### 3.1 ICM Training, Clinical Demand and Workforce in the Thames Valley Deanery Area

**This information is based on the presentation given by Dr Ian Rechner and Dr Kathy Nolan and reflects their views on ICM training and workforce in the Thames Valley Deanery area. It reflects personal opinion where it is not clearly referenced to existing data from other sources. The main focus is on the medical doctors in training workforce in the Thames Valley area.**

Thames Valley has 9 Intensive Care units (ICUs) with 100 beds and is located in the 3 counties of Oxfordshire, Berkshire and Buckinghamshire, serving a population of 2 million people. In the south, the Royal Berkshire hospital has 19 beds, Wexham Park in the southeast has 12 beds, Buckingham Healthcare in the east has 16 beds, Milton Keynes in the north has 9 beds and the other ICUs and specialist services are located in the west in Oxford.

Back in 2001, the Intercollegiate Board for ICM was formed and the first regional advisor (RA) for ICM was appointed. They held the post of training programme director (TPD) as well and came under the control of the School of Anaesthesia. The GMC sanctioned specialist training in ICM in 2003 and the region produced about 3 consultants per year and all training was undertaken in the Adult ICU in Oxford. The posts of RA and TPD were undertaken by 2 individuals in 2011 and 0.25 programmed activities or 1 hour a week was paid by the deanery to the TPD to manage approximately 10 trainees who were on the Joint training programme. In 2012, the Dual ICM programme was introduced. The Thames Valley deanery at that time converted 5 anaesthesia NTNs to ICM, which enabled standalone ICM training posts to be recruited into. With the addition of academic training posts and posts funded by hospitals, on average there have been 10 trainees appointed per year to the training programme for the last 5 years.

Thames Valley undertook a point prevalent study in April 2019 to determine the number of trainees on the programme. This had to be done as the trainee workforce is flexible and factors such as research, out of programme activities, additional training time and part time work influence the total numbers. There were 61 trainees. The TPD currently receives 0.5 PAs to manage this.

| Dual/Single | Number | Dual/Single | Number |
|---|---|---|---|
| Single | 14 | Academia | 11 |
| Dual with Anaesthesia | 25 | Pre hospital | 1 |
| Dual with AIM | 7 | RCoA Chief Registrar | 2 |
| Dual with Respiratory | 1 | Dual with Renal | 3 |
| Military | 3 | Dual with EM | 4 |

There were 30 trainees in Stage 1, 18 in Stage 2 and 13 in Stage 3.

The old Joint Training Programme will cease within the region in 2020. Looking at projections from 2020 to 2024, there will be on average 10 consultant Intensivists produced per year.

From the table above there is a diverse group of trainees and there are 11 trainees who are in a research training post of some form or another. Every hospital within the region has ICM trainees and all departments have a FICM approved tutor.

The geography of the region means it is relatively easy to get around all the hospitals and there is not a big distance when transferring patients between the ICUs. Capacity is always difficult to measure

but when reviewing ICNARC network data, there is a relatively low number of non-clinical transfers between regions, this suggests capacity is about right. This will not measure patients being managed in non-ICU areas within hospitals though and the quality of care delivered in these hospitals.

Looking at the GPICS staffing standards, there should be 1 trainee for 8 patients overnight and during the day there should be a presence of 1 consultant for 8 to 12 patients. To ensure the local units are staffed sufficiently there would be a need for 91 trainees across the region (assuming a 1:7 rota). There would have to be 12 consultants working during the day as well across the region. We are currently nowhere near this. Trainees from other specialties, such as ACCS and Anaesthesia, fill some of these roles. With the number of consultants being produced we could potentially achieve the consultant staffing levels but this would require the Integrated Care Partnership (ICP) to provide additional funding to the Critical Care community.

The Advanced Critical Care Practitioner programme has been started in the cardiac unit in Oxford and in Reading as well, although the Reading ACCPs are currently on the Outreach Team as opposed to working in the ICU.

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

In summary, Thames Valley has a very healthy ICM training programme. Posts available have a high recruitment rate for highly skilled and motivated trainees. Work in the future needs to ensure that ICM can function as a specialty on its own and not rely on the workforce from other specialties. There needs to be further investment and expansion of the allied health workers to ensure GPICS standards are met and there needs to be innovation to ensure that the nursing workforce is recruited to and continues to stay and work in the critical care world.

## 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 Thames Valley. 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:
  - maintain the current critical care service provision?
  - meet the Standards of GPICS?
  - 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.

**Buckinghamshire Healthcare NHS Trust**

**Stoke Mandeville Hospital**

- 12 bed unit.
- Funded for eight Level 3 and four Level 2 beds.
- 15 consultants in total.
- 70.2 nurses.
- 1 consultant weekday pattern.
- 1 consultant weekend pattern.
- 12-14 trainees in total (Foundation: 2, Core: 4, Higher: 4-6, Non-training post: 2).
- They do not have any ACCPs.
- The Stoke Mandeville nursing leadership has been decimated. They have gone from three nursing leadership roles to one and it is not sustainable.

**Wycombe Hospital**

- 8 bed unit, but only funded for 6 currently.
- Funded for four Level 3 and two Level 2 Beds.
- 14 consultants in total.
- 40.4 nurses.
- 0 trainees.
- They do not have any ACCPs.
- Doctors cross cover at Wycombe Hospital and have a doubled up rota where they rotate across the two sites but with separate on-call rotas. They do 1:7. At Stoke Mandeville, consultants are on call for ICU only but at Wycombe they are on call Mon-Fri out of hours

and in the rare event of a medical emergency they will also be expected to cover that. There is locum cover too and they only take pay when they are called into work. There is a first and second on-call anaesthetist at the weekends that needs to be applied during the week Monday-Friday too.

