The Faculty of Intensive Care Medicine

WORKFORCE DATABANK

for Adult Critcal Care

May 2021

Introduction to the Workforce Data Bank

The Faculty of Intensive Care Medicine's (FICM) Careers, Recruitment & Workforce Committee (FICMCRW) has prepared a workforce data pack as a summary for Regional Advisors to use locally to support workforce and recruitment discussions since 2014. Following the ***Critical Engagements report***, the Faculty wanted to ensure it recognised the essential role that all Critical Care doctors, nurses, practitioners and Allied Health Professionals have in championing the specialty and its workforce.

The original data pack was therefore reworked as a public Data Bank in 2018 and gives a useful summary of the current workforce data and challenges, and can be used to demonstrate resource needs locally. This is the first full revision.

The FICMCRW has utilised a number of data sources to prepare this workforce document: FICM Census' results, recruitment data, CCT output numbers, consultant appointment data and data from our Critical Care partner organisations.

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Definition of Critical Care

Critical Care, also referred to as intensive care, is an exciting and dynamic specialty with the responsibility for caring for the most critically ill patients in hospital. Whilst other specialties deal exclusively with specific organs or body systems, Critical Care encompasses the entire spectrum of medical and surgical pathology. The Critical Care team is able to provide advanced organ support during critical illness and coordinate the care of patients on Critical Care units (intensive care and high dependency units). This includes the investigation, diagnosis, and treatment of acute illness, systems management and patient safety, ethics, end-of-life care, and the support of patients and families including beyond their critical illness to follow-up of physical and mental wellbeing and return to active life. The specialty for doctors in training is known as Intensive Care Medicine (ICM).

Critical Care is a rapidly evolving high tech, lifesaving medical specialty that is essential to 21st century medicine. It underpins and interacts with all other areas of acute hospital care.

1. The Five Workforce Messages

Critical Care is at the heart of any acute hospital.

The Emergency Department (eg accidents, heart attacks), Surgery (eg cardiac bypasses, cancer operations, transplantation), Medical Wards (eg infectious diseases, stroke, sepsis) and Maternity Care (eg childbirth complications) all require Critical Care services to function safely and effectively. COVID-19 highlighted the impact on the operation of many services from the loss of Critical Care support.

There is a significant growth in the need for Critical Care services predicted.

Prior to COVID, three separate reviews of future Critical Care demand, each estimated a significant (up to 100% in 20 years) demand in Critical Care. As the population ages and as medical innovations increase, Critical Care will be in greater demand. Some of this increase in demand can be managed with efficient reconfiguration or review of services, but new funding will be needed to address the remaining demand. This requires investment and development of Enhanced Care services as well as growth of existing level 2 (and in some places level 3) Critical Care provision.

We need more trained Critical Care consultants, continue to increase posts for new doctors in training and expand the Advanced Critical Care Practitioner (ACCP) workforce.

There has been an historical under-provision of trained doctors in Critical Care. The COVID response required considerable support from other groups to deliver a basic service. As overall service demand grows, the provision gap of trained intensivists is widening. Whilst the Faculty has achieved a doubling of training posts available since 2012, this still falls short of the number of consultants the NHS needs just to keep services running to current demand. A one-off COVID related increase of 100 training posts was issued by HEE for England for 2020, this needs to be continued to close the gap in provision. Northern Ireland, Scotland and Wales also received an increase in post numbers. ACCP numbers need to increase to support the delivery of medical care in more units.

There is a growing staffing issue for Critical Care nurses. The safe provision of Critical Care pharmacists and Allied Health Professionals varies considerably by hospital and needs to be made uniform.

The COVID pandemic has illustrated the essential need for trained Critical Care nurses by the bedside, pharmacists to advise and manage medication supplies and Allied Health Professionals to help deliver the package of care that critically ill patients need. Critical Care nursing vacancies are growing, notably among senior nurses. Short-staffing places the remaining dedicated nurses in a difficult environment that increases risk of burnout. Training and resourcing for dedicated Critical Care pharmacists is not uniformly provided. A Critical Care service that meets modern agreed standards needs Allied Health Professions (AHP) across Physiotherapy, Speech and Language Therapy, Psychology, Dietetics, and Occupational Therapy to contribute to the team effort.

