REGIONAL WORKFORCE ENGAGEMENT REPORT:

EAST MIDLANDS

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 East Midlands region by representatives from each Trust, the networks, the Specialist Training Committee and School. Dr Parry Jones writes:

I drove through driving rain from South Wales to the East Midlands the night before the meeting. The following morning it was freezing cold, a sign of the winter ahead. The Faculty team were very warmly met by the East Midlands Critical Care multidisciplinary teams. A particular thank you to Som Sarkar for his kind hospitality. I hope all those who were present agree that we had an interesting and productive day.

This was the sixth engagement that the Faculty team have done and my third. There are staffing themes common to all regions to varying degrees which are outlined in this report. The Faculty have also drawn these common regional themes together and will be publishing a report on this separately soon. Sadly the Faculty cannot solve these problems for you, but we can help to highlight the problems, whilst also offering and promoting potential solutions for the regions to pick up on.

The East Midlands does have some issues which were more striking that other regions and I think three of these are worth highlighting:

The first was the geographical differences between the clinical networks that serve the region and the divide between training (deanery), networks and other regional structures. Many in the room argued that these structural issues would benefit from realignment and it certainly appears that they are worse than some other regions. The northwest region for instance, whilst sharing many of the same common themes, has the structures better lined up to provide the solutions and implement them. Communication between these structures of training, junior placement, and clinical networks is likely to be absolutely crucial to the nuanced identification of regional medical staffing problems, and the regional solutions to those problems.

Secondly, more units in the East Midlands than elsewhere seem to be struggling over years to recruit critical care consultants and where rotas are very onerous are also then struggling to retain working critical care consultants. We know that the consultants of the future most often come from the trainees in the region. The argument for increasing critical care trainees in the East Midlands is already there. If this is not addressed then critical care consultant staffing in some hospitals will become exponentially worse with retirements, early loss to anaesthesia, and centralisation of critical care consultants to hospitals that have perceived better rotas and perceived better work life balance. Uncertainty and lack of concrete planning in the region, and lack of engagement with critical care in regional planning are compounding this recruitment difficulty for some hospitals.

Thirdly, whilst there are Advanced Critical Care Practitioners (ACCPs) working and training in the East Midlands the training programmes aren't as far forward as in some other regions. We know from the workforce census in 2017 that 20% of units across the U.K are either training or are already employing ACCPs. ACCPs are clearly not the solution to all medical staffing problems but they do offer a means of supporting the junior medical tier whilst also offering other significant benefits.

I hope that the East Midlands find this report useful. First and foremost it is yours. The Faculty team are grateful for your engagement. It was a pleasure for me to meet many of you there on the day.

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 2016), engagement with workforce modelling projects and drawing information from audit and research.

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

ICM presents a unique challenge for workforce planners:

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

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

1.2 Projected demand

1.2.1 Census data

Between the 2014 and 2016 censuses, the figure for those intending to drop ICM sessions rose from 22% to 38%. The most common reasons across the 2014, 2015 and 2016 censuses for wanting to leave ICM were all focussed on workforce issues:

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

In 2016, 51% of respondents (an increase of 4% from 2015) felt that they found ICM stressful enough that it would influence their future career plans.

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

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

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

1.2.2 Intensive Care National Audit and Research Centre (ICNARC)

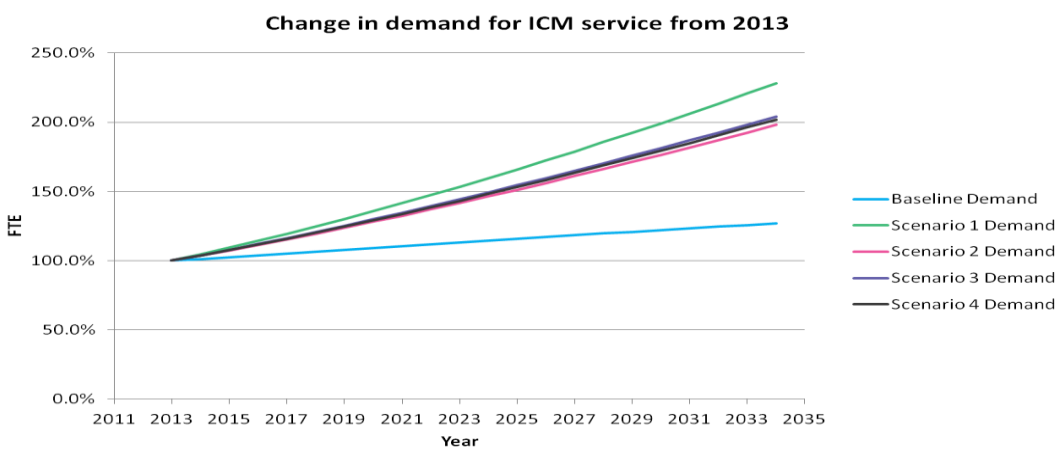
ICNARC is currently undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014.

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

1.2.3 Centre for Workforce Intelligence (CfWI)

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

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



1.2.4 Workforce aims

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

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

2. BACKGROUND TO THE ENGAGEMENT

In October 2014 the FICM Board accepted a position paper as a statement of current provision and UK-wide projected trends for ICU services. The Board recognised the need for modelling of workforce demand in the home nations and regions, requesting that two pilot studies be undertaken. The first engagement was held in Wales in November 2015, followed by West Midlands in May 2016, Scotland in September 2016, Yorkshire & Humber in November 2016 and the North West in March 2017.

The East Midlands was the Sixth region to request an engagement with the Faculty, which we happily accepted. The East Midlands has experienced consecutive years of a 100% fill rate for the ICM training posts that they have made available however, 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 significant numbers.

Following extensive discussion representatives (please see Appendix 1) were agreed for each Trust and local training leads. We are grateful to the assistance given by the Mid Trent Network and Regional Advisor.

2.1 Engagement Aims

The engagements would be conducted with the aim of:

- Describing the current supply of ICM/critical care facilities in the East Midlands and presenting an assessment of likely future (5-10 years) demand.
- Identifying the likely future location of critical care services based upon current provision and networks of clinical care surrounding regional centres.
- Presenting the best estimates that can be made of the current trained medical workforce in ICM in the East Midlands, their distribution and demographic; and the workforce in training.
- Conducting discussion sessions to reconcile supply and likely demand for ICM, with the current and projected workforce.
- Providing a data report that could be used by the region to exert professional pressure in order to address areas of workforce concern.

