# REGIONAL WORKFORCE ENGAGEMENT REPORT:

# NORTH WEST

The Faculty of
Intensive Care Medicine

## CONTENTS

## EXECUTIVE SUMMARY

*The Faculty, represented by 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 North West region by representatives from each Trust, the networks, the Specialist Training Committee and School. Dr Parry Jones writes:*

It was a real pleasure to represent the Faculty's Careers, Recruitment & Workforce Committee in Bolton at the North West regional workforce engagement. We were very grateful for the warm reception given to us as the Faculty team. I was really struck by the enthused, often humorous engagement to find and share solutions, rather than a resignation to fate. There are very dynamic, strong, well known individuals in the region, and there are also others with vision, coupled with determined, hardworking efficiency. A proper northern powerhouse.

The Northwest region is large; covering a population of 7 million, encompassing 3 critical care networks, and 31 general and specialist critical care units ranging from the very large urban units to the small, geographically isolated ones. The challenges for the North West region are shared across the whole country. How big units provide multiple junior tiers to care for pods of 8-15 patients, depending on the case mix of the unit?" (GPICS 2015) How will small units provide ICM trained consultant delivered care? How will specialist cardiothoracic, cancer and neurocritical units be staffed? And how will the geographically isolated units function in the future?

The purpose of these Faculty workforce engagement meetings is distinctly not to beat the General Provision of Intensive Care Services (GPICS) drum. It was interesting however in the North West to see how GPICS is being viewed by some as a tool to be utilised, alongside Care Quality Commission (CQC) visits, to drive forward improvements and garner resources for critical care services. This includes the need to improve staffing levels across the multi-disciplinary team. This is a much healthier way for us to view GPICS, rather than as a stick to beat ourselves, and each other with.

There were certain areas of general agreement:

1. **The demand for critical care services is rising.** The majority, but not all of this increase in demand falls on level 2 provision.
2. **Some of this demand could be managed better with wider understanding in the medical and public sphere, of what critical care can and can't do.** We, the critical care community, need to manage these expectations in order to try and meet the demand; otherwise we will not be able to reliably deliver appropriate care to those who might better benefit from it. There needs to be involvement of professional bodies, and better education to improve the understanding of critical care.
3. **Post Anaesthesia Care Units (PACUs) may relieve some of the burden of increases in demand** but only if Critical care is not directly responsible for staffing the PACU.
4. **Critical care needs much better recognition as being absolutely central to 21st century secondary health care provision**. When hospital services are being reconfigured, critical care services need to be at the forefront of administrators minds. There are examples in the North West region where Sustainability and Transformation Partnerships (STPs), and reconfigurations of services have not included critical care services (including the critical care networks) from the outset. Leaving critical care as an afterthought will result in failure.
5. **There are wider concerns that the holes in the provision of junior critical care cover, or the lack of the junior tier's experience, is being filled increasingly by the consultant**. This will, in the long term reduce the recruitment of trainees, and reduce the retention of older consultants. The recruitment of trainees in the North West at present however remains very good but there are significant risks here.
6. **Trainees will tend to stay (be tied to the region by mortgages, children's education etc.) in the region is which they train at a senior level. Therefore the local supply of future**

**intensivists needs to be responsive to increases in local regional demand.** "What has become clear is that we are not supplying the current predicted demand in Intensive Care Consultants".

7. **A recent survey conducted by the head of School identified that 80-100 new consultants intensivists will be required in the region in the next 5 years.** This won't be met, and may be a driver for reconfiguration of services especially for geographically isolated units if the same quality of care is to be met.
8. **Specialist units – particularly cardiothoracic medical staffing is in particular difficulty with recruitment and retention.** This reflects a national problem.

The North West has already worked hard to put in place some solutions. Innovative structural changes have already been made through close collaboration and good working relationships between the Deanery, Critical Care Medicine and Anaesthesia Regional Advisors and Educational individuals to create the first stand-alone School of Intensive Care Medicine in the U.K. This must have required a lot of hard work and courage.

Some critical care consultant staffing model solutions, whilst not unique are still rare; on the one hand in a large unit resident on-call consultant, and on the other in a small isolated unit weekend daytime critical care consultant sessions with overnight general anaesthesia cover. I think we are likely to see more of both these solutions to the lack of experienced junior cover, and the lack of CCT holding critical care consultants to sustainably meet patient need for weekend and bank holiday cover in small isolated units.

The use of Advanced Critical Care Practitioners (ACCPs) across some of the region's units, whilst not unique is very well developed. And again I expect we will see more ACCP solutions to workforce demands across the U.K. What ACCPs are doing clinically in some units continues to expand beyond that originally imagined. The key appears to be in the training, supervision, on-going support and regulation. Maintaining a well-motivated nursing workforce is absolutely crucial to the provision of critical care and that workforce needs to have appropriate progression through to senior grades, research, outreach and management. The ACCP route provides another avenue and reduces stagnation and inertia in the nursing workforce.

There were some areas of general on-going discussion for critical care which will no doubt continue. How will we integrate telemedicine into critical care in the future? Is it just to aid the provision of 24/7 critical care expertise to generalists within a stabilise-treat-transfer hub and spoke model.
There is a view that the definitions of levels of critical care (Level 1, 2 and 3) don't apply very well and need to be reviewed. Concerns were expressed from around the room that patients are being defined as level 2, and therefore require critical care when in fact they could be level 1 with care provided by their medical or surgical team. Critical Care cannot take on the huge burden of "Level 1.5" work within the resources that we are currently being allocated. The huge increase in physical beds and equipment is one issue but the greatest resource deficit is nursing and medical staffing.

Flexible job plans with creative new ways of working, maintaining the ageing workforce in work, supporting non career grades appropriately, and protocoled care in the right context were all discussed as having roles in the future provision of staffing solutions. These may well be local solutions for individual units and help solve a local problem but with a much wider context when shared.

At the end of the day's proceedings I left feeling more positive (and not a little jealous), that the Northwest region has the necessary individuals, flexibility of mind, and structures in their Deanery, School, Networks and Trusts to try and solve the greatest challenge that we face in critical care - to adequately staff the range of units in the present political and financial environment. It certainly won't be easy. I'm sure however that lessons learnt in the Northwest will be applicable to others across the U.K. and are certainly worth sharing.

# 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)

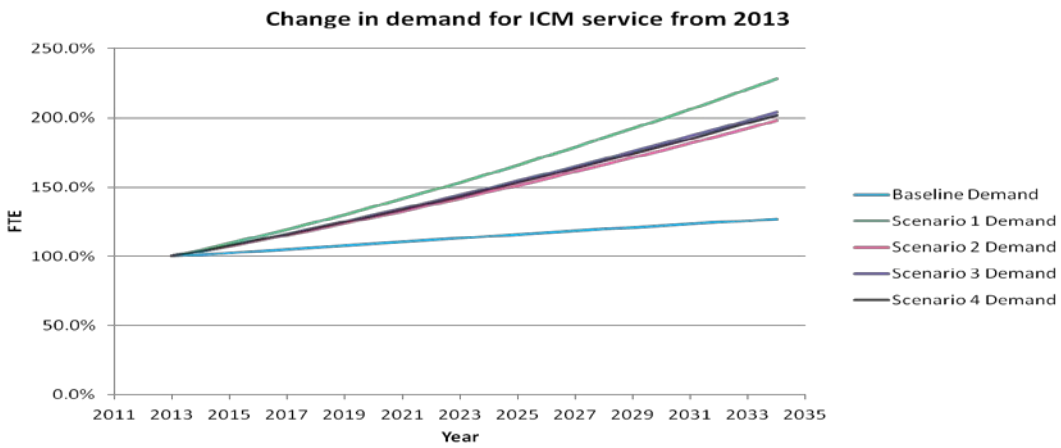
ICNARC is currently undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014.

"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 and Scotland in September 2016.

The North West was the fifth home nation or region to request an engagement with the Faculty, which we happily accepted. The North West is a Super LETB, covering training in both the North West and Mersey regions. This was our largest group to date, and there is considerable data and enthusiasm available for the combined regions. Both Mersey and the North West have experienced consecutive years of an impressively high fill rate for their ICM training posts 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.

In July 2016, Dr Sarah Clarke (the Regional Advisor for the North West) responded to Faculty correspondence to Regional Advisors enquiring if any believe their region or home nation would benefit from an Engagement Meeting. Dr Clarke received support from the ICM Regional Advisor for Mersey (Dr Mark Hughes), from the Critical Care Delivery Networks and the LETB.

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 Network Lead, Managers and Regional Advisors.

### 2.1 Engagement Aims

The engagements would be conducted with the aim of:

- Describing the current supply of ICM/critical care facilities in the North West 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 North West, 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 NORTH WEST

## 3.1 ICM TRAINING IN THE NORTH WEST

**This information is based on the presentations given by Dr Sarah Clarke and Dr Mark Hughes and reflects their opinions on ICM training in the North West. It reflects personal opinion where it is not clearly referenced to existing data from other sources.**

The provision of Critical Care services in the North West continues, like the rest of the UK, to face considerable pressures and is in constant flux with multifactorial contributions. Increased demand on critical care provision, with higher patient expectations, complexities of co-morbidities and surgery contribute to a year-on-year increase in admissions. Fully staffed trainee rotas are a luxury of the past, with a reduction of trainee presence due to the European Working Time Directive and implementation of the new junior doctor contract. We face uncertainties of recruitment of both nursing and medical staff from outside of the UK, both Europe and beyond, even pre-Brexit, and finally, the pressures of implementing and delivering GPICS compliance, with 24/7 working and a consultant-led delivery of safe and effective critical care services.

The North West region has local considerations also. Covering 5,500 square miles and a population of over 7 million, we have one school of ICM within the super-LETB, Health Education North West, but two training programmes, two STCs, TPDs and RAs. There are three critical care networks: Cheshire & Mersey, Greater Manchester and Lancashire & South Cumbria. The reconfiguration of services across the Greater Manchester Healthier Together project also contributes a complex, dynamic aspect to the provision of regional critical care services. There are 31 Units across the whole region, including Specialists Units.

Before the introduction of the new CCT in ICM, in 2012, Manchester and Mersey appointed a total of 16 trainees to the Joint programme, towards the end of a trainee's base speciality training. Thus there were few delays in final CCT dates, and attrition was zero. Since the new CCT programme has commenced, we have seen trainees undergoing longer periods in training (as a result of the Dual programme), extended periods of training for maternity, LTFT, research and a few exam failures. There is also a small (<5%) attrition from the programme. Each trainee, depending on their background core training has a bespoke training programme, which consumes considerable logistics and resources. The sheer complexities of this have left workforce managers at the LETB perplexed and confused: any attempt at a predictive input: output model of supply and demand is proving extremely problematic.

One trainee has completed their CCT in ICM, and is employed in the region; further CCTs are due this year. However as a result of expansion of services, and the factors outlined at the beginning of this report, along with the retirement horizon, what has become clear is that we are not supplying the current predicted demand in Intensive Care Consultants. A recent survey conducted by the Head of School identified that 80-100 new consultants will be required in the next 5 years, in this region alone. The presentations attached to this report identify significant shortfalls in CCT projections, with further information of the two training programmes and issues faced by the training Committee highlighted.

