REGIONAL WORKFORCE ENGAGEMENT REPORT:

WESSEX

The Faculty of Intensive Care Medicine

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EXECUTIVE SUMMARY

The Faculty, represented by Dr Daniele Bryden and Dr Jack Parry-Jones (the current Lead for Workforce, reporting to the Careers, Recruitment and Workforce Committee (FICMCRW), Ms Natalie Bell (Board and Training Projects Manager) and Miss Susan Hall, were welcomed to the Wessex region by representatives from most Trusts, the Network, the Specialist Training Committee and School. Dr Parry Jones writes:

Wessex was the Faculty's ninth in-depth workforce review, and my seventh, having missed out on two since the programme commenced in Wales. There is a downside to doing these reviews; the cumulative effect on feelings of inadequacy – a new syndrome for Intensivists, but one I am sure you recognise well when one considers our chances of good long-term outcomes when called upon to care for the multiple co-morbid patient with multiple organ failure. There are some excellent, very talented and hardworking people working in critical care and it is easy to feel inadequate when confronted with their achievements, often made despite the obstacles in their way. The Faculty's hope continues to be that by sharing the hard-earnt gains in some regions, we can reduce the work required in others to achieve similar workforce goals.

In Wessex we heard two excellent presentations from Matt Williams as the Regional Advisor, and Kathy Nolan as the Clinical Lead for the Network. Kathy led us through the issues currently being faced across their Network: ageing population, increasing demand, static capacity, staffing shortfalls made worse by Brexit fears, delayed transfers of care out of critical care, and difficulties repatriating patients from tertiary to secondary care. These are common themes to all of us. The proposed solutions of: an admissions policy, preoperative assessment, enhanced care, early decision-making, and palliative care are also familiar but possibly not laid out so succinctly. Across the Network, over 600 bed days per quarter are lost due to delays in transfers of care greater than 24 hours (DToCs). Better than my region you might be saying, but the inefficiencies that continue to plague the wider systems most, if not all of us work in, are seriously impacting on the critical care we can provide to those that need it most, when they need it most. The Network has well-established links with neighbouring Networks, not least because Kathy's remit extends into Thames Valley. The amount of work being done to obtain data to support the case for better resources appears excellent. Whilst 80% of units meet service specifications, the major identified shortfalls across the Network are DToCs, psychology, pharmacy, repatriations delayed more than 48 hours, and rehabilitation. Delayed repatriations have a major service impact on the tertiary neuro-critical care service in Southampton, which then spills out into their general ICU service. The Network has been doing unit visits. A peer review process is being used with some units also using a Service 360-degree appraisal form, supplied by CR Systems, on selected users of their critical care service.

Matt Williams took us through some history of critical care in Wessex, including their own Wessex Intensive Care Society established in 1998. Their society is certainly a strength for the region with biannual meetings, especially when taken alongside the diversity of opportunities, good academic and specialist training, and a set of very engaged ICM tutors. There have been challenges too of course, and historically a number of Wessex ICM trainees resigned their training number. Over the last 18-12 months, significant efforts to rectify this loss to their programme has paid dividends. There are 30 ICM trainees in post with a mix of dual and single CCT (over 20%), with a projected output of up to 8 CCT holders per year. During the afternoon sessions, actual or proposed plans for unit and service expansion in the region were aired, and with a proposed maximum of 8 CCT holders coming through per year, this appears to be inadequate to meet the necessary consultant numbers in the next few years. The region will need either to increase ICM training places or appoint trainees

from other deaneries. The retention of ICM consultants through their whole NHS career remains a key area for all of us, and the Faculty.

There were two other areas worth highlighting. The first is the real difficulties faced by the small and remote critical care units, and the interdependency between their service and the services reliant on them. Most regions have one or more small units, but Newport on the Isle of Wight is a good example of a unit, both geographically isolated and at certain times overnight, inaccessible by public transport, and small. Some hospital services are reliant on a critical care service being present and functional and this may require additional support.

Secondly, in many regions the greatest difficulties in ICM staffing are often faced by specialist units – neuro, cardiac and burns. Southampton, as the cardiothoracic service for the region was no different. A lot of dedication and effort has been required to provide a training service recognised within Europe and outside of Europe. This has reaped significant rewards with a more stable, competent and rota compliant workforce that other cardiac and specialist units might wish to emulate.

The Faculty team of Susan, Natalie, Danny and me, thank you all for your warm hospitality and an excellent day in the “Shane Warne” end of the Ageas stadium. Home to the Beefy Botham restaurant. Two people who may not have struggled with inadequacy syndrome, but then what is cricket compared to life and death?

1. Introduction: The Critical Care Workforce

This section is common to all FICM Workforce Engagement reports.

1.1 Critical Care in the NHS

Historically, there has been little or no workforce data published for Intensive Care Medicine (ICM) in the UK. With the birth of the Faculty of Intensive Care Medicine (2010), there has been the opportunity to begin generating crucial workforce data through a series of censuses (2012, and 2014 to 2019), engagement with workforce modelling projects and drawing information from audit and research.

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

ICM presents a unique challenge for workforce planners:

- The recognition by the General Medical Council (GMC) of Intensive Care Medicine (ICM) as a specialty, some inevitable decoupling from its traditional base in Anaesthesia and the evolution of training systems through joint, dual and single specialty programmes, means workforce planning for ICM is multi-faceted.
- Training is based traditionally around teaching hospitals and in conurbations. Some 86% of trainees now end up as consultants working in the same area in which they trained. Arguably, areas that struggle to recruit trainees or have few allocated to them will struggle to fill additional consultant posts even if funding is available to create them.

Joint Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) standards - *Guidelines for the Provision of Intensive Care Services (known as GPICS)* were first published in 2015, with the publication of GPICS2 in June 2019. However, a number of units in England do not currently meet some of these standards, often through a lack of provision of separate ICM Consultant rotas. Some critically-ill patients are therefore being cared for overnight, over weekends and bank holidays by non-ICM trained consultants. Furthermore, since the publication of GPICS2 in June 2019, units will have to re-evaluate which standards they do and do not meet.

Whilst central government policy can set out to determine how many doctors are needed, the final number that can be employed in a particular geographical location is determined by the money available to employ them. In times of relative plenty (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%. However, data from the 2017 and 2018 censuses showed that this number dropped from 16.6% to 16.07% respectively. The most recent census in 2019 showed the figure for those intending to drop ICM sessions nationally rose again to 23%. The most common reasons across the censuses for wanting to leave ICM are all focused on workforce issues:

- Work-life balance
- Work intensity / burnout
- Frequency of on call

- Lack of available beds/critical care facilities
- Lack of junior doctors

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

1.2.2 Expected increase in patient and NHS need for Critical Care

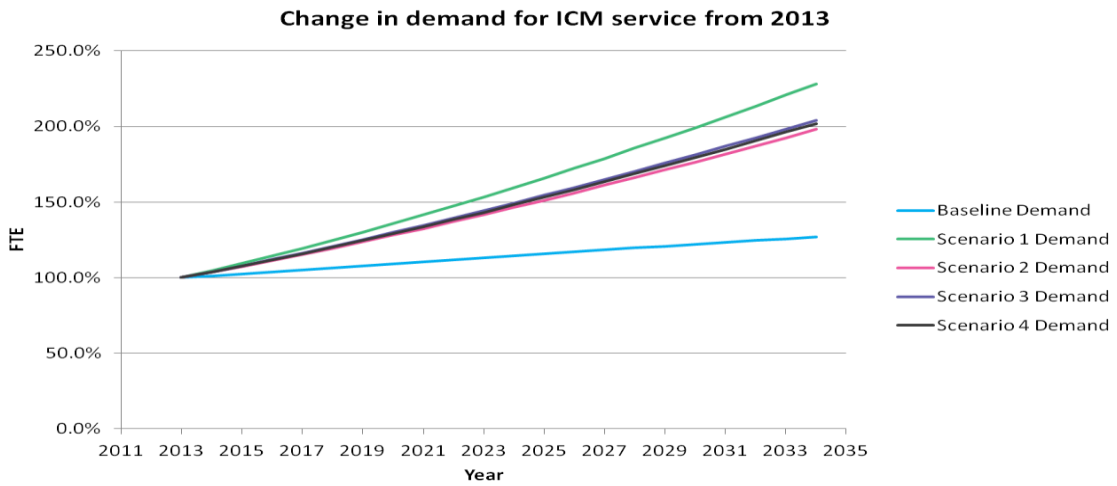
The **Intensive Care National Audit and Research Centre (ICNARC)** is undertaking a long-term review of critical care bed utilisation rates. They released the statement below to us in 2014:

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

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

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

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



1.2.3 Workforce aims

All current national data sources suggest that with an aging population with increasing co-morbidities, demand for critical care services will outstrip current supply levels. The censuses reveal that the current workforce is beginning to experience the added stresses and uncertainty of working in critical care at a time where demand is not being met with increased provision. The FICM 2019 census focused on the impact of ageing on those working in ICM to identify the impact on individual wellbeing.

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

2. BACKGROUND TO THE ENGAGEMENT

In October 2014, the FICM Board accepted a position paper as a statement of current provision and UK-wide projected trends for ICU services. The Board recognised the need for modelling of workforce demand in the home nations and regions, requesting that two pilot studies be undertaken. The first engagement was held in Wales in November 2015, followed by the West Midlands in May 2016, Scotland in September 2016, Yorkshire & Humber in November 2016, the North West in March 2017, the East Midlands in November 2017, the South West Peninsula in November 2018 and Thames Valley in May 2019.

Wessex was the ninth region to request an engagement with the Faculty, which we happily accepted. Wessex filled seven of their eight available posts in 2018; however, in 2019, Wessex only filled five of the eight posts available in National recruitment. Like many regions around the UK, they have concerns about the CCT output numbers in the intervening years between the Joint CCT finishers and the new ICM CCT trainees completing their training in sustainable numbers.

Following extensive discussion, representatives to attend the engagement meeting (see Appendix 1) were agreed for each trust and included local training leads. We are grateful to the assistance given by the Network Medical Lead (Dr Kathy Nolan), and the Regional Advisor (Dr Matthew Williams) who both helped facilitate the event.

2.1 Engagement Aims

The engagement would be conducted with the aim of:

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

The engagement would not aim to:

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

The engagement would result in this final report and its appendices that could be used by the local stakeholders (across the Health Boards, Networks, School and Deanery) to manage workforce decisions in the specialty.