- They offer a 24/7 service but the two sites are geographically unhelpful being 14 miles apart.
- Really need to recruit intensive care physicians to plug the existing gaps.
- Nursing – they do not have any ACCPs. They have been planning and investigating how to implement ACCPs at the hospital for 4 years but nothing has been put in place. There has been a recent nursing restructure at the two sites; at Wycombe, they have a 20% vacancy for nursing recruitment. Stoke Mandeville are OK for nursing. Therefore, they are looking to over recruit at Stoke in order to cover Wycombe.
- Geography and proximity to London are part of the issue. It is hard to keep nurses when units are on the border of where the London weighting stops. If you only have to commute perhaps 20 or 30 minutes more to receive a London weighted salary, it is an obvious draw for many professionals.
- There is a dedicated tier of junior staff at Stoke and the daily staffing is quite good. At Wycombe they have SAS grade and non-training grade doctors mainly.
- Separated two roles at consultant level between Stoke Mandeville and Wycombe, both airway trained.
- Reported a gap created by a lack of middle tier doctors on the rota. ACCPs would help relieve the pressures created by this.

**Milton Keynes Hospital)**

- 9 bed unit.
- Seven Level 3 beds if required.
- 10 consultants in total.
- 50 nurses.
- 1 consultant weekday pattern.
- 1 consultant weekend pattern.
- 12 trainees in total (Foundation: 1, Core: 5, Higher: 6, Non-training post: 0).
- They do not have any ACCPs.
- Funding for 10 consultants. Current consultant morale is good.
- There are 3 tiers of staff 24/7 although not all rotas are filled.
- Staff grade doctors form the majority of the ICU team. They are not quite up to capacity with registrars.
- Anaesthesia and ICM is one department and there are no plans to separate them at the moment.

**Oxford University Hospitals NHS Foundation Trust (4 sites)**

**Cardiothoracic Critical Care, Oxford**

- 21 bed unit.
- Ten Level 3 and eleven Level 2 beds.
- 4.5 consultants in total.
- 91.5 nurses.
- 1 consultant weekday pattern.
- 1 consultant weekend pattern.
- 10.5 trainees in total (Foundation: 0, Core: 4.5, Higher: 6, Non-training post: 0).
- They have 2 trainee ACCPs.
- The cardiac unit has shortages of both nurses and Doctors.

**Churchill Hospital, Oxford**

- 8 bed unit.
- Eight Level 3 beds.
- 18 consultants in total.
- 26 nurses.
- 1 consultant weekday pattern.
- 1 consultant weekend pattern.
- 8 trainees in total (Foundation: 1, Core: 2, Higher: 8, Non-training post:).
- They have no ACCPs.

**Neurosciences Intensive Care Unit, Oxford**

- 16 bed unit.
- Funded for thirteen Level 3 beds.
- 9 consultants in total.
- 90 nurses.
- 2 consultants' weekday pattern.
- 1 consultant weekend pattern.
- 16.5 WTE trainees in total (Foundation: 1, Core: 0, Higher: 14.5, Non-training post: 1).
- They do not have ACCPs.
- Junior staffing – no dedicated junior tier of trainees, long day shifts and night shifts are covered by anaesthetics trainees on their neuroanaesthesia block. These trainees are in theatre for the rest of their time. Most of the time there is 1 ICM trainee attached to NICU for their stage 2 neuro-critical care block.
- There is a sporadic trainee presence outside of single ICM trainee that potentially affects continuity of care. They are not GPICS compliant in terms of junior staff at the weekend or at night (there is only one trainee to cover).
- Due to the nature of the work and the low numbers of trainees the consultants have to be very hands on. Better training could be provided if more trainees were present to free up consultant time.
- There are always two consultants on the shop floor 7 days a week. Consultants are very present, so trainees feel well supported because of this. They receive great feedback. It is a welcoming department with an increasingly complex case mix of patients. The Neuro ICU also takes trauma patients with head injuries, plastics, maxillofacial and head and neck postoperative electives and emergencies.
- ACCP support has been discussed as a route they will have to investigate and implement in the future or they could also develop a fellowship programme.
- Most consultants do neuroanaesthesia as well. Keen to get some non-anaesthetic consultants into the group.
- Morale of the consultant group is good. There are only 9 consultants, but the small, close-knit group all get on well and work well together.
- The morale of the intermediate anaesthetic trainees is not so good as they undertake an ICM heavy training programme during their ST3 year in Oxford. A decision has been made that Internal Medicine Trainees will not be sent to NICU so they will not be available to cover gaps in the NICU staffing to release the pressure on the anaesthetic trainees.
- The nursing staff are under huge pressure, due to complex patients with often challenging family dynamics. There is little down time due to capacity issues.

**John Radcliffe Hospital, Oxford**

- 16 bed unit.
- Sixteen Level 3 beds.
- 18 consultants in total.
- 79 nurses.
- 2 consultants weekday pattern.