### 3.2 North West Region

**This information is based on the presentation given by Dr Paul Dean and reflects their opinion on ICM clinical demand in the North West. It reflects personal opinion where it is not clearly referenced to existing data from other sources.**

The North West region consists of three Adult Critical Care Operational Delivery Networks covering Cheshire and Mersey, Greater Manchester and Lancashire and South Cumbria. They vary in geographical area, distances between Critical Care Units and size and configuration of beds. They all however face increasing demand that generally reflects the 4% year on year increase that ICNARC and National Census figures demonstrate. Bed occupancy in some units often exceeds 90% and we are beginning to see a rise in non-clinical transfers. Regionalisation of some services (e.g. vascular) has put further increasing demand on these centres.

Demand appears to be a reflection of increasing complexity and comorbidity of our patients but also an increasing realisation that many patients benefit from a level of care unable to be provided on wards, in addition to level 2 care being offered to increasing numbers of patients at an earlier stage of their illness with a clear benefit.

Whilst demand increases, patient flow through our hospitals remains problematic which has a knock on effect of increasing length of stay as a result of delayed discharges within critical care; this further exacerbates the demand.

Whilst clinical demand for resource is a challenge, a potentially greater challenge is that of workforce. Rapid expansion of some units, retirement, recruitment, retention, limited supply and clinical standards are all influencing consultant workforce availability.

The availability of non-consultant medical staff to deliver a service has diminished due a number of reasons; the European Working Time Directive, changes in anaesthesia training, inability to recruit staff from outside and increasingly inside European boundaries, new contracts, HEE restrictions on training numbers (even though in the NW we have a large number of trainees), less than full time working. In addition the ‘new’ generation are increasingly looking to work and train differently; many foundation trainees are looking for an additional year before embarking on specialist training, many are opting to work abroad. In addition, skills and competency of available staff is variable demanding greater consultant presence.

Lack of access to non-consultant staff, is in some units necessitating increasing on site consultant presence out of hours and overnight. All this, coupled with geographical isolation of some units may ultimately drive reconfiguration of services in order to maintain delivery of high quality Critical Care.

The North West is actively engaging in the Advanced Critical Care Practitioner (ACCP) programme and many (larger at present) units are looking to implement tiers of ACCPs in order to deliver a consistent high quality service; these however take time to develop.

Our problems are not unique and are reflected in other areas nationally. We cannot solve our problems with the same thinking we used to create them (Albert Einstein). We need to manage our demand appropriately using an evidence base where possible, be creative in how we use our existing workforce (medical, nursing and AHP), look to different delivery models (most Intensive Care Consultants have another speciality occupying some of their clinical time), plan to retain the knowledge of the aging workforce, standardise and protocolise where this is appropriate and sensible to do so, look to technology, review where and how we deliver care, engage and listen to the younger generation. We have a great number of challenges or opportunities!

## 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 North West. 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.

**Aintree University Hospital NHS Foundation Trust**

- 23 bedded unit with a young Consultant workforce.
- The unit has a well-established consultant resident on call rota. There needs to be a minimum of 12 consultants to staff it. Consultants have a real worry about burnout.
- They are finishing training two ACCPs.
- The unit has the posts and training capacity but is not seeing the numbers to fill them. This is not the only trainee gap in the Mersey region at the moment. 2-3 trainee potential posts unfilled.

**Arrowe Park Hospital**

- 18 beds – mixed level 2 and 3 unit.
- 12 Consultants.
- They currently have 13 trainees. Trainees are on a split rota that incorporates airway/non-airway skills.
- Well supported with nurses and other AHPs except for rehabilitation physiotherapists.
- Retention is a problem for nursing – lack of promotion and low morale.
- Currently they do not have ACCPs but they are very interested in this for the future.
- Culture change is occurring – A&E call the unit for airway specialists but as not all trainees are anaesthetists this cannot always be supported and non-anaesthetic trainees will increase in numbers.

**Blackpool Victoria Hospital – Blackpool Teaching Hospitals NHS Foundation Trust**

- Blackpool shrinking DGH with a loss of several surgical specialties over the last few years
- Demand for critical care remains high with over 900 admissions per annum
- There has been a radical shift from a surgical critical care to a medical one over the last 10 years.
- Increasing demands from physicians for level 1/1+ patients – however no Trust strategy to deal with these patients on the wards.
- The hospital is a heart attack centre – we take all PPCI / OOH cardiac arrests – patients primarily come to general ICU but can be on cardiac ITU. No sieving or end of life planning by cardiology on arrival of these patients. Repatriation can be problematic.
- General critical care comprises 6 level 2 bed and 7 level 3 beds that can be flexed up to 8.
- No idea how the beds are commissioned or funded.
- ICU trainee rota is separate and of varying airways competencies as can be a CT2 or an St7. As yet we have avoided having FY on call at night but there are significant rota pressures as ICU, maternity, CITU and general theatres need out of hours cover.
- Currently 9 ICU consultants (one unfilled vacancy) and likely to have 3 retirements by end of 2019.
- Consultants work a seven day block rota
- Uncertainty on the long term viability of the general ICU as a standalone unit as problems with consultant recruitment, local competition with larger intensive care units, potential diminution of trainee numbers and possible further loss of surgical services.
- A desire to merge with cardiac ICU but so far has stalled due to financial, political and personal barriers.
- A desire to have ACCP's but as yet no funding.

**Blackpool Victoria hospital Cardiac ITU (Blackpool Teaching Hospitals NHS Foundation Trust)**

- 20 bedded unit (mixed level 2 and 3), with 1500 to 1600 admissions a year,
- 11 anaesthetic consultants and one Intensivist (making up 11 WTE), one ANP, one ACCP trainee and 88 registered nursing staff (plus 6 unregistered nurses)
- All the anaesthetic consultants have theatre sessions and one ITU session a week. The intensivist works two sessions a week in ITU.
- Difficult to recruit medical workforce and maintain rota. Depending very much on locum cover for frequent rota gaps.
- There is a separate General ITU onsite and we are working to improve collaboration.

**Bolton NHS Foundation Trust**

- They have 12 Consultants - it averages out to a 1 in 8
- 2 tiers – middle and junior, middle consists of 8-10 staff grades and 6 Foundation, Core & Dual trainees
- 18 beds on the unit – 8 level 3 and 10 level 2
- They have not encountered recruitment issues to Consultant posts but Nursing numbers are struggling. They do not have supernumerary cover. One ACCP is currently being trained.
- Pharmacist numbers are down, and they have not being given the green light to recruit to these positions.
- They have a well-established outreach team.

**Central Manchester University Hospitals NHS Foundation Trust (Manchester Royal Infirmary)**

- There are 2 Adult Critical Care units on this site: General and Cardiac.

- The general unit is 40 bedded unit, 20 level 2 and 20 level 3 beds
- There are 23 Consultants and 26 Trainees. They also have 2 ACCPs in training, and 2 additional trainees planned to start in Autumn 2017.4 consultants work daily in week days (increasing to 5 with elective HDU) and 3 at weekends. Trainees are drawn from all acute specialities.
- The hospital is developing a peri-operative unit which will be an Elective Critical Care Unit (Level 2) . This unit will start with 4 beds, increasing to 8 in time and will open Monday to Friday, reflecting the elective surgical programme. The ACCPs will integrate into medical workforce. Consultants work in blocks, including on call cover. There is ongoing reconfiguration of general surgery in Manchester and the Trust has invested in an elective HDU.
- The service has developed a very robust follow-up service and delivers "critical care without walls" to the adult wards. In addition the service supports a high care unit in Trafford and an obstetric HDU in St Mary's.

**The Christie NHS Foundation Trust**

- This is an 8 bedded specialist Oncological Critical Care unit, 2 of which can support level 3 admissions
- At present they have 14 Consultants, supported by 8 staff/SAS grade doctors and 33 nurses.
- They currently have 2 higher specialty Acute Medicine trainees rotating through the unit.
- Although at present they do not have ACCPs, they would be very keen for ACCPs to join their workforce in the future. They have a well-established outreach team.

**Countess of Chester Hospital NHS Foundation Trust**

- The unit has 15 beds, currently used as 8 level 2 and 7 level 3
- At present there are 11 Consultants, supported by 95 nurses.
- The unit currently has 16 trainees/SASGs benefiting from training and providing cover,, comprising a junior tier of 8 non airway trained F2s and junior fellows (6WTE) and 8 airway trained anaesthetic trainees: CT2s, ACCSs on ICU basic training modules and some specialist registrars in anaesthesia and some SASGs participating in the rota.
- Service posts between Foundation and Core training (junior fellows) are increasingly difficult to fill: the unit is constantly advertising and interviewing to keep these posts filled, however doctors from these posts have gone on to achieve CT posts in a range of specialties.
- The unit is looking at ACCP posts as a solution to the recruitment difficulties to this grade.
- The Trust is approved to take ICM trainees for basic and intermediate training (stage 1 training in the ICM curriculum) and does provide basic ICM training for anaesthetic trainees and ACCS trainees. The unit has not yet been allocated ST3/4 trainees for ICM from anaesthesia or other specialties.

**Cross Region - Cardiac and Neuro ICUs**

- Recruitment for specific units is an issue now and will continue to be so in the future. ICM trainees do not want to work in specialist units. The region is looking at ways around this; working with other specialties and combining or not splitting rotas may be the only option.
- Cardiac ICM will involve lots of complex treatment in the future and is even more of an issue than recruitment to Neuro-ICM. Due to the low number of consultants, burnout within cardiac-ICM is a real concern at the moment.

**East Cheshire NHS Trust - Macclesfield District General Hospital**

- 8 beds, 5 of which can be for level 3 use.
- They have 5 intensivists and 3 generalists with a shared on call rota.

- At present they manage but the biggest issue is the middle grade. They only have 2 trainees so are heavily dependent on middle grades. 11 have been recruited.
- They have tried hard to recruit from overseas. There agency spend is low but bank spend is high on locums.
- They struggle with supernumerary nursing as they get called away during the day. Pharmacist numbers are fine, and they have physio during the daytime.
- Retention of all is not a problem but the initial recruitment is.

**East Lancashire Teaching Hospitals NHS Foundation Trust- Royal Blackburn**

- 24 beds, 4 level 2 and 20 level 2/3, staffed for 16 level 3 and 8 level 2
- The current trainee number is 8, this comprises 4 Core trainee and 4 higher trainees, with 1 Foundation Doctor and 5 Trust Specialty Doctors
- One ACCP currently
- Consultants have doubled up at weekends; this means working the same number of weekends- but an extra weekend session. This eases the burden of decision making. This is possible as the unit has sufficient consultants (16 at present). There is no cost implication and the nurses seem happier with this arrangement.

