

# Clinical demand and workforce in Wales

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# Perfect storm or good employment prospects?

- **1. More work (demand):**
- ICNARC predicting a 4% annual increase
- Patient demographics
- Expectations – public, political, professional
  
- **2. Fewer workers - or the same number doing less work (reduced supply):**
- EWTD, Deaneries and rotas, Anaesthesia training
- Early retirements, return to anaesthesia, part time working with feminisation of the workforce

- **3. Too many hospitals trying to provide a full specification service**
- Political, public and professional reluctance to centralise
  
- **4. Target driven NHS – with resource allocation.**
- Not an NHS driven by meeting agreed standards for patient care

# We are where we are - but where is that?

- (Even) in Wales we aren't all in the same place – in time, place or person
- **Time:** Views on staffing evolve over time?
- **Place:** Cardiff vs Wrexham vs Aberystwyth
- **Person:** Should you, can you and do you want to do the same job at 40 as at 65 years old?

# Welsh utopia

- In utopia 5 hospitals each covering a population of 600,000 people
- Each hospital has 5 critical care beds per 100,000 population
- Five 30 bedded units
- 12-15 consultants per unit, working a minimum of a 1:8 on-call rota
- 1 junior anaesthesia tier with airway training
- FICM trainees dependent on stage of training
- 1-2 tiers of medicine + surgery juniors/accp cover (1 for every 10-15 patients)

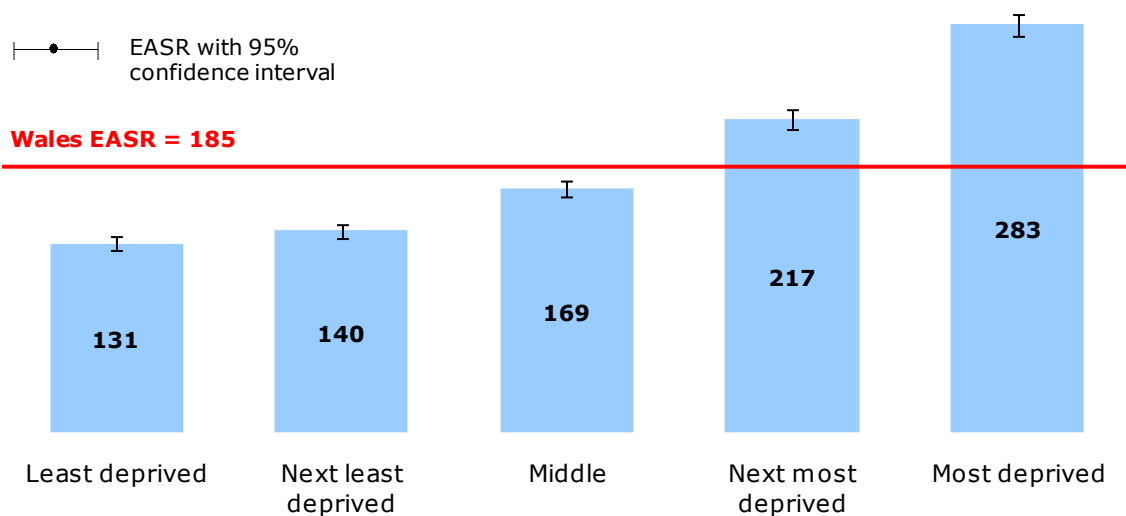
# Instead - dystopia

## 14 critical care units

- 14 critical care units offering level 3 care to a population of 3 million
- Ranging in size from 6 to > 20 beds
- Large HB variation in critical care beds to population served
- Inequitable access to critical care – post code lottery (social class)

### Unplanned critical care admissions\* by WIMD 2008 fifth, European age-standardised rates per 100,000 persons, 2007-2010

Produced by Public Health Wales Observatory, using CCMDS (NWIS) and MYE (ONS)

