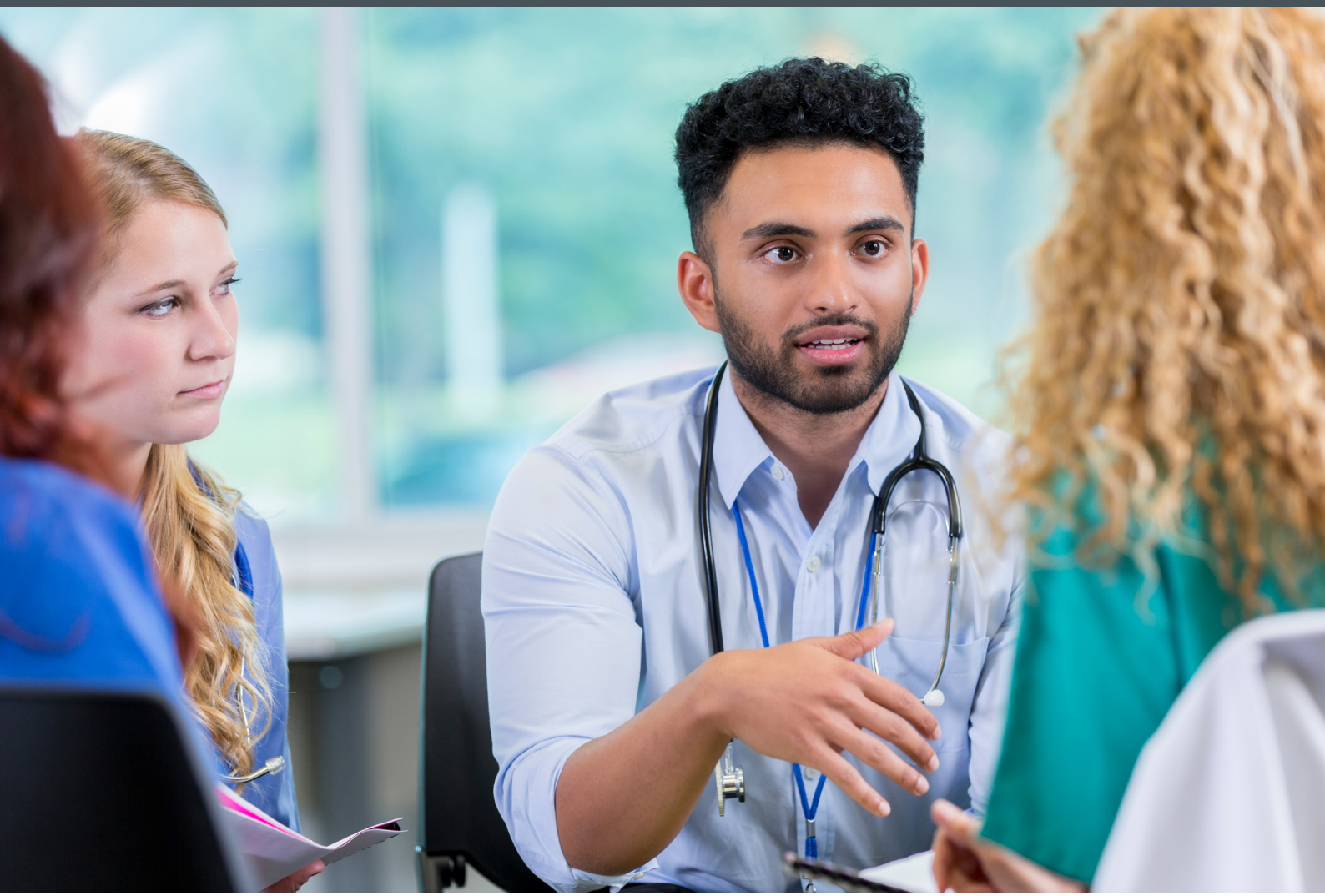
CRITICAL ENGAGEMENTS

Key Findings and Recommendations from the Regional Engagements

April 2018



The Faculty of
Intensive Care Medicine

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"Overall I found the FICM engagement day, and the process and thought around, it really useful. Scotland has a small, but cohesive critical care community, and whilst I've had many of the same discussions more informally with colleagues from across the country it was useful for us all to meet and discuss things in a more formal and structured fashion.

Many of the issues highlighted were not new, and relate to the difficulties of providing high quality critical care services across a large geographical area with generally lower population density than England. There are many small units similar to mine, and as always useful to think of how we can reach solutions/compliance with GPICS etc. with colleagues facing similar challenges.

