HEE Workforce Planning 2014/15 – Call for Evidence

To submit your evidence please complete this form. Please make your submissions relevant to the categories provided in the boxes provided. We have categorised the known drivers of demand and supply under the following headings, and believe this to be a comprehensive description of the variable involved.

You can provide extracts of reports into the free text boxes below, or submit a whole report with this form by clicking on the email at the bottom of this form. Please mark clearly in the email which of the below categories the report/evidence relates to, including any relevant page numbers. Where an extract is provided, please reference the source.

Please use Part 3 to submit any information/evidence that does not fit the below categories. You can also leave any comments/observations in the free text box.

Before completing the form below please submit your contact details here:

Name:…Daniel Waeland……..

Job title:…Head of Faculty……...

Organisation:…FICM……..

Contact email:…dwaeland@rcoa.ac.uk……

Contact number:…020 7092 1727……

Form submission:

Once completed please submit the form via email to hee.workforceplanning1@nhs.net making sure all supporting documents are also attached to the email.

Please make the subject of the email: HEE Workforce Planning 2014/15 Call for Evidence-[Insert your organisation's name]

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

If you want the information in your response to be kept within HEE's executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

PART 1 – Future Service and Workforce Models

1. **Drivers of Future Service Demand**
    - Needs identified by patients and the public
    - Activity and epidemiology
    - Quality. Innovation, prevention and productivity
    - Funding
    - Other
2. **Future Service Models**
3. **Future Workforce Models**
    - Associated knowledge and skills – and assessments of the supply and demand position*
    - Associated values and behaviours – and assessments as above*
    - Workforce structure, team structure, skill mix, new roles.
    - Workforce performance and productivity

*NB: – this may include views on the efficacy and quality of education processes in equipping staff with these skills, knowledge, values and behaviours.

1) Drivers of future service demand

- An aging population with co-morbidities will put increasing pressure on the critical care services.
- The tentative findings from the CfWI's in-depth review indicate a doubling of the need for ICU service provision by 2033 is feasible, with the aging population being a significant part of that projected demand.
- This is line with the preliminary findings of an ongoing research project by ICNARC which indicates the potential for a significant increase in ICU admissions over the next 20 years. "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." [1]
- The DH 'Comprehensive Critical Care' publication (2000) led to a necessary expansion in ICU provision, but this has largely remained the same since.
- Patient flow through the hospital for elective procedures can be constrained by inadequate critical care capacity; as these become more complex demand will again rise.
- Increasing public expectations that critical care will be provided in an acute illness
- Increased medical expectations that critical care will be provided coupled with the increasing role of critical care in defining the limits of interventional care throughout the hospital

- The reduction in the number of experienced trainees outside of routine hours and their increasing need for backup from critical care teams
- The move to true 24 hour acute service provision with the emphasis on rapid investigation and treatment. Investigations and treatment are no longer delayed until normal working hours placing increased pressure on critical care teams.

2) Future Hospital Commission [2]

- From the 2011/12 Workforce Census: 31.1% of hospitals have between 6 and 10 ICU beds, 24.2% between 11 and 20, 14.9% between 16 and 20 and the remainder have 21+ beds. Only 6 hospitals have fewer than 5 funded beds. There is an expectation that there will be an increase in funded beds by 178 in the next 12 months and a decrease of 26.
- The effect of any centralization of specialised services (eg vascular surgery, complex GI surgery) may have a significant impact on the ability of units within smaller hospitals to function effectively.

3) Advanced Critical Care Practitioners (ACCPs) [3]

- An ACCP curriculum is currently being created by the FICM in conjunction with the National Association of ACCPs. ACCPs trained to this standard will be able to provide considerable support to ICU services. How this new speciality will complement or expand the existing workforce is as yet unclear.
- ACCPs are championed by the FICM and the specialty as a whole, but there is still considerable financial risk associated with the local funding and training of an ACCP.
- There is no formal body that will undertake the regulation of ACCPs.

4) Anaesthetic service provision

- Currently, due to the historical shortfall in manpower to the specialty, a notable proportion of ICM on-call is provided by trainees and some service provision is provided by consultants in anaesthesia. Anaesthetics will experience its own increase in service demands and as ICM moves from being 90% Anaesthetic to a more even division between its medical and anaesthetic components, there is likely to be considerable pressure on this organic service configuration.

5) Seven Day Consultant Present Care [4]

- ICM is largely a Consultant-delivered service at present but this report and its recommendations may have significant impact on the specialties with which it is intrinsically linked.