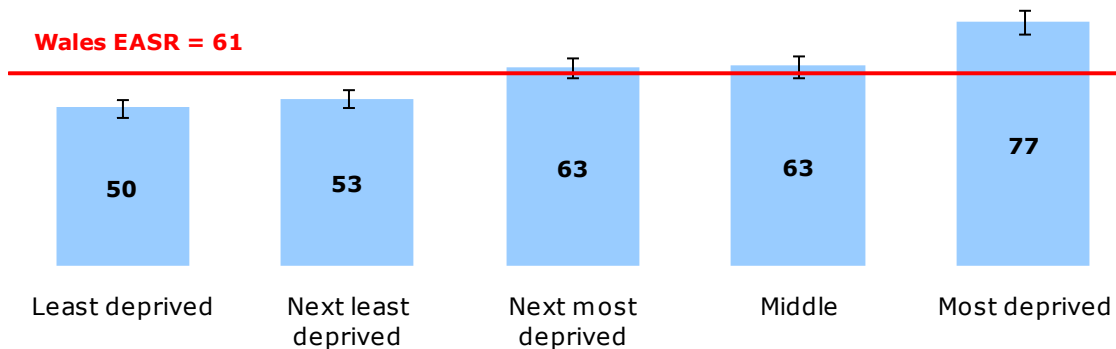


\* The method of data extraction limits each patient aged 16 and over to one admission per calendar year - this answers the question "How many people (aged 16+) have had at least one unplanned admission to critical care?" for any given year

## Planned critical care admissions\* by WIMD 2008 fifth, European age-standardised rates per 100,000 persons, 2007-2010

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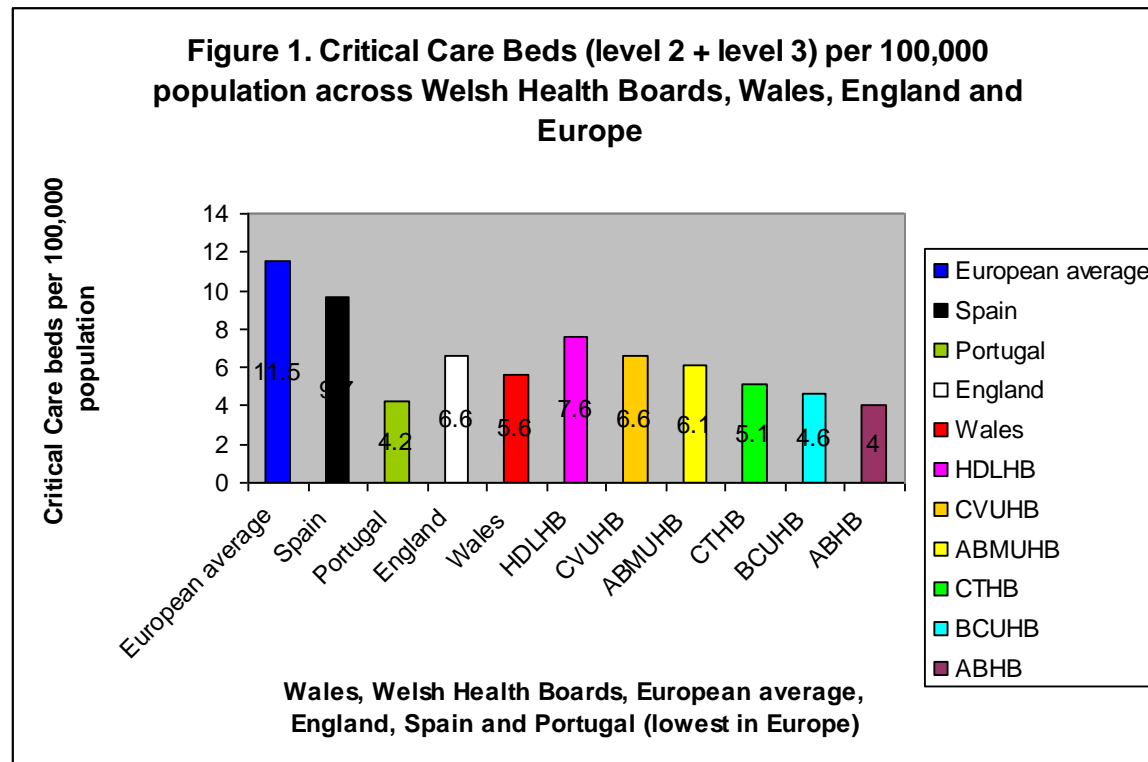
—●— EASR with 95% confidence interval