3. THE WORKFORCE IN WESSEX

3.1 Clinical Demand and Workforce in the Wessex Deanery Area

This information is based on the presentation given by Dr Kathy Nolan and reflects their views on ICM workforce in the Wessex Deanery area. It reflects personal opinion where it is not clearly referenced to existing data from other sources.

Clinical Demand and Workforce in the Wessex region
Dr K Nolan, Medical Lead
Thames Valley & Wessex Adult Critical Care Network

The Thames Valley and Wessex Adult Critical Care Operational Delivery Network (ODN) covers 21 units and includes two cardiac and two neuro intensive care units.

The Wessex region has a total of 12 critical care units including a cardiac and neuro intensive care unit at Southampton.

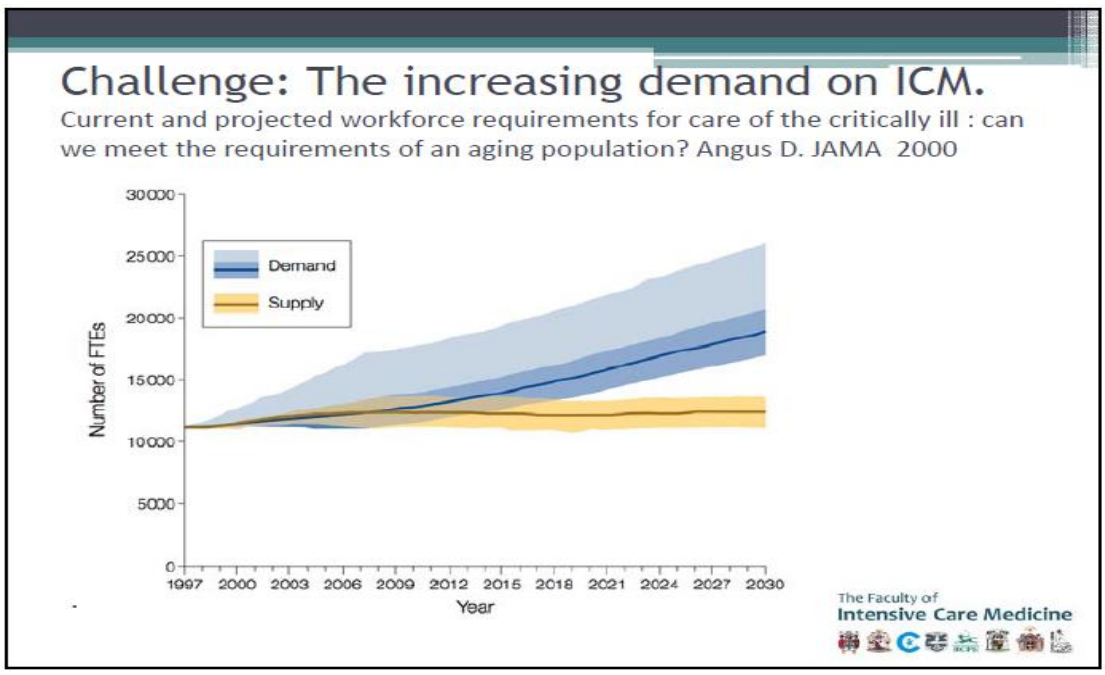
The total number of funded Level 3 equivalent beds is 126 but with the capability to increase to 169, as funding and workforce permits.

ICU	Funded L3	Funded L2	L3 equivalent	Total beds
IOW	6		6	7
Bournemouth	5	6	8	13
Dorchester	4	4	6	11
Basingstoke	6	10	11	16
Winchester	3	4	5	10
Poole	5	6	8	12
Portsmouth	19		19	24
Salisbury	6	4	8	12
UHS GICU	17	8	21	25

UHS NICU	11	2	11	13
UHS CICU	15		15	16
Chichester	6	4	8	10
Total	101	50	126	169

ICNARC predicts a 4% increase in overall bed days per annum with a 7% increase in Level 2 and a projected 2% reduction in Level 3.

A 5.9% increase in population is predicted between 2016 – 2026 and the number of older people is expected to double.



Demand on ICU services is predicted to increase due to the increase in an ageing population with associated co-morbidities, increasing patient acuity, increasing interventions, winter pressures and the reconfiguration of services.

However, there are developing initiatives that may provide alternative patient pathways and potentially reduce demand. These include implementation of evidence considered admission policies, enhanced preoperative and Cardiopulmonary Exercise Testing (CPET) assessments, earlier decision making, earlier involvement of palliative care and provision of Enhanced Care areas may help reduce demand on critical care.

Demand and Capacity has been a particular focus of NHS England in the South. Thames Valley (TV) & Wessex's Adult Critical Care ODN collaborates with the South West and South East ODNs in the collection and evaluation of the data associated with the Improving Value Scheme. The network's other priorities include benchmarking, unit visits/ peer support and keeping the units updated.

The aims of the Improving value scheme are to
- Drive quality, safety and appropriate use of ACC
- Improve access and patient flow
- Reconfigure capacity and pathways where needed
- Drive culture where critical care is a protected resource similar to front door
- Payments in line with contracted activity
- Address coding/charging issues

Delayed discharges were a particular focus of the Improving Value scheme in an effort to improve patient access and flow, and ensure appropriate use of critical care.

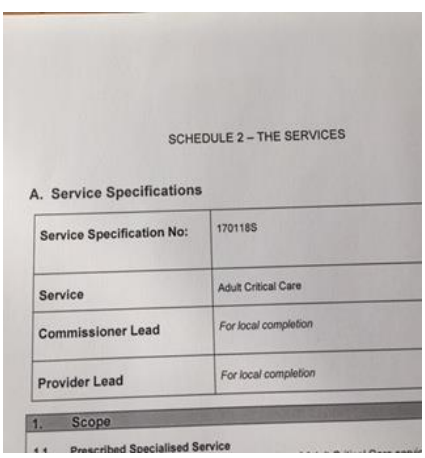
Delayed Discharges
2016/17 – approx. £11m spent on patients delayed >24hrs in NHSE South

Network	Trust	Unit	2016/17				2017/18	
			Q1	Q2	Q3	Q4	Q1	
TV&W	Buckinghamshire Healthcare NHS Trust	Stoke Mandeville Hospital-ICU/HDU	22	9	13	43	19	
		Wycombe Hospital-ICU	0	0	0	0	0	
	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital-ICU/ HDU	0	9	0	17	0	
	Frimley Health NHS Foundation Trust	Wexham Park Hospital-ICU	31	68	23	64	46	
	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital-ICU	50	87	85	98	98	
		Royal Hampshire County Hospital-ICU / HDU	42	16	42	18	26	
	Isle of Wight NHS Trust	St Mary's Hospital Isle of Wight-ICU	33	40	49	71	31	
	Oxford University Hospitals NHS Trust	Horton Hospital-ICU	32	48	44	56	67	
		John Radcliffe Hospital-Adult ICU	0	15	7	8	11	
		John Radcliffe Hospital-Neurosciences ICU	0	0	0	0	6	
		Churchill Hospital-ICU	0	0	0	0	0	
	Poole Hospital NHS Foundation Trust	Poole Hospital-ICU/ HDU	62	69	91	54	27	
	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital-ICU	43	62	72	76	90	
	Royal Berkshire NHS Foundation Trust	Royal Berkshire Hospital-ICU	99	59	59	74	22	
	Salisbury NHS Foundation Trust	Salisbury District Hospital-Radnor Ward	48	59	16	32	31	
	The Royal Bournemouth and Christchurch Hospitals NHS Four	Royal Bournemouth Hospital-ICU / HDU	22	25	33	20	56	
	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital-ICU/ HDU	19	10	25	27	0	
	Western Sussex Hospitals NHS Foundation Trust	St Richard's Hospital-ICU	64	42	42	0	0	
TV&W Total			567	619	600	657	529	

- Out of Hours Discharges *(approx. 7% discharged between 10pm and 8am, 15% discharged between 8pm and 8am in TV&W 2018/19)*
- Delayed Repatriations

TV & Wessex ACC ODN was focused on implementation of the D05 Service Specification for Adult Critical Care.

GPICS vs Service Specification



GPICS: 'definitive reference source for planning and delivery of UK Intensive Care Services' However, it is a Standards document – and is not contractual.

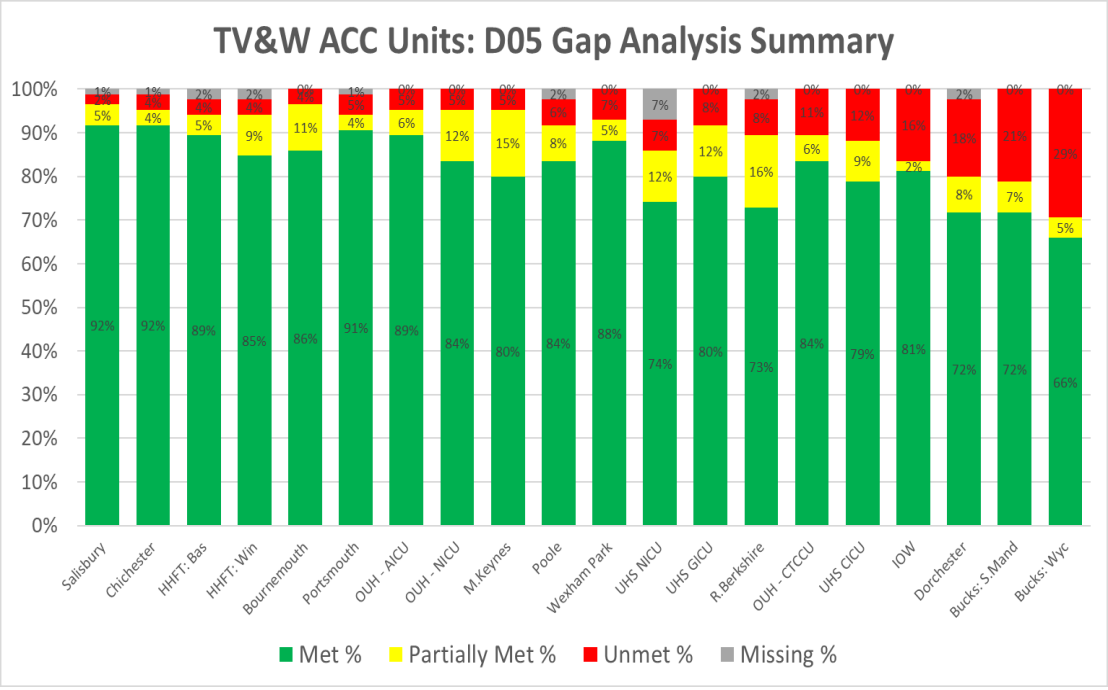
The Service Specification is a contractual document, and units would be expected to deliver everything requested from it.