- 1 consultant weekend pattern.
- 23 trainees in total (Foundation: 3, Core: 5, Higher: 4, Non-training post: 11).
- They do not have any ACCPs.
- Supporting undertaking academia alongside a dual training programme is a philosophy supported by the Deanery and the Dean. It runs like a school of academic trainees. Oxford and Cambridge are the only regions that do this. It requires a huge amount of work for the TPDs but they are made aware of this at interview. In Oxford, there is lots of flexibility for ICM trainees and they get programmes tailored to their individual requirements thanks in part to a very supportive TPD. It would be useful to highlight how Oxford has managed to achieve this flexibility to Deans nationally via the Lead Dean.
- Morale amongst the trainees is quite high. They have the same issues with respect to anaesthetic trainees cross covering the ICU. Most trainees stay in the region for consultant jobs although they do lose a couple to London.
- They are however, in a slightly different position to other units because they have a huge fellowship programme meaning the fellows can act as seniors as they are all post CCT. This allows them to be 'top heavy' to cope with the medical trainee over subscription. There is a further issue that medical trainees need to be paid an out of hour's supplement, which again affects resources.
- The ICU has a good amount of medical trainees and many fellow posts but nursing vacancies are a big issue.
- Oxford have established Advanced Nurse Practitioners (ANP) who provide a post-ICU follow up service and support retrievals from the Horton hospital. There are plans to develop an ANP-based outreach service.
- They have introduced a wellbeing group as part of an effort to make sure there is a group staff can participate in to voice their concerns about bullying, how to create a safe environment for staff and how teams are managed and treated.

**Royal Berkshire Hospital**

- 19 bed unit.
- 11 consultants in total.
- 90 nurses.
- 14 trainees in total (Foundation: 1, Core: 6, Higher: 7, Non-training post:).
- They have do not have any ACCPs.
- ICM consultant job plans receive 10 PAs, divided into 8.5 DCCs and 1.5 SPA. They should be able to count management roles in DCCs instead; they are currently modelling how to do this.
- Clinical Fellows – the junior rota is OK as they have 9 junior members of staff. They are currently trying to fill the senior rota. They currently have 6/7 doctors on the senior tier. The department has three tiers: Obstetric, General Anaesthesia and ICU. The ICU tier is a mixture of senior and junior doctors. Recruiting to the senior ICU tier has been problematic. They have moved away from insisting on the airway-trained requirement, as it has been difficult to recruit people with these skills. Anaesthetic support should be provided for the whole hospital.
- They did not have any vacancies at all up until a short while ago.
- They have a dilute skill-mix of nurses with less than 50% being critical care trained. The department supports education but they rely on EU colleagues (from Portugal and Spain mainly) to help. Staff retention is good due to the locality people stay. However, the area has the London-weighting cost of living without the London-weighting in salaries. This adversely affects nursing recruitment.

**Wexham Hospital**

- The data sheet for Wexham has not been returned
- Medical staffing – in the last three years they have lost 5 consultants (3 retired and 2 relocated back to their home country). They have only managed to appoint 1 consultant in that time to replace these five. Morale is therefore very low as it is an extremely busy and hard place to work. They also have challenging family dynamics of the patients to contend with. All of the consultants are doing lots of overtime.
- Wexham does have ACCPs and they have been very successful and wish to grow the number, but funding prevents this.
- Funding of the Enhanced Care area is an issue. Who runs it? Who is going to staff it? If no organ support is required, then ICU would not want to deal with these patients as they would not receive any funding. These kinds of patients really need enhanced nursing support. There might be a way to develop the funding for ACCPs.

**General Service level**

Service levels vary across the region's different units. All units are experiencing some gaps in their rotas. Some units are experiencing a bigger vacancy crisis than others and there is a worry that appearing as a unit under pressure is affecting the ability to recruit. It is felt there is difficulty in establishing the severity of gaps on the rotas. They all vary but when there are bigger gaps, they are huge.

One of the largest areas of concern was the nursing levels on the units and being able to retain nurses. Geography and proximity to London are part of the issue. It is hard to keep nurses when units are on the border where the London weighting stops. If a nurse only has to commute perhaps 20 or 30 minutes more to receive a London weighted salary, it is an obvious draw for many professionals.

Units stated that they often lose nurses immediately after their training course. Another factor is the nature of ICU nursing. ICUs often take only newly qualified nurses and the nature of the specialty is not suited to everyone but they will not know if it is the right fit for them until they have experienced it.

Royal Berkshire reported that their buildings are in desperate need of repairs and upgrades, it is incredibly difficult to provide the level of care required in buildings that are not up to standard.

**Follow-up clinics**

Stoke Mandeville has a follow-up clinic but are moving towards more of a nurse-led follow-up clinic due to consultant shortages. There is one consultant session but two nurse sessions per month. However, they have lost their psychologist and physiotherapist for this service. Trauma patients get a follow-up but rehab have an issue.

Stoke Mandeville are experiencing low support from Pharmacy. They also have recruitment issues for AHP Staff. There is a shortage of AHP staff in the Buckinghamshire Trust generally and the Wycombe unit is feeling the effects of this shortage more than Stoke Mandeville.

Royal Berkshire has a Follow-up Clinic, a Bereavement Team and an Outreach Team – flexibility in job plans is key to build resilience and retention.

Oxford has lots of Allied Health Professional (AHP) staff, all are funded and run through their own therapy departments so there is not a lot of control over them. It may be an idea to bring them under the critical care budgets to gain better control. Currently, AHPs are under the therapies model.

**Trainees**

The region has an excellent training programme in spite of a lack of funding and job plan support for RAs and the TPD. A lot of goodwill from consultants is being used to keep the programme operating at this high standard. Thames Valley is under resourced in educational provisions especially considering what it delivers. Despite the lack of funding, the training programme is functioning well and it is vital that this continues to allow for a stable and capable workforce in the future.