In regard to workforce planning it was concerning about the workforce/demand projections. Whilst the workforce projections are frightening, I felt strangely reassured knowing that everyone else is in the same boat, facing similar issues, and that we have the support of the Faculty with this. Personally working in a small unit with unfilled posts the event was useful to focus the mind and to think about how we may be able to recruit."

Gordon Houston, Lead Clinician Intensive Care Medicine
Crosshouse Hospital, Kilmarnock

> *"[It] helped to clarify the issues with delivering critical care in our region, mainly through the work already carried out before the event, especially by the training committee. The discussions raised some interesting points and ideas that wouldn't have been thought of otherwise. My main concern is that although a lot of issues were identified, there appears to be no way to solve most of them which is a bit disheartening."*
>
> **North West Region Faculty Tutor**

1 EXECUTIVE SUMMARY

1.1 Developing a workforce dataset for critical care

Over the last few years, the Faculty has been able to undertake a handful of censuses to provide the specialty with key information about the medical workforce for critical care (consultants, doctors in training, Staff and Associate Specialists, Advanced Critical Care Practitioners). This national headline data proved essential in taking forward work with the Centre for Workforce Intelligence during their in depth review of the specialty which predicted a significant growth in the need for critical care services over the coming twenty years. The Critical Care Network – National Nurse Leads (CC3N) added invaluable data to this national picture with their National Critical Care Non-Medical Workforce Survey (2016) and their subsequent nursing workforce survey (2018), which supplied key information on the nursing and Allied Health Professional workforce in critical care. We thank them for sharing their latest findings in Section 2.3 of this report.

1.2 The need for regional workforce engagements

In 2015, the Faculty agreed the need to supplement, bolster and improve this data with the regional engagements. The engagements were conducted with the aim of:

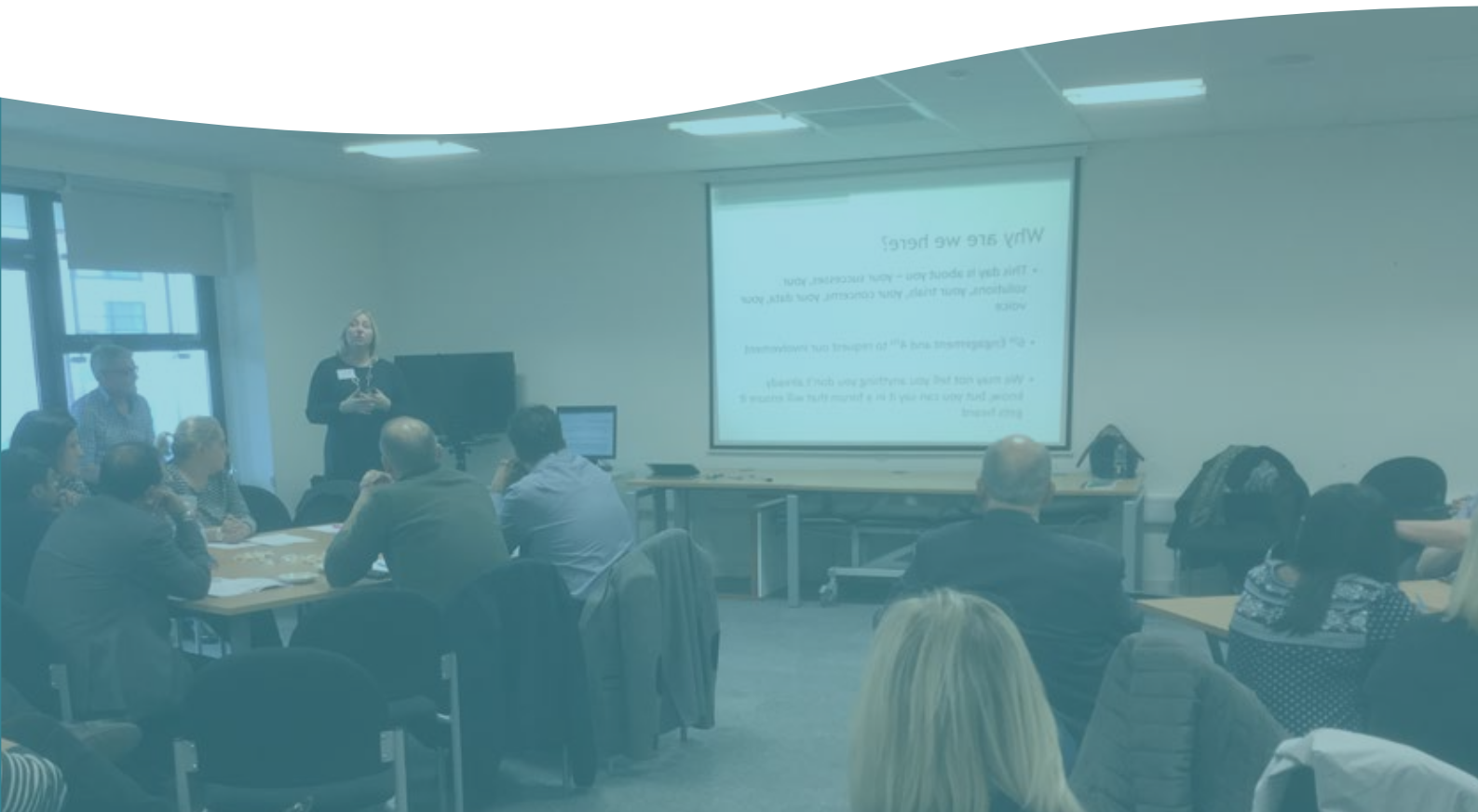
- Describing the current supply of ICM/critical care facilities in each participating region and presenting an assessment of likely future (5-10 years) demand.
- Identifying the likely future location of critical care services based upon current service provision and networks of clinical care surrounding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