Examples of workforce requirements from the Service Specification:

- Patients in Critical Care should receive twice daily ward reviews by a Consultant in Intensive Care Medicine (in line with 7 day standards). In addition, there should be multidisciplinary 7 day input available from the extended team (microbiology, pharmacy, dietetics, physiotherapy, and where applicable speech and language therapy)
- There must be a training strategy in place to achieve a min of 50% of nursing staff with a post registration award in critical care nursing
- Each critical care unit must aim to have a supernumerary shift clinical coordinator 24/7
- Consultants must be freed from all other clinical commitments when covering Intensive Care and this must include other on-call duties.
- Decision to admit patients must be made by a consultant in ICM
- A competent resident clinician with advanced airway skills available 24/7

Following publication of the Service Specification in 2019, they performed a gap analysis of all units across the South of England and the 21 units in the TV & Wessex ACC ODN achieved 75% of the requirements. The lack of pharmacy and psychology services were the most common gaps identified and one unit did not meet the requirement for dedicated consultant cover out of hours.

South of England Gap analysis



The National Network Nursing Organisation, Critical Care National Network Nurse Leads Forum (CC3N), conducted a nursing workforce survey in 2017 which was published in April 2018 and identified the following changes since the previous survey in 2015. The total number of nursing vacancies was 1440 and represented 8.35% of the workforce. TV & Wessex Units had a higher percentage of nurses recruited from the EU than the national average that may have implications following Brexit.

The number of units recruiting Advanced Critical Care Practitioners (ACCPs) has also increased since the 2017 survey and this is expected to rise as more units in the Wessex region are now recruiting ACCPs. The CC3N has repeated the workforce survey in November 2019, which has yet to be analysed.

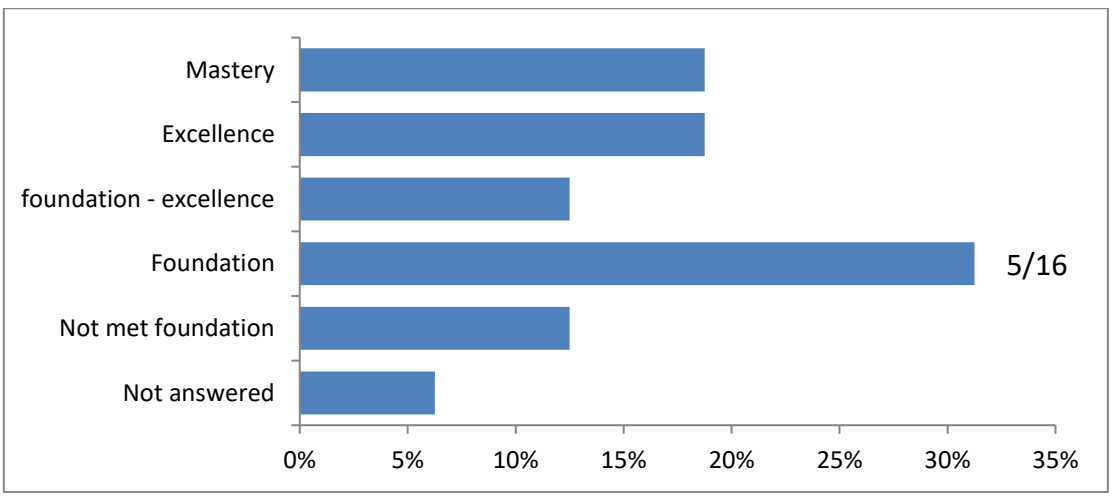
National Critical Care nursing workforce report April 2018

	National average %	TV & Wessex %
Nurses > 50yrs of age	12.2	10.8
Staff turnover	10.1	15.1
Overseas recruitment EU	9.9	23.8
Overseas recruitment non-EU	16.6	16.5

Advanced Critical Care Practitioners ACCPs

ACCPs	**2015**	**2017**
% of ICUs	**11.6%**	**23%**
Trainees		**116**
Qualified		**93**

A Pharmacy benchmarking survey was conducted in the TV & Wessex units by Dr Mark Borthwick in 2019 to identify the level of practice of the most senior pharmacist who works on the ICU.



Half of the 'Leads' do not have minimum competencies

Discussion

At the round table discussion at the workforce meeting in November 2019, the following points were discussed.

Workforce is a concern for all units including nursing, medical and Allied Health Professions (AHPs). Many units are exploring the ACCP route, but it was recognised that many are trained nurses and so may deplete the nursing workforce. However, it was recognised as a pathway for progression for some but that it also needed a clear career progression pathway to make it a sustainable solution. Lack of experienced middle grade doctors was also a concern and units were considering fellowship programmes to try and address this gap.

Within Wessex, there are several new developments and many units are in the process of expansion and redesign. The Poole/Bournemouth service reconfiguration is making progress with the planned location of all acute services on the Bournemouth site with an increase in ICU capacity there but there will also be a requirement for HDU/Enhanced Care Facilities on the Poole site for major elective surgical patients. This will require an increased multidisciplinary workforce to deliver the service.

Southampton ICU is also undergoing a major refurbishment with an increase in capacity from 25 to 32 critical care beds. Funding for these extra beds has not yet been agreed but with service reconfiguration will more than likely require an increase in workforce of all disciplines to staff these beds.

Dorchester is also planning an expansion of beds and will also require an increase in workforce to meet the demands.

The planned ICU expansions, with predicted consultant retirements, and potential changes in work patterns in the coming years will increase the demand for new consultants. Based on current trainee numbers in the Wessex Deanery there is likely to be a shortfall of CCTs to meet the consultant demand.

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 Wessex. 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 reflect these discussions and the opinions of those who took part.

Dorchester

- Has 11 beds, 8 funded but they regularly run at 6 because of nursing gaps.
- They do not run a split rota from Anaesthetics.
- They have a 1 in 8 rota for middle grade doctors, using ACCPs etc.
- 16 WTE in Anaesthesia. 6 consultants with an interest in Intensive Care cover the daytime. Nights and weekends are supported by all 16.
- Nursing staff – retention is a huge issue; money has been provided but the applicants are just not there. They have also tried to increase the pay of their existing nurses.
- They have a problem with transfers. For out of hours work, they use the ambulance and are sent to Bournemouth. If it is not time critical then there is no provider. Two doctors with advanced airway skills cover three areas at night; losing one to medical transfer is very costly on the service.
- With transfers, no one takes clear responsibility for repatriation of Level 2 patients.
- With respect to Pharmacy, they have junior support for 2 hours a day. They do not have any therapists.

North Hampshire Hospital, Basingstoke

- Has a 16 bedded mixed ITU and HDU, currently building 2 further HDU beds to open in 2020.
- Busy elective programme resulting from the National Peritoneal Malignancy Institute patients who all require post-operative critical care.
- Run an 8 Consultant out of hour's rota exclusively for Critical Care on the Basingstoke site. Currently advertising a further consultant post to support service expansion. NHH does not usually struggle to attract applicants to ICU posts.
- Separate Anaesthetic consultant rota.

- Out of hours, airway cover for the ICU depends currently on the anaesthetic middle grade rota, although trainees, clinical fellows and ACCPs are dedicated to working on the ICU.
- Currently have 12 Consultants working on the Basingstoke ICU in daytime (some shared with Winchester) and four trained ACCPs, with two further ACCPs in training. Matron in post for Basingstoke ICU.
- Recent service reorganisation moves all trauma to the Basingstoke site, with the development of an elective orthopaedic site in Winchester. Already emergency cardiology on the Basingstoke site. Currently ED services maintained across both hospitals.

Poole Hospital

- Has an 11 bedded unit with flexible Level 2/3 beds, funding covers 5 x Level 3 and 6 x Level 2.
- They have a 12th non-funded escalation bed available.
- They currently have 6 consultants that will be increasing to 7 in February 2020.
- They do not struggle to retain and recruit nurses. Newly qualified nurses start in ICU; they get an invite to critical care training as soon as they start to get exposure to the Band 6 competencies. Succession planning and an established training package is important for attracting people to the hospital.
- Acute Medical Units (AMUs) /Clinical Decision Units (CDUs) feed into ICUs but they are overstretched as they see 50 patients a day. It is a heavy workload.
- Outreach services sit with the Clinical site, rather than with the ICU.

Portsmouth

- Has a 24 bed unit, 19 of which can be used for Level 3 patients.
- They currently have 16 consultants and 9 ACCPs (made up of trainees and trained ACCPs)
- 20-30% of admissions are elective the rest are all emergency.
- Juniors – they have two dedicated junior tiers, plus the ACCP tier.
- Resident consultant tier – is complicated. 18 months ago, they were resident for a year, in part because of fluctuating trainee numbers and ACCPs coming through. Now consultants are not resident Mon-Thurs as all the ACCP programme has matured. Some consultants choose residency for geographical reasons.
- Lack of middle grade doctors has led to consultants having to be the resident on call at night.
- ACCPs – Portsmouth has four qualified and a further two just about to finish training. They have three trainees in year one training. This has enabled them to create a separate tier on the unit for daytime, but the ambition is to complete a 24/7 tier. The programme has extended to Paramedics as well, from its inception.
- ACCPs are resident for long day shifts during the week and only resident at night for the Friday-Sunday nights. If they could attract a full complement of ACCPs it would improve the service coverage greatly.
- They have lost one trainee through resignation, and one ACCP to the ambulance service . Subsequent to the engagement meeting, two more have left, to other Trusts/University/Pre-hospital combined roles.
- D05, GPICS – Compliant in most things but they do not currently have a psychologist, there is a business case open now for one. They have a pharmacist of the appropriate grade but there is a gap in provision currently. They have a follow-up clinic that is mainly nurse led.
- They have had a business case open for PACU for 3 years now but have not yet been successful. Hospital wide there are many business cases open with competing agendas. A review of the whole of the higher care provision within the trust is needed.