The engagements would not aim to:

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

The engagement would result in this final report and its appendices which 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 EAST MIDLANDS

3.1 ICM TRAINING, CLINICAL DEMAND AND WORKFORCE IN THE EAST MIDLANDS

This information is based on the presentation given by Dr Som Sarkar and reflects their opinion on ICM training and Workforce in the East Midlands. It reflects personal opinion where it is not clearly referenced to existing data from other sources.

The East Midlands, as the rest of the U.K, is facing increasing difficulties in adequately staffing Critical Care units to minimum levels.

Whilst already present, they are likely to deteriorate as the demand for Critical Care increases. The Intensive Care National Audit and Research Centre (ICNARC) predicts an annual 4% increase in Critical Care demand, with Critical Care bed days (levels 2 and 3) delivered in general (i.e. non-specialist) units noted to have increased from 650,000 (2007) to 740,000 (2013).

The region delivers Critical Care in 14 units serving a population of around 4.5 million across an area of 6000 square miles. It is projected to have higher population growth over the next 25 years than any other English region with particularly high increases in the older age groups. This ageing population along with multi-morbidity, advances in therapies and differing expectations of patients, their relatives and parent teams, are compounding the demand on services.

We have 30 trainees currently in programme. There is a lack of HE East Midlands financial support to expand posts, whilst National ICM recruitment is oversubscribed for the posts that are available. There are very few Trust funded posts unlike other regions, which reduces the number of trainees who could be accommodated within the region. Following the debacle of Modernising Medical Careers, the numbers of doctors gaining CCT in ICM locally (and nationally) is unlikely to address the demands placed by current and future ICUs, especially with increasing associated roles including Outreach, Follow-up, Education and Governance.

The overall drive to save money in the already underfunded NHS is impacting healthcare and Critical Care is no exception. The European Working Time Directive, changes in anaesthesia and ICM training/accreditation, inability to recruit staff from outside European boundaries and Deaneries imposing well-meaning hour's limits have all affected how we staff our units, especially with doctors in training. Each junior doctor now delivers significantly fewer service hours than in the past, whilst training years remain similar. The 2014 FICM workforce census highlighted the biggest source of stress to consultant intensivists as "Trainees – inadequate numbers, inadequate competencies." Solutions to staffing standards include ACCPs, non-anaesthetists needed on rotas and for their training. There is also the mandatory requirement for resident staff with advanced airway skills.

Critical Care consultants face increasing demands, which impact on early retirement plans, health and part time working. It is predicted that up to 50% of current Consultants in the region will be retiring within the next 10 years, leaving Trusts with a significant workforce-planning burden now. Accepting the status quo, ignoring this and attributing low risk-ratings to this problem is unacceptable for the wider population we are commissioned to treat and serve. Trusts, especially peripheral hospitals, must acknowledge the decrease in anaesthetic dual-CCT holders complementing the rise in medical/EM dual-CCT holders in the future and realign their acute services accordingly.

The focus of Critical Care was notably absent initially from the STP consultations, highlighting the need for us as a profession to raise our voice. We must offer the right solutions and opportunities to our Commissioners, Deaneries, Universities and Trusts to sustain our population's healthcare in the future. We have highly motivated, caring and talented colleagues either in, or who wish to pursue, a career in Critical Care. It is up to us to create the blueprint of a realistic model, support them and look forward to the future of our specialty

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 East Midlands. The attendees were divided into two groups and were asked to discuss the following points:

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

Chesterfield

- Seven level 3 beds and eight level 2 beds, in a geographically spilt site.
- 13 consultants dedicated to ICU, they plan to recruit more to enable 24 hour HDU cover.
- They work a 1 in 12 weekday nights; weekend day shift is 8 till 3. Annualised for night.
- 1 in 7 middle grade on call, which is made up of 2 or 3 anaesthetic and ACCS trainees and clinical fellows. They have not yet had stage 3 trainees but hope to.
- They have 6 ACPs at the moment but no ACCPs; they hope to increase this by 4 more ACPs. They undertake a general programme, rotating through other areas. Once trained in 2019, two of these will be destined for Critical Care.
- They have workforce gaps.
- Nursing staff are leaving, as there is not enough development opportunity for them.
- They will be exploring the Medical Training Inititative (MTI) programme to help the junior tier and echo fellows.
- They have preliminary approval for a combined unit.

Derby Hospital

- The unit has 1200 mixed admissions a year.
- Although the unit has 20 beds, which can be used flexibly, only 16 are actually functional with current nursing support.
- They should have a 1 in 10 rota with 10 Consultants but are currently one down and looking to recruit to this post now.

- The have a 2 tier out of hours (OOH) for ITU. Five staff grade make up the junior tier of OOH and they do very little daytime work. During the day, they have a minimum of three trainees, which is a mix of Anaesthetics and medical trainees. They have not had FICM trainees for some time.
- No ACCPs, but they are finding staff grade group replenishment difficult so ACCPs may well be explored as a solution. The hospital does have ACPs but they are hospital flexible, rather than ICU dedicated.
- Recruiting Consultants has been a problem, some retirements are coming so two further posts will need to be recruited to. 10 Consultants works well so they must maintain this number.
- They are roughly 16 down on nurses and recruitment is slow. They need 14 nurses for a shift, but mostly operate with 12 at present. They do have a successful model of targeting nurses that are more senior.
- There are plans for a merger with Burton Hospital, which is 11 miles away from Derby Hospital; they are in the same Network but not the East Midlands region.

Kettering Hospital

- 1500-1600 admissions.
- They split the ICU/Anaesthetics rota 4 and half years ago.
- They have a nice new unit with 16 physical beds, 2 for dialysis.
- They can have 10 level 3 beds on a daily basis but the normal mix is 6 level 2 and six level 3. They usually have 12-13 patients.
- They have Consultant staffing issues. They were six consultants doing a 1 in 6. They are slowly increasing to 8 but have had one Consultant leave so are down to 7 and have another one thinking of moving solely to Anaesthetics. They have advertised 3 times, no UK applicants.
- They are supposed to be resident 8am to 8pm but the reality is 8am to 10pm.
- Sparse junior tier, they usually have one Foundation trainee, 2 ACCS trainees of varying competence and currently have their first higher Anaesthetics trainee. The remaining 4 are trust grade. They have no FICM trainees.
- They do not have any ACCPs, and while they might consider them in the future, attracting them might be hard.
- Nursing levels are OK.