1.3 Themes from the first six engagements

This report provides an overview of the themes discussed during the first six workforce engagements conducted by the Faculty. The themes have been grouped and where applicable, suggestions for future action by the Faculty or other stakeholders have been identified. The first six workforce engagements included the devolved nations of Scotland and Wales and four English regions of the North West, the West Midlands, Yorkshire & Humber and the East Midlands.

As demonstrated in Section 2 below, these engagements have given the Faculty essential information about how workforce decisions are moving forward locally. This does not mean the end of the regional engagements and we look forward to starting the second wave of engagements in November this year in South West Peninsula. If you are interested in having an engagement in your region, please contact the Faculty.

The information from the first six engagements, along with census data and the solutions gathered from the Critical Futures initiative, has now given us the weight to take forward discussions with national bodies effectively. See Section 3 for further information.



2 THEMES

2.1 General points

- All regions contain areas of high population density (large teaching/associated teaching hospital units), small rural DGHs (isolated) and intensive care units in hospitals serving a much lower population density. **Regions had different combinations of challenges from balancing the needs of these different populations** (i.e. the geographical boundaries of mountains in Wales, the large area of Yorkshire and Humber).
- Increasing ward demands and the associated de-skilling of ward care was linked to the perceived **mismatch in expectations from parent teams about what critical care can achieve**. There is work to do on managing expectation from referring teams and patients/relatives, which can be considered as part of an escalation of treatment project under the Faculty's new End of Life Care initiative, borne from Critical Futures.
- Each region had different **local systems (i.e. Networks, Schools) to connect and share solutions and reach common goals**, but these differed in how well they functioned. There would be much benefit in streamlining ways to share best practice.
- There are many external factors affecting the increasing requirements of critical care provision, including an **ageing population and increasing patient frailty**.

2.2 Staffing: Key overall points

- There was widespread recognition of **a general lack of staff to effectively run units**, with medical, **nursing and Allied Health Professionals (AHP)** groups all affected. This corresponds to data from the CC3N report.
- **Smaller units often reported a lack of resident medical staff** with adequate competencies to provide cover. The resident is often providing cross cover to other areas (i.e. theatres or obstetrics). Smaller units also reported having difficulty recruiting consultant staff with a CCT (or equivalent) in ICM.
- **Some larger units lack sufficient resident staff to support a ratio of 1 doctor to 8 patients**.
- Though there was enthusiasm about **teleworking/combining rotas**, the majority felt this could not be a workable solution on its own to current ICM staffing concerns.
- **Geography is a significant factor in staffing some units**: long commuting distances are undesirable and there is a notable impact on recruitment and retention if staff are expected to move between sites.

2.3 Staffing: Nursing and Allied Health Professionals

- There was **a direct link between the pressure on nursing staff working practices (e.g. bed ratios) and low morale and retention issues** for nurses.
- **AHP and pharmacist support is only resourced well in some areas**. Despite this provision being essential, GPICS recommendations do not seem to have impacted greatly on this element of service provision.