- Funding from HEE Wessex is an issue to assist with post-graduate development for non-medical staff.
- No recruitment or retention problems in Portsmouth but they are in a unique position. They have invested in training, education and staff wellbeing to look after staff. They are gradually seeing more and more units with gaps. Housing prices are having an effect. Need to develop career progression in order to improve retention.
- Nursing workforce – they had a trust initiative to recruit a lot of overseas non-European nurses, they have seen in the last two years a huge attrition of European nurses, this means they have lost their middle group experience wise, and have lots of new nurses. Currently, they do not have any vacancies. Recruitment is relatively easy in Portsmouth, due to a very stable service, many have trained and worked in the region, they also benefit from lots of military nurses joining them after leaving military service.
- The training programme has been set up to allow nurses to rotate through teaching, outreach, and research posts for professional development. It increases their skills and keeps the jobs interesting. During this period, they spend 50% of their time in the ICU and 50% in their chosen specialty. If the unit is short, they will be pulled from their other duties. All of this is funded via the nursing budget and follows a Band 5/Band 6 model. It does however increase the workload for job planning.
- Across the whole trust, they are recruiting many nurses from India that are working in the Middle East. They have found them to be highly skilled e.g. ECMO etc. They must pass lots of English exams to get registered with the Nursing and Midwifery Council (NMC) in the UK, so the hospital supports them with study leave and time off to do the exam. They start at Band 3 and work on the ICU to get their PIN number to move up to the Band 5 level. To reduce costs for interviews they arrange Skype videoconferences at international meetings.
- NHSE Paediatric CARE Review will be the next big thing for the unit. They have a dedicated paediatric bed. They currently receive 140 Paediatric referrals a year and send around 80 of those on to Southampton's unit.
- For the nursing staff, Paediatric skills are a concern, there was a conversion course available but access to this dried up about 3 years ago. They are lucky at present to have retained the staff, but this could be a future issue.
- International Medical Graduates have been identified by the GMC as the only growth area for doctors. Portsmouth is running a dedicated MTI programme (helping them with their applications) for IMGs as they can work at the middle grade level and will help address this gap.

Royal Bournemouth Hospital

- They have 13 beds, 8 consultants, and all the anaesthetists are on a separate rota.
- They have increased capacity for non-training grades.
- Non-airway, they have two FY2 trainees and one CT2 medical trainee. In an overlap stage, they have an Internal Medicine Trainee (IMT) in office hours for the next 5 weeks. Hopefully next year they should increase in numbers and to 10-week rotations.
- The Care Quality Commission (CQC) has highlighted that the airway provision overnight is insufficient.
- They have eight nurses working on the unit at night.
- They have a high proportion of EU nurses (from Spain and Portugal) but have lost a lot in recent months due to the uncertainty of Brexit or they have left to get married back home. The government has said it will not recognise any post registration certification, which has made things difficult. Also, to maintain their competencies they have to go back home to take an exam to revalidate.

- They have implemented flexible shift patterns in order to help retain staff.
- They have a pharmacist with the correct experience and 24-hour access to physiotherapy. They do not have any access to a psychologist, but at a recent strategy meeting it was on the radar of hospital management.
- Pan-Wessex roles might be worth investigating for pharmacy, psychology etc. as many units struggle with this. Salisbury is the exception as they have a set up. Staff and patients need access to the service.
- 50% of their work is elective, they are an outlier for delayed discharge.
- They are in danger of downgrading skills of the rest of the hospital, taking a few cases then turns into all cases as other departments refuse patients.
- They are looking into recruiting ACCPs and maybe sharing with Poole/Dorset
- Potential merger with Poole – between the units there are currently? 25 beds, a merger could see this become a 30-bed unit. This could be a challenge with workforce, between the two sites there are 5-6 consultants are approaching retirement. It is not guaranteed that they will move to the new site.
- They run a monthly follow-up clinic. Pilots of follow-up clinics can be useful, as they demonstrate a need.
- They have a 24/7 nurse-led outreach service. The clinical lead for the service is an ICU consultant. They offer a nurse practitioner course and to obtain a non-medical prescribing qualification. It involves lots of teaching and expands the skillset of the nurses, which is attractive. It is a rewarding job with a lot of professional development; burnout is not as high as people are led to believe. The nurses have a lot of autonomy. They also support the lung unit as they do many of the internal transfers.

Royal Hampshire County Hospital, Winchester

- Forms one trust with Basingstoke. Basingstoke has a much bigger elective throughput.
- Winchester is approximately 10% elective surgery.
- Recruitment of consultants is difficult. There is initial interest but no applications, the second round of recruitment will commence soon for their current vacancy. (Update – no suitable applicants)
- Split rotas; they have a 1 in 8 dedicated ICU rota.
- Several consultants are the same age, three in their mid-50s, so whilst they are currently recruiting for one position this could easily jump up to three vacancies at once. Their recent appointments have all come from out of the region – they do not seem to attract Wessex-based applicants.
- They have a nephrologist on the team, who does cross-site working; this addition has been brilliant for the team.
- Junior tier are mainly CT1s, they do not currently have any middle grades in Critical Care.
- At night after 9pm, all anaesthetics are given by consultants, this works extremely well.
- ICU - during the day, junior level CTs cover, 1 or 2 at a time, other support is provided by clinical fellows. This is very variable, they have some great individuals, but this cohort of doctors is disappearing. They have taken the decision and financial hit to offer Anaesthetic/ICU clinical fellow posts; this has shown some early success.
- ACCPs are shared between Winchester and Basingstoke but work predominantly in Basingstoke.
- Nursing – they are a couple short of their 30 WTE complement, they are normally between 0-5 nurses short. They can recruit but are aware this means taking from the Emergency Department etc. so it moves staff issues around the hospital.
- They have pharmacy support but only at a junior level, and currently have access to 2 hours of psychology a week, which is not enough.

- They do run a follow-up clinic, but this is voluntary, using consultant SPA time. It is not a funded service, but it is expected monthly. The consultant that currently runs the service is making the case for it to be added into their job plan.

St Mary's Hospital, Isle of Wight (IoW)

- They have not managed to split ICM and Anaesthetics rotas.
- The unit has 8 beds with 6 Level 3 beds.
- They currently have 12 consultants, and are recruiting to 14 soon.
- Nursing has a full quota, non-European overseas staff make up the rota.
- They lack a clinical psychologist, and only have one pharmacist.
- They do not currently run a follow-up clinic and delayed discharge is a big issue for them. A quarter of patients are discharged on time.
- The whole trust is in special measures. Critical care came in to focus, unfairly they feel, and this has affected nursing retention.
- SAS doctors make up their middle grade tier, they usually have 6-7 but these numbers fluctuate. They are mostly European doctors and they have had good recruitment success lately for this group.
- Portsmouth and Southampton help them with specialist services. Often cases are pre-selected for air assets before hitting the IoW hospital. Portsmouth takes air assets until 2am, then it's over to the coastguard. The unit very rarely deals with Paediatric cases, these are usually retrieved.
- They do not feel annual demand fluctuations as much as you might think; there is not a clear pattern, it is not always a summer heavy service. There is a large elderly population and in the summer months the paediatric population increases.
- The other units in the region all provide support. They have tried to improve shared learning between the units, but it is ad hoc due to availability. They have shared Mortality and Morbidity Meetings.
- They have clinical specialist partnerships, vascular cases go to Southampton and urology to Portsmouth.

Cardiac Intensive Care Unit (CICU), University Hospital Southampton

- They have two 8-person rotas. They need 16 people to run the service provision as well as run the training programme. The lead currently has to supervise 12 fellows. They have agreement from the trust to over recruit as it takes 6 months to recruit someone if they are not from the EU. It is the only UK centre to attract EACTA (European Association of Cardiothoracic Anaesthesiology) accreditation for its fellowship programme.
- Southampton is the fastest growing cardiac centre in the last 15 years. In 2006, they had 800 Cardiac pulmonary bypasses and 230 paediatric cases, by 2018 they had 1400 adult cardiac pump cases and 430 paediatric cases. All balloon pumps come to them.
- They have had an upscale in beds, but this has not satisfied demand. They are currently running at 110% bed occupancy.
- They also purchased space at a private hospital nearby, and undertake about 30 cases a month. They assume this is more cost effective than expanding the unit further.
- They are increasing the workforce at junior level, they have a fellow programme promoted internationally and they usually have eight in post but have the funding for 12. It is an attractive education programme. It's very successful and is imperative for the unit to function. Drawbacks are the time it takes to recruit and clear the fellows with visas etc. to avoid the gaps.
- They would be interested in exploring recruiting MTIs.

- Between 8am-5pm they have 3 juniors, and there is 1 dedicated member of staff to facilitate discharge.
- Nursing wise, they are funded to 104, currently down by 15.78 WTE
- Able to recruit – shared service between Neuro/adult ICU. The European nurses leaving to go home are a concern.
- They do not have any access to a psychologist, and do not have a follow-up clinic.
- They do have high-level pharmacy input 5 days a week.
- If it was mandated to split Anaesthetics/ICU they would be unable to, they are not resourced for this.
- They have a second person on call, so they can relieve each other for fatigue etc.
- Mon-Fri they have a dedicated ICU consultant without any anaesthetic responsibilities.
- They have enough fellows so have not explored the ACCP route yet.

General Intensive Care Unit, University Hospital Southampton (UHS)

- 25 bed unit, 17 x Level 3 and 8 x Level 2 beds with the ability to flex if required
- Currently they have 16 consultants and one ACCP on the unit
- Current registered nurse? vacancies are at 15% with a turnover rate of 20% – bed pressures have been due to staffing shortages. They have a high turnover of staff; they obtain the experience in critical care then leave.
- Skype provision introduced in UHS to help facilitate international recruitment. They do not ask for detailed references for nurses anymore, only attendance records and formal warning status. The process is all handled centrally by HR. They recruit more based on attitude and behaviours. Therefore, they must be very careful with the questions asked at interview. On occasion, there have been large cultural differences that have been difficult to manage when they arrive on the unit. The poor IT infrastructure at the trust makes it difficult to organise interviews as they must work with a variable internet connection contacting people in very rural communities and there is only one computer that can support this in the hospital.
- From an academic perspective, they have the space to expand their research fellowships. NIHR has a large programme in Wessex. They have eight ACFs (Academic Clinical Fellows) that have been through/are currently going through the system in the region. Ad-hoc trust-based opportunities are more difficult to fund. They could tap into the local clinical research networks for advice.
- They struggle to recruit research nurses. Might be useful to explore offering secondments to improve retention.
- They have a special technician role at UHS that runs the renal replacement service, transfer services for PICU, bronchoscopies and is trained in retrieval. They even drive the ambulances for PICU referrals, which has greatly improved the PICU service. The technicians are invaluable. It would take ICU over an hour to take patients for a CT scan, but they can do it within 20 minutes.