Finding Critical Care beds for patients is becoming a threat to quality of care.

The number of Critical Care beds per head of population in the UK is one of the lowest in Europe and has not been able to keep pace with growing service demand even before COVID-19. Clinicians are now deeply concerned that quality of care is being compromised and COVID illustrated significant differences in Critical Care provision locally and regionally. All healthcare staff that work in Critical Care feel passionate about their work and the growing stress that a lack of bed resources presents will significantly affect staff retention, staff wellbeing and further impact on patient safety.

2. National Picture (Critical Futures, CfWI, ICNARC, HES)

KEY MESSAGES	
1	All national research into the specialty pre COVID-19 indicated a significant growth in demand for Critical Care services over the next 20 years. There are many external factors affecting the increasing requirements for Critical Care services, including an ageing population, increasing patient frailty, and the evolution of medical and surgical care.
2	Multiple sources, including NHS collected data, all indicate a 4-5% growth year on year in Critical Care activity to meet existing demand. The COVID pandemic has highlighted the need to develop a reserve workforce that can be rapidly upskilled to provide additional support when required.
3	There are a number of solutions to the growing workforce problem, which largely fall into new ways of working (reconfiguration) and careful new investment in resources (both people and beds).

2.1 Critical Futures

In October 2017, the Faculty released the first report of the Critical Futures initiative, which was based on a detailed survey of all members and sister organisations across the multidisciplinary team. Concerns regarding workforce and resources were common themes and recognised both the current shortfall in resources and the growing demand for the future.

Of note from Section 4.2 of the report:

- *"Almost all (450/511) reported that workforce was a limiting factor in meeting increasing demand for Critical Care: rota gaps, weekend and night cover with a small pool of consultants, constant demands to balance emergency and elective workload leading to a high degree of frustration and the sense of a service struggling along in an under-resourced environment were all highlighted as issues."*
- *"Unsurprisingly no responders had too many trainees. All felt an increase in training numbers was urgent to staff rotas now and supply consultants for the future."*
- *"There were 420 responses which referred to nurses, and 73% thought there was a need for change [to the assessment of nurse to patient staffing ratios]".*

Workforce relevant recommendations are:

- Recommendation 6: TRAINEE DOCTORS: RECRUITMENT AND RETENTION
  There must be an urgent review of the funding of trainee doctor numbers across the UK in order to secure the future consultant workforce.
  2020 response: 114 extra training places were secured across the UK in response to COVID. These numbers alone will not address the existing consultant gap and training numbers must continue to be expanded.

- Recommendation 7: CREATING SUSTAINABLE CAREERS
  The ICM community, the devolved nations and NHS England must consider how working in acute specialties can be supported as long-term sustainable careers.

2020 response: rapid redeployment and cross-skilling of professionals during the pandemic to support existing Critical Care staff must not be considered as a 'one off' response. There is a need to create a 'reserve' workforce that can reduce the burden on existing Critical Care staff.

- Recommendation 8: ADVANCED CRITICAL CARE PRACTITIONERS
  It is essential to recognise the importance of Advanced Critical Care Practitioners (ACCPs) nationally and centrally. The FICM has taken forward a curriculum for ACCPs and a portfolio assessment process. It also provides a home for their professional matters. Regulation, funding and career pathways must be explored.
  2020 response: the COVID pandemic has illustrated the enormous value that ACCPs add to a Critical Care service and delivery of patient care. Funding and support is now needed across all 4 nations to expand ACCP training so they can be embedded in more Critical Care units.

Solutions for improving the efficient use of Critical Care services were covered in Recommendation 2 (Level 2 care), Recommendation 3 (Enhanced Care) and Recommendation 10 (on escalation of treatment). The Faculty has since produced a national report on Care at the End of Life and escalation of treatment. It has also released its report on Enhanced Care that provides a template going forward to unlocking NHS services and identifying a reserve workforce to support existing Critical Care services as we adjust to working with COVID in the community and NHS.

2.2 Annual Critical Care activity data

NHS Digital collects and publishes on their website a summary of data from the Hospital Episodes Statistics (HES) warehouse on adult Critical Care activity.

In the table below we have summarised the % change in activity between each 12 month period. This is, on average, a **4% increase per year over the period below