It can be difficult for a single CCT trainee to define their identity as an intensivist (through lack of role models, and a belief by others that you 'need' to dual train). In the Thames Valley region training is currently structured in such a way that Single ICM trainees must join the Anaesthesia department. But times are changing, whilst some of the consultant body feel unsure how a Single intensivists job plan will work in the future, many are encouraging and see it as the future of the speciality.

Not all units have separated the ICU rota from the other specialties. Most trainees appreciate ICM cannot be separated from anaesthetics as the trainee numbers are not there yet and it is not necessarily viewed as a hindrance. In Wycombe, the trainees cover other rotas but at Stoke Mandeville they have separated their rotas despite both units being part of the Buckinghamshire Trust. Often trainees feel they are in some way 'under Anaesthesia' and are trying to get the recognition that they are clinically and operationally a separate entity. Often consultants are also anaesthetists, so trainees are less likely to see a single intensivist in their role further along their career path. This is now changing as more single intensivists CCT but it still feels that there is a level of co-dependency with Anaesthesia that it is difficult to stand out from.

It can be difficult to separate out rotas for the trainees as everything is so stretched, another department may have to cover something here and there. When resources are scarce, it is very challenging to do this.

Some units voiced concern that there is too much influence from Anaesthesia on ICM within the region and that the next stage for Thames Valley and possibly nationally is for ICM to make critical care focussed job plans a priority. This would help the specialty move forward.

**ACCPs**

Several units reported that there was a willingness to embrace Advanced Nurse Practitioners (ANPs) over Advanced Critical Care Practitioners (ACCPs). There was also widespread concern at the huge turnover of nursing staff. Nurses have been leaving for a variety of reasons.

Units felt that a significant reason for the lack of willingness to begin investing in training ACCPs to resolve workforce pressures is that they feel their governance is unclear. Not understanding how they fit into the Medical Associated Professionals (MAPs) structure or if they will remain within the MAPs structure at all is leading to some ambivalence when it comes to investing in ACCPs.

For comparison, Southampton (Wessex region) has ACCPs. They found there was some reluctance to having ACCPs initially, but they now have 1 fully trained ACCP and 4 ACCP trainees as the training has been so successful. They have found support provided by this part of the ICM workforce invaluable.

Units with ACCPs on the rota reported that they are fantastic and really helpful but are cognisant of the fact that progression for ACCPs can be a factor in being able to retain them.

Perhaps the solution to retaining ACCPs is providing them with more academic projects, research opportunities and teaching roles. This would be a good way to ensure progression, including more individual and personal development of the role with a defined career path.

Oxford have an established Advanced Nurse Practitioner training programme.

There was some confusion among the units regarding the definition of ACCPs. Highlighting why it is important for the ACCP role to establish itself as a recognisable workforce option.

Trainee representatives at the meeting reported that ACCPs are the bedrock for trainees and for those that have worked with them, they are generally seen very favourably within this region.

**Recruitment**

Recruitment and retention of nursing staff is an issue for many units. For example, at Wycombe Hospital there is no approval for medical training, which affects nursing staff recruitment as it affects the patient case mix etc., making it less attractive.

In Milton Keynes, the biggest concern in recruiting ACCPs is the outlay of funding required to train them, for them to potentially move out of the region.

Recruiting senior staff has been so difficult for some units that they have had to no longer insist that senior staff are trained in airway management. Wexham reported that that are constantly recruiting locum and substantive posts just to fill the gaps but these are more expensive. Traditionally, Wexham had very good middle-grade cover. They now have 1 senior and 1 junior trainee in the daytime. They have lost quite a few to consultant jobs and relocations.

It was felt by several units that if a unit can fix the fundamentals, like not having an over-stretched rota, then a unit can flourish but there needs to be less pressure on consultants to make this possible. It's very hard to deliver the care one wants to achieve when working under the circumstances outlined by Wexham.

**Morale**

Morale varies across the region, but all units are feeling pressure in different ways depending on their situation. Wexham are coping with 7 out of 9 consultant posts filled and not enough middle grade doctors to help support. This understandably is taking its toll on the staff and the consultants are doing a large amount of overtime. But other units (for example Milton Keynes), report that junior staff and consultants are doing well but are struggling with too few nurses due to the training required for new starters.

One unit mentioned there had been a culture of bullying with an 'old guard' of some senior nurses. Not only is it important to deal with bullying for the wellbeing of all staff but this kind of culture was making it difficult to retain nurses. The unit altered their nursing leadership centering the role around wellbeing to ensure that the nurse taking on the role would be prepared to put changes in places to alter the bullying culture, subsequently the 'old guard' left and the unit is functioning well without a bullying problem. Units advised it is important to make sure to actively look out for bullying behaviour to make sure it is dealt with before it becomes part of the culture of a unit.

**Finance processes and Funding**

There are issues with Healthcare Resource Group (HRG) finance coding, the tariff earned from admitting a patient must go into someone's cost centre. If you have admitting rights then you

receive the entire HRG funding. There needs to be a concerted effort to change the system to reflect the true cost of patient care from admittance to discharge.

Further to this, everyone can see which department is bringing in money. At Royal Berkshire, most units will be given a certain amount or bring in a certain amount of money but they have to give back roughly a third of this for the basics (lights, heating, water etc.) to the hospital. This means, the amount of money the ICU generates goes and the financial power of Critical Care gets reduced, which makes expansion difficult. Royal Berkshire have increased the budget by 14% for the first time in a very long time though.