Neuro Intensive Care Unit (NICU), University Hospital Southampton

- Unit capacity is 13 beds, that's 11 Level 3 and 2 Level 2 beds
- For the last 3 months, they have been at full occupancy, which is not sustainable.
- Structurally the ability to expand is very limited.
- The junior tier is made up of post F2 fellows. They have two fully-trained ACCPs and two in training, and are looking to add a further two into training soon.
- They currently have an ICM trainee with them doing a special skills year.
- Consultant recruitment is an issue. They have 10 consultants on the rota, and a 1 in 5 on call. At the weekend, one consultant covers days and one nights.

- They have pharmacy input, but a business case is needed for a dedicated pharmacist.
- Psychology is hugely important; violence against staff is prevalent and effects recruitment retention. They had a trial post that went well.
- Rehabilitation – Physiotherapy is needed and could help with improving discharge as delayed discharge is an issue.
- Repatriation is a problem as they do take people purely for investigation.
- They do not have a follow-up clinic currently, there may not be a need for it.
- Referring rights are firmly theirs; they want to open communication to regional units.
- Nurse recruitment is not too bad now, they have a moveable workforce though, and a significant portion of European nurses who are brilliant.

General

Nurses

There are shortages in every single job role, more time needs to be spent addressing how to get more people into training e.g. nurses and pharmacists etc., there are not enough people coming through. All professions are taking from the same pot. ICM nursing seems to be more junior than ever. There are lots of vacancies that means people move around a lot more. They are not staying because agency roles attract a higher salary. There are highly skilled ICU nurses at the Band 5 Level compared to ward nurses at Bands 6 and 7.

Bournemouth and Poole have started an apprenticeship where nurses can work in their home ward then do an Open University (OU) course but they are not able to backfill for their roles so it is cost intensive. However, if they successfully complete the OU course they are guaranteed a job at the start of their training. There is no stipulation that they must work in the region for a certain length of time after completion of their training though, so once trained they may choose to move on.

Overseas nurses are doing their ICU courses as distance learning from their home countries. More funding needs to be allocated to training critical care nurses.

Allied Health professionals (AHPs)

Most units in the region are struggling with the provision of some or all of the following: physiotherapists, psychologists and pharmacists. Some physiotherapists are funded by critical care, but others are trust funded, and the budget for these roles has been pulled away for other specialties. Allocation of funding has a huge impact on the service provision.

50% of pharmacists are not even at Foundation Level. The region is definitely not meeting the service level requirements in GPICSv2 and D05 for Pharmacy and Speech and Language Therapists (SALTs) across the region.

ACCPs

It is always a balance between service provision and training time. There are now several ACCPs in the region that are a great resource but there are some understandable concerns for whether the career is sustainable if their work patterns include an intense rota that is predominantly to support clinical service delivery. Considerable thought needs to be put to long term work plans and career progression so as to limit the risk of burnout of the Advanced Clinical Practitioner (ACP) workforce; some ACCPs may well already be at risk.

Sharing information on ACCP career progression needs further thought. It is mentioned in the ACCP resources online with a career framework explained https://www.ficm.ac.uk/accps/cpd-and-appraisal but there was the suggestion that further details on how to manage this in practice would be useful. A clear progression pathway for ACCPs is vital to help mitigate against attrition in the future. It was acknowledged that job descriptions and pay banding vary across hospitals nationally.

Training in the region

The trainee representative advised the group that there is good morale amongst the trainees following the attrition spike from 18 months ago, which saw 4 trainees leave the programme in 12 months. The trainee group has worked hard on this.

The spread of trainees is broadening. Meeting the training demands of this broad group is becoming more of a challenge. The competing interests of different groups needs attention, as they have different objectives. It is not clearly defined where the trainees are heading in the future but appointments post CCT are currently good within the region.

A suggestion was made that Stage 3 trainees could attend a District General Hospital for a 3-month period where they can act up as a consultant with supervision. This would allow them to experience the DGH environment and hopefully entice trainees to apply for DGH jobs once trained. This would be a flexible offer as it may not be of interest to everyone.

Portsmouth and Guildford have funded a post-CCT Fellow post. It is an expensive way of plugging the workforce gap as you must pay for a full-time post for only 30% or less clinical time. However, a number of people want to work somewhere first before they get their consultant job. This way, they get to try it for a year before they commit. The model has worked in other hospitals, so it is worth trying to emulate.

Consultant appointments

Just as training needs for a broad group of trainee intensivists requires attention and planning, so too does the future employment of non-anaesthetic intensivists. Units need to prepare and plan for this, most could handle one but not a steady stream in their workforce currently.

Winchester have employed a non-anaesthetic intensivist and it has been a huge success. Initially the job planning and contract work was stressful for the applicant, but it has been a great appointment, with the whole team benefiting. Robust job planning needs further thought and attention though, as at first, they struggled to define the role. This was made easier by the pro-active nature of the applicant on this occasion, but plans need to be put in place to make this recruitment easy and smooth in the future for all parties.

Existing teams need to consider their mind-set, do they really need to appoint Dual Anaesthetic applicants? It is not being reflected in the job advertisements being released. The Regional Advisor Matt Williams, advised that RAs could review and approve job plan/adverts and it is in a department's interest to seek out and use that service. Foundation Trusts do not have to do this but it's available if required. An easy approach would be to advertise for Intensivists, with a note to say Dual applicants are welcome to apply. However, the smaller units need to be able to accommodate the Dual element, which could be Acute Medicine, Renal, Respiratory or Emergency Medicine and they may struggle with this.

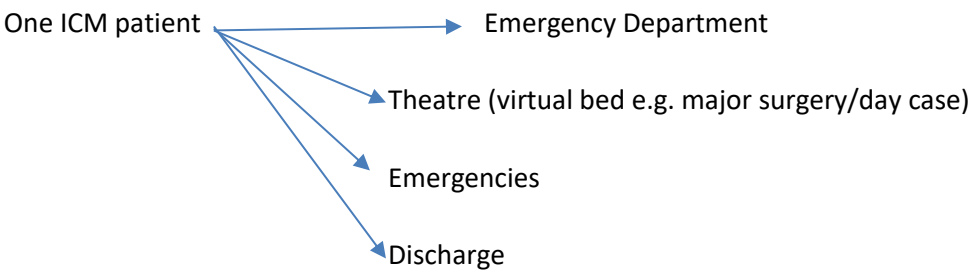
For the last 2 years, Portsmouth have not successfully filled an empty consultant post. Consideration is needed on how to make it attractive again. Is ICM a long-term, fulfilling and sustainable career or is there still an image surrounding it that means it looks like it is not sustainable, especially for the remainder of people's medical careers? Capacity and service rationing issues were one of the least appealing aspects for some. If the bed capacity issue can be addressed, it would help improve matters.

The region should be promoting single ICM. It is very difficult to go into academia/research or medical management if you are a dual. It should not be seen as a failure to drop a specialty, either in training or as a consultant, it is a positive move for some, depending on your career plans and this should be promoted.

Capacity/rationing

Capacity is an issue for many of the units in the region. University Hospital Southampton has a very low percentage of elective cases, 70% of its workload are emergencies. Trust capacity is going to be an issue over the next few years. Staff are being asked to prioritise who goes ahead and who does not as the unit is constantly short of beds. It seems to be an integral part of the job, a daily issue in having to reject patients that would benefit from a stay in ICU due to capacity.

Capacity is being managed by the effective and excellent outreach service propping up the ICU. Nurses that have left ICU have been retained in the outreach service which is run by the junior doctor tier in the hospital. Senior nurses in outreach are Band 7s or 8a's.



They are all competing for one bed – trusts need to look at patient flow and try and prevent blockages.

Poole's main problem is discharge/getting patients out of critical care. Most of their activity is emergencies too. They are an outlier for cutting beds and forward flow out of critical care.

Some units have 12 bed spaces but are only funded for 8. Other units will not have free bed space or the staff to look after the patients even if they do have the beds.

CICU Southampton can see 8-10 patients per day. They had a period a while ago where consultants were waiting till 1am to find an ICU bed for the patients but now it is not an issue so beds must have come from somewhere else. However, the cardiac unit makes money, so it is more difficult to refuse their requests. The duty matron and bed manager are engaged, the unit is aware they are somewhat protected against this as they are an income generator.

Outreach services

Outreach services are completely different in every trust. With a 24/7 outreach service you are more confident in doing what would have otherwise been a slightly risky discharge, it mitigates against capacity issues and can help facilitate discussions about who should not come to the ICU. In some units, outreach is funded by critical care but in others it is funded differently. The argument needs to be made it is a short term hit for a long-term gain.

IT

If IT support is subpar it can negatively impact nursing time and recruitment as it can take hours out of their day which could have been spent on the unit/with patients.

GPICS, D05 and service specification gaps

In general, Wessex is compliant with the regulations but there are areas where it falls down, such as psychology input on the units for patients and staff. At University Hospital Southampton, they

ran a pilot follow-up service of psychologists for a year, the remit was too large perhaps as it was to cover staff, relatives and the outreach service and the funding has since been pulled. Schemes must prove their worth with evidence first rather than it just being a great idea, which can be quite frustrating.

The region also falls down on the 4 hour post-op pharmacy input. There is a general lack of pharmacy input and lack of training for pharmacists.

90% of units in the region would fulfil the standard that states 'consultants should always be involved with decision to admit patients to critical care'.

The remote unit on the Isle of Wight (IoW) does not have a separate/split rota. They do have dedicated intensivists during the week but not out of hours cover. They have the ability to contact consultant intensivists if an anaesthetist is covering the role. It is extremely difficult to get dedicated intensivists for out of hours cover there.

CQC

Several units have used the CQC recommendations to the benefit of their services. They reiterated the importance of the GPICS standards to the review team and highlighted gaps/what was needed in order to meet them. They then appeared in the CQC report as recommendations for the trust. ICUs are not income generators for trusts per se, so they have to get leverage for service developments in other ways.