King's Mill

- King's Mill Hospital is a district general hospital (DGH) with 13 beds, which are used flexibly between levels 2 and 3.
- They usually have 9 nurses per shift and this determines the amount of patients they can admit.
- Currently they have 8 consultants; two are due to retire in the next couple of years. They have the funding to increase to 9 posts but have experienced 3 years of failed recruitment to the role.
- They do 1 in 8 on call with prospective cover, and operate a separate ICU on call rota. A week of daytimes on the unit provides good continuity of care. They are occasionally drawn into Paediatric cases until anaesthetic cover arrives. A slow retrieval service on the site ties up staff.
- Junior tier is problematic, as they see an erratic flow of trainees and differing training needs when they are on site. Trainees doing their Anaesthetics block, which forms part of their service commitment, cover night and OOHs. Daytime is not a dedicated team and they can end up with no trainees. They have previously converted staff grade posts to ICM training but for the next 6 months, they will not have an FICM trainee.

- The site does not currently have ACCPs and the nursing team are worried about their staff being poached to supply ACCPs. A business case has since been submitted.
- They are struggling to convince the trust that they need a matron for ICU; currently they only have a band 7 lead, which goes against Care Quality Commission (CQC) Standards. This has now fortunately happened since the engagement meeting.
- OOHs is one consultant and one registrar.
- They last had a CQC visit 18 months ago and are due another later this year with the trust coming out of Special measures.

Leicester – Glenfield, Leicester General and Leicester Royal

- Three units in Leicester – Leicester General, Leicester Royal Infirmary (LRI) and Glenfield.
- Service configuration is planned; there is an expectation to expand Glenfield by 10 and the Leicester Royal by 5 more bed spaces. This will mean they need to look at recruitment at all levels. There is movement of beds from the Leicester General to the other two sites.
- Recruitment is challenging. Consultant vacancies at Leicester Royal presently, which should have 13 but only currently has 11. Vacancies at the Glenfield presently, which should have 10 but have 9.
- Glenfield have extracorporeal membrane oxygenation (ECMO). ECMO consultants do daytime ITU and 1 in 5 on call transport rota.
- They have applied for a locum ECMO consultant post in preparation for movement of paediatric services to the LRI and loss of 1 consultant to the Paediatric ECMO rota. .
- When the beds move to Glenfield, they should have 16. Consultants from Leicester General are reluctant to move to Glenfield.
- At Leicester General, they have many staff grade doctors staffing the ITU during the day.
- Three MTI posts rotate between the Glenfield and Leicester Royal In addition, Glenfield have one ITU clinical fellow, 1 ECHO Fellow, 2 ECMO fellows and 3 ACCPs. The rota is very reliant on this workforce. The Leicester Royal have 2-4 non-training grade doctors
- Trainee doctors: A variable number of anaesthesia and ICM trainees are allocated to the units at the Glenfield and LRI. Sporadic and unreliable for rota planning
- Considering if they could convert one of the Fellow posts into a trainee post. Barriers are created by the curriculum, as they want to get Affiliate ICM status but the 1 year of medicine is a big barrier. There are vacant medicine posts but these are not good vacancies as they cover the least popular of medical posts and provide little educational value. The potential applicants to these medical slots are usually quite senior, so the unpopular nature of the posts make it hard to fill. If Trusts do fund the posts there will be more control over who goes where.
- Only Glenfield has the ACCP route for nurses. They would like this to be expanded across the region so nurses can stay in clinical work.
- Currently three ACCPs at Glenfield, two critical care nurses and one ODP – all are permanent members of staff and provide great care and workforce. This has been viewed as good for ICM trainees too and it is hoped they will also be set up at Leicester Royal. The ACCPs are functioning at junior doctor level. When the unit expands, they will definitely look to expand ACCP numbers as well.
- Leicester University are setting up a life science division – this could be a great opportunity to set up masters' style courses.

Lincoln Hospital

- Part of a Trust that includes Pilgrim Hospital and Grantham Hospital.
- Grantham is struggling to keep its A&E open and it is conceivable that reconfiguration may mean that acute inpatient services are not continued and it becomes a cold site centre. Reconfiguration of other services between Pilgrim and Lincoln may mean that

services such as vascular and maternity, come to one main site, however the details of "if", "how" and "when" are far from clear.
- Workload is increasing, 9 out of 10 consultants is the norm, and they have 1 retirement due next year.
- Aging population of consultants so could go down to 7 in a short period of time, which would mean the unit would struggle to cope; burnout could affect the remaining workforce and effect training.
- Junior tier is made up of foundation years and anaesthetic registrars (typically ST3)
- They have discussed ACCPs but are undecided on whether to pursue this.

Northampton Hospital

- 16-bedded unit: they took over the HDU 5/6 years ago.
- The theory is they can be flexible with up to 14 level 3 beds.
- They currently run with 10 consultants, one of which is from a Medicine background. They have funding for 14 Consultants but have not successfully recruited since 2011.
- One in 10 weekdays and 1 in 5 weeknights.
- The junior rotas have funding for 16, but they have never had that many. They currently have 1 registrar and 2 ACCS trainees. They do have a few Foundation doctors that are very keen and helpful during the day but limited with capabilities on the unit. They also have Clinical Fellows equivalent to FY3 that prove incredibly useful to the team, as they are unit specific, stay the whole year and are some of the best doctors they have.
- They have committed to converting trust grade posts to training posts but have yet to be sent any great number of FICM trainees by the Deanery rotation. Earlier this year they had a FICM trainee with them, from a Medicine background, and this was a good experience.
- They looked into ACCPs some time ago and will consider this again in the future, as they feel it would be attractive to nurses for development.

Nottingham University Hospital

- Two Hospitals – Queens Medical Centre and Nottingham City Hospital, the sites are 2.5 miles apart. More than3000 admissions a year between the sites.
- QMC has 20 Level 2 beds and 21 level 3.
- Nottingham City has 17 combined beds.
- Consultant heavy delivered service, with consultant resident until 2am at QMC and 12pm at City. At QMC after midnight, one-consultant covers 41 patients and City covers 17 patients.
- Fully annualised rota. They have two vacancies, which they have not successfully appointed to yet so they will be advertised again shortly.
- There are no overnight consultant facilities; but there are for trainees on both sites.
- Junior tier at QMC has 16. They have eight ST Senior tier, at night they have three trainees for 41 beds. Like all hospitals the rotas are supported by locums and clinical fellows
- On the City site, they have three trainees in the day and one at night. They can have a whole rota with no airway-trained trainees; lead consultant has to let other departments know that there are no airway skills.
- They have ACCPs; currently the funding comes from the nursing budget. They wish to train more ACCPs. Trainees' stays are too short; ACCPs will be a consistent workforce. Regulation is key, there is currently little use in training Paramedics and ODPs as they cannot prescribe but the skill set is good.
- All FICM trainees come through the unit at some point. Currently they have three advanced trainees, which is the largest number of trainees they have had at once.
- They have over recruited nurses, which has supported winter pressures.