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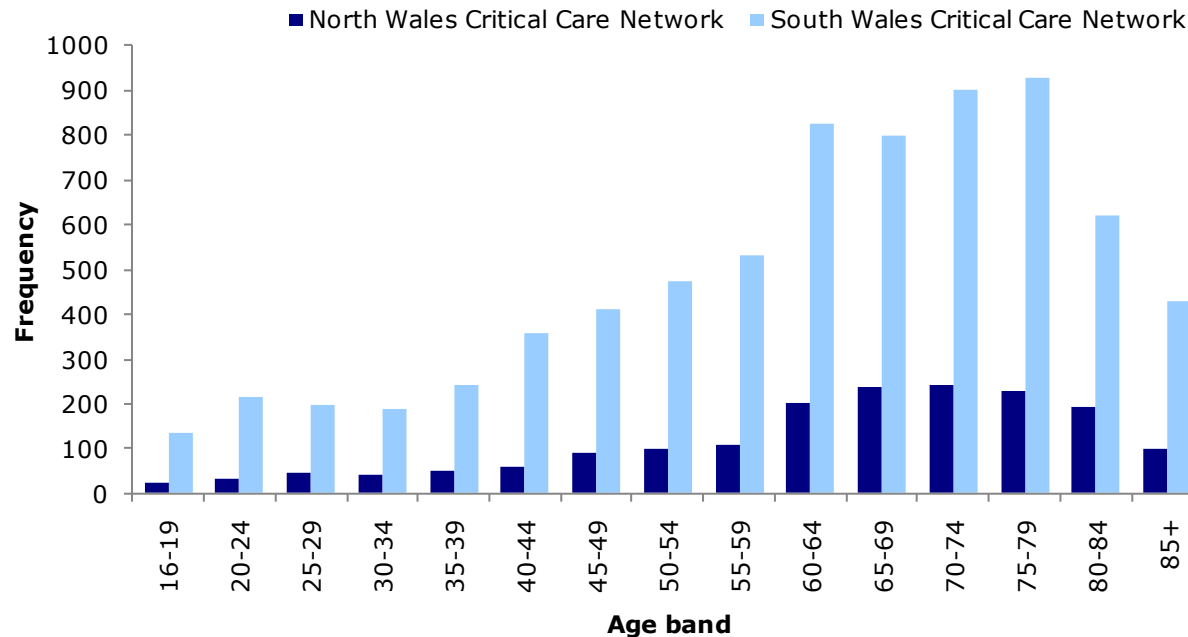
# Catch 22 of needing to increase supply to meet demand but unable to - Risk falling standards



# Increasing demand - ICNARC projection 4% per annum

## Frequency of admissions to critical care by area of residence and age on admission, 2010

Produced by Public Health Wales Observatory, data from CCMS (NWIS)



# 2014 Audit of Welsh Critical Care Unit medical staffing against ICS core standards

- 50% of Welsh Critical Care units do not currently meet Intensive Care Medicine (ICM) consultant staffing standards
- Little progress has been made in meeting ICM consultant staffing requirements in the 8 years since Welsh critical care standards for consultant staffing were originally published
- Largest cause of failure to meet standards is “Tier 3” units being staffed out of hours and weekends by non ICM trained consultants