The Critical Care Network National Nurse Leads (CC3N) published an Overview Report on the National Critical Care Non-Medical Workforce Survey in March 2016, which covered data on AHP workforces. It is available on the CC3N website at http://cc3n.org.uk/. We have quoted the key findings below:

- "These data suggest that 86% (145/169) of critical care environments have access to a **dietitian**.
- These data suggest that only 30% (43/145) of critical care environments can identify a **Speech and Language Therapist**.
- These data suggest that funded staffing for **Occupational Therapy** in critical care is very low with 14% (20/146) of units reporting any form of Occupational Therapy input.
- These data suggest only 17% (23/135) of units in the country have a service offering **psychological support** to patients and families in the unit, with the majority (65%) of these units having access to only one psychologist (15/23).
- On-going physical rehabilitation was limited, with only 29% of units reporting **physiotherapy** contributing to follow-up clinics and only 19% reporting the provision of outpatient based services when discharged.
- Of the 186 units who responded 165 (89%) had a dedicated critical care **pharmacist**; 21 (11%) did not. For the units who report having a critical care pharmacist graph 6 provides a breakdown by banding."

CC3N also published a recent critical care nursing workforce survey (CC3N, 2018) which indicates that:

- An **increased number of critical care units are seeking to recruit registered nurses from overseas to fill vacancies**, with some regions reporting up to 50% of the registered nursing staff workforce being from overseas countries. Nationally, 9.9% of the critical care nursing workforce is made up of staff from EU countries, with a further 16.6% being recruited from non-EU countries.
- At the time of the survey there were **over 1440 registered nursing vacancies reported in critical care areas**, representing 8.35% of the nursing workforce. The change to pre- registration nurse training from a bursary supported programme is highly likely to impact on the numbers of newly qualified registered nurses in the near future. Agency use has reduced since the previous survey, although this is likely to be as a result of the introduction of the cap on agency spending and may not necessarily indicate improved staffing numbers.
- There are now **fewer regions with in excess of 20% of the nursing workforce over the age of 50; however this represents a loss of critical care nursing experience**.
- **Critical care nursing staff are increasingly being requested to fill gaps in ward staffing** which is a poor use of a specialist nursing workforce and can impact on training and development, morale, sickness and staff turnover. At the time of the survey, 18 critical care units reported an annual staff turnover in excess of 20% with some as high as 42%.

- Since the survey undertaken in 2016, there has been an **increase on the number of units having a supernumerary clinical coordinator rostered across all shifts**.
- Although there has been a**n increase in the number of ACCPs to support medical staffing rotas, these posts are mostly filled by experienced nursing staff**. Whilst this provides benefit to patient care and provides another route for clinical career development, there is a further loss of senior nursing leadership, mentorship and support to junior nursing staff.
- There has been a **significant increase in the adoption of the CC3N national step competency framework for critical care nurse education**.
- 48.8% of registered nursing staff have completed a critical care course, there are however **serious concerns about the reduction in CPD funding** and the impact that will have on the access and provision of future post-registration critical care nurse education.

2.4 Staffing: Consultants

- **The frequency of on-call is a significant problem** in many units but especially in those units where the on-call has been split from anaesthesia and the unit cannot recruit new consultants with ICM training or interest.
- The intensity of on-call is rapidly increasing as expectations of the public and the medical profession as a whole rise. The intensity means more on the floor presence when "on-call". **A number of concerns were raised by consultants as they face the prospect of their own ageing, increased retirement age and the ability to manage the on-call element of their work .** There is a need for job planning to more widely reflect the actual working of ICM consultants.
- Attendees desired guidance on minimum on-call rotas, managing on-calls, and job planning, as they get older. **Newer, flexible ways of working need exploration and publicity**, which are already under review by the Faculty.
- There was a direct link reported between **a lack of middle grade cover/trainee availability** to negative views by consultants on their desire to keep working in ICM. Consultants 'acting down' are not generally desirable long term workforce solutions.
- There is a perception from some that they are currently **unable to support non-anaesthetic ICM consultants working on ICU (mostly smaller or remote hospitals)**. Much more needs to be done to promote the value of ICM consultants to an acute care hospital regardless of training origin.
- The greatest need reported was for **consultant posts in hospitals delivering little/no ICM training** at present and consequently thought to be unattractive to ICM CCT holders who want to remain connected to training. These posts if filled will be by anaesthetists without an ICM CCT in some regions.

2.5 Staffing: Doctors in training

- Many attendees felt **ICM trainees might be attracted to smaller units if they had some experience working on these units**. All regions with remote hospitals noted

that there is little preparation for consultants to work in remote sites. This is something under consideration by Regional Advisors.