**Fairfield General Hospital – Pennine Acute Hospitals NHS Trust**

- This unit works a 1:7 rota, made up from 4 consultants based at Fairfield General Hospital (three of whom also work at Oldham) with the remainder covered by consultants based at Oldham. The medium-long term plan is to have a shared pool working on both sites. They currently have one vacancy based at FGH (out of five posts), and one other who has relinquished on call duties since June 2017.
- 5 Staff grade doctors are also on the unit.
- There are two ACCP trainees across the while of the Pennine, at any one time one of these is based at Fairfield. The ACCPs rotate between all 3 sites but once trained, they will be based at The Royal Oldham. There are plans to recruit a further 2 ACCP trainees from February 2018, who will follow the same rotation, and once trained work at The Royal Oldham.
- The unit is not approved for ICM training at present.
- The consultant rota is largely separate but there are problems with this. There is a need to cover ENT; this is a mixed blessing as OOH ENT is not busy and means there is an additional resident anaesthetist (whose primary role is ENT cover) but also means the service is not D16 compliant, and restricts consultants who can do on call at FGH to those with an anaesthetic background.
- This is the smallest unit in the region. It's a combined unit with 4x L3/2 though business case is being submitted to open a 5$^{th}$ L3 bed.

**Liverpool Heart and Chest Hospital**

- 30 bedded unit, with 1800-1900 admissions a year, there is a big push to increase this to 2400. To support this they would need to increase to 34 beds
- They have the funding for another tier but recruitment has fallen flat. They are due to undertake another recruitment round and have 7 applicants to interview – all of which are from overseas.
- They need to establish a night-time tier then they will be able to increase to 34 beds.
- 200 nurses have been recruited to the hospital, which has slashed agency use and improved morale.

**Manchester Royal Infirmary Cardiothoracic specialist ITU**

- The unit has 9 Level 3 beds and 7 Level 2 beds. This is in addition to the 40 general ITU beds and consultant staffing is separate. All cardiac intensivists have anaesthetic sessions as well

as dedicated ITU sessions.

**Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital)**

- This is an 11 bedded unit, with a mix of level 2 & 3. They have 14 spaces but currently only have 11 commissioned.
- At present they have 9 Consultants, supported by 7 staff/SAS grade doctors and 61 nurses.
- They currently have 6 trainees rotating through the unit, this comprises of 2 higher specialty trainees and 4 anaesthetic registrars for out of hours cover.

**Noble's Hospital – Isle of Man**

- The unit has 6 beds and takes all patients including paeds but is unable to transfer if the weather is bad.
- Currently no training or emphasis on working in small and remote ICU.
- 2 consultants have retired, 2 replacements will undertake some ICU sessions and 1 additional appointment will not. 5 consultants will probably retire in the next 5 years, 3 of whom do ICM.
- The unit is trying to expand all skill sets so consultants are not just doing ICM.
- Relying on transfer isn't an option and there is not always the space in bigger hospitals to transfer patients to.

**North Manchester General Hospital**

- The unit has 8 Consultants, supported by 1 ACCP and 55 WTE Nurses.
- There are 10 trainees, 3 foundation, 3 core and 4 higher. It is a 12 bedded unit with 6 x Level 2 and 6 x Level 3 beds.
- NMGH meets current GPICS standards for provision of a critical care service. NMGH has a multidisciplinary culture, providing training for students, doctors, nurses, ACCPs and AHPs.

**Pennine Acute Hospitals NHS Trust (The Royal Oldham)**

- The Royal Oldham currently has an 8 person consultant rota. There are actually more consultants than this (approx. 10) but they cover some slots at Fairfield between them. They are currently trying to recruit to make this up to 12 from 8 but have been having difficulty appointing and therefore have 4 vacancies. They have appointed one substantive consultant but two have retired. They will need to move to the twelve person rota with locum gaps in order to cover HDU 24/7. The new tier of middle grades being appointed will allow them to extend cover to the HDU they will be exclusively for ICM out of hours with some daytime base specialty work. This means there will be two tiers of critical care resident doctors.
- They do have a successful recruitment record for appointing middle grades from overseas but recognise that these appointments will take some time to settle into the NHS before they form a fully functioning rota tier.
- They have a stage 1 ICM trainee joining them from August 2017. Trainees and staff grades from anaesthetics cover the ICU rota including some anaesthetic trainees doing ICM modules – one to two at a time.
- They have 2 ACCPs in training at the moment and have 2 more posts approved for the 2-year training programme. They are also recruiting for AHPs – the business case has been submitted but the posts have not yet been approved.

**Preston & Chorley – Lancashire Teaching Hospitals NHS Trust**

- They have 2 sites, one 28 bedded unit and one 4 bedded unit
- The 5 year plan is to increase the larger site to 34 beds; the finances for this have been

signed off.

- They have 18 Consultants – 2 are not part of the on call or out of hours rota.
- The expansion will require an increase to 24 Consultants. They will look to add 1 a year which should be manageable; they have a good record of recruiting.
- They have capacity for 24 juniors but currently only have 20 in place. 11 are non-training posts, CT3+, Clinical Fellows, and MTI Trainees.
- They are aggressively increasing ACCPs to help with the expansion. Currently they have 2 ACCP trainees, expecting to increase to 5-6.
- For Allied Health professionals they are 3 pharmacists below the requirements and 1 below for Physio. Nursing numbers are OK. No one in the workforce is over 55 at the moment.

**Royal Liverpool University & Broadgreen Hospitals NHS Trust**

- The hospital has 14 Level 2 beds and 19 Level 3 beds these are closed units run by the Critical Care Directorate.
- 2xL2 + 2xL3 Post-op Critical Care (POCCU) beds are run by Anaesthesia.
- At the moment they have 18 Critical Care consultants (16.5WTE), mostly young, next retirement more than 5 years away. Currently this is a full team relative to demand/beds.
- In 2018 they will move into new hospital with fewer total beds (which may worsen delayed discharges reducing effective capacity problem), but total critical care beds increased by 3 up to 40 (20ICU, 10HDU run by critical care plus 10 POCCU run (=current plan) by Anaesthesia.
- There is uncertainty at the moment as to whether CCG will commission all 40 critical care beds. Uncertainty too as to the effect on demands when Clatterbridge come on site (expected to be 2019), and the transfer of complex services between RLUH and Aintree.

**Royal Albert Edward Infirmary**

- The unit has 11 beds – 7 level 3 and 4 level 2. There is a degree of flexibility in their use.
- They had 8 Consultants, but this has just dropped to 7 from August 2017. They have been unable to recruit a new consultant so, currently have 1 vacancy.
- They do a 1:8 rota. Hot week Mon-Thur between 08:00 and 18:00 and then hot weekend (Fri 08:00 to 18:00 and 48hr weekend Sat 08:00 until Mon 09:00). Hot week and hot weekend in different weeks.
- They have one tier of resident on-call. This can be any from CT, staff grades or ST. We currently have 3 staff grades that cover ICU on-calls. Up to 6 trainees at varying stages that also cover ICU on-calls.
- They tend to cover gaps with locums on a regular basis. (they try to use doctors they are familiar with).
- They have a daily pharmacist (on the morning ward round) and a consultant microbiologist in the afternoon (Monday to Friday).
- They have a well-established outreach team.
- They are exploring ACCPs as an option.

**Salford Royal NHS Foundation Trust**

- The unit has 17 Consultants, supported by 3 ACCPs and 150 nurses.
- They have 18 trainees and 2 trainee ACCPs
- It is a 32 bedded unit, split into 8 x level 2 and 24 x level 3 beds
- The hospital has had a medical HDU for many years and the system seems to work well.

**Southport & Ormskirk Hospital NHS Trust**

- This is a unit with 14 physical bed spaces, 11 of which are funded to a state equivalent to 6 level 2 and 5 level 3
- The unit uses physiotherapists for weaning; this works better for the patients as it provides consistency and free ups nursing and consultant staff. Implementing this process has reduced referrals to the Aintree Hospital's long-term ventilation unit.
- The unit does not have a separate rota as there is not enough consultant staff, but they have explored how this would be possible. The unit would need 10 consultants to sustainably split from anaesthesia and they currently only have 7; 2 consultants don't do on call, 2 are estimated to be within 5 years of retirement, and 1 is funded/available for one day a week. New ways of working with anaesthesia are being explored to provide someone providing specialist ICM skills 24/7 within a joint rota.
- The department is promoting a new model with ICM and anaesthesia consultants working flexibly between the specialties.
- The unit is 3 consultants down currently; with expected retirements, the unit would need 5 additional consultants to split the rota and meet GPICS.
- The most senior trainees senior trainees sent to the unit are ST4 anaesthetists. The unit receives good scores in the GMC survey and informally, but trainees in ICM don't apply for jobs there.

**Stepping Hill Hospital – Stockport NHS Foundation Trust**

- This is a 13 bedded unit, with 6 level 2 beds and 7 level 3.
- They have 13 Consultants, 2 staff grade doctors, 1 ACCP and 90 nurses.
- They don't currently have a 2nd tier for night-time. ACCP/staff grade/foundation they have funding but no takers, difficulty recruiting.
- No Supernumerary nursing staff for night and not enough pharmacy technical support
- They are currently OK with Consultant numbers but they have 5 consultants due to retire in the next few years. The Unit has plans for 4 critical care bed expansions and this will also affect consultant numbers. So in the next 5 year period they are likely to need 5 new consultant appointments.

**Tameside General Hospital**

- This is an 9 bedded unit, 2 of which can support level 2 admissions and 7 can support level 3 admissions
- At present they have 9 Consultants, supported by 10 staff/SAS grade doctors and 49 nurses.
- They currently have 2 trainees rotating through the unit.
- Although at present they do not have ACCPs, they would be very keen for ACCPs to join their workforce in the future

**University Hospitals of Morecambe Bay NHS Foundation Trust – Furness General Hospital**

- Furness General Hospital has 6 beds. They should have 7 Consultants but are currently 2 consultants down and recruitment to the posts is difficult. They do not have trainees. Demographics suggest further retirements in the near future and if recruitment remains difficult may result in a significant strain on the effective running of the unit without further support
- The unit at FGH is also small (only 6 beds) and could be considered to be geographically isolated.
- Furness has a rota whereby ICM consultants work 9-5 weekends, and there is ICM on-call

consultant. FGH ICU has ICM consultants doing non-resident on-call from 17:00 – 09:00 & weekends. Currently this includes cross cover of the maternity unit.
- Consultant recruitment in the Trust will be an issue in the future and there is a need for extra anaesthetic consultants to enable dedicated cover for ICU.

**University Hospitals of Morecambe Bay NHS Foundation Trust – Royal Lancaster Infirmary**

- This is an 8 bedded unit, current staffing allows for 6 level 3 beds but the unit could accommodate 8 level 3 admissions
- At present they have 7 Consultants, supported by 43 nurses.
- They currently have 14 trainees rotating through the unit.
- Although at present they do not have ACCPs, they would be very keen for ACCPs to join their workforce in the future
- Lancaster has a dedicated separate rota for consultants.