Some units are funded by bed occupancy, with units in the region having several different structures of financing in place, it can be very difficult to keep up with. Not only does a Clinical Lead have to focus on clinically running a unit but also there is the added pressure to comprehend different finance structures across one site.

Oxford uses the method of 'unbundled days' in their financing of the ICU. Surgeries have a tariff but the ICU does not receive any of the funding from the tariff despite looking after the patient pre and post-surgery.

Stoke Mandeville and Wycombe noted that outreach centres and Emergency Operation Plans (EOPs) have an opaque finance process which is frustrating.

## 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 Thames Valley. 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.

**Capacity**

Many units want to focus on solutions for capacity and infrastructure for the future.

There is no acceptable 'automatic policy' of accepting adults for Neurosurgery and in some places, it is felt there is a certain amount of 'gate-keeping' via the neuro registrar. There is a barrier with the Neurosurgeons, which may be compounded by the fact that the ICU consultants do not have any admission rights.

Within the Oxford University Hospitals Trust, there has been good support of the ICU's bed capacity concerns. They have made repatriations of patients a Trust-level issue. Clinicians fill in a form to start the process but the to-ing and fro-ing over a patient's repatriation does not need to involve the consultant directly. It stops consultants being the ones that fight for the bed space so they can concentrate on patient care.

Stoke Mandeville Hospital often has a quarter of their beds taken up by patients that they cannot move, and it is often Long-Term Ventilation (LTV) patients. This is prevalent with tracheostomy patients, as wards have descaled their ability to deal with them, so the responsibility falls back to the ICU when really, they should be in another area. Respiratory wards can manage these patients as there is higher respiratory support and they are able to do non-invasive ventilation outside of the ICU. Stoke Mandeville's newly purchased ventilators do not deliver at the right pressure for appropriate treatment, they were bought to replace the 12-year-old ventilators that were failing. There are further complications when discharging patients like this, as there is quite a burden on the family to care for them, so this dynamic must be considered when trying to discharge patients and free up beds. Wycombe is now the default clinical transfer site as its capacity is usually at 50%.

Wexham say the unit is still struggling and has been for about 6 years. They have Level 2 facilities but they want to accommodate lower-level patients, to take on patients they feel they can help. However, as they are often at capacity with the acutely ill, they cannot take on more Level 1 patients. They often feel they cannot make a difference with this cohort of patients, which is adversely affecting their morale.

Units felt there needed to be more data gathered on adults on Long-Term Ventilation. It is well known that the Royal Brompton has a data roadmap of all children on LTV but it is less clear if there is similar research on adult populations. Within the Oxford University Hospitals Trust, anyone new to the trust on a ventilator goes through ICU automatically.

**Retirement**

There are concerns that the current retirement rate will affect some units in the region. Some ICUs are already seeing consultants retiring the ICU component of their job plans whilst continuing with another specialty.

In Oxford, they have had two consultants leave in the past two years and looking at the future retirement rate, they will have a further three of the current consultant staff retire over the next three years.

The Royal Berkshire Hospital does not anticipate any problems with recruitment to address future retirements.

**Trainees and continuing the success of ICM Training Programme**

The region would like to see the training programme move forward and to have more deputy RAs, e.g. a deputy RA for education supervision to engage specifically with training. Essentially creating a larger infrastructure for ICM training. At present, they have a good relationship with the School of Anaesthesia; they value them and their input. For example, when running ICM ARCPs they have many trainees to see over two days, so the TPD for Anaesthesia will help and sit in on the single ICM trainee panel if needed. They would like to be able to expand the ICM infrastructure but there is not really any funding.

The trainees in the region are enthusiastic and motivated. They have made a fantastic website for themselves and future trainees. Whilst the region did experience some attrition from the ICM training programme between 2016-2017, the trainees have worked hard on resources and morale for those remaining. Trainees can choose to leave a programme for many reasons and Thames Valley is not alone in seeing some attrition against the programme. This has now stabilised and between 2018-2019 no further trainee resignations were received.

Thames Valley are running a recruitment prep course in January and the deanery have funded 20 places for ICM trainees to use Crit-IQ (an Australian ICM learning resources site) as they approach the exam.

There are some concerns over job availability for a single CCT intensivist. Stoke Mandeville will be expanding but noted that based on current working patterns, they would struggle to appoint a single CCT intensivist. However, some units advised that it might be about finding the gaps e.g. making someone a governance lead to help those who are single ICM to rota. Other units noted that the key to appointing a single CCT intensivist is finding the SPAs to fill the job plan. Dual consultants will fill this with other clinical responsibilities outside of ICM but the single intensivist will need to fill their job plans with follow-up clinics and teaching. Many units felt there were plenty of jobs for people to do but people need to think outside the box in terms of job plans for single CCT intensivists.

A renal specialist runs Oxford's academic programme and the byword for the programme is 'flexibility'. This is the philosophy that they have tried to carry across into the training programme. There is strong support from both the School of Medicine and ICM for the new Internal Medicine Training (IMT) programme that now mandates for IMT trainees to complete a block of intensive care medicine training. The programme is running well in Oxford and Milton Keynes. Wexham felt that ICM might look unattractive to some core medical trainees, as they will see which

departments are able to resource them well when they specialise. There is sometimes pushback from the IMT trainees to spend time within the ICU as part of their rotas.