- Outreach (CCUT) has been decommissioned to 8am-10pm.
- They want to build up their junior tier with ACCPs so they can be a more consultant led service, than consultant run service.
- An expansion of level 1 beds is planned; this is to alleviate level 2, which is being used by patients needing a little bit of care but not critical care.

Cardiac – Nottingham University Hospital

- The unit takes 600-800 cardiac cases a year
- 14 beds, 8 level 3 and 6 level 2, they have 5 consultants.
- The unit is covered by nurse practitioner and run by anaesthetic consultants.
- OOH sees one Consultant at home; Anaesthetics Department can be called in a crisis.
- They have no junior trainees, but all FICM trainees go to Leicester for their Cardiac placements. Leicester also offers ECMO.

Pilgrim's Hospital, Boston

- The unit has 8 funded beds and 4 unfunded beds, and takes 350-400 level 3 admissions a year, roughly 800 a year combined.
- The unit sees a large number of older patients as the area is attractive to retirees.
- They work a 1 in 8 rota, and currently do 72 hour continuous on call.
- They have had 1 locum in post for a year, and 2 consultants are about to retire. Morale is very low because of workforce issues and the onslaught on job plans. Consultants are not supported in their training roles, no time or pay is protected for FICM Faculty Tutor role or training and guardian role for junior doctors.
- Trainees make up the middle grade; it is dedicated but the quality and needs of the individual vary.
- They have just started to have FICM Trainees and the feedback was very good. They would like to have more, as a consistent ST3/ST4 presence would be good.
- ACCPs have been discussed in the past and they are keen to pursue but unsure how to take this further.

General

Service level

The group discussed the possibility of trusts establishing and allowing flexible job plans and shared PAs, which would effectively operate as hybrid jobs. There is a current example of this with a consultant at Northampton also having some PAs in Wales. Certainly, for this individual the system works, but smaller scale movement would probably be more likely. Hybrid jobs are in use in other regions too, although these are usually for Medicine/ITU consultants, as opposed to anaesthetists.

Follow up clinics

The group discussed the availability of Follow up clinics within the region. Pilgrims has a funded Clinic, once a month this is Consultant led, the rest is nurse led. Northampton's is entirely nurse led and Kettering has Consultant sessions but the clinic only runs as and when it is needed. A Nurse Consultant runs the King's Mill clinic but they have just handed in their notice. The unit is keen to keep this service going. Derby advised that currently on average 4 patients a month take up the offer of the follow up clinic. Leicester also runs follow-up clinics; two clinics per month at the Glenfield and LRI and one at the Leicester general. They are consultant led with nurse and occupational therapy input.

Trainees

All units agreed that larger trainee numbers are needed.

In many cases, the tier of junior doctors is made up of predominately of non-trainees. The appearance of FICM trainees are too sporadic and the duration of their posts can be incredibly short at just 3 months. The group also noted that the RCoA has restricted the ICM exposure of their trainees and this has had an impact on units and the trainee traffic that they see.

Regions cannot secure posts without the funding. In principle, the Deanery supports an increase in numbers but money would have to come from the trusts and the trusts are underfunded. If the Trusts can find the funding then the Deanery may support it. Trusts generally want more senior posts not junior ones, but they have to have novice trainees first to supply this throughput of trainees as they progress. Arranging trust funding for a new post requires a lot of negotiation with lots of parties involved. King's Mill managed to convert an unfilled Clinical fellow post to a training post as the position is already there. Completely new posts are more difficult. Depends greatly on the relationship with management and service leads. Some Trusts are reactive. Units need to make the business case, locums are expensive, there is a risk to service etc., and mentioning all of these things could assist with securing training posts.

In the East Midlands, HEE fund most of the posts so the region assumes this is how it is done, but Trust funded posts are possible and common in some other regions.

All units would appreciate good notice and good communication regarding placements so you know when to expect someone on the unit.

In the East Midlands, there are gaps in acute medicine so it is these posts that are filled by those requiring 12 months medicine.

Trainees are paid for on call during novice training period in anaesthetics, even though they are not signed off for anaesthetics on call. The idea was floated that trainees could be paid for ITU on call also.

Middle grade rotas are very variable in the region. Nottingham City does not have a middle grade tier; the rota is completely made up of junior trainees. Queens struggles to fill its senior trainee rota. DGHs are covered by whoever is doing their ITU block at that moment, this means that some are very junior trainees so rely on Anaesthetic care.

ACCPs

ACCPs curriculum is specific to ITU. Work needs to be done here to ensure trainee are being trained to a standard that will be recognised by FICM Associate Status at the end of their training.

HEE are looking at ACCPs for the ITU workforce and many were aware of the current consultation on the MAP role regulation. There was some concern that if ACCPs were regulated they would lose the regional variations to training, but also agreement that regulation changes for paramedics and ODPs, so they could prescribe, would be beneficial.

As raised in some other regional engagements the group discussed concerns that FICM trainees may have trouble getting adequate time and opportunities in training if a unit also trained ACCPs. Lincoln advised that they would not be able to avoid affecting ICM trainees if they started training ACCPs now, as they are too short staffed to dedicate the time to all. Whilst trainees that are more senior can be used to help trainee ACCPs, junior trainees are a concern, as their training time

could be impacted. For Lincoln's predicament, in particular the group discussed the possibility of ACCPs being trained at Glenfield, if the money was there to support this, as this could alleviate the training burden for the Lincoln unit but they would benefit from trained ACCPs at the end. This hub and spoke system needs more details but could be a proactive solution.

Recruitment

Recruitment was considered a universal problem, with trainee numbers, Consultant posts and nursing numbers all posing issues to units in the region. The group discussed the practices of other regions where they actively go out and head hunt individuals, and Chesterfield shared details of their successful recruitment of couples in previous years.

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 East Midlands. 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.

Consultant level cover

The group debated whether units could run without a Consultant level of cover, as the consensus was a resounding no, time and effort needs to be put into considering how to attract more ICM consultants. Smaller units in particular have a more hands on consultant presence.

The group queried if ICM training had been made too difficult. Now trainees are constantly fighting for posts throughout their training career CT, ST etc. With other factors such as the possibility of two exams if dual, extra training time, junior doctor pay not as attractive under the new Contract, cost of living rising etc., playing a part in if a trainee would choose ICM. Trainees can struggle with exam performance whilst working full time and training and many trainees take the exam a few times, so it can be very expensive. Qualified used to be based on experience. The group considered how the training path might be changed to make it more accessible, and while they were mindful of the fact that this could go against the ethos of FICM and its Standards, it is difficult to streamline standards and maintain a wide workforce. It was noted there is the additional flexibility, unique to the ICM training system, of Affiliate Training.