[1] *ICNARC Summary; D Harrison, K Rowan*
[2] http://www.rcplondon.ac.uk/projects/future-hospital-commission
[3] http://www.rcoa.ac.uk/careers-training/anaesthesia-related-professionals/advanced-critical-

care-practitioners
[4] http://www.aomrc.org.uk/projects/seven.html

PART 2 – Forecast of future supply and demand – volumes

If you want to input evidence into the forecasting of future numbers you can report your perspectives on either;

i) the high level indicators; supply, demand, and any forecast under / over supply, or if available - Part 2.1
ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition – Part 2.2

2.1 Summary forecasts

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

- The average number of consultant appointments with sessions in ICM is 137 pa over the last five years. Over the same period the average number of trainees reaching CCT was 81, leading to an overall average shortfall of ICM trained doctors of 56 per year. This is currently filled by partner specialty trainees who train to an intermediate level in the specialty. As of the current 2014 recruitment, the number of training posts has risen to 108, which is still under the threshold to fill all ICM consultant positions with a doctor trained in the specialty.
- As with the American studies utilizing APACHE II in the 1980s [1], trained ICU staff achieve better outcomes.
- The increase in consultant posts and training posts is not currently at the rate to meet the predicted future requirements covered in Part 1 above.

[1] http://www.ncbi.nlm.nih.gov/pubmed/3210284

2.2 Detailed / Component forecasts

Forecast Workforce Demand

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

1) Feminisation

- In the 2011/12 Workforce Census, 16.9% of respondents were female. Data from the last decade of Joint CCT recruitment indicates this has risen to 32%.
- ICM is achieving its aim of being a specialty which is seen as welcoming to female doctors. There may be some future shortfall caused be LTFT working.

2) Future ICM skill mix: Pure ICM

- The 2011/12 Workforce Census indicated that only 5.3% of doctors do 'pure' ICM.
- Under the new single CCT, the number of trainees considering training solely in ICM has risen progressively to 8% as of the declaration forms at the 2014 national recruitment round.
- The 2011/12 Census indicated that the average number of DCC PAs in ICM per consultant is 4.24, meaning a pure ICM consultant is a noticeably divergent from the mean in terms of potential service provision.

3) Future ICM skill mix: Dual ICM

- The FICM Fellow database (comprising c.95% of ICM consultants) indicated that 91.2% do Anaesthetics/ICM. Of Joint trainees since 2001, 82.5% of them trained in Anaesthetics / ICM. At the most recent recruitment (as offers are still underway for 2014), 61% of doctors were recruited from a background in anaesthesia.

Forecast Supply from HEE commissioned education

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

1) Transition from Joint to Single/Dual CCTs

- In 2001, the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) introduced

the Joint CCT. Trainees were recruited from 'parent' specialties, usually in ST5, to complete a period of training in addition to that of their parent specialty. The Joint CCT generally took 7.5 years.

- In 2010 the GMC requested the newly formed FICM to create a single CCT for the specialty. This was approved in 2011 and recruited to for the first time in 2012.
- Trainees are recruited from Core Medical Training, Core Anaesthetic Training and all three branches of the Acute Care Common Stem. As well as training solely in the specialty, it is also possible to train in a Dual CCTs Programme with (currently) Acute Medicine, Anaesthetics, Emergency Medicine, Renal Medicine and Respiratory Medicine. Other dual programs may emerge.
- A Single CCT Programme takes a trainee 7 years from CT1 to CCT. All Dual CCT Programmes take 8.5 years from CT1 to CCT. However, these are naturally baseline timeframes and with Out of Programme Experience, maternity leave, Less Than Full Time training, sick leave, ARCP Outcome 4s and other related reasons, many trainees who take longer (sometimes considerably longer) to complete their training.
- The new Dual CCT is 12 months longer than the Joint CCT. Due to the tight transition timeframe defined by the GMC, there is likely to be a period of undersupply from 2016-2018 when output will be significantly lower than in previous years.

2) Growth of the Single/Dual CCT

- The number of posts on offer for annual national recruitment to ICM has risen from 72 in 2012 to 88 in 2013 and finally 108 (including some backfills, so not entirely fresh posts) in 2014. Fill rates have been 72% (2012), 88% (2013) and 96% (2014).
- Almost all funding options for the conversion of Trust posts have been fully explored. Some of the new funding for 2014 has come at the cost of Anaesthetics CT3 and ST3 posts, which is unsustainable long-term and detrimental to Anaesthetics.
- Our Regional Advisors report that there is a considerable risk that the growth in training numbers will be stalled.

Forecast Supply – Other Supply and Turnover

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and 'return to practice'
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)
- Retirement

- Information on these areas is currently limited. The 2014 FICM Workforce Census is currently underway.

PART 3 – General / Other Evidence not included elsewhere

Insert evidence here….