It is extremely beneficial for clinicians to go to management meetings to argue the case effectively for extra posts/service provision in order to get the message across, as often the panel do not fully understand the importance of what is being asked for.

Education

The funding budget to support ICU courses for nurses has gone down significantly, while the course fees have increased. The money available just does not go anywhere now, the Medical workforce cannot be effectively supported and trained on such a small budget. Hospital Sterilisation and Disinfection Unit (HSDU)/Anaesthesia/Theatres/ICU all get a £25k pot for around 700 peoples' training needs. The money that came from the HEE budget used to be £60k for this.

5. MAPPING THE FUTURE

As with Section 4, the information below was generated as part of the discussions regarding the future of critical care services in the Wessex region. The attendees were asked to consider different models based on the short-term future (5-10 years):

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

The comments below reflect these discussions and the opinions of those who took part.

Dorchester

- There has been a Dorset review, which suggested that the west side should stay as they are. Although they know they are going to grow, there is no extra funding for expansion. They plan to submit a business case for redevelopment for a new build 24 bed unit, with a staggered implementation, so in 5 years' time they will have 12 beds, then 18 and then reaching 24 over the course of a decade. The staggered expansion is planned to assist but staffing increases will be required.
- What to do with the workforce while waiting to reach the critical number? For example, with ACCPs, they would need four to complete a rota but do not have the capacity and funding to go from none to four in one go. What do units do with the smaller numbers as the group grows?
- They do not have a patient IT system. They know of three separate companies being used in the region so there is no standardisation to assist their decision of who to go with. Digital improvements will certainly help, and it seems something will appear with a new build.
- Nursing recruitment is an issue; they estimate it will take 5 years to recruit the full complement of nurses for the first phase of 12 beds.
- A new build would force them to split the rota, which causes some concern, as it is a very harmonious team at the moment.
- They face the difficulty of only serving a quarter of the regional population but over a large area.

North Hampshire Hospital, Basingstoke

- The trust merged with Winchester in 2012 and has ICUs on both sites.
- The development of the critical care units will depend on any service reconfigurations across the trust. Hampshire Hospital Foundation Trust is to be included in the NHS Health Infrastructure plan for redevelopment of estates, which may result in a new hospital building and site. Trust planning must be cohesive with the wider healthcare community and other local providers
- They need to increase the current consultant out of hours cover to meet GPICS standards, as they are expanding the Unit to 18 beds. Currently, they have one consultant on call at evenings and weekends for 16 beds. They may have to look at split on calls at the weekends to make the workload more palatable, and enhance patient safety once the two new beds come online.
- They are currently recruiting a further ICU Consultant to support this, further posts may be required.
- They would support decentralisation of ICU training posts across the Wessex region and would welcome advanced trainees in ICM to Basingstoke.
- Further ACCP training posts are desirable.

Bournemouth/Poole

- The two trusts are planned to merge in October 2020.
- The reconfiguration of services will result in all the ICU provision moving to Bournemouth.
- A 12-bed unit (funded for 11 beds) will become a 30-bed unit with 26 beds commissioned.
- A significant number of critical care nurses (20 extra WTEs nurses required) will need to be found, even on the assumption that everyone will want to move.
- There is lots of uncertainty, mainly in the provision of nurses, and they do not know where the extra are going to come from. It will be an exciting place to work though, so should attract interest but that may be to the detriment of other units.
- There is a whole work stream on transport and the ICU teams are involved in its development.
- They have not started the build yet – they have a joint shadow board that will carry on with the two ICUs then will think about the build later. They have designed the new building but have not obtained planning permission yet. The plans are 1:50 scale. Many of the hospital services are dependent on critical care and critical care is dependent on many other services. The new larger ICU is planned to be built by July 2023. At the moment, there are only plans for a PACU to be based at Poole with no critical care cover. Medical cover at night will be ward-based cover.
- Will there be a knock-on effect at Dorchester? It is part of the Clinical Services Reconfiguration, but the existing provision of services is not planned to change. The plan is to make Poole a purely elective site (cold site). Anaesthetic cover is deemed too expensive to provide a full Level 2 service.
- The Poole and Bournemouth sites are 6 miles apart but in the summer tourist season it will take over an hour by car to get between the two sites for staff.
- They currently have 5 consultants – need 2-3 more for the expanded unit assuming the 5 they already have will want to make the move. They may need even more.

Portsmouth

- There are not any current plans for expansion. They did have plans for a respiratory high care unit but numbers have plateaued. It will eventually happen though. It will be located next to the two current ICU pods for the units to expand into. There will be 24 visible beds, with 19 Level 3 beds, so it would still have room to expand.
- There is not enough non-medical staff to support activities.
- Violence/aggression from patients is a problem and is causing staff attrition.
- They can see a more flexible/multi-professional group in the future. There is currently 1 nurse for Level 3 and 1 nurse for two Level 2 patients, they are likely to have to move away from this model.
- Budgets are disappearing for network training for ICU nurses.
- They are on their third generation of Clinical Information System (CIS) system.
- 20% of the unit has single side rooms, a few units have the rooms but there is not enough and many are not fit for purpose.
- They are aiming to have 10 ACCPs. They currently have around five (three trained and three about to qualify) but not all of them might stay longer term.
- Nursing numbers are OK, in fact a little bit over. They have a couple of nurses retiring but have cover back from different teams.

- Enhanced Care areas – Respiratory High Care, Surgical High Care. There is talk about having a PACU, Medical High Care and Gastro High Care areas but it is not clear who is going to staff them.

Royal Bournemouth Hospital

- Royal Bournemouth has merged at an executive level with Poole and it is estimated that by 2023 they will have a combined 30 bed unit, based at the Bournemouth site. Poole would become purely elective.
- The IT services being discussed are exciting but there is a real fear that staff will not want to make the move.
- They really want to attract senior trainees but need to ensure they have the training provisions.
- They will continue to face nursing and medical staffing issues, as they have a transitional workforce, middle grades are primarily made up of those wanting to get back into training. The goal is to have 2 airway tiers at night.
- Funding is in place for the above, but discussions have stalled.
- They have a Lung Unit in a bay on the respiratory ward which staff rotate through.
- On the gastroenterology ward they have a 4-bed bay for monitoring sicker patients.
- The ICU team is involved in all the nursing education for the enhanced care areas.

Royal Hampshire County Hospital, Winchester

- In a trust with Basingstoke but geographically they are far apart, roughly 25 miles. Scarred by the promise of a new build that did not materialize. A lot of effort and work went into the planning.
- Centralisation of some services is imminent as of 06 December 2019, just as they enter winter pressures season. Complaints are expected from Eastleigh residents as they come under Winchester's catchment but if it is a trauma case this will now be moved to Basingstoke, rather than Southampton, which is only 4 miles away from them. These plans do not have universal clinical support and have been implemented based on an external recommendation. Consultation was carried out after the decision was made.
- The distance between the sites affects the ability and willingness of staff to do on call across both sites.
- They do have some engagement with service provision discussions and changes.
- They experience peaks and troughs of emergency demand; they have a very low numbers of elective cases that makes it hard to predict requirements.

St Mary's Hospital, Isle of Wight

- Due to this unit's remote location it is always under review, they are geographically distant, and they do sometimes struggle.
- There has been a review of the surgical services and they are trying to rationalise the types of patients having surgery there. If they are going to be complex, then they are transferred to Portsmouth or Southampton.
- The Emergency Department will always have to exist there due to the winter and summer population flux. 70% of their admissions are medical so they will have to have some form of Intensive Care provision.
- A telephone advice avenue would reduce inappropriate admissions to ICU and a business case for a Clinical Information system (CIS) is due to be produced.

Cardiac Intensive Care Unit (CICU), University Hospital Southampton

- They have up to 15 Level 3 beds with an additional 20 level 2 beds in the neighbouring cardiac HDU – they operate aa 2-3 fast track PACU model and have a degree of flexibility for stepping up\down. This has been in place for 10 years and works well.
- They had expansion between 2006-2010 so no further expansion is currently required.
- They have been approached by the Cardiac HDU concerning a takeover but have so far declined.
- There is scope to expand space wise, but the need just is not there at present, and this would also come with increased workforce pressures.
- Good IT systems are in place, remote access is available to assist staff when off site, this helps with the decision of whether to go in, and junior staff take comfort in this system too.
- They have now had two years without an Advanced Anaesthetics trainee. They do not currently have ACCPs, but this is something they would like to investigate further.
- They run a successful European Association Cardio Thoracic Anaesthetist programme (EACTA) – which is well attended and received.
- They have not split the rotas in the cardiac units so would need to do that to be GPICS compliant but would need double the amount of consultants to do this and it would mean double the amount of on calls, so it would stretch the workforce.
- The cardiac unit has 4 retirements in the next few years, but they have been good at forward planning and have boosted numbers to try and get people to stay.

General Intensive Care Unit, University Hospital Southampton (UHS)

- They are building more beds in the general ICU that is currently housed in a building from the 1960's, which is not a great environment for patients.
- A 25-bed mixed Level 2 and 3 unit will increase to 32 beds, but the extra beds have not been commissioned yet.
- There is also a 10-bedded surgical HDU.
- Currently they are 16 WTE nurses down on what they need to operate the unit safely. They need to recruit 184.1 WTE in total from the existing 132 WTE staff.
- When they open the unit there will be a lot of redundancy initially, the jobs will come after the beds have been opened. The build should be ready in 2021/22.
- They will need 4-6 ICM consultants if the extra beds are commissioned. There are currently at least three projected retirements, so we are likely to need 7-9 new consultants in the next few years.

Neuro Intensive Care Unit (NICU), University Hospital Southampton

- They need to extend by 3 or 4 beds and recruit 6 consultants to cover impending retirements
- Interest in neuro ICM is not common; they need to get people interested. Stage 2 trainees do go there but this is for a short time and ultimately the programme is training general intensivists.
- They have discussed the possibility of creating a job plan that bridges adult ICM and Neuro, which has not been done yet and further training would be needed on both sides.
- They could consider a hybrid version in the meantime but are concerned it would not address the problem. They would be interested in exploring this further but are not sure the individuals are there who would want this role. Single ICM CCT'ers could fulfil this and ACCPs would be a huge benefit.

- Although GPICS suggests split rotas, there is a rider for specialist and smaller units.