- There was a strong view that **more ICM training is needed for physicians to support their general medical experience** and for other groups, e.g. Foundation Doctors, to encourage recruitment into ICM. This must be accompanied by their service provision to ICM to make the investment in their training worthwhile. The FICM has undertaken extensive discussions with the Royal Colleges of Physicians to have ICM included for the first time in core medical training. The new Internal Medicine curriculum will be introduced in 2019).
- **Recruitment and trainee post growth differs considerably by region**, with some regions regularly not filling all of their posts whilst some regularly reaching 100% fill rates with appointable candidates being turned away. The CRW will work directly with regions where growth is most needed following the finalisation of 2018's national recruitment numbers.

2.6 Staffing: Advanced Critical Care Practitioners (ACCPs)

- In the FICM census (2017) **20% of units are now training or have ACCPs working in the unit**. This is the most radical change in ICM critical care staffing in recent years.
- The ACCP workforce needs to grow but making it happen is an issue as most hospitals are **unable to finance** and train when they may have need for only 1 or 2 ACCPs on their staff.
- A need was identified for **regional finance/planning of ACCP training** to facilitate this growth plus an agreement on payscales to stop poaching between hospitals. The Faculty has promoted the importance of ACCP regulation and will now review promotion of the ACCP workforce to regional training budget holders.

> ***The need for a national ACCP training programme – a view from the North Trent Critical Care Network.***
>
> *"A few years ago Sheffield Teaching Hospitals (STH) correctly predicted the future and saw reductions in medical workforce numbers for critical care. They developed a business case and along with Sheffield Hallam University (SHU) invested and developed a course and trained enough ACCP's to successfully replace a tier of junior doctors covering the critical care unit. This course continues today and is managed by both STH and SHU.*
>
> *The smaller hospitals within the network are now experiencing difficulties with the [reduction in] numbers of the medical workforce. However, as it is not a complete loss of a tier of doctors in any one of the hospitals ,they don't feel they can develop a standalone business case to invest in training 1 or 2 ACCPs for their own Trust. All the smaller hospitals would however be keen for a regional (or national) training scheme for ACCPs that they could contribute to and benefit from."*
>
> ***Dr Chris Scott***
> ***Clinical Lead North Trent Critical Care Network***

2.7 Resources: Beds and commissioning

- It was felt there was **a definite need to develop enhanced facilities** to support elective activity e.g. Enhanced Care / Post Anaesthesia Care Units (Level 1+) and that these are NOT covered by critical care medical staff. Places that have developed them have found benefit, but if covered by critical care medical staff it adds to the critical care burden. This is being taken forward through the Faculty's Enhanced Care working group, taking place under the Critical Futures initiative.
- **Some larger units also lack physical resources like staffed beds**. This possibly reflects the fact that smaller units may refer into larger units for complex or specialist treatments like complex pancreatitis management. This creates a constant demand on larger centres.
- Resources do not follow the patient so centralisation of services (i.e. through commissioning reconfiguration) without discussion with ICM is having an impact in all areas. **There was generally a lack of direct ICM involvement with service reconfiguration, though where it has occurred it has worked well.** Critical care is pivotal to 21st century medicine but is often not perceived by administrators as a driving factor in reconfiguration of services.

2.8 Impact of GPICS and visiting

- **Whilst those present were positive about the need to have clearly defined provision standards, there was a mixed response regarding the benefits of GPICS in encouraging change**. Some respondents felt the aspirational aspect of some of the standards made making the case for investment in ICM difficult. However, others reported that using the standards was a very effective means to facilitate change e.g. the appointment of additional consultant staff.
- It was noticeable that **splitting of consultant rotas has been much easier in population dense and urban areas**; other units are struggling to achieve a solution.
- Care Quality Commission visits (which utilise GPICS standards) were viewed as having been largely beneficial in bringing about change.

2.9 Specialist critical care provision

- **No specific concerns were raised regarding neurocritical care provision** (and one region with a standalone neuro ICU had no recruitment issues) but general comments were made regarding ICM CCT holders being more likely to want to work in general rather than in specialised units.
- **Cardiac ICM was noted to be of special concern**: there are more standalone Cardiac ICUs and rotas were perceived as onerous. Solutions discussed included using some general ICU specialists to input into daytime CICU sessions and appointing cardiac trained anaesthetists with an interest in ICM.
- The now Smaller and Specialist Units Advisory Group is closely connected in with the cardiac and neuro organisations to take forward discussions in these areas longer term.