**Warrington & Halton Hospitals NHS Foundation Trust**

- 18 beds on the units, 10 Level 2 and 8 Level 3
- They have 7 Consultants, supported by 7 SAS Doctors and 80 nurses
- At present they have 12 trainees

**Wythenshawe Cardiac (UHSM)**

- 31 beds on the unit
- 20 Level 3, they can have up to 10 on mechanical support
- 17 Consultants – one of which has just come off on call
- They carry out respiratory Echmo retrievals
- They have 3 consultants on every day. 2 are actually needed but the shortage of trainees and cardiothoracic theatre take trainees away from the ICU, so the Consultants must cover.
- AHP – Dietician number is down but other areas are well provided

**Wythenshawe Acute (UHSM)**

- 17 Mixed level 2&3 beds on the acute ICU & 2 ICU Beds on the Regional Burns Unit
- 16 Consultants, 14 of which are ICM and Anaesthetics and 2 are ICM and Respiratory. 4 Consultants are over age of 55.
- 2 consultants on the unit each day in the week and one at weekends
- 12 junior doctors make up a 2nd tier but there are regular gaps in training post rotation and clinical fellow posts.
- It can be difficult to make a clear second tier due to the variable skill mix and experience of the trainees.
- They are considering adding ACCPs to the workforce.
- They are GPICs compliant with their Allied Health professionals. They have good support on the unit.
- Nursing are suffering from gaps, They always have several posts vacant.

**GENERAL DISCUSSION POINTS – Issues currently facing critical care**

**General**

While all present are aware of regional commissioning discussions, they did not feel involved or consulted. Some are beginning to force involvement by using GPICS, as this is a helpful tool to

support discussions on resources and provisions.

**Service reconfiguration**

ICM service provision and facilities seem to be a late consideration when Trusts are looking at service reconfiguration; this can cause problems when acute services should ideally be planned based on what critical care services are available. In Fairfield for example, service reconfiguration resulted in a very small ICU still being required at the hospital in order to support other services.

In contrast, the Lancashire and South Cumbria Network were asked to drive service reconfiguration. The group noted that neither the Cheshire and Mersey or Greater Manchester Networks were involved in STP planning.

**Trust management**

There was a feeling among some of the group that ICM consultants are not respected by Trust management in an environment where they are more concerned with costs than people. Patients are sometimes moved between units to minimise costs; management do not see the quality change in care and only appear interested in the financial bottom line. ICM needs to demonstrate its value.

There is no leverage to make Trusts adhere to standards; the biggest incentive/deterrent in recent years had been fear of breaching single-sex ward rules.

**Levels of Care**

Levels of care are not as clearly defined as they used to be. A new type of unit needs to be developed to take some of the responsibility however, there needs to be serious consideration as to its remit and what it will be called in order to determine where its funding will come from. There is a need for Level 1+ supported by critical care.

Some Level 2 patients can be looked after by enhanced recovery teams. Trusts need to be cautious when calling a unit Level 2 as ICUs will be required to provide the staff. There was some concern that if ICM took over all Level 2 beds, the rest of the hospital would become de-skilled. In some circumstances the rest of the hospital environment is already becoming de-skilled or not prepared to maintain skills due to the impact on workload, activity and capacity.

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

Workforce standards should be separated from patient care standards to encompass all units. Currently it suggests that x number of doctors equates to better care which is not always the case.

CQC are referring to GPICS. It can be a useful discussion tool. It also touches on supporting services such as Allied Health Professionals.

One unit had 4 empty Consultant posts. After the CQC visit, the standards were used as leverage to fund the required posts. Unfortunately recruitment to the posts is another issue. Not enough doctors are being produced across the specialties.

**Consultant numbers and split rotas**

Most units agreed they can cope with the Consultant numbers at the moment but could always use more. They are coping by combining rotas – To split the ICM rota would require many more Consultants. Units are actively trying to address and adhere to GPICS but they have to 'bend' the

standards to deliver a service.

Pennine Acute had considered amalgamating sites but there were real fears that an individual might be on call and become torn between patients and sites.

Dr Eddleston advised that this was managed at Trafford by lowering the intensity on one site and operating a dedicated retrieval service, with acute take partially selected. The group recognised that this is not applicable or achievable across many sites as it depends on population and services.

For a split rota it really depends on the size of the group, it presents difficulties for workforce and organisation.

**Skill sets**

Units need to be more focussed on the skills on the unit rather than the specialty the trainees/consultants are trained in. Super-specialisation is not the way forward; it results in resource implications as patients require input from more specialties.

The region should be wary of centralising services too far as this was done by paediatrics and has caused major problems; DGHs have become de-skilled and are unable to treat paediatric patients. However, there is not enough space or enough staff in larger hospitals to accept all transfers from other units.

Skill sets need to be more imaginative as ICM is not training enough consultants with airway skills and this is likely to increase in the future. Communication with other specialties could assist with this.

**Increase in demand/changes to remit**

ICM consultants seem to have assumed responsibilities and roles that they did not have previously, including the role of 'hospital decision maker'. The specialty is struggling to meet the demands placed upon it by others within the hospital and needs to be clearer about its boundaries and capabilities. If other services require more from critical care, they need to provide more help.

**Locum cover**

Locum cover is being used excessively in some Trusts however, it is becoming more difficult to find locums and this will only get harder when trainees stop doing locum shifts.

**SAS Doctors**

Greater Manchester relies heavily on SAS doctors, mainly from anaesthesia, to cover critical care at night. This is written into their job plan. The region needs to ensure these doctors are properly supported and developed as they are an important group of clinicians. In Lancashire, this has been recognised due to some SAS doctors leaving because they felt undervalued. Those left now have educational supervisors funded by the Trust as well as individual Personal Development Plans and modular training. It seems to have benefited the service. The same thing has been done in Leighton and this has helped with staff retention. The region needs to look at people who are almost appointable and try to develop them until they *are* appointable. The development needs for SAS doctors are different and they sometimes need more support than trainees; Brexit may affect their appointment and retention in the future. The Christie Hospital does not have anaesthetic or ICM trainees so values middle-grade doctors because of this. They are well supported and one has

obtained a Certificate of Equivalence for Specialist Registration (CESR).

**Advanced Critical Care Practitioners (ACCPs)**

It is highly motivating for nurses to see the ACCP programme; it allows career progression and means they can remain on their unit. The counterargument to this is that it creates gaps in the nursing staff so could be perceived as 'robbing Peter to pay Paul'. They are also not a cheap option and take at least two years to train but if they are well supported they tend to remain on the unit they trained in. ACCPs are also good for continuity of care for patients and trainees. In Greater Manchester, there is a regional paygrade agreement for ACCPs to prevent poaching (7 in training, 8a when qualified) although the group acknowledged other incentives could be used. Although ACCPs are not a cheap solution, comparing the cost of ACCPs to that of locum bills makes them more appealing in the long run. There will need to be a period of additional locum use while ACCPs are being trained. Dr Barnes advised that ACCPs are desired for the Cardiac unit at Wythenshawe but they are not getting the support from the Trust to start these posts.

**Training**

The groups agreed they are currently in a period between the Joint and the Single/Dual programmes where output of trainees has fallen. It was recognised that FICM had advised the GMC of this likelihood at the inception of the programme but the end date for recruitment to the Joint programme was kept by the GMC as 2013. Although everyone knew this was coming, we are just beginning to feel the effects. If more trainees were to stay as single ICM this would shorten the timeline but the reality is that nearly all will Dual accredit at present. Figures shown in the introduction are predicted CCT dates only – this is constantly changing.

Recruitment is taking place from abroad and also from other regions. Other regions also have senior trainees to draw upon, which helps.

The group discussed Consultant led versus Consultant delivered service. Dr Shaikh advised that units have the intention of a Consultant led service but the reality is it is Consultant delivered as there are not enough trainees. How do units fill the middle grade – it goes back to the lack of trainee numbers and non-trainee grades.

**Rotas/on-call/models of working**

Mixed tier rotas can be very useful in larger units; a FY trainee may not be able to work independently if they are the only person covering the unit but they can be excellent at assisting. There is also the possibility of adapting the on call rota so older colleagues do weekend days and younger colleagues cover nights. This could also be used as part of cross-site working. Caution is required to ensure that not all consultants leave the night time on call rota at the same time and that it does not deter trainees or younger consultants. Reducing on call in a staggered fashion would probably be better to ensure not everyone leaves at once; losing on call also significantly reduces salary.

**Contract issues**

Mersey was the first to encounter the contract issue, whereby rotation into another specialty for Dual trainees breaks the existing contract. This will be affecting trainees becoming dual in 2016/2017. Central HEE has confirmed this is the right implementation so this will be rolled out to all

regions increasing the numbers of those affected. Predicted calculations suggest a potential 9-17k loss during the final 2-3 years of training. The group felt this went against the spirit of training; The Faculty are aware and involved and have been in liaison with the British Medical Association.

While this may affect just a few, word spreads and this could dissuade new trainees. The likely outcome is that those affected will seriously consider dropping one specialty to stay pay protected for the entirety of their training. This will once again impact on the crucial CCT numbers and may lead to an increase in CESR applications.

**Encouragement**

Units could devolve power down to enthusiastic lower tiers. For example:

- Changing the mind-set of tasks that can be done by certain people
- Extended roles for some team members

Many would welcome this opportunity rather than having to impose it on people.

Dr Barnes advised that they have a band 6 nurse on the cardiac unit daily who is tasked with care, while this is all double checked by Consultants this has really freed up the Consultant workload and works very well.

There was agreement that there is a high level of interest in nurses coming to ICU but taking them from other areas of a hospital causes problems for other departments.

**Morale**

Across the region sickness rates and moving jobs are increasing. Less staff means burnout is likely to increase and there is no formal process for dealing with burnout. Only 1 unit has access to a clinical psychologist for staff but it was noted that staff should have access to this via their occupational health department. At The Christie Hospital, services available to patients are also available to staff. Leighton Hospital monitors its nursing moral but not that of medical staff and has complimentary therapies available to staff.

Nursing morale in particular is low and made worse due to pressure from management to keep beds free. Many are leaving or are signed off on long-term sick leave. Consultant and middle grade morale seems ok at the moment but there has been an increase in the number of trainees in difficulty due to burnout.

The group discussed the recent anaesthetics survey on burnout, which suggested 50% were dropping out before Core Training. This figure surprised some as the medical rotas are struggling to accommodate the ST3 ICM trainees that need Medicine as part of stage 1 so the Core placements are full in the Mersey/North West region. The group were concerned that there are no obvious warning signs for burnout. Cheshire has been carrying out an annual staff survey. A report will follow after the 3rd full year. This could be shared with Mersey and other regions for them to replicate.

The positive point was that applicant numbers are still good for ICM in the region. There are undoubtedly difficulties but there are also positives to promote; they key is balance between highlighting issues but with the right message rather than just reinforcing negatives.

The primary job of the leaders within a team should be to stop department battles and senior

management pressures affecting the workforce. Developing strong leads and leaders is the goal; the Faculty, by setting up a Clinical Leads Day, could encourage this.

Staff turnover is expensive, time consuming and can affect quality.

## 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 North West. 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 which 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.