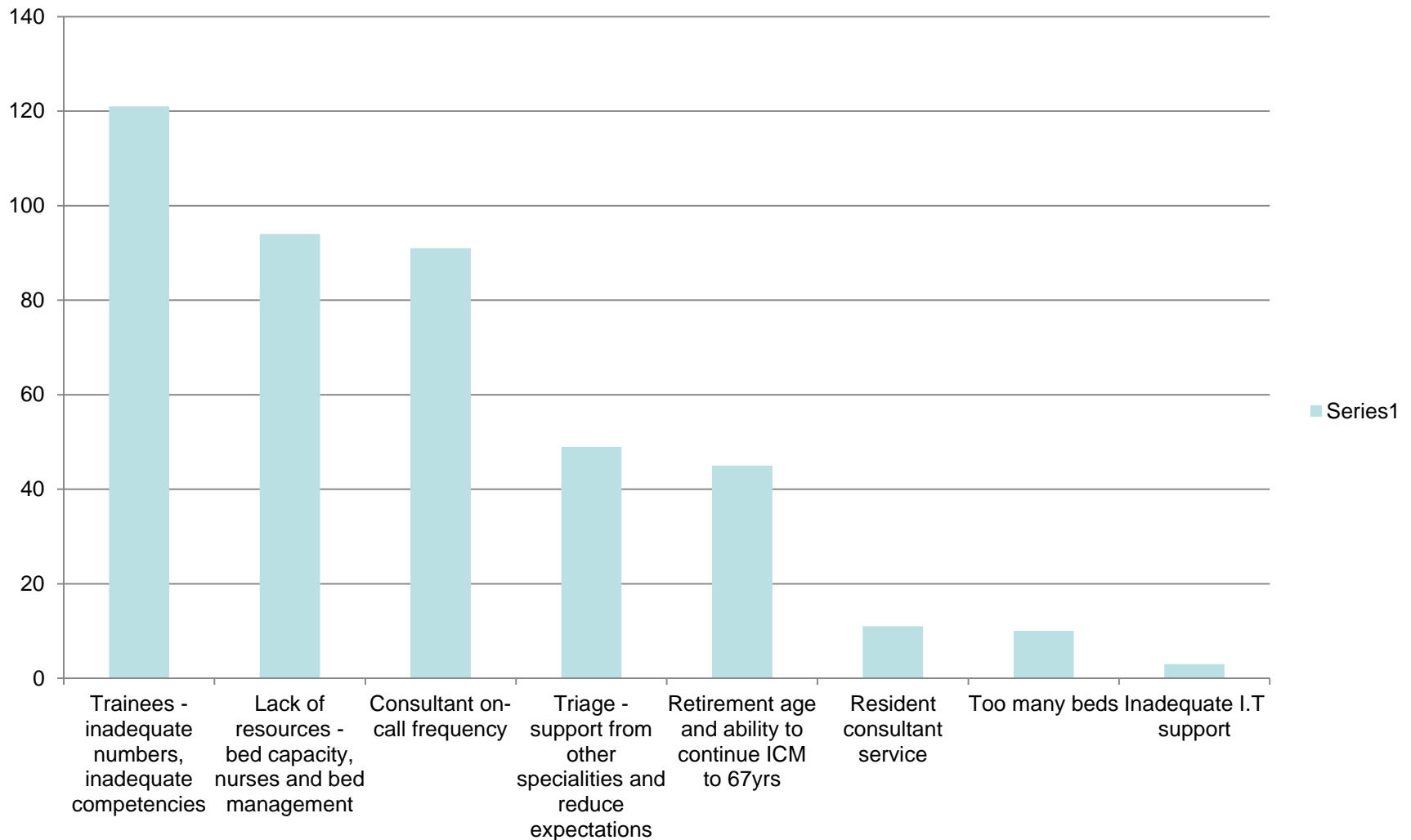
# 2014 Audit of Welsh Critical Care Unit medical staffing against ICS core standards

- 50% of units share their out of hours resident (junior) cover with theatres or obstetrics
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- 80% of units do not meet all the standards for junior staffing – either shared cover 6/14 or covering too many patients out of hours 3/14
- 
- Too many units reliant on anaesthetic junior cover with a dwindling work force due to the EWTD, a reduction in the stipulated critical care commitment by trainee anaesthetists by the Royal College of Anaesthetists and an inability to recruit non-training grade staff to cover critical care
- 
- At current trainee staffing there are too many Tier 3 critical care units in Wales

# Workforce Advisory Group Census 2014

- Faculty Advisory Group
- RCOA representation at managerial level
- Representation from England, Scotland and Wales
- Trainee representation
- First census in 2014 with advice from RCP who have been doing theirs for years
- Some joint work with the CfWI
- Census sent to all critical care CDs and lead clinicians
- Census sent to all FICM consultants