It was noted that many specialties are suffering with consultant numbers so consideration should be given to whether ICM is not attracting Consultants or that the potential applicants are just not there in the first place.

The group discussed the potential for there to be a pool of staff for a region, but the local region would need an effective method to control it. No hub and spoke models in operation around the table. Whilst some counties, such as Northamptonshire, would benefit from this job share/shared rotas, geographical limitations would need to be considered regionally, as many regions cover a very large area. Units have to try to attract new consultants but individuals would have concerns about geography to suit families, houses etc.

Lincoln advised the group that they have a 6-month locum contract so people can try it out first before committing further. Choosing a position is not just about money, the working environment is important too and ICM has a great teamwork ethos that should be highlighted and promoted more.

Retirement

Pending retirements were a concern for many units, for both nursing and consultant roles. Many nurses are coming up to retirement and there is a real need for more junior nurses to start in ICU. A Lack of nurses determines how many beds a unit has on any given day. Demand for more beds is steadily increasing but there are not enough nurses out there to run them. Costs of using agency over in-house nursing is huge.

The workforce have expressed an interest in a phased reduction in working commitments. The group were also aware of consultants who were opting to retire to return to work. This group of

individuals retire and then come back for purely clinical activity, to avoid other aspects that come with the full time role, which led the discussion on to ways of working that would improve the flow of work through a unit in the future.

Working procedures

Many agreed that paperwork transference through a hospital would make a massive difference to workload. It would eliminate unnecessary duplication as this really adds to daily task load. It was also noted that Organ donation teams now have dedicated nursing staff for discussion/paperwork/consent – this practice might be worthwhile exploring for ICU, as a senior nurse could take ownership of end of life or detailed family explanations as this takes a lot of time for consultants.

Several attendees mentioned that they do not have remote access to emails but other groups such as EMRAD East Midlands Radiologists do have a remote access system. Enabling access from home should be relatively simple to implement but some trusts in the region are not allowing this and even accessing just emails from home is not permitted. This would be a relatively easy thing to set up and have a huge impact on consultants.

The group considered if telemedicine has a place. In Brussels recently telemedicine was heralded to be a major player for the future but on the ground, it is not so clear. There was agreement that while it is never going to remove the need for a doctor's presence it might well help to support it. There was not much formal use or experience of this system by the attendees present to draw upon.

Network/Region boundaries

Three separate networks cover the East midlands region; however, these Networks do not match the HEE Training region, so crossover exists with the Networks covering Central England and South Yorkshire.

The three Networks and the East Midlands units they cover are listed below;

- North Trent – Chesterfield
- Mid Trent – Nottingham, King's Mill, Derby, Lincoln, Pilgrim, Grantham, Burton
- Central England – Northampton, Kettering and Leicester

The Networks do not operate in the same way. Central England Network comes under West Midlands so those units feel in a void. In the Central England Network, many units have stopped attending the meetings, so they cannot get much out of it. Leicester have made an approach about these units separating out from the West Midlands and joining the majority of the East Midlands, units under Mid Trent Critical Care Network. A decision on this has not yet been reached. Northampton is also being pulled towards Oxford, who they were aligned with until 2009. Chesterfield has the same issue as it is in South Yorkshire, but they also benefit as they get Sheffield trainees.

The group believe there is a clear recommendation to align with Mid Trent Network to reduce overlap.

Trainees

The group had already discussed the possibility of increasing post numbers using trust-funded posts. It was also agreed that an attempt to ring fence trainee numbers for 5 years hence, or at least with as much notice as possible, would be beneficial, while it was acknowledged that there would be no guarantees it would help with workforce planning.

The group also discussed the predicament that they can sometimes find themselves in if they do not manage to fill posts as they cannot then be protected and will be taken off them with HR then doubting the post was needed as the unit survives without them.

There is a lack of private work to supplement training, other departments and specialties have this option from early on in their career, which is attractive.

CT3 trainees are popular throughout the region as they stay in post for an entire year, whilst prepping for exam retakes or taking extra time between CT and ST training. However, the RCoA's exam timing changes have affected the region as it has stopped a group of these individuals from popping out of the system and taking extra time. It was noted that ST trainees too have hinted that longer placements would be preferable.

There are other routes available, such as CESR or Affiliate, but it was acknowledged that it could be hard to give guaranteed careers advice on these routes and their longevity. As more trainees qualify, it will become harder to do 'equivalence' routes and be appointed.

The training leads try hard to send trainees to units appropriately, taking in to account living location, as if based in Northampton they might be reluctant to do posts in Derby and vice versa.

They have two trainees coming in from other regions for OOPT/Interdeanery transfer to carry out posts in their units, which is encouraging, and shows that the effort put into the programme and regional offerings is attractive to trainees.

Training changes - It is worth noting in this section on staff shortages that seemingly small changes within specialty training programmes can also have a big impact on Intensive care units and their trainee rotations. This can be demonstrated by the recent change made within the Anaesthetics training programme, which extended the exam completion timeline to include the ST5 year. Previously the completed exam was required earlier, before progression to Intermediate training; this one-year adjustment to the time line has stopped a group of individuals from popping out of the system to undertake extra study and exam attempts whilst working, potentially on an ICU. This is a loss of valuable team members, if only for a short time.

Local set ups

King's Mill have a community hospital which they can move patients to if needed, this is quite a luxury and not normal in other trusts. It is important that the beds in the Community unit are not decreased by CQC as they are used effectively for moving patients and freeing up beds on the ITU.

Mergers

Several mergers are being considered in the region. One is Derby and Burton. 1st stage is set for April 2018. It will be a drip fed change over many years so hard to react and plan ahead definitely. There has been talk of a new site in the middle of both locations but that is neither a popular nor a cheap idea. Derby has spent a lot of money recently so a new site seems unproductive. Consideration is also being given to staff travelling between the sites. Implementing a shared rota would potentially put people off applying for either Hospital.

Pilgrims Hospital, Bolton has also been discussed for a possible merger but they cover a large geographical area so would still need an A&E and ICU regardless. They also have a very elderly population to cater for.

The merging of sites is potentially easier on younger consultants. Older consultants vote with their feet and move back into their parent specialty to remain on one site. Care needs to be taken to ensure they feel like they belong.

There is a real need to address how we accommodate intensivists later in their careers. Older consultants could do more weekend days but not nights. Anaesthetists may oppose this, as it would be a big change to their working pattern.

GPICS

GPICS version 2 is designed to be less English tertiary unit led and comprise of a broader author list.