General

Deficient mental health provision for staff and patients

The region has noticed a significant increase in the number of mental health patients being sent to ICUs. There have been a lot of volatile patients, with lots of violence and aggression on units that is not good for the staff or the other patients. The clinical training of nurses needs to be improved to help them manage these patients more effectively e.g. RMN ethics module. Level 2 patients are a lot more work than Level 3 patients, there isn't often a ward bed for them and then the ICU becomes the de facto safest place for them to be. Links with the liaison psychiatry service have massively reduced. It is hard to get a mental health review for patients while they are in ICU as they are not seen as a priority as they are already deemed to be in a safe place. There has been an increased demand from mental health patients on critical care provision in Wessex; it is currently at least a fifth of the workload. Staff need to be protected and supported as these patients can have a significant impact on the unit.

NHS England Paediatric Surgical Review

The NHS England Paediatric Critical Care and Surgery in Children Review will also have an impact on the region. The 24/7 retrieval service is excellent from the Southampton and Oxford Retrieval and Transfer Team (SORT), which covers Thames Valley and Wessex, ambulances even go so far as Milton Keynes and Plymouth. It can also be used to repatriate patients to their hospital after a stay in ICU/HDU. In Portsmouth, there is always a paediatric nurse available for retrieval on every shift. Some units will not take paediatric patients at all, so they will be held in recovery or the Emergency Department (ED). Some units will take them and hold them for transfer. There is huge variation across the region. There is talk of Portsmouth becoming a Level 2 unit in the NHSE Paeds Review. If this is the case, then they will need an additional paediatric nurse and another consultant to facilitate this. There is going to be a potential increase in demand on services in the region with respect to the transition of paediatric patients to adult critical care e.g. for Long Term Ventilation (LTV) for these cohort of patients.

Palliative Care

There is a burgeoning need for palliative care. UHS has gone from 10 referrals to 150 referrals per year (2-3 patients per week). Funding needs to be given to provide palliative care dedicated to critical care time. There is an increasing interest in what palliative care can do for patients in ICUs. ICM needs to invest the time developing skills in this area – perhaps by providing dual training via ICM and palliative care fellowships. Guildford have started advertising for a senior fellowship, welcoming open applications for palliative care consultants with an interest in critical care. The new unit in Southampton will include an open palliative care suite – which might be something to consider for GPICS v3. There is the need to integrate palliative care services into critical care rather than it being an ad hoc referral service.

Trainees

Basingstoke would love to be able to have Stage 2 trainees, and in turn this may decrease pressure on Southampton. There is capacity in Portsmouth for them too. The new cohort of Internal Medicine Training (IMT) trainees that are now mandated to spend time on the ICU, presents an opportunity to start re-educating medical specialties in how to recognise the deteriorating patient.

Surgical/Medical HDUs

Surgical/Medical HDUs have been proposed in the region. This should ease the pressure on critical care, but the proposals also make staff anxious about who is best to look after these patients. Specifically, not Critical Care staff, good protocols and nursing will be required.

6. PROBLEMS AND SOLUTIONS

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

6.1 PROBLEMS

6.1.2 Staffing Shortages

It is important to stress that not all units were experiencing staffing issues in terms of current numbers and recruitment across all of the groups below. However, most did express issues in at least one area and also recognised that future plans for retirements, mergers and expansions may well influence current stability.

(i) **Consultants**

Most units reported being in a good position with consultant numbers matching current requirements. However, a couple of units were struggling to fill empty consultant posts, which would force them to run the recruitment advert/round a second time. Any extended time without a full quota of consultants is keenly felt by those on the unit. For future consideration, several of the units are aware of potential mergers and expansions on the horizon and there are concerns over what this might mean for the current workforce. In the case of an expanding unit like University Hospital Southampton, they are projecting a requirement of 4-6 new consultants to facilitate the move to a 32 bedded unit, however when coupled with impending retirements this could increase to 7-9 consultants required in quick succession. Poole and Bournemouth are aware of a possible merger between the sites in the near future that would see services move from Poole to Bournemouth. There are concerns that those approaching retirement will decide to leave at this transition point, which could mean 5-6 vacancies across the two sites at once. These are obviously large recruitment drives to undertake and appropriate planning is essential.

(ii) **Nurses**

Although Portsmouth seemed to be in a good position with respect to nursing numbers and recruitment, nursing provision is an issue throughout the UK, especially with the uncertainty of Brexit. European nurses are choosing to move on, and this has been felt in the Wessex region too within the last year or so. Whilst non-European nurses are joining the workforce successfully, they can be quite junior so for the time being at least it feels as if many experienced nurses have left at once. The numbers of nurses in training is also worryingly low, so forward planning shows there will still be issues.

(iii) **ACCPs**

ACCPs have now been a feature within the ICU's of some of the regions Hospitals for several years, whilst this is great news for the ICU workforce, ACCPs need to be considered and looked after as a group moving forward. There are some understandable concerns for whether the career is sustainable if their work patterns

include an intense rota, that is predominantly to support clinical service delivery. Considerable thought needs to be put to long term work plans and career progression so as to limit the risk of burnout of the Advanced Clinical Practitioner (ACP) workforce; some ACCPs may well already be at risk.

Sharing information on ACCP career progression needs further thought. It is mentioned in the ACCP resources online with a career framework explained https://www.ficm.ac.uk/accps/cpd-and-appraisal but there was the suggestion that further details on how to manage this in practice would be useful. This will be fed back to the FICM ACCP sub-committee for further thought.

(iv) AHPs

All the units involved in the discussions on the day, were experiencing problems with the provision of some or all of the following AHP roles; Pharmacists, Physiotherapists and Psychologists.

These roles are crucial to support the effective running of an ICU unit. These roles support and complete a journey through Intensive Care, helping patients to recover and come to terms with their circumstances.

It is also worth mentioning here that psychological support is not only important for patients but increasingly this service should be available to staff working in Intensive Care Units. Instances of aggression from patients towards staff appear to be increasing in some of the units. Staff security and wellbeing is of paramount importance and having appropriate support services in place to not only limit these occurrences, but also to support staff in the aftermath should be a top priority for hospital management.

(v) Trainees

The trainee representatives in the region have worked hard to increase morale amongst the trainees after the attrition spike of 2018. Trainees leave the ICM training programme for many different reasons and early indications suggest that this particular year was an outlier for the region. Morale amongst the trainees is now reported to be good. The representative was keen to stress that forward planning is key to helping the trainee group, with their broad histories and future training needs, feel secure and that their needs are being addressed with the planned training path. This individual training path is recognised as being hard work for the TPD and RA to keep on top of in each region. Despite healthy recruitment statistics of trainees completing their ICM training in the region, concerns have also been raised about the destination of the current cohort of trainees once they complete their training, particularly the Single ICM trainees. Forward planning and publication of the successful appointments post training may help to alleviate these concerns.

6.1.3 IT

While some units were happy with their IT systems, there were also several units that felt the IT systems in place were not supporting their work effectively. Ways of working are changing, and staff feel that the IT systems are not keeping up with this pace of change. This was particularly evident when the group were discussing new modern ways of carrying out long distance interviews and

recruitment and the restrictions and issues they encountered whilst doing this. Many also expressed concern for the nurses using the systems throughout the day, current issues are making simple tasks hard and taking away crucial time on the ward. IT infrastructure needs to complement the daily activities of the workforce, easing burden not creating it.

6.2 SOLUTIONS

6.2.1 Staffing

Many of the issues felt within the region came down to workforce pressures, however, units are coming up with inventive ways to ease these pressures. Whilst one unit's solution may not be the perfect fit for another it is important to have good communication between the units so they can all learn from each other and devise their own suitable solutions.

For example, Portsmouth and Guildford have funded a post-CCT Fellow post, whilst it is an expensive way of plugging workforce gaps, as you have to pay for a full-time post for a smaller % of clinical time, it could work in other units too. There are a group of people who want to work somewhere first before they get their consultant job. This way they get to try it for a year before they commit. The model has worked in other hospitals, so it is worth trying to emulate it.

(i) ACCPs

As identified in the problems section, career progression needs further thought amongst those offering ACCP roles. Forward planning for individuals in this role is crucial and the region has raised an important point for the FICM ACCP Sub-Committee to consider in terms of guidance. Through open discussions on the day, it also became apparent that not all of the units were administering the ACCP roles in the same way, which may inadvertently affect their ability to retain ACCPs on certain units. Good communication between units in the region should help to iron out this difference if desired. There was a genuine desire to look after ACCPs working within the region as they have proved themselves to be of huge benefit to the Intensive Care team.

(ii) Trainees

Trainers at some of the District General Hospitals within the region expressed an interest in offering rotations for Stage 3 trainees. Giving them the opportunity to experience a DGH whilst acting up as a consultant, with supervision. The trainees present supported this idea but were mindful that it might not appeal to all trainees so it would work best as an optional placement. Even if trainees only attended for 3 months, this exposure could entice them to apply for posts at DGHs in the future. The units interested in offering Stage 3 training should discuss the approval process further with their Regional Advisor.

(iii) Consultants

Through the open discussions the group were challenged to consider how they approach consultant job adverts, with the default setting being a preference for recruiting dual trained ICM consultants with Anaesthesia. Whilst in some cases this may be entirely appropriate for the hospital's requirements, is it always the case? Could a single ICM CCT holder work or a dual trained consultant with another specialty, such as renal or respiratory be a good fit? Winchester shared a good example of how this has worked for them with the employment of an ICM and Renal

Consultant. They also shared some lessons learnt for the future about job planning and preparation for a new role.

(iv) AHPs

The provision of various AHP roles was undoubtedly a problem within the region, and the group floated the suggestion of pan-Wessex roles to address this. Although this would need more investigation to determine the details of how this could work in practice e.g. how the time could be fairly and realistically distributed, it would certainly be worth exploring to increase the support for units when it comes to physio and psychology services in particular.

(v) IMGs

The GMC has identified International Medical Graduates (IMGs) as the biggest growth area for doctors in the immediate future. With this in mind, units would do well to prepare for IMGs working on their unit and look into how best to support them with their careers. Southampton is preparing for this by running a dedicated CESR Assistance programme that aims to help with CESR applications whilst the individual completes placements on the unit. The faculty too are focusing on this area within its Careers, Recruitment and Workforce Committee, with the aim of providing advice and guidance for IMGs and those supporting them in the workplace.