Some core medical trainees are very keen, and units want to be able to encourage this enthusiasm for the specialty and dedicate enough time to supporting them but this is difficult when units are overstretched. The worry is that ICM will miss enthusiastic trainees applying for ICM by not being able to influence them earlier on in their medical careers.

However, at School Board level there is good support from the Lead Dean, to help merge the core medical trainees into the ICU rotas and this has been effective in Milton Keynes.

# 6. PROBLEMS AND SOLUTIONS

Sections 4 and 5 of this report detail the problems currently facing the ICM workforce in Thames Valley. 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 UK.

## 6.1 PROBLEMS

### 6.1.1 Staffing shortages and retention of staff

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 highlighted 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. Stoke Mandeville has a follow-up clinic but are moving towards more of a nurse-led follow-up clinic due to consultant shortages.

### 6.1.2 Capacity

Stoke Mandeville is continually over capacity and Wycombe is usually under, however they are 14 miles apart and that can make transfers of critically ill patients difficult, but this would ease the pressure at Stoke Mandeville. Many non-clinical transfers affect the teams. Conversely, many patients need transfers back to Stoke Mandeville for further treatment if they deteriorate. The whole pathway is not in the patient's best interests.

Wexham have a Surgical Higher Dependency unit (SDU) running at high capacity (over 95%). They want to see that the SDU is functioning before increasing the number of beds. It has been proposed that the surgeons will manage the SDU. The governance and funding of this is an issue.

Oxford NICU plans to expand their unit to include two more Level 3 beds. The physical space is big enough for the expansion but they do not have the staff to support it. They need more nurses. They currently have 90 Full Time Equivalents (FTEs) but need 104 and are running at or over capacity much of the time.

### 6.1.3 Resources for the training programme

Many units reported that a lot of the success of the training programme was down to the 'goodwill' of the consultants. There are not enough resources and many job plans do not allow enough time to be dedicated to the administration of the programme.

A few individuals are driving the strengths of the region's training programme. The region needs to keep up the high standards currently being achieved but a lot of this is only possible because of the goodwill of some individuals. The question is how they keep the goodwill in place but also what can be done to better support those that are working and teaching well beyond their means.

### 6.1.4 Workforce Wellbeing/Morale

This is tied into the staffing gaps. Some units have lots of new starters but for example at Royal Berkshire, 23.5% of their nursing workforce comes from the EU. Morale of the EU nurses is low due to negative patient interactions related to Brexit. One cannot divorce politics from workforce issues.

### 6.1.5 Guidelines for the Provision of Intensive Care Services (GPICS)

Units reported they were short of the standards of GPICS in some areas but again this was down to rota gaps and the number of staff available, which is a symptom of the larger problem of retaining and recruiting staff.

## 6.2 SOLUTIONS

### 6.2.1 Staffing solutions

It was suggested that units want to try expanding their Special Skills Year (SSY) provision for single ICM CCT trainees, as they include significant portions of audit and QI. A number of units have created posts that include either ECHO training, Simulation training or Research (Reading, Stoke and Oxford).

### 6.2.2 ACCPs

Stoke Mandeville reported a gap created by lack of middle tier doctors on the rota and they can see how ACCPs would help relieve the pressures created by this. ACCPs are a good way of providing consistency of care across a unit but there is a downside in that there is a huge investment upfront as the market is created. There are these factors to consider but it would mean a unit would not have to pay a locum at night as the ACCP could cover this.

### 6.2.3 Ways of working

Oxford have found that having two consultants paired together on the rota has been very positive; mixing the rota up so they do not get the same pairing. It allows for a rolling variation and gets people to achieve commons goals together. Oxford actively want to work on what will make a workforce happy - though this is different for everyone.

### 6.2.4 Capacity solutions

Oxford University Hospitals NHS Foundation Trust NICU have plans to expand the unit for two more Level 3 beds. The physical space is big enough for the expansion but they do not have the nursing or junior medical staff to support it at present. They need more nurses. They currently have 90 Full Time Equivalents (FTEs) but would need 104. They are running over capacity much of the time. They are also moving towards a 24/7 stroke service in Oxford which may have implications on NICU demand. Some neurosurgery patients need an HDU environment for 24hrs. Development of a separate high dependency area would allow them to avoid admission to ICU.
Royal Berkshire have plans to increase capacity as the ICU is 20 years old. However, the hospital is on a fixed site with no spare ground, so the only way to expand is by building on

top of the existing buildings but they cannot support the extra weight. The vision is to have an 'Emergency' block.

Stoke Mandeville and Wycombe have a £58m plan to build more theatres but they are running into infrastructure problems due to asbestos and old wiring that is unsafe but not illegal.

### 6.2.5 Resources for training programme

There is inadequate Health Education Thames Valley (HETV) resource for the ICM training programme. In terms of administrative support and funded time, the current TPD receives 0.75 PAs. The RA is funded at 0.5 PA. This is based on deanery funded NTN trainee numbers and does not take into account complexity of programme and need for liaison with dual specialities. A longer-term strategy to address this would be to have a School of ICM in the region but would require additional funding.