Northampton advised that GPICS helped a little in fighting against some conditions locally but CQC also used it as the definitive standard from day one, which caused issues to units. King's Mill felt that they were used as a standard against them, despite some being 'aspirational', only two months after its initial launch.

When it has suggested items that units need to fight for, and CQC support them in this, it has been useful but the trusts do not necessarily fix the issues or adhere to it.

The group agreed that fighting trust by trust is difficult but a Network could do more to group the concerns and go back to trusts as one voice.

GPICS v2 should make staffing recommendations rather than mandate or make general statements as, without context of the unit, this is not helpful. The junior numbers in particular were very non-specific which meant it was not at all helpful. It was very vague on what level the trainee should be, so it has not helped with staffing. If HR see you have one Foundation trainee they think it is all fine.

The King's Mill CQC inspection produced some fair and valid criticisms, so in that sense GPICS was good and highlighted what was needed in these areas but it did not take into account what happens in the peripheral hospital. It was good to have it as a stick though. CQC visits in general have been more pragmatic. Beneficial to benchmark against GPICS i.e. for microbiology input. Useful for getting extra staff, can be used as a tool to negotiate

A tick box approach does not necessarily indicate good quality of care. Things that are not evidence based should not appear in GPICS, evidence should be found to support recommendations etc. For example multi professional ward rounds are not always realistic, the pharmacist may have gone around earlier, does not need to be at the same time.

On call in GPICS is well-structured – documented evening ward round = better handover. Takes effort but helps focus.

6. PROBLEMS AND SOLUTIONS

Sections 4 and 5 of this report detail the many problems currently facing the ICM workforce in the East Midlands. 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. Whilst some units were only experiencing current recruitment issues for one particular role or group, be it nurses, junior tier staff or ITU 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 affect that would be felt by remaining staff after repeated failed attempts to recruit and retain adequate staffing numbers.

6.1.2 Doctors in training

All units agreed that larger trainee numbers are required. The East Midlands is not an unpopular region for ICM training. Since joining national recruitment in 2013, the region has enjoyed an annual 100% fill rate of the posts they make available which has steadily increased to 8 posts in 2017. Due to financial constraints, further extra posts have not materialized and posts numbers in the region are now remaining static with 7 posts being the current prediction for 2018 numbers. Even units that have secured extra trust funded posts such as Northampton were failing to see the actual trainees appointed.

At the time of the meeting 8 of the 13 units represented did not have ST3 + ICM trainees in post, despite all of them being keen to have them on board and capable of offering the training. Some units, such as Pilgrim's Hospital in Boston, had experienced ICM trainees in the recent past and were extremely keen to repeat the process, hoping for a consistent ST3/ST4 presence. Many of the units expanded on this sporadic presence of trainees and the difficulties this presents for rota and workforce planning. Even units that regularly host the ICM trainees, such as Nottingham University Hospital, advised of the limited impact the short duration of trainee placements (sometimes as short as three months) can have on a unit.

6.1.3 Consultants

Many of the units in the region have experienced slow or failed attempts to recruit new consultants in recent years. This is leading units that are currently finely balanced on a specific consultant number to have concerns for the immediate future as they have foresee retirements on the horizon. They are not unique in this situation with several units foreseeing retirements coming that will impact on their numbers, with some locations having experienced recent recruitment round failures. 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 into just their partner specialty for the later stages of their career. This detrimental effect on consultant numbers could be further exasperated by the uncertainty surrounding possible mergers as they choose to vote with their feet against potential service reconfiguration and shared rotas between two sites.

6.1.4 Nurses

Concern over nursing numbers was also a common theme for units across the region, with low numbers resulting in several units being unable to utilize their full bed capacity due to lack of nursing care available to patients. What made this harder to plan for was the fact that this could fluctuate from day to day. Recruitment, retention issues and forthcoming retirements were all present. There was also concern that nursing staff were leaving units due to a lack of career development for them in certain locations, while the ACCP route offers this development, nursing teams are understandably nervous that their numbers will be further depleted by ACCP recruitment, which is on the rise.

6.1.5 Uncertainty of mergers

Several of the units represented on the day were aware of potential service reconfigurations and possible mergers being considered for the future. Whilst not necessarily opposed to these changes, they do present periods of uncertainty for staff and services. Undetermined structures and timelines for implementation make workforce planning for the future very difficult. Even where plans are further along, time needs to be allocated for the changes and the settling in of these location and service changes.

6.1.6 Burnout

All of the above staffing issues and periods of change associated with training changes and potential mergers can easily contribute to the current and remaining staff struggling. Staff retention and motivation is a huge source of workforce woes, combined with recent headline dominating pieces, such as the junior doctors contract, it is understandable that staff morale can become low. There is a real need for sensible employee treatment to prevent workforce problems from continuing to grow.

With low staffing numbers, remaining staff often find themselves pulling together and coping somehow, while this is a credit to those teams, the message that can sometimes be picked up from HR and trusts is that more staff are not urgently needed for the unit to run.

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 this and having open cultures 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. Problems seem to arrive in interpretation and implementation of the standards. In this region, in particular the quick interpretation of the standards by the CQC did affect trusts and units being inspected immediately after its release, leaving little or no time for them to consider the standards and how they might bring themselves in line with them, before they were judged against them.

Clarity was also raised as a negative for GPICS v1, and it is hoped that these concerns can be addressed in v2 due out in 2018. Further clarity over staffing numbers etc. would help units to make the case for more junior staff members and AHPs with official standards as their evidence.

6.1.8 Networks

The disparity between the HE East Midlands training region and the critical care networks operating in the region is unique with three separate networks covering the units in this region. The weight and support a network can bring to units seeking extra resources and change can be evidenced in other regions with active networks. To this end, aligning the networks with the training region or uniting the networks, enabling them to collaborate for important issues, could bring significant benefits for individual units in need of support.

6.2 SOLUTIONS

6.2.1 Staffing solutions

It was acknowledged that more trainee posts are needed, and that units would appreciate a good share of the trainees, along with good notice and communication of their rotations to assist with rota planning. While it is not always possible, a 5-year forward view of ring fenced posts would be the ideal. This visibility would also alleviate the difficulty that units face after fighting for posts, which then go unfilled. The danger is losing the post completely as it is not deemed necessary by trusts/HR, but 6 months later a trainee might be eligible to rotate into the unit. The conversion of trust posts was of interest to some units and they could learn from those units that have successfully done this in the past. Ultimately, although the numbers remain low and there is a lack of trainees in many units it should also be acknowledged that the region remains attractive to trainees. This is highlighted in the repeated 100% fill rate at recruitment and the recent OOP placements that are bringing trainees in from outside of the region to train here. This is a credit to the training programme that local trainers have established in the East Midlands, and should be celebrated and built upon. There is a need for a region-wide approach to this issue where lessons can be learned from regions that have already successfully converted a number of trust posts. Training needs to be promoted, developed and delivered in the DGHs, especially at stage 3. This corresponds to lessons learned from other regions where DGHs could be a rich source of Trust-funded training posts. In addition, through the Faculty's Smaller & Specialist Units Advisory Group, it is clear that recruitment to DGH consultant posts is improved when trainees have experienced training in DGHs.