6.2.2 CQC and GPICS

The discussions showed that several units have used CQC recommendations to the benefit of their services. During CQC visits, staff were able to stress the importance of the GPICS Standards for Critical Care so that review teams could see areas that needed improvement and make recommendations accordingly in their final reports.

6.2.3 Successes in the region

Throughout the day it became clear that there is fantastic collaboration and open communication between units. There is also a willingness to share best practice and mistakes to avoid others repeating them. In the immediate future, individuals could liaise and help each other write business cases etc. drawing on previous experience.

The region shows lots of creativity when approaching workforce issues and success should be celebrated and shared. The special technician role at the University Hospital Southampton (UHS), is a good example of a support role that has directly impacted the working day of the ICU staff, assisting them and taking away some time-consuming tasks. The Cardiac Unit at UHS has also set up an incredibly popular EACTA accredited fellowship programme. It is the only UK unit to achieve this, which is a huge achievement. Whilst there are obstacles to work with, such as some longer recruitment times whilst sorting visas etc. the programme is in demand and helps the unit address workforce issues at the same time.

These success stories may not be appropriate or possible to apply to all units but sharing the details and the learning involved in their implementation can assist units in finding their own workable solutions.

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.

HOSPITAL	CONSULTANTS		SAS Grade		ACCPs		NURSES	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
North Hampshire Hospital, Basingstoke	12	13	5	5	4	5	58	60
Poole Hospital	6	7	4	3	0	0	55	55
Portsmouth Hospitals NHS Trust	16	16	0	0	8.5*	10*	139	147
Royal Bournemouth Hospital	8	-	7	-	0	-	50	-
Royal Hampshire County Hospital	8	8	0	0	0	0	-	-
Salisbury Hospital (Radnor ITU/HDU)	7	-	2	-	-	-	60	-
St Mary's Hospital, Isle of Wight	6	-	6	-	0	-	55	-
University Hospital Southampton (Cardiac ICU)	14	14	5	5	0	0	104	104
University Hospital Southampton (General ICU)	16	22	3	4	1	4	148	-
University Hospital Southampton (Neuro ICU)	10	-	0	-	3*	-	83	-

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.

HOSPITAL	CONSULTANTS		SAS Grade		ACCPs		NURSES	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
North Hampshire Hospital, Basingstoke	5	5.5 or above	1.5	1.5	4	5	66.58	68.5
Poole Hospital	6	7	3	6	0	0	52	55
Portsmouth Hospitals NHS Trust	15.3	16	0	0	8.5*	10*	125.5	133.5
Royal Bournemouth Hospital	8	-	6	-	0	-	48.7	-
Royal Hampshire County Hospital	8	8	0	0	0	0	30	30
Salisbury Hospital (Radnor ITU/HDU	-	-	-	-	-	-	50.66	-
St Mary's Hospital, Isle of Wight	6	-	8	-	0	-	43.73	-
University Hospital Southampton (Cardiac ICU)	13.5	13.5	5	5	0	0	104.82	104.82
University Hospital Southampton (General ICU)	16	22	3	4	0.7	4	132.1	184.1
University Hospital Southampton (Neuro ICU)	9.6	-	0	-	3	-	74.88	-

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 the table indicate that the information was not available or not provided.

HOSPITAL	Foundation		Core		Higher		Non Training Posts		Total	
	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE	NOW	FUTURE
North Hampshire Hospital, Basingstoke	3	3	12	12	3	5	0	2	18	22
Poole Hospital	0	0	8	8	0	0	0	0	8	8
Portsmouth Hospitals NHS Trust	3	3	8	8	9	9	3	1-3	20	20
Royal Bournemouth Hospital	2	-	1	-	1	-	0	-	4	-
Royal Hampshire County Hospital	2	2	1-2	1-2	0	0	1-2	1-2	5	5
Salisbury Hospital (Radnor ITU/HDU)	-	-	-	-	-	-	-	-	-	-
St Mary's Hospital, Isle of Wight	1	-	0	-	0	-	0	-	1	-
University Hospital Southampton (Cardiac ICU)	0	0	0	0	3-5	3.5	8-12	8-12	3-5	3-5
University Hospital Southampton (General ICU)	4	4	5	4	7	11	10	11	26	30
University Hospital Southampton (Neuro ICU)	0	-	0	-	-	-	13	-	1	-

* The - within the tables indicate that the information was not available or not provided.
* Including trainees

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
North Hampshire Hospital, Basingstoke			
WTE for Consultants	5	5.5 or above	Increase
WTE for SAS/Staff grades	1.5	1.5	Remain the same
WTE for ACCPs	4	5	Increase
WTE for Nurses	66.58	68.5	Increase
Number of trainees	18	22	Increase
Poole Hospital			
WTE for Consultants	6	7	Increase
WTE for SAS/Staff grades	3	6	Increase
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	52	55	Increase
Number of trainees	8	8	Remains the same
Portsmouth Hospitals NHS Trust			
WTE for Consultants	15.3	16	Increase
WTE for SAS/Staff grades	0	0	Remains the same
WTE for ACCPs	8.5	10	Increase
WTE for Nurses	125.5	133.5	Increase
Number of trainees	20	20	Remains the same
Royal Bournemouth Hospital			
WTE for Consultants	8	No data	-
WTE for SAS/Staff grades	6	No data	-
WTE for ACCPs	0	No data	-
WTE for Nurses	48.7	No data	-
Number of trainees	4	No data	-
Royal Hampshire County Hospital			
WTE for Consultants	8	8	Remains the same
WTE for SAS/Staff grades	0	0	Remains the same
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	30	30	Remains the same
Number of trainees	5	5	Remains the same
Salisbury Hospital			
WTE for Consultants	No data	No data	-
WTE for SAS/Staff grades	No data	No data	-
WTE for ACCPs	No data	No data	-
WTE for Nurses	50.66	No data	-
Number of trainees	No data	No data	-

St Mary's Hospital, Isle of Wight			
WTE for Consultants	6	No data	-
WTE for SAS/Staff Grades	8	No data	-
WTE for ACCPs	0	No data	-
WTE for Nurses	43.73	No data	-
Number of trainees	1	No data	-
University Hospital Southampton (Cardiac ICU)			
WTE for Consultants	13.5	13.5	Remains the same
WTE for SAS/Staff Grades	5	5	Remains the same
WTE for ACCPs	0	0	Remains the same
WTE for Nurses	104.82	104.82	Remains the same
Number of trainees	3-5	3-5	Remains the same
University Hospital Southampton (General ICU)			
WTE for Consultants	16	22	Increase
WTE for SAS/Staff grades	3	4	Increase
WTE for ACCPs	0.7	4	Increase
WTE for Nurses	132.1	184.1	Increase
Number of trainees	26	30	Increase
University Hospital Southampton (Neuro ICU)			
WTE for Consultants	9.6	No data	-
WTE for SAS/Staff grades	0	No data	-
WTE for ACCPs	3	No data	-
WTE for Nurses	74.88	No data	-
Number of trainees	1	No data	-

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. In 2018, Wessex enjoyed a good fill rate, filling 7 of the 8 posts offered at National Recruitment. However, their 2019 recruitment showed a decline in the fill rate with only 5 of the 8 posts offered being filled. 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.

	2018 training post to population	**2019 training post to population**
1	KSS (1,465,438)	KSS (879,263)
2	East of England (850,596)	West Midlands (810,673)
3	West Midlands (810,673)	East of England (744,271)
4	East Midlands (656,961)	Northern (587,453)
5	Wales (513,735)	East Midlands (459,873)
6	Thames Valley (463,260)	**Wessex (394,978)**
7	**Wessex (451,403)**	Wales (385,302)
8	Scotland (443,975)	Scotland (355,180)
9	Yorkshire and Humber (437,316)	Yorkshire & Humber (349,853)
10	Northern (419,609)	South West (305,697)
11	Northern Ireland (365,945)	London (283,122)
12	South West (305,697)	North West (264,091)
13	North Western (264,091)	Northern Ireland (261,389)
14	London (242,676)	Thames Valley (231,630)

APPENDIX 1: LIST OF ATTENDEES

ICU/Organisation	Name
Portsmouth Hospital, Senior Matron	Caroline Cawkill
GICU, University Hospital Southampton, Faculty Tutor	Rob Chambers
Dorchester Hospital, Faculty Tutor	Duncan Chambler
Bournemouth Hospital, Faculty Tutor	Nigel Chee
Portsmouth Hospital, ACCP	Stuart Cox
CICU, University Hospital Southampton	Andy Curry
Bournemouth Hospital, Senior Matron	Ruth Dodgson
University Hospital Southampton, CRN Lead	Mark Edwards
Poole Hospital, Senior Matron	David Gooby
Network Nursing Lead	Gillian Leaver
Portsmouth Hospital, Senior Sister and Clinical Educator	Sara Lilly
Network Medical Lead	Kathy Nolan
ICM Wessex Deanery, Programme Lead	Anna Parsons
Basingstoke Hospital, Faculty Tutor	Richard Partridge
Portsmouth Hospital, Faculty Tutor	Helen Peet
Isle of Wight Hospital, Clinical Lead	Muriel Prager
Portsmouth Hospital	Jonarthan Thevanaygam
NICU, University Hospital Southampton	Benjamin Thomas
ICM Trainee Representative	Liz Webb
ICM Trainee Representative	Francois Wessels
Portsmouth Hospital, Regional Advisor	Matt Williams
CICU, Southampton University Hospital	Kirstin Wilkinson
Winchester Hospital, Clinical Lead	Stephen Wimbush

APPENDIX 2: 2019 CENSUS DATA

COUNT: 48 respondents (out of 1106).
88% of the respondents are practicing in both Anaesthetics and ICM. This compares to 82.2% in East Midlands, 84% in South West Peninsula and 86% in Thames Valley.

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

	Wessex
Increase	4
Decrease	12
Neither	32

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

ANSWER	Wessex
Yes	33
No	15

3 units were represented in the Clinical Leads section

Do you have ACCPs on the unit	Wessex
Yes	2 units

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

%	Wessex
0-24%	5
25-50%	14
51-75%	22
76-100%	7

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

%	Wessex
0-24%	15
25-50%	10
51-75%	18
76-100%	5

NB: Per week PA data across the region

	Total DCC-PA numbers in your Job plan	All SPAs (ICM and non-ICM)
RANGE	5.5	3.5
MEAN	11	2.1
MEDIAN	11	2
MODE	11	2

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