## 7. DATA

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

### 7.1 Headcount

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

| HOSPITAL | CONSULTANTS | | SAS Grade | | ACCPs | | NURSES | |
|---|---|---|---|---|---|---|---|---|
| | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE |
| Cardiothoracic Critical Care, Oxford | 7 | 9 | 3 | 2 | 2* | 5 | 100 | 100 |
| Churchill Hospital | 18 | 16 | 0 | 0 | 0 | 0 | 26 | - |
| John Radcliffe Hospital | 18 | 16 | 0 | 0 | 0 | 0 | 79 | - |
| Milton Keynes Hospital | 10 | 10 | 0 | 0 | 0 | 0 | 50 | 50 |
| Oxford University Hospital - Neuro | 9 | 11 | 0 | 0 | 0 | 0 | - | - |
| Royal Berkshire Hospital | 11 | 15 | 0 | 0 | 0 | 6 | 90 | 120 |
| Stoke Mandeville Hospital | 15 | 19 | 10 | 10 | 0 | 0 | 87 | - |
| Wexham Hospital* | - | - | - | - | - | - | - | - |
| Wycombe Hospital | 15 | 19 | 8 | 10 | 0 | 0 | 37 | - |

### 7.2 Whole time equivalents (WTEs)

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

| HOSPITAL | CONSULTANTS | | SAS Grade | | ACCPs | | NURSES | |
|---|---|---|---|---|---|---|---|---|
| | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE |
| Cardiothoracic Critical Care, Oxford | 4.5 | 6 | 2 | 1 | 2* | 5 | 91.5 | 100 |
| Churchill Hospital | 16 | - | 0 | 0 | 0 | 0 | 24 | - |
| John Radcliffe Hospital | 16 | - | 0 | 0 | 0 | 0 | 75 | - |
| Milton Keynes Hospital | 10 | 10 | 0 | 0 | 0 | 0 | - | - |
| Oxford University Hospital - Neuro | 9 | 9 | 0 | 0 | 0 | 0 | 90.3 | 104.13 |
| Royal Berkshire Hospital | 9 | 11 | 0 | 0 | 0 | 6 | 77.83 | 120 |
| Stoke Mandeville Hospital | 15 | 20 | 10 | 18 | 0 | 2 | 70.2 | 94 |
| Wexham Hospital* | - | - | - | - | - | - | - | - |
| Wycombe Hospital | 14 | 14 | 10 | 10 | 0 | 0 | 40.4 | 48.4 |

### 7.3 Trainees

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

| HOSPITAL | Foundation | | Core | | Higher | | Non Training Posts | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE | NOW | FUTURE |
| Cardiothoracic Critical Care, Oxford | 0 | 0 | 0 | 0 | 4.5 | 5 | 6 | 6 | 10.5 | 11 |
| Churchill Hospital | 0 | - | 1 | - | 2 | - | 5 | - | 8 | - |
| John Radcliffe Hospital | 3 | - | 5 | - | 4 | - | 11 | - | 23 | - |
| Milton Keynes Hospital | 1 | 1 | 5 | 5 | 6 | 6 | 0 | 2 | 12 | 14 |
| Oxford University Hospital - Neuro | 1 | 2 | 0 | 4 | 14.5 WTE | 14.5 WTE | 1 | 4 | 16.5 WTE | 24.5 |
| Royal Berkshire Hospital | 1 | 1 | 6 | 6 | 7 | 7 | 0 | 0 | 14 | 14 |
| Stoke Mandeville Hospital | 2 | 2 | 4 | 6 | 4-6 | 4-6 | 2 | 4 | 12-14 | 16-18 |
| Wexham Hospital* | - | - | - | - | - | - | - | - | - | - |
| Wycombe Hospital | 0 | 0 | 0 | 1-2 | 0 | 1-2 | 0 | 0 | 0 | 2-4 |

*** No Data returned from Wexham Hospital**

### 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 in the tables indicate that the information was not available or not provided.

| HOSPITAL | NOW | FUTURE | INCREASE OR DECREASE |
|---|---|---|---|
| **Cardiothoracic Critical Care, Oxford** | | | |
| WTE for Consultants | 4.5 | 6 | Increase |
| WTE for SAS/Staff Grades | 2 | 1 | Decrease |
| WTE for ACCPs | 2 | 5 | Increase |
| WTE for Nurses | 91.5 | 100 | Increase |
| Number of Trainees | 13.5 | 11 | Decrease |
| | | | |
| **Churchill Hospital** | | | |
| WTE for Consultants | 16 | - | - |
| WTE for SAS/Staff Grades | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 24 | - | - |
| Number of Trainees | 8 | - | - |
| | | | |
| **John Radcliffe Hospital** | | | |
| WTE for Consultants | 16 | - | - |
| WTE for SAS/Staff Grades | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 75 | - | - |
| Number of Trainees | 23 | - | - |
| | | | |
| **Milton Keynes Hospital** | | | |
| WTE for Consultants | 10 | 10 | Remains the same |
| WTE for SAS/Staff Grades | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | - | - | - |
| Number of Trainees | 12 | 14 | Increase |
| | | | |
| **Oxford University Hospital – Neuro ICU** | | | |
| WTE for Consultants | 9 | 9 | Remains the same |
| WTE for SAS/Staff Grades | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 90.03 | 104.13 | Increase |
| Number of Trainees | 16.5 | 24.5 | Increase |
| | | | |
| **Royal Berkshire Hospital** | | | |
| WTE for Consultants | 9 | 11 | Increase |
| WTE for SAS/Staff Grades | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 6 | Increase |
| WTE for Nurses | 77.83 | 120 | Increase |
| Number of Trainees | 14 | 14 | Remains the same |
| | | | |