## Do you find ICM stressful enough to influence your future career plans?



# Trainee staffing

- Largest cause of stress to consultant staff:
- Not enough of them
- Too junior
- Inadequate training programmes
- Lacking competencies
- *“the level of junior staff is at an all time low - this is not their fault but we need another level of cover to allow us to think and deliver effective care rather than being flat out trying to do everything both physically and mentally”*

# Trainee staffing

- *“.. I was increasingly expected to perform not only my role as a consultant but also the duties more familiar from the start of my career. An open ended tab is picked up by consultants due to shrinkage of junior doctors' numbers, experience, hours and confidence...”*
- *“We have very junior CT1 and CT2 trainees on our DGH ICU making the out of hours on calls and commitments greater than hospitals with ST trainees”*
- *“We are struggling with trainee numbers - consultants often perform basic tasks on our unit as well as trying to manage and lead.. Work load dictates that it is difficult to find time to train up trainees ... I believe our trainees' training experience is suboptimal”*



# Trainee staffing

- Dwindling work force due:
- EWTD. Some Deaneries want rotas run on a 1:11
- Reduction in the critical care commitment by trainee anaesthetists by the Royal College of Anaesthetists
- No increase in total time to get critical care competencies
- Inability to recruit non-training grade staff to cover critical care from outside Europe

# 1. Too much on call / more consultants

- Do we need our medical politicians to push for a minimum acceptable consultant rota?
- Burnout – how real is it?
- Sessional commitment out of hours needs to be properly accounted for and therefore time off after on-call

# Triage / Expectations

- Increasing number of elderly admissions with poor outlook
- Increasing expectations of families, and medical and surgical colleagues
- Lack of consultant involvement in decisions around end of life
- As a consequence we are having to make very difficult decisions with no prior relationship with the family

# Triage / Expectations

- *“the reluctance of non-ICM colleagues to assume responsibility for decisions in circumstances which are frequently futile, places the burden of this responsibility on ICM in many instances; increasingly these decisions are questioned ...”*
- *“sensible approach of society and non ICU colleagues to recognise what is appropriate and recognise when patients are dying”*
- *“other specialities making decisions around end of life care that do NOT require ICM input”*
- *“better end of life planning. Better national expectation of treatment in the elderly and terminal care ... I treat the dying now rather than do critical care”*

# Green Green Grass of ...anaesthesia or early retirement ...or burnout



Retirement - who do you want looking after you?



# Green grass retirement and anaesthesia

- *“...even with the most perfectly designed rota, I cannot imagine being a consultant in ICM with the trainee and junior staffing as it is, past the age of 60”*
- *“Stop out-of-hours on call. have found it increasingly difficult to cope since age 55”*
- *“Intensity of on call work and difficult sleep patterns without adequate rest and time to recover. More difficult with age, cannot see me managing anywhere near to retirement”*

# Retirement and anaesthesia

- *“ITU is the more stressful part of it (job) and if it becomes too much I can back off into pure anaesthesia possibly with no out of hours role ( as my colleagues in pure anaesthesia >55yrs already have)”*
- *“The specialty needs to develop an approach to career progress within ICM (which does not equate to just giving up ICM to do more anaesthetic sessions!)”*
- *“I do not intend remaining on the night rota beyond 60 years of age. However HM Gov expects me to work until I am 68!”*



# Resident on-call

- *“I never ever want to be resident on call. It will ruin me.”*
- *“On call frequency and senior enough ICM-resident would allow non-resident ICM senior to perform on-call until retirement”*
- *“quality of middle grade cover is pivotal”*
- Unplanned resident consultant to cover lack of junior staff
- In most units we don't need to be resident provided we have sufficient trainees with adequate competencies!