**GENERAL DISCUSSION POINTS – Mapping the future**

**GPICS/CQC/standards**

There were differing opinions about how useful the CQC was and how much of an impact their recommendations really had (outside of special measures or closing a unit). Others felt that CQC reports were the only thing which pushed Trusts to make changes. Some of the group believed that standards did not help to improve units but actually made things harder for staff.

There were discussions around mandating the NHS England D05 service specification and utilising financial penalties if Trusts were not compliant. It was acknowledged that this might not help Trusts who will find it near impossible to meet the standards. GPICS for example could not be mandated because most units would not meet every single standards and the CQC would have to close the unit.

Most units in the region will not achieve GPICS standards without additional funding. The remaining options are a) Close some units and centralise services, b) Accept the current system and fund it as it is or c) Do not accept the current system and provide funding to improve it.

**New working styles**

Manchester Royal Infirmary is currently assessing whether tasks undertaken in the evening on the general wards can be moved back into daytime by increasing numbers of staff in the day, thereby freeing night staff to deal with only emergencies. To date a successful pilot has been undertaken during the week which has released more time for staff on night shifts

**Telemedicine**

Telemedicine would be helpful for isolated units; however, this still does not help with bodies on the ground and face to face interaction. There was a suggestion for 2 tiers; 1 being a senior, experienced consultant and the other a more junior consultant or experienced trainee. The first tier could provide advice to the second tier using telemedicine however this would obviously depend on the competence and capability of both tiers. It would also not help as an extra pair of hands when needed.

**Levels of Care**

Post-operative care units and their equivalents could look after Level 1+ patients.

**Reducing demand**

Reducing demand for critical care will reduce the need for staffing increases; improving patient flow will mean HDU and ICU beds are more readily available and reduce the need to cancel surgeries.

One of the advantages of a larger hospital is there is the flexibility to discuss admissions with colleagues and perhaps prevent those which are not entirely necessary.

Shortages in other specialties are having an impact on ICU admissions; some of the group were also of the opinion that some related acute specialties were exacerbating the problem. Patients were being escalated to the ICU because the other specialty consultant was not available or because they were under pressure from patients/relatives.

Managing patient expectations could also help reduce demand for ICU beds; there are occasions, for example, when the relatives of an elderly patient with co-morbidities expect more than general care. Level 1 or Level 1+ care could play a part in this. The patient will not require ventilation so does not need to be admitted to ICU however, they are escalated to a specialist unit so in this way expectations can be met.

**Consultant staffing**

The group discussed appointing consultants to Networks rather than Trusts to enable them to move around the Network where necessary in order to fill gaps and maintain skill sets. This may not be attractive for consultants who have to travel some distance and would involve working with new teams on a regular basis. However, cross-site contracts may be appealing where there is a less attractive unit. There was a concern that gaps would be moved round rather than filled and this could create problems with Trusts arguing that their situation was worse in order to get more staff. There was a general agreement that there is a lack of appointable candidates in the region.

**Consultant remit**

Difficult decision making is a hard but sometimes necessary part of the role of the ICM consultant; some in the group did not feel comfortable leaving this to other specialties.

ICM consultants are paid a significant amount of money to make those difficult decisions when needed. They chose the specialty because it is challenging and should not be paid to or made to simply follow process. Minimising the unnecessary aspects of the role will hopefully help with staff retention.

**Job planning**

The current system of job planning is not ideal. There are not always enough DCC-PAs to undertake extra work. Trusts need to change the way they view sessions and have additional non-clinical responsibilities (such as supervision, management etc.) recognised as part of the working week.

In Greater Manchester, almost no one worked part time historically but this has changed and is likely to increase with the number of Less Than Full Time (LTFT) trainees currently in the programme.

Annualised job plans mean that staff can be moved around to suit demand.

**Training and trainees**

Trainees should be sent to all units, including smaller units where there are several benefits such as more autonomy, experience of running a unit and decision making which is less available on larger units. Training allocation, like the suggestion for consultants, could be on a regional or network basis however it was acknowledged that different models might be required for different Trusts within the region.

There are a group of trainees doing SAS doctor positions for a year in between core and specialty training – this is a workforce to tap into and encourage as they are receiving great exposure.

**General ICU training blocks**

ICM should embrace competency training and use this to find additional trainees (in an ICM programme or not) to staff the units. The Royal College of Physicians (RCP) had approached the specialty to request they take core trainees for a 3 month block. The Training Programme Directors (TPDs) felt this would be a struggle to accommodate, as they will need supernumerary training but the group agreed that this could be beneficial if these trainees came with funding. Embracing medical students and junior trainees early in their training would hopefully help encourage them to take up ICM as part of their higher specialty training. Training works both ways, units that have respiratory trainees rotating through have found this mutually beneficial for learning.

The group agreed this is where ACCP/Nurses are fantastic. They create a larger group capable of training these very junior doctors.

**Single specialty**

The question was asked about whether ICM should give up links with anaesthesia. This would probably not be a popular solution as working would be more weighted towards out of hours. In Australia, most intensivists work in ICM only until they retire however, they do have more options in the form of research, teaching and private practice. Many current consultants would prefer to have another specialty to work in; however, the new generation of consultants are looking into other aspects of the role such as research, quality improvement etc.

With the introduction of the single ICM CCT, there could be an increase in consultants working in one specialty. It is also possible that trainees will not find this option as attractive as it would restrict working in other specialties. However, ICM trainees tend to take on more of a leadership and decision making role than a lot of other trainees and may be able to develop into research and teaching.

**ACCPs**

ACCPs are being trained effectively in many units, this could provide a localised solution but they are not currently able to train at every unit.

The group referred to the outcome of previous engagement meetings where it was reported that some trainees are concerned that the rise of the ACCP could impact on their own training, with different trainees competing for the same competencies. Dr Williams believes ACCPs should be seen as an opportunity not a threat and all agreed it improves the training capabilities of a unit. The group

agreed that it is up to them to take the leadership here in their own units to unify the team.

Dr Eddleston confirmed that Greater Manchester has developed a robust training programme for ACCPs. In her own hospital, Central Manchester University Hospitals NHS Foundation Trust) the team are creating 7 posts to provide a 24/7 rota. To date only 2 trainees are in post with a further 3 starting in September 2017. Within the Region there are probably 6 ACCPs. The majority are working is at core level, but she is aware that some individuals in other parts of the country deliver ST3 level care. Apprenticeship schemes are being pushed locally. This could be a way of introducing ACCPs. If the budgets are not used they will be removed rather than accumulating.

For ACCP training programmes it needs to be understood and built into the model that they may well move on once trained. It is difficult to stop other units from poaching ACCPs away from the units who paid for their training. Trusts can request contracts are signed to require an ACCP to remain on their unit for a specified period of time following their training however, people are reluctant to sign them and they are difficult to enforce.

**Nursing staff**

Nursing staff need to be supported and developed to help with existing, and prevent more, staff shortages. In East Lancashire, a project was undertaken to make nursing staff responsible for Nasogastric (NG) feeding and they are now almost entirely autonomous in this area. Consultants need to help with nurse development and it was positive that this was already happening with ACCPs. Historically there has been very little career progression for senior nurses on the unit. Some units (like Leighton Hospital) now have clinical Band 7s.

**Future services**

The possibility of service reconfigurations are making Trusts reluctant to look at future workforce planning and future services. There is little or no proactive modelling occurring within the region. This is partially because some felt that any modelling done on a unit would be largely ignored by Trust management if it required additional spending.

Some within the group felt that consultants should be responsible for making decisions about future workforce provision and driving change rather than Trust management. Others felt they had no power to do so. It was suggested that the region could standardise processes, forms, drug concentrations etc. and this would lead to change.

## 6. PROBLEMS AND SOLUTIONS

Sections 4 and 5 of this report detail the many problems currently facing the ICM workforce in the North West. 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

**Staffing shortages**

**Trainees –** The North West has to date been fortunate to enjoy a continued high fill rate for the ICM training posts offered. However, the new Single ICM programme with its Dual possibilities will take some time, due to length of training, to replicate the CCT output numbers of the past. The group are very aware of the hiatus between the Joint and the Dual/Single programme. Although it was acknowledged that this would happen, it is only now, as the Joint trainee CCT output begins to slow down that the effects are beginning to be felt nationally. Figures shown in the presentations from the Northwest engagement day are predicted CCT dates only and several factors could affect these predictions, such as OOPE, Maternity or Research.

**Consultants –** The groups touched on the concept of Consultant led vs Consultant delivered. It was felt that whilst units have the intention of Consultant led the reality is Consultant delivered, as there are not enough trainees. While most units agreed they can cope with the Consultant numbers at the moment, future targets to move to a GPICS recommended split rota would not be possible without further funding and recruitment. Units are coping by combining rotas; to split the ICM rota would require many more Consultants which would not be feasible for all units.

**Nursing –** Nursing morale in particular is low and made worse due to pressure from management to keep beds free. Many are leaving or being signed off sick. Nearly all of the units that provided data for the Faculty on workforce projections stipulated that an increase in WTE nursing staff would be required in the next five years. ACCPs are increasing and this does offer senior nurses in Critical Care the opportunity to develop and progress in their career but many units do not yet have ACCPs as part of the workforce and smaller units in particular will not be able to offer training for ACCPs and might well struggle to recruit them once trained.

**Allied Health Professionals (AHPs) –** While the group agreed that Guidelines for the Provision of Intensive Care Services (GPICS) standards and recommendations on AHP numbers were useful to highlight requirements to Trusts, many advised that their current numbers were slightly below those expected and funding for and recruitment to the posts can be slow to gain approval and come to fruition.

**Burnout –** Less staff means burnout is likely to increase and there did not appear to be any formal process in place for dealing with burnout in the region. There has been an increase in the number of trainees in difficulty due to burnout and some units have serious concern about Consultant burnout as they continue to cover for the reduced number of trainees. The group were concerned that there are no obvious warning signs for burnout.

**Contract issues –** The group discussed the new incoming contract and the Mersey training leads were able to advise that rotation into another speciality for Dual trainees breaks the existing contract. This will be affecting trainees becoming dual in 2016/2017. While this may affect just a few, word spreads and there is real concern that this could dissuade new trainees. The likely

outcome is that those affected will seriously consider dropping one specialty to stay pay protected for the entirety of their training and with the Single CCT in ICM still in its infancy the group felt that ICM may well be the speciality that suffers. This will once again impact on the crucial CCT numbers.

**Location and size of units –** The North West is a large region with several large hospitals in fairly close proximity to each other. However, there are small units in the region and there is one in particular, on the Isle of Man, which is geographically isolated. Whilst these units work and provide a valued service, they present challenges for their staff both in the organisation of delivering the required service, with transfers etc. and in attracting the workforce to fill Consultant posts and trainee experience.

**Uncertainty of mergers and combined sites –** While expansion and growth is a positive sign the uncertainty that some units are currently experiencing in terms of future mergers and combined site proposals, and how this might look for their organisations, makes immediate workforce planning very difficult.

**Standards –** The topic of GPICS received a mixed response throughout the discussions, with both positive and negative outcomes being seen since its publication. CQC have been referring to GPICS and while this can be a benefit, as we learned one unit was able to use the standards as leverage for further consultant posts to be funded, it can also have a detrimental effect when it is applied to units that cannot meet it, making it harder for staff rather than improving units. It was felt that version 2 should evolve to separate out workforce standards from patient care.