Making use of the MTI programme should also be explored.

6.2.2 Ways of working

Through their discussion of consultant recruitment and retention, the group raised some possible solutions that warrant further exploration. Using an example of a Northampton consultant who also has PAs in Wales the discussion touched on more localised hybrid jobs that could work. In this region, this could translate to a pool of staff available to certain sites. This would obviously need considerable planning and effective management once in place. While this could assist particular locations struggling with consultant numbers, questions were raised over whether individuals would actually apply for this style of 'flexible location' job.

Other ideas were also proposed by attendees of solutions that have proved effective for their own units, for example, Chesterfield have successfully recruited couples, which eases the need for those individuals to consider tough decisions surrounding travel/distance from family etc. Lincoln also

advised the group of a recent approach they took, offering a 6-month locum post so that the appointed individual could try the post/area out before committing to permanent.

There is much discussion in the ICM community of how the specialty can remain attractive to consultants later in their careers. Phased reduction of work was discussed and the idea were floated of reducing on call for these consultants but potentially asking them to cover more weekends. These altered job plans could be explored further locally.

6.2.3 ACCPs

Some of the larger units in the region have already established ACCP training and they were keen to highlight the benefit of this emerging role within critical care teams and for workforce planning. Units such as Nottingham and Leicester are both keen to continue expanding their ACCP numbers in the future. From the remaining units there was a lot of interest in developing the ACCP role but also concern raised on how feasible this would be for smaller and more remote units. This was coupled with concern on how existing trainers at these sites, already squeezed by trusts on protected and recognised teaching time could add ACCP training to their portfolio, without negatively impacting themselves and considerable existing trainee groups requiring their time, such as Foundation, Core, ST3+ and MTI's. The group discussed interesting ways of potentially training ACCPs at the larger units, but ensuring that post training they were destined to work in the units that would struggle to offer the training programme but would benefit hugely from dedicated, permanent, qualified ACCPs as part of their workforce in the future. This hub and spoke system needs further consideration as a matter of priority and the FICM ACCP Sub-Committee are looking into potential models for this now.

6.2.4 Networks

Efforts to align the networks operating within the region would be a beneficial task. The group agreed that fighting trust by trust for change is not always productive, but a network could group concerns and speak as one voice. This might take the shape of units moving network, which we understand is currently being explored by Leicester, as they wish to join the majority of units in the region under the mid Trent Network banner, or it might simply involve greater collaboration between the existing three networks currently working in the East Midlands.

6.2.5 Technology

Through the group discussions, it became apparent that some small updates to technology, access and current procedures could reap immediate benefits for the ICU teams. On the procedures side adapting a similar model to the one currently in use by the organ donation team to utilize senior nursing staff to handle certain family interactions and explanations could help to free up consultants already pressed for time. Remote access to emails would also be hugely beneficial to staff and easy to implement with today's technology. The fact that some hospital teams already have access shows that the infrastructure to facilitate this change is already in place. These small changes would really help staff to utilize their time more effectively. It would be beneficial to do this at the regional or Network level.

6.2.6 Standards, training and end of life

Although not local solutions, it was recognised that improvements in GPICS v2, greater flexibility in the upcoming curriculum rewriting and the consideration of the role of senior nurses in end of life care could be taken forward as part of existing FICM projects.

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
Chesterfield Hospital	?	?	?	?	?	?	?	?
Glenfield Hospital*	14	16-20	0	0-7	3	4-7	142	170-180
Kettering Hospital	?	?	?	?	?	?	?	?
Leicester General Infirmary	9	8-10	7	7	0	0	57	20
Leicester Royal Infirmary*	13	14	0	0-7	0	0	124	135-140
Lincoln County Hospital	9	12	0	4	0	0	?	?
Northampton Hospital	?	?	?	?	?	?	?	?
Nottingham University Hospital QMC & Nottingham City	29	32-34	1	?	1	8	?	?
Nottingham University Hospital Trent Cardiac Unit	5	6	0	0	7	8	49	55
Pilgrim Hospital, Boston	8	?	8	?	0	?	60	?
Royal Derby Hospital	9	10	5	5	0	0	?	?
Sherwood Forest Hospitals NHS Foundation Trust	8	12	0	3	0	4-8	59	?

*Reconfiguration expected in 2019
? Data not provided

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
Chesterfield Hospital	?	?	?	?	?	?	?	?
Glenfield Hospital*	8	11	0	0-7	3	4-7	130	160-170
Kettering Hospital	?	?	?	?	?	?	?	?
Leicester General Infirmary	4	2-2.5	7	7	0	0	56	18
Leicester Royal Infirmary*	9	9.6	0	0-7	0	0	114	126-130
Lincoln County Hospital	9	12	0	4	0	0	68.42	90
Northampton Hospital	?	?	?	?	?	?	?	?
Nottingham University Hospital QMC & Nottingham City	24.2	?	0.6	?	1	?	485.65	?
Nottingham University Hospital Trent Cardiac Unit	5	6	0	0	7	8	47.48	53.48
Pilgrim Hospital, Boston	4.9	?	8	?	0	?	60	?
Royal Derby Hospital	?	?	?	?	?	?	92.23	?
Sherwood Forest Hospitals NHS Foundation Trust	8	12	0	3	0	4-8	55.64	68

*Reconfiguration expected 2019
? Data not provided

7.3 Trainees

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

HOSPITAL	FOUNDATION		CORE		HIGHER		NON-TRAINING		TOTAL	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
Chesterfield Hospital	?	?	?	?	?	?	?	?	?	?
Glenfield Hospital*	3.6	3.6-5	0	0	4~	7	1	2-4	8.6	15-18
Kettering Hospital	?	?	?	?	?	?	?	?	?	?
Leicester General Infirmary	1	1	0	0	0	0	0	0	1	1
Leicester Royal Infirmary*	3	3	7	8	6	7	2	4	18	22
Lincoln County Hospital	3	4	1	2	0	2	0	0	4	8
Northampton Hospital	?	?	?	?	?	?	?	?	?	?
Nottingham University Hospital QMC & Nottingham City	0	?	4	?	6	?	14	?	37	?
Nottingham University Hospital Trent Cardiac Unit	0	0	0	0	0	0	0	0	0	0
Pilgrim Hospital, Boston	1	?	0-1	?	0-1	?	0-1	?	2	?
Royal Derby Hospital	0	?	4	?	1	?	1	?	6	?
Sherwood Forest Hospitals NHS Foundation Trust	0-1	?	0-2	?	0-2	?	1	?	0-4	4-8