| | | | |
|---|---|---|---|
| **Stoke Mandeville Hospital** | | | |
| WTE for Consultants | 14 | 20 | Increase |
| WTE for SAS/Staff Grades | 10 | 18 | Increase |
| WTE for ACCPs | 0 | 2 | Increase |
| WTE for Nurses | 70.2 | 94 | Increase |
| Number of Trainees | 25-30 | 34 | Increase |
| | | | |
| **Wexham Hospital – No data returned from Wexham** | | | |
| WTE for Consultants | - | - | - |
| WTE for SAS/Staff Grades | - | - | - |
| WTE for ACCPs | - | - | - |
| WTE for Nurses | - | - | - |
| Number of Trainees | - | - | - |
| | | | |
| **Wycombe Hospital** | | | |
| WTE for Consultants | 14 | 14 | Remains the same |
| WTE for SAS/Staff Grades | 7.5 | 10 | Increase |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 33 | 48.4 | Increase |
| Number of Trainees | 0 | 2-4 | Increase |
| | | | |

### 7.5 Training Posts

One of the many workforce metrics that the FICM has used to monitor the growth of training posts in the UK has been comparing the number of posts recruited each year for a region or home nation against its population. The table below indicates the population serviced per training post recruited to in each year. Thames Valley experienced a decline in its training to population number in 2018, offering ten posts but only filling seven posts at National Recruitment. In 2019, Thames valley had a 100% fill rate, filling all ten available posts. 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 (1,465,438) |
| 2 | North Western (1,144,398) | East of England (850,596) |
| 3 | KSS (879,263) | West Midlands (810,673) |
| 4 | East of England (744,271) | East Midlands (656,961) |
| 5 | Wessex (631,964) | Wales (513,735) |
| 6 | South West (611,395) | **Thames Valley (463,260)** |
| 7 | Northern Ireland (609,908) | Wessex (451,403) |
| 8 | East Midlands (574,841) | Scotland (443,975) |
| 9 | Scotland (532,770) | Yorkshire and Humber (437,316) |
| 10 | Northern (367,158) | Northern (419,609) |
| 11 | Yorkshire & Humber (349,853) | Northern Ireland (365,945) |
| 12 | Wales (280,219) | South West (305,697) |
| 13 | London (249,814) | North Western (264,091) |
| 14 | **Thames Valley (231,630)** | London (242,676) |

## APPENDIX 1: LIST OF ATTENDEES

| ICU/Organisation | Name |
|---|---|
| Royal Berkshire Hospital | Dr Graham Barker |
| Royal Berkshire Hospital | Dr Jerome Cockings |
| Royal Berkshire Hospital | Ms Melanie Gager |
| Oxford University Hospitals | Mr Owen Gustafson |
| Oxford University Hospitals | Dr Jon Hughes |
| Royal Berkshire Hospital | Dr Andrew Jacques |
| Royal Berkshire Hospital | Dr Liza Keating |
| Buckinghamshire Healthcare NHS Trust | Dr Carl Morris |
| HETV deptuty | Dr Jeremy Noble |
| Southampton | Dr Kathy Nolan |
| Oxford University Hospitals | Dr Christopher Palin |
| Oxford University Hospitals | Dr Hannah Potter |
| Royal Berkshire NHS Foundation | Dr Ian Rechner |
| Stoke Mandeville Hospital | Ms Sally Scott |
| Stoke Mandeville Hospital | Dr Prad Shanmugasundaram |
| Oxford University Hospitals | Dr Richard Siviter |
| Milton Keynes General | Dr Richard Stewart |
| Wexham Park Hospital | Dr Piotr Szawarski |
| Wexham Park Hospital | Dr Tina Tamm |
| Royal Berkshire Hospital | Dr Carl Waldmann |
| Oxford University Hospital | Prof Peter Watkinson |
| Oxford University Hospital | Dr James Weitz |
| Portsmouth | Dr Matthew Williams |
| | |
| FICMCRW Committee Chair | Dr Danielle Bryden |
| FICMCRW Workforce Lead | Dr Jack Parry-Jones |
| FICM Board & Training Projects Manager | Ms Natalie Bell |
| FICM Education and Engagement Coordinator | Ms Lucy Rowan |
| | |

## APPENDIX 2: 2019 CENSUS DATA

**COUNT:** 22 respondents (out of 1106).
86% of the respondents are practicing in both Anaesthetics and ICM. This compares to 82% in the North West, 82.2% in East Midlands and 84% in the South West Peninsula.

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

| | Thames Valley |
|---|---|
| Increase | 3 |
| Decrease | 6 |
| Neither | 13 |

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

| ANSWER | Thames Valley |
|---|---|
| Yes | 18 |
| No | 4 |

3 units were represented in the Clinical Leads section

| Do you have ACCPs on the unit | Thames Valley |
|---|---|
| Yes | No Units |

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

| % | Thames Valley |
|---|---|
| 0-24% | 0 |
| 25-50% | 6 |
| 51-75% | 10 |
| 76-100% | 6 |

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

| % | Thames Valley |
|---|---|
| 0-24% | 6 |
| 25-50% | 6 |
| 51-75% | 5 |
| 76-100% | 5 |

NB: Per week PA data across the region

| | Total DCC-PAs number in your Job plan | All SPAs (ICM and non-ICM) |
|---|---|---|
| RANGE | 7.4 | 3 |
| MEAN | 10.9 | 1.9 |
| MEDIAN | 11 | 2 |
| MODE | 11 | Joint 1/1.5/2.5 |

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