## 6.2 SOLUTIONS

**Redefining ICM**

Consideration was given as to whether it is time for ICM to be redefined and the three areas covered below all relate to that discussion. Do we need to redefine what ICM is? Lots of anaesthetists are familiar with providing immediate critical care so an ICM consultant is not always necessary. However, not all anaesthetists are capable of providing sustained critical care or covering an ICU.

**Levels of Care**

Levels of Care are not as clearly defined as they used to be. Several proposals were put forward to address this. One solution would be the development of post-operative care units to care for the level 1+ patient. It was also proposed that a new type of unit should evolve to take some of the responsibility and burden from existing ICUs. It was recognised that serious consideration would need to be given to the name, remit and funding of such a unit. Manchester Royal Infirmary also updated the group on a new working style they are currently trialling, where they are assessing night time tasks and where possible moving them back into the schedule of the daytime team, thereby freeing night staff to deal with emergencies only. This is working well for them to date but in order to implement this it has meant an increase in daytime staffing numbers which might not be possible for all units.

**Changes to hospital culture and ICU remit**

It was very apparent that shortages in other specialties are having an impact on the number of ICU admissions. Patients are being escalated to ICU due to Consultants in other specialities being unavailable or as a result of pressure from patients or relatives who believe ICU is where they should be cared for. Managing patient expectations more effectively could well reduce the demand and pressure for ICU beds, and this solution would have an immediate impact. Consultants would also benefit from a more standardised approach from trusts towards recognising teaching and other activities as this differs widely amongst individuals. Adequate time should be allowed within job plans to continue these important activities, which add to the specialities future.

**Tasks / encouragement**

It was felt by some that smaller units should have trainees rotating through them. Not only to assist the unit itself but also to provide vital exposure of this environment to the trainees, as they experience autonomy, running a unit and the decision making practices on these units and how it differs from that available on larger units in which they do their training. This might also help with future recruitment. Many units also advised that they have junior doctors choosing to do staff grade posts in between Core and Speciality training and this is a workforce that should be encouraged, as it benefits both parties, the unit for workforce and the trainee for exposure to ICM and a clear decision on if they wish to pursue ICM as a career. There was also the suggestion that a unit could alter its approach dependant on the strengths of its workforce at any one time. This could mean devolving power to enthusiastic lower tiers, extending their roles. It was believed that many individuals would welcome this opportunity. This would involve changing the mind-set of who in a team can do certain tasks, but this would be achievable if led by the Consultants.

**Investing time in SAS Doctors**

Many units rely heavily on SAS doctors to deliver their service. The attendees were in agreement that SAS doctors should be supported, developed and recognised as valued members of a team and workforce. Lancashire and Leighton shared examples of what happened when the SAS grades felt undervalued and moved on to other units. In response the units have arranged positive changes, such as Educational Supervisor support, and staff retention and job satisfaction appear to have improved as a result of these changes. The consensus was that time and effort spent on these important team members is rewarded.

**ACCPs**

ACCPs are being trained effectively in a few of the units represented here today, and the discussions on future workforce, and data returned to the Faculty, clearly highlighted that many more units would like to add them to their teams in the future. ACCPs should be seen as a very real and current opportunity. All agreed it improves the training capabilities of a unit, as experienced ACCPs create a larger group capable of training junior doctors, in turn easing the demand on ICM consultants. The distribution of ACCP trainees is limited at the moment and further thought on how to recruit ACCPs into smaller units once trained will need consideration. After a costly two year training programme larger units would quite rightly be reluctant to lose a qualified ACCP from their team. Dr Eddleston advised the group of the Apprenticeship schemes developing locally. If this was explored further this might be a way of introducing ACCPs. The FICM has been in discussion with HEE about Apprenticeships.

**ICU exposure**

The group were of the opinion that ICM should embrace competency training. The news that the RCP will be looking to add 3 months ICM training to their Core Medical Training programme was welcomed. As well as assisting with staffing issues this may assist in recruiting more Core Medical Trainees into the ICM training programme, acting as taster sessions early in their career. The TPDs did raise a note of caution over the practicalities of arranging these posts, as they will need supernumerary training, but most were of the opinion that this could be beneficial if these trainees came with funding. Some units reported the reciprocal nature of these mixed training groups, as units that had experienced respiratory trainees rotating through have found this mutually beneficial for learning.

## 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 |
| Aintree University Hospital NHS Foundation Trust | 13 | 13 | 0 | 0 | 0 | 2 | 114 | 114 |
| Arrowe Park Hospital (Wirral University Teaching Hospitals NHS Foundation Trust) | 12 | 12 | 0 | 0 | 0 | ? | 108 | ? |
| Blackpool Victoria Hospital (Blackpool Teaching Hospitals NHS Foundation Trust) | 9 | 14 | 0 | 0 | 0 | 4 | 61 | 71 |
| Blackpool Victoria Hospital Cardiac ICU (Blackpool Teaching Hospitals NHS Foundation Trust) | 12 | 12 | 1 | 2 | 0 | 2 | 95 | 95 |
| Bolton NHS Foundation | 12 | ? | ? | ? | 1~ | ? | 80 | 80 |
| Central Manchester University Hospitals NHS Foundation Trust (Manchester Royal Infirmary) | 23 | ? | 0 | ? | 2~ | ? | 250 | ? |
| The Christie NHS Foundation Trust | 14 | 15 | 8 | 9 | 0 | 2 | 33 | 35 |
| Countess of Chester Hospital NHS Foundation Trust | 11 | 11 | 6 | 6 | 0 | 2 | 95 | 99 |
| East Cheshire NHS Trust (Macclesfield District General Hospital) | 8.2 | 14 | 12 | 12 | 0 | 0 | 28 | 30 |
| East Lancashire Teaching Hospitals NHS Foundation Trust – Royal Blackburn | 15.5 | ? | 5 | 5 | 1 | ? | 150 | 150 |
| Fairfield General Hospital (Pennine Acute Hospitals NHS Trust) | 10 | 10 | 5 | 5 | 0 | 0 | 35 | ? |
| Liverpool Heart and Chest Hospital | ? | ? | ? | ? | ? | ? | ? | ? |
| Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital) | 9 | ? | 7 | ? | 0 | ? | 61 | ? |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Noble's Hospital – Isle of Man | 13 | 13 | 3 | 3 | 0 | 0 | 25 | 25 |
| North Manchester General Hospital | 8 | 8 | 0 | 0 | 1 | 1 | 75 | 75 |
| Royal Oldham Hospital (Pennine Acute Hospitals NHS Trust) | 10 | 12 | 0 | 7 | 0 | 4 | 72 | ? |
| Preston & Chorley (Lancashire Teaching Hospitals NHS Trust) | 18 | 24 | 21 | ? | 2~ | 8 | 198 | ? |
| Royal Albert Edward Infirmary | 8 | 8 | 3 | 6 | 0 | 0 | 61 | 65 |
| Royal Liverpool University & Broadgreen Hospitals NHS Trust | 18 | ? | ? | ? | ? | ? | ? | ? |
| Salford Royal NHS Foundation Trust | 17 | 17 | 0 | 0 | 3 | 3 | 150 | 150 |
| Southport & Ormskirk NHS Foundation Trust | 17.25 | 21 | 15 | 18 | 0 | 4 | 64 | 64 |
| Stepping Hill Hospital (Stockport NHS Foundation Trust) | 13 | ? | 2 | ? | 1 | ? | 90 | ? |
| St Helens & Knowsley (Whiston Hospital) | 7 | 8 | 1 | 1 | 0 | 0 | 105 | 105 |
| Tameside General Hospital | 9 | 9 | 10 | 16 | 0 | 2 | 49 | 55 |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Furness Hospital | 7 | 7 | 0 | 0 | 0 | 0 | 35 | 38 |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Royal Lancaster Hospital | 7 | 7 | 0 | 0 | 0 | 0 | 43 | 45 |
| The Walton Centre | ? | ? | ? | ? | ? | ? | ? | ? |
| Warrington & Halton Hospitals | 7 | 8 | 7 | 7 | 0 | 0 | 80 | 85 |
| Wythenshawe Cardiac (UHSM) | 17 | / | 0 | / | 0 | / | 220 | / |
| Wythenshawe Acute (UHSM) | 16 | / | 1 | / | 0 | / | 93 | / |

~In training
*Covering ICU and Anaesthesia
/ Unable to provide data at this time
? 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 |
| Aintree University Hospital NHS Foundation Trust | 12 | 12.7 | 0 | 0 | 0 | 1.6 | 101 | 101 |
| Arrowe Park Hospital (Wirral University Teaching Hospitals NHS Foundation Trust) | 7 | ? | 0 | ? | 0 | ? | 97 | ? |
| Blackpool Victoria Hospital (Blackpool Teaching Hospitals NHS Foundation Trust) | 9 | 14 | 0 | 0 | 0 | 4 | 69.05 | 71 |
| Blackpool Victoria Hospital Cardiac ICU (Blackpool Teaching Hospitals NHS Foundation Trust) | 11 | 12 | 1 | 2 | 0 | 2 | 87 | 87 |
| Bolton NHS Foundation | ? | ? | ? | ? | 1 | ? | 79.10 | 79.10 |
| Central Manchester University Hospitals NHS Foundation Trust (Manchester Royal Infirmary) | 21 | ? | 0 | ? | 2~ | ? | 210 | ? |
| The Christie NHS Foundation Trust | 4.6 | 4.6 | 7.8 | 9 | 0 | 1 | 23.7 | 35 |
| Countess of Chester Hospital NHS Foundation Trust | 6 | 6 | 1 | 1 | 0 | 2 | 80.6 | 80.6 |
| East Cheshire NHS Trust (Macclesfield District General Hospital) | 8.2 | 14 | 11.25 | 12 | 0 | 0 | 24.23 | 26.7 |
| East Lancashire Teaching Hospitals NHS Foundation Trust – Royal Blackburn | 15.5 | ? | 5 | 5 | 1 | ? | 150 | 150 |
| Fairfield General Hospital (Pennine Acute Hospitals NHS Trust) | 7 | 7 | 7 | 7 | 0 | 0 | 32.6 | ? |
| Liverpool Heart and Chest Hospital | ? | ? | ? | ? | ? | ? | ? | ? |
| Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital) | 9 | ? | 7 | 9 | 0 | 0 | 54.23 | 54 |
| Noble's Hospital – Isle of Man | 17 | 17 | 0 | 5 | 0 | 0 | 23 | 23 |
| North Manchester General Hospital | 8 | 8 | 0 | 0 | 1 | 1 | 55 | 60 |
| Royal Oldham Hospital (Pennine Acute Hospitals NHS Trust) | 8 | 12 | 0 | 7 | 0 | 4 | 66.5 | 78 |
| Preston & Chorley (Lancashire Teaching Hospitals NHS Trust) | 9 | 12 | 17 | 6 | 0 | 8 | 174.41 | 197.05 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Royal Albert Edward Infirmary | 8 | 8 | 3 | 6 | 0 | 0 | 53 | 55 |
| Royal Liverpool University & Broadgreen Hospitals NHS Trust | 16.5 | ? | ? | ? | ? | ? | ? | ? |
| Salford Royal NHS Foundation Trust | 14.5 | 22 | 0 | 0 | 3 | 10 | 124 | 168 |
| Southport & Ormskirk NHS Foundation Trust | 21 | 21 | 16 | 18 | 0 | 4 | 57.35 | 62.79 |
| Stepping Hill Hospital (Stockport NHS Foundation Trust) | 14 | ? | ? | ? | ? | ? | ? | ? |
| St Helens & Knowsley (Whiston Hospital) | ? | 8.35 | 1 | 1 | 0 | 0 | ? | 85 |
| Tameside General Hospital | 9 | 9 | 10 | 16 | 0 | 2 | 48.7 | 55 |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Furness Hospital | 7 | 7 | 0 | 0 | 0 | 0 | 20.16 | 22.66 |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Royal Lancaster Hospital | 7 | 7 | 0 | 0 | 0 | 0 | 41 | 45 |
| The Walton Centre | ? | ? | ? | ? | ? | ? | ? | ? |
| Warrington & Halton Hospitals | 7 | 7 | 7 | 7 | 0 | 0 | 75 | 84 |
| Wythenshawe Cardiac (UHSM) | 17 | / | 0 | / | 0 | / | 185 | / |
| Wythenshawe Acute (UHSM) | 8.85 | / | 0.5 | / | 0 | / | 79.26 | / |