3 RECOMMENDATIONS

> *"It was helpful to highlight some idea of the extent of the problems associated with medical staffing in critical care and have an idea of the trainees expected to come out of the system and the projected demand as estimated by the clinical teams in the different units. It could also be that the meeting made people think about the problem and how it could be dealt with."*
>
> ***ODN Lead, North West***

3.1 Engagement with national bodies

The Faculty now has a strong enough evidence base to take forward an exercise in increasing the engagement of the specialty nationally with key stakeholders (NHS England, Health Education England, devolved nation governments, NHS Improvement, commissioning bodies). This should be via direct meetings and through a summarising document of the key issues in the specialty. The Faculty should work with media stakeholders to make the specialty's workforce issues more publically available, whilst preserving the essential relationship with national stakeholder bodies.

There is the opportunity via the Getting It Right First Time (GIRFT) programme to review the bed and human resource requirements of critical care. Although limited initially to England, the UK-wide Faculty's engagement with this project presents an opportunity for its outcomes to be heard across all four nations.

3.2 Engagement with clinical leads and sharing solutions

The Faculty should set up a **Clinical Leads Network** involving both hospital and Operational Delivery Network leads, to increase engagement with these individuals. Many of the issues raised are not within the power of individual Clinical Leads to resolve and so need discussion and central Faculty lobbying as well as information sharing regarding solutions. Examples include lack of ICM input into service reconfigurations and funding negotiations.

There is a need to more visibly share and promote solutions that have worked in regions, including cross-site and hub and spoke working. This can be achieved through the Faculty's Careers, Recruitment & Workforce (CRW) Committee as well as through the newly developed Clinical Leads Network. One example would be demonstrating how to develop job plans and funding for non-anaesthetic ICM CCT holders to work in hospitals currently advertising posts for ICM/anaesthetic ICM CCT holders only.

3.3 Engagement with members

Several themes are already under consideration by the Faculty but awareness of Faculty activity in these areas is sometimes patchy. The Faculty will take forward wider promotion of its activities with members. This should include turning the workforce data pack (which has been made available to Regional Advisors since 2014 to present the case for growing training numbers) into a public resource that brings together a larger suite of information.

3.4 Engagement with nursing and AHP organisations

The Engagements have demonstrated clear issues across all critical care workforce groups. The Faculty should work more closely with nursing and AHP organisations to ensure they we can provide support for their workforce needs and working conditions, and to ensure all critical care workforce needs are clearly communicated to national stakeholders. The Faculty should offer nurses and AHPs direct affiliation to the Faculty so their involvement becomes a greater part of our day-to-day business.

3.5 ACCP training, funding and regulation

The ACCP training and funding situation is an important and immediate risk to the wider expansion of a professional group that is demonstrating a significant way forward to issues of middle grade staffing, meeting the GPICS recommended ratios, and support for smaller units. The need to fund and organise training on a wider basis than through individual hospitals has been a strong theme. This was perceived as a more important issue than regulation at present. The Faculty will take this forward through the CRW's ACCP Sub-Committee.

On regulation, the Faculty has taken on the cause of ACCPs and making the case for ACCP regulation. The Faculty is taking an active part in the ongoing HEE Medical Associate Professionals project that is most likely to make this happen in what, unfortunately, is an environment in which the DH remains unreceptive to this need. The Faculty should continue to engage at the highest levels with national stakeholders on the need to develop this group and support their training aspirations.

3.6 Training exposure and reviewing specialist training

There is a need to ensure earlier and more sustained exposure to ICM training prior to specialist training. Exposure during Core training, through the Faculty's engagement in the Acute Care Common Stem committee and the new addition of ICM training as part of the Internal Medicine curriculum, is developing well. Undergraduate Training is beginning to move forwards with the production of the first undergraduate framework for the specialty. The Faculty can now usefully take forward some work on a framework for Foundation doctors in critical care.

Similarly, specialist training, which was introduced in full for the first time in 2012, needs a review to match workforce requirements and learn lessons from its initial period of operation. Fortunately, the recent GMC curriculum standards changes have now enabled the Faculty to take forward a move to a more flexible outcome-based curricula.

3.7 Support for the 12 Critical Futures recommendations

Summarising the engagements has been a useful triangulation exercise against the survey responses that informed the 12 recommendations contained within Critical Futures: A Report on the First Wave Survey. The work streams that have come from this (i.e. the End of Life Care and Enhanced Care initiatives) will help towards finding solutions for some of the issues faced.