? Data not provided
*Reconfiguration expected 2019
~ on call rota supplemented by trainees on cardiac anaesthesia module

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
Chesterfield Hospital			
WTE for Consultants	?	?	?
WTE for SAS Doctors	?	?	?
WTE for ACCPs	?	?	?
WTE for Nurses	?	?	?
Number of Trainees	?	?	?
Glenfield Hospital			
WTE for Consultants	8	11	Increase
WTE for SAS Doctors	0	0-7	Potential Increase
WTE for ACCPs	3	4-7	Increase
WTE for Nurses	130	160-170	Increase
Number of Trainees	8.6	15-19	Increase
Kettering Hospital			
WTE for Consultants	?	?	?
WTE for SAS Doctors	?	?	?
WTE for ACCPs	?	?	?
WTE for Nurses	?	?	?
Number of Trainees	?	?	?
Leicester General Infirmary			
WTE for Consultants	4	2-2.5	Decrease
WTE for SAS Doctors	7	7	Remains the same
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	56	18	Decrease
Number of Trainees	1	1	Remains the same
Leicester Royal Infirmary			
WTE for Consultants	9	9.6	Increase
WTE for SAS Doctors	0	0-7	Potential Increase
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	114	126-130	Increase
Number of Trainees	18	22	Increase
Lincoln County Hospital			
WTE for Consultants	9	12	Increase
WTE for SAS Doctors	0	4	Increase
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	68.42	90	Increase
Number of Trainees	8	10	Increase

Northampton Hospital			
WTE for Consultants	?	?	?
WTE for SAS Doctors	?	?	?
WTE for ACCPs	?	?	?
WTE for Nurses	?	?	?
Number of Trainees	?	?	?
Nottingham University Hospital QMC & Nottingham City			
WTE for Consultants	24.2	?	?
WTE for SAS Doctors	0.6	?	?
WTE for ACCPs	1	?	?
WTE for Nurses	485.65	?	?
Number of Trainees	37	?	?
Nottingham University Hospital Trent Cardiac Unit			
WTE for Consultants	5	6	Increase
WTE for SAS Doctors	0	0	Remains the same
WTE for ACCPs	7	8	Increase
WTE for Nurses	47.48	53.48	Increase
Number of Trainees	0	0	Remains the same
Pilgrim Hospital, Boston			
WTE for Consultants	4.9	?	?
WTE for SAS Doctors	8	?	?
WTE for ACCPs	0	?	?
WTE for Nurses	60	?	?
Number of Trainees	2	?	?
Royal Derby Hospital			
WTE for Consultants	?	?	?
WTE for SAS Doctors	?	?	?
WTE for ACCPs	0	?	?
WTE for Nurses	92.23	?	?
Number of Trainees	6	?	?
Sherwood Forest Hospitals NHS Foundation Trust			
WTE for Consultants	8	12	Increase
WTE for SAS Doctors	0	3	Increase
WTE for ACCPs	0	?	?
WTE for Nurses	55.64	68	Increase
Number of Trainees	0-4	?	?

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 the population of each region or home nation. The table below indicates the population serviced per training post recruited to in each year. The East Midlands has improved its training to population number in 2017, 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.

	2016 training post to population	**2017 training post to population**
1	West Midlands (810,673)	West Midlands (1,418,678)
2	East of England (744,271)	North Western (1,144,398)
3	**East Midlands (656,961)**	KSS (879,263)
4	Northern Ireland (609,908)	East of England (744,271)
5	Scotland (591,967)	Wessex (631,964)
6	KSS (559,184)	South West (611,395)
7	Wessex (394,978)	Northern Ireland (609,908)
8	Wales (385,302)	**East Midlands (574,841)**
9	South West (356,647)	Scotland (532,770)
10	Yorkshire & Humber (349,853)	Northern (367,158)
11	Thames Valley (330,900)	Yorkshire & Humber (349,853)
12	North Western (312,109)	Wales (280,219)
13	Northern (293,726)	London (249,814)
14	London (283,122)	Thames Valley (231,630)

APPENDIX 1: LIST OF ATTENDEES

Associate Postgraduate Dean	Dr Whitelaw
Chesterfield Hospital	Dr Padmakumar
Glenfield Hospital, Leicester	Dr Annamaneni
Glenfield Hospital, Leicester	Ms Clerk
Head of School	Dr Leighton
Kettering Hospital	Dr Watt
ICM Trainee Representative	Dr Blagnys
Lay Rep	Mr Gallagher
Lincoln County Hospital	Dr Barber
Mid Trent Critical Care Network Director	Dr Shepherd
Northampton Hospital	Dr Hames
Nottingham City Hospital	Dr Sherman
Nottingham Queens Medical Campus	Dr de Beer
Nottingham Queens Medical Campus	Dr Sharman
Nottingham University Hospital Cardiac Unit	Dr Mahmoud
Pilgrim Hospital, Boston	Dr Pogodaev
Pilgrim Hospital, Boston	Dr Chablani
Regional Advisor ICM	Dr Sarkar
Royal Derby Hospital	Dr Kiani
Sherwood Forest Hospitals NHS Foundation Trust	Dr Milligan

APPENDIX 2: 2017 CENSUS DATA

COUNT: 102 respondents (out of 875).
88% of the respondents are practicing in both Anaesthetics and ICM. This compares to 83.3% in Scotland, 85.7% in West Midlands, 98.1% in Yorkshire and Humber and 82% in the North West.

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

	East Mids
Increase	7
Decrease	16
Neither	79

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

ANSWER	East Mids
Yes	77
No	24

15 units were represented in the Clinical Leads section

Do you have ACCPs on the unit	East Mids
Yes	1 Unit

Do you have SAS Grade Doctors on the unit	East Mids
Yes	4 Units

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

%	East Mids
0-25%	6
25-50%	34
50-75%	44
75-100%	18

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

%	East Mids
0-25%	41
25-50%	28
50-75%	17
75-100%	15

NB: Per week PA data across the region

	Total DCC-PAs number in your Job plan	All SPAs (ICM and non-ICM)	Additional PAs for all other activities outside of ICM
RANGE	0-14.55	0-10	0-11.5
MEAN	11.2	2.2	4.1
MEDIAN	12	2	4
MODE	12	1.5	5