~In training
/ Unable to provide data at this time
? 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 |
| Aintree University Hospital NHS Foundation Trust | 1 | 1 | 4 | 4 | 8 (7.2 WTE) | 8 (7.2 WTE) | 2 | 0 | 15 (14.2 WTE) | 15 (14.2 WTE) |
| Arrowe Park Hospital (Wirral University Teaching Hospitals NHS Foundation Trust) | 2 | ? | 5 | ? | 2 | ? | 0 | ? | 13 | ? |
| Blackpool Victoria Hospital (Blackpool Teaching Hospitals NHS Foundation Trust) | 1 | 1 | 1 | 2 | 2 | 8 | 0 | 0 | 1-4 | 11 |
| Blackpool Victoria Hospital Cardiac ICU (Blackpool Teaching Hospitals NHS Foundation Trust) | 0 | 0 | 0 | 1 | 2 | 1 | 1 | 2 | 3 | 4 |
| Bolton NHS Foundation | ? | ? | ? | ? | ? | ? | ? | ? | ? | ? |
| Central Manchester University Hospitals NHS Foundation Trust (Manchester Royal Infirmary) | 2 | ? | 6 | ? | 6 | ? | 12 | ? | 26 | ? |
| The Christie NHS Foundation Trust | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 8 | 2 | 10 |
| Countess of Chester Hospital NHS Foundation Trust | 2 | 2 | 5 (1.75 WTE) | 5 (1.75 WTE) | 0 | ? | 4 (WTE) | 6 | 16 (10 WTE) | 16 |
| East Cheshire NHS Trust (Macclesfield District General Hospital) | 0 | 0 | 2 | 4 | 2 | 2 | 0 | 0 | 4 | 6 |
| East Lancashire Teaching Hospitals NHS Foundation Trust – Royal Blackburn | 1 | 1 | 4 | ? | 4 | ? | 5 | 5 | 14 | ? |
| Fairfield General Hospital (Pennine Acute Hospitals NHS Trust) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Liverpool Heart and Chest Hospital | ? | ? | ? | ? | ? | ? | ? | ? | ? | ? |
| Mid Cheshire Hospitals NHS Foundation Trust (Leighton | 0 | ? | 2 | ? | 0 | ? | 0 | ? | 6 | ? |

| Hospital) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Noble's Hospital – Isle of Man | 0.25 | 0.25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| North Manchester General Hospital | 3 | 3 | 3 | 3 | 4 | 4 | 0 | 0 | 10 | 10 |
| Royal Oldham Hospital (Pennine Acute Hospitals NHS Trust) | 2 | 3 | 1 | 1 | 1 | 2 | 0 | 0 | 3 | 6 |
| Preston & Chorley (Lancashire Teaching Hospitals NHS Trust) | 3 | 3 | 3 | 3 | 3-5 | 3-5 | 4 | ? | 10-12 | 10-12 |
| Royal Albert Edward Infirmary | 0 | 0 | 3 | 3 | 3 | 3 | 0 | 0 | 6 | 6 |
| Royal Liverpool University & Broadgreen Hospitals NHS Trust | ? | ? | ? | ? | ? | ? | ? | ? | ? | ? |
| Salford Royal NHS Foundation Trust | 4 | 4 | 4 | 4 | 8 | 8 | 2 | 2 | 18 | 18 |
| Southport & Ormskirk NHS Foundation Trust | 0 | 0 | 3 | 4 | 2 | 3 | 0 | 0 | 8 | 10 |
| Stepping Hill Hospital (Stockport NHS Foundation Trust) | ? | ? | ? | ? | ? | ? | ? | ? | ? | ? |
| St Helens & Knowsley (Whiston Hospital) | 3 | 2 | 6 | 5 | 2 | 2 | 3 | 3 | 11 | 11 |
| Tameside General Hospital | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 2 | 2 | 4 |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Furness Hospital | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Royal Lancaster Hospital | 1 | 1 | 12 | 12 | 0 | 0 | 1 | 1 | 14 | 14 |
| The Walton Centre | ? | ? | ? | ? | ? | ? | ? | ? | ? | ? |
| Warrington & Halton Hospitals | 1 | 1 | 8 | 8 | 3 | 3 | 2 | 2 | 12 | 12 |
| Wythenshawe Cardiac (UHSM) | 0 | / | 0 | / | 6-8 | / | 6-8 | / | 12-16 | / |
| Wythenshawe Acute (UHSM) | 1 | / | 5 | / | 6 | / | 1 | / | 12 | / |

/ Unable to provide data at this time
? Data not provided

### 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 |
|---|---|---|---|
| Aintree University Hospital NHS Foundation Trust | | | |
| WTE for Consultants | 12 | 12.7 | Increase |
| WTE for SAS Doctors | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 1.6 | Increase |
| WTE for Nurses | 101 | 101 | Remains the same |
| Number of Trainees | 15 | 15 | Remains the same |
| | | | |
| Arrowe Park Hospital (Wirral University Teaching Hospitals NHS Foundation Trust) | | | |
| WTE for Consultants | 7 | ? | ? |
| WTE for SAS Doctors | 0 | ? | ? |
| WTE for ACCPs | 0 | ? | ? |
| WTE for Nurses | 97 | ? | ? |
| Number of Trainees | 13 | ? | ? |
| | | | |
| Blackpool Victoria Hospital (Blackpool Teaching Hospitals NHS Foundation Trust) | | | |
| WTE for Consultants | 9 | 14 | Increase |
| WTE for SAS Doctors | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 4 | Increase |
| WTE for Nurses | 69.05 | 71 | Increase |
| Number of Trainees | 1-4 | 11 | Increase |
| | | | |
| Blackpool Victoria Hospital Cardiac ICU (Blackpool Teaching Hospitals NHS Foundation Trust) | | | |
| WTE for Consultants | 11 | 12 | Increase |
| WTE for SAS Doctors | 1 | 2 | Increase |
| WTE for ACCPs | 0 | 2 | Increase |
| WTE for Nurses | 87 | 87 | Remains the same |
| Number of Trainees | 3 | 4 | Increase |
| | | | |
| Bolton NHS Foundation | | | |
| WTE for Consultants | ? | ? | ? |
| WTE for SAS Doctors | ? | ? | ? |
| WTE for ACCPs | ? | ? | ? |
| WTE for Nurses | 79.10 | 79.10 | Remains the same |
| Number of Trainees | ? | ? | ? |
| | | | |
| Central Manchester University Hospitals NHS Foundation Trust (General unit Manchester Royal Infirmary) | | | |
| WTE for Consultants | 21 | 24 | ? |
| WTE for SAS Doctors | 0 | ? | ? |
| WTE for ACCPs | 2 | ? | ? |
| WTE for Nurses | 210 | ? | ? |
| Number of Trainees | 26 | ? | ? |
| | | | |

| | | | |
|---|---|---|---|
| The Christie NHS Foundation Trust | | | |
| WTE for Consultants | 4.6 | ? | ? |
| WTE for SAS Doctors | 7.8 | 9 | Increase |
| WTE for ACCPs | 0 | 1 | Increase |
| WTE for Nurses | 23.7 | 35 | Increase |
| Number of Trainees | 2 | 10 | Increase |
| | | | |
| Countess of Chester Hospital NHS Foundation Trust | | | |
| WTE for Consultants | 6 | 6 | Remains the same |
| WTE for SAS Doctors | 0 | ? | ? |
| WTE for ACCPs | 0 | 2 | Increase |
| WTE for Nurses | 80.6 | 80.6 | Remains the same |
| Number of Trainees | 16 | 16 | Remains the same |
| | | | |
| East Cheshire NHS Trust (Macclesfield District General Hospital) | | | |
| WTE for Consultants | 8.2 | 14 | Increase |
| WTE for SAS Doctors | 11.25 | 12 | Increase |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 24.23 | 26.7 | Increase |
| Number of Trainees | 4 | 6 | Increase |
| | | | |
| East Lancashire Teaching Hospitals NHS Foundation Trust – Royal Blackburn | | | |
| WTE for Consultants | 15.5 | ? | ? |
| WTE for SAS Doctors | 5 | ? | ? |
| WTE for ACCPs | 1 | ? | ? |
| WTE for Nurses | 150 | 150 | Same |
| Number of Trainees | 8 | ? | ? |
| | | | |
| Fairfield General Hospital (Pennine Acute Hospitals NHS Trust) | | | |
| WTE for Consultants | 7 | 7 | Remains the same |
| WTE for SAS Doctors | 7 | 7 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 32.6 | ? | ? |
| Number of Trainees | 0 | 0 | Remains the same |
| | | | |
| Liverpool Heart and Chest Hospital | | | |
| WTE for Consultants | ? | ? | ? |
| WTE for SAS Doctors | ? | ? | ? |
| WTE for ACCPs | ? | ? | ? |
| WTE for Nurses | ? | ? | ? |
| Number of Trainees | ? | ? | ? |
| | | | |
| Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital) | | | |
| WTE for Consultants | 9 | ? | ? |
| WTE for SAS Doctors | 7 | 9 | Increase |
| WTE for ACCPs | 0 | ? | ? |
| WTE for Nurses | 54.23 | 54 | Decrease |
| Number of Trainees | 6 | ? | ? |