- “Resident full-time specialists in the ICU:  
a survivable model?” J Parry-Jones, A Garland. *Curr Opin Crit Care* 2012, 18:677–682

# Conclusions

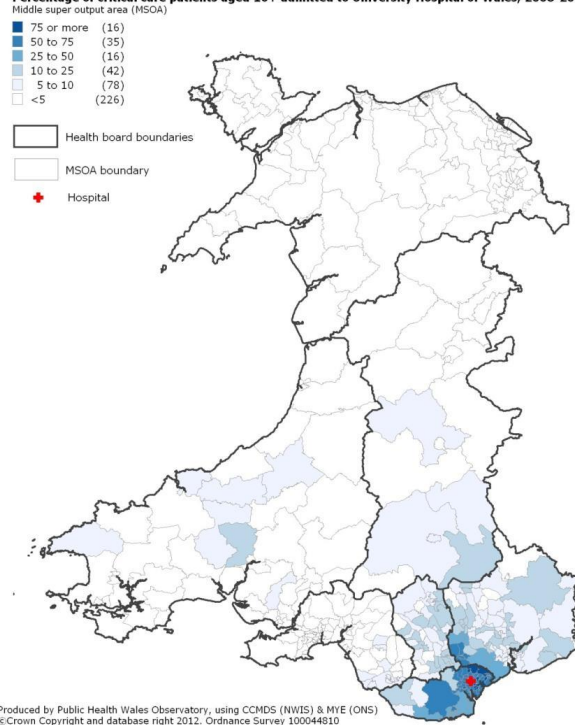
- 1. Increasing demand
- 2. Demand not met by supply of staffing and resources
- 3. Falling junior numbers, falling experience
- 4. Consultants picking up additional work with concern about personal and professional fallout
- 5. Inequity of care – no prospect of meeting agreed standards – poor job satisfaction
  - **Recruitment into critical care falls**

# Conclusions

- Realignment of resources to better meet demand
- Solutions to staffing standards include ACCPs
- Non anaesthetists needed on rotas (and for their training)
- Meet agreed national standards in order to improve training and attraction to critical care
- Agreed minimum rotas and on-call age limits
- **Will require difficult decisions about how many units in Wales**
- Risk of substandard critical care just to meet others specialities wishes

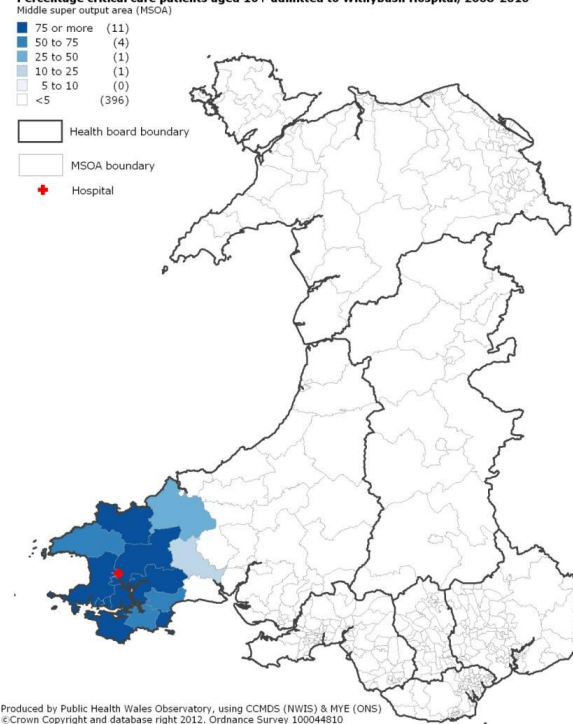
# Critical care admissions by postcode Cardiff and Haverfordwest. EMRTS effect.

Percentage of critical care patients aged 16+ admitted to University Hospital of Wales, 2008-2010



The percentages calculated for this map are based on Wales residents aged 16+ admitted to Welsh critical care units (allowing one admission per person, per year for 2008-2010). Persons admitted to units outside of Wales, and non-Welsh residents attending Welsh units are not included in the calculations. MSOAs with less than four persons admitted to critical care units in Wales in 2008-2010 have been excluded from the analysis; this applied to 7 MSOAs in total.

Percentage critical care patients aged 16+ admitted to Wwithybussh Hospital, 2008-2010



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Questions?