| | | | |
|---|---|---|---|
| | | | |
| Noble's Hospital – Isle of Man | | | |
| WTE for Consultants | 17 | 17 | Remains the same |
| WTE for SAS Doctors | 0 | 5 | Increase |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 23 | 23 | Remains the same |
| Number of Trainees | 0 | 0 | Remains the same |
| | | | |
| North Manchester General Hospital | | | |
| WTE for Consultants | 8 | 8 | Remains the same |
| WTE for SAS Doctors | 0 | 0 | Remains the same |
| WTE for ACCPs | 1 | 1 | Remains the same |
| WTE for Nurses | 55 | 60 | Increase |
| Number of Trainees | 10 | 10 | Remains the same |
| | | | |
| Royal Oldham Hospital (Pennine Acute Hospitals NHS Trust) | | | |
| WTE for Consultants | 8 | 12 | Increase |
| WTE for SAS Doctors | 0 | 7 | Increase |
| WTE for ACCPs | 0 | 4 | Increase |
| WTE for Nurses | 66.5 | 78 | Increase |
| Number of Trainees | 3 | 6 | Increase |
| | | | |
| Preston & Chorley (Lancashire Teaching Hospitals NHS Trust) | | | |
| WTE for Consultants | 9 | 12 | Increase |
| WTE for SAS Doctors | 17 | 4-6 | Decrease |
| WTE for ACCPs | 0 | 8-10 | Increase |
| WTE for Nurses | 174.41 | 197.05 | Increase |
| Number of Trainees | 10-12 | 10-12 | Remains the same |
| | | | |
| Royal Albert Edward Infirmary | | | |
| WTE for Consultants | 8 | 8 | Remains the same |
| WTE for SAS Doctors | 3 | 6 | Increase |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 53 | 55 | Increase |
| Number of Trainees | 6 | 6 | Remains the same |
| | | | |
| Royal Liverpool University & Broadgreen Hospitals NHS Trust | | | |
| WTE for Consultants | ? | ? | ? |
| WTE for SAS Doctors | ? | ? | ? |
| WTE for ACCPs | ? | ? | ? |
| WTE for Nurses | ? | ? | ? |
| Number of Trainees | ? | ? | ? |
| | | | |
| Salford Royal NHS Foundation Trust | | | |
| WTE for Consultants | 14.5 | 22 | Increase |
| WTE for SAS Doctors | 0 | 0 | Remains the same |
| WTE for ACCPs | 3 | 10 | Increase |
| WTE for Nurses | 124 | 168 | Increase |
| Number of Trainees | 18 | 18 | Remains the same |

| | | | |
|---|---|---|---|
| Southport & Ormskirk NHS Foundation Trust | | | |
| WTE for Consultants | 21 | 21 | Remains the same |
| WTE for SAS Doctors | 15 | 18 | Increase |
| WTE for ACCPs | 0 | 4 | Increase |
| WTE for Nurses | 57.35 | 62.79 | Increase |
| Number of Trainees | 8 | 10 | Increase |
| | | | |
| Stepping Hill Hospital (Stockport NHS Foundation Trust) | | | |
| WTE for Consultants | 14 | ? | ? |
| WTE for SAS Doctors | ? | ? | ? |
| WTE for ACCPs | ? | ? | ? |
| WTE for Nurses | ? | ? | ? |
| Number of Trainees | ? | ? | ? |
| | | | |
| St Helens & Knowsley (Whiston Hospital) | | | |
| WTE for Consultants | ? | 8.35 | ? |
| WTE for SAS Doctors | 1 | 1 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | ? | 85 | ? |
| Number of Trainees | 11 | 11 | Remains the same |
| | | | |
| Tameside General Hospital | | | |
| WTE for Consultants | 9 | 9 | Remains the same |
| WTE for SAS Doctors | 10 | 16 | Increase |
| WTE for ACCPs | 0 | 2 | Increase |
| WTE for Nurses | 49 | 55 | Increase |
| Number of Trainees | 2 | 4 | Increase |
| | | | |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Furness Hospital | | | |
| WTE for Consultants | 7 | 7 | Remains the same |
| WTE for SAS Doctors | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 20.16 | 22.66 | Increase |
| Number of Trainees | 1 | 1 | Remains the same |
| | | | |
| University Hospitals of Morecambe Bay NHS Foundation Trust – Royal Lancaster Hospital | | | |
| WTE for Consultants | 7 | 7 | Remains the same |
| WTE for SAS Doctors | 0 | 0 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 43 | 45 | Increase |
| Number of Trainees | 14 | 14 | Remains the same |
| | | | |
| The Walton Centre | | | |
| WTE for Consultants | ? | ? | ? |
| WTE for SAS Doctors | ? | ? | ? |
| WTE for ACCPs | ? | ? | ? |
| WTE for Nurses | ? | ? | ? |
| Number of Trainees | ? | ? | ? |

| | | | |
|---|---|---|---|
| Warrington & Halton Hospitals | | | |
| WTE for Consultants | 7 | 7 | Remains the same |
| WTE for SAS Doctors | 7 | 7 | Remains the same |
| WTE for ACCPs | 0 | 0 | Remains the same |
| WTE for Nurses | 75 | 84 | Increase |
| Number of Trainees | 12 | 12 | Remains the same |
| | | | |
| Wythenshawe Cardiac (UHSM) | | | |
| WTE for Consultants | 17 | / | ? |
| WTE for SAS Doctors | 0 | / | ? |
| WTE for ACCPs | 0 | / | ? |
| WTE for Nurses | 185 | / | ? |
| Number of Trainees | 12-16 | / | ? |
| | | | |
| Wythenshawe Acute (UHSM) | | | |
| WTE for Consultants | 8.85 | / | ? |
| WTE for SAS Doctors | 0.5 | / | ? |
| WTE for ACCPs | 0 | / | ? |
| WTE for Nurses | 79.26 | / | ? |
| Number of Trainees | 12 | / | ? |

### 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 North West has remained towards the positive end of the list, with one new post per 312,109 of the population. 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.

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

## APPENDIX 1: LIST OF ATTENDEES

| | |
|---|---|
| John Adams | Health Education North West |
| Claire Alexander | University Hospitals of Morecambe Bay NHS Foundation Trust |
| Alan Ashworth | University Hospital South Manchester |
| Sian Axon | Leighton Hospital |
| Andrea Baldwin | Lancashire & South Cumbria Critical Care Network |
| Fiona Ball | Health Education North West |
| Andrew Bentley | University Hospital of South Manchester NHS Foundation Trust |
| Karen Berry | Greater Manchester Critical Care Network |
| Katy Chadwick | University Hospitals of Morecambe Bay NHS Foundation Trust |
| Sengottiyan Chandrasekaran | Stockport NHS Foundation Trust |
| Sarah Clarke | Regional Advisor for the North West |
| Paul Dean | Lancashire & South Cumbria Critical Care Network |
| Helen Derrick | Central Manchester Foundation Trust |
| Andrew Drummond | Pennine Acute Hospitals NHS Trust |
| Tracey Duncan | North Manchester General Hospital |
| Jane Eddleston | Greater Manchester Critical Care Network |
| Lisa Eland | Blackpool Teaching Hospitals NHS Foundation Trust |
| Ajmal Eusuf | Bolton NHS Foundation Trust |
| Catherine Farrimond | Health Education North West |
| Paul Ferris | Salford Royal NHS Foundation Trust |
| Chris Goddard | Southport & Ormskirk Hospital NHS Trust |
| Claire Hammell | Leighton Hospital |
| David Highley | Noble's Hospital |
| Claire Horsfield | Lancashire & South Cumbria Critical Care Network |
| Mark Hughes | Regional Advisor for the Mersey Region |
| Nick Jones | North Manchester General Hospital |
| Vidya Kasipandian | The Christie NHS Foundation Trust |
| Wael Khalaf | Wrightington, Wigan & Leigh NHS Foundation Trust |
| Shondipon Laha | Lancashire Teaching Hospitals NHS Trust |
| Sandeep Lakhani | The Walton Centre |
| Jackie Livesey | Pennine Acute Hospitals NHS Trust |
| Gary Masterson | Cheshire & Mersey Critical Care Network |
| Jerome McCann | Warrington & Halton Hospitals |
| Ken McGrattan | TPD for North West |
| John Moore | Central Manchester NHS Foundation Trust |
| Shankara Nagaraja | Aintree University Hospital NHS Foundation Trust |
| Kathryn Naylor | The Royal Oldham Hospital |
| Richard Nelson | Countess of Chester Hospital |
| Dan Nethercott | Bolton NHS Foundation Trust |
| Victoria Parr | Greater Manchester Critical Care Network |
| Justin Ratmasingham | Liverpool Heart & Chest Hospital |
| Shafee Shaikh | Stockport NHS Foundation Trust |
| Emily Shardlow | University Hospital of South Manchester NHS Foundation Trust |
| Lutfi Sulaiman | Macclesfield District General Hospital |
| Tony Thomas | Greater Manchester Critical Care Network |
| Nick Tierney | Pennine Acute Hospitals NHS Trust |

| | |
|---|---|
| Redmund Tully | Pennine Acute Hospitals NHS Trust |
| Simon Vaughan | Blackpool Teaching Hospital NHS Foundation Trust |
| Alison Wake | Central Manchester Foundation Trust |
| Mark Wilkinson | University Hospitals of Morecambe Bay NHS Foundation Trust |
| Tom Williams | Arrowe Park Hospital – TPD Mersey |

## APPENDIX 2: 2016 CENSUS DATA

**COUNT:** 109 respondents (out of 770).

82% of the respondents are practicing in both Anaesthetics and ICM. This compares to 83.3% in Scotland, 85.7% in West Midlands and 98.1% in Yorkshire and Humber.

At what age do you anticipate permanently stopping clinical critical care medicine?

| AGE RANGE | North West |
|---|---|
| Pre 50 | 2 |
| 50-54 | 8 |
| 55-59 | 28 |
| 60-64 | 52 |
| 65+ | 16 |

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

| ANSWER | North West |
|---|---|
| Yes | 76 |
| No | 31 |

If 'NO', why? (MULTIPLE SELECTIONS PERMISSIBLE FOR THIS QUESTION – TOP 5 OPTIONS GIVEN)

| ANSWER | COUNT |
|---|---|
| Work-life balance | 25 |
| Frequency of on-call, stress, work intensity | 21 |
| Lack of critical care capacity and finding beds | 14 |
| Intend to stop/reduce ICM in favour of another speciality | 14 |
| Lack of junior medical staff | 6 |

**PA AND SERVICE TIME DATA**

NB: Per week PA data across the region

| | ICM DCC-PAs | Non-ICM DCC-PAs | SPAs (ICM and non-ICM) | Additional duty PAs for ICM |
|---|---|---|---|---|
| RANGE | 2-10 | 1-7.8 | 1-3 | 0-7 |
| MEAN | 4.6 | 4.2 | 2.2 | 0.52 |
| MEDIAN | 4.5 | 4 | 2.5 | 0 |
| MODE | 4 | 5 | 2.5 | 0 |

| | OOH/Weekends unplanned hours per week | Nights per week worked | Weekends per year worked |
|---|---|---|---|
| RANGE | 0-12 | 0-5 | 4-17 |
| MEAN | 4 | 1.1 | 9.2 |
| MEDIAN | 4 | 1 | 8 |
| MODE | 2 | 1 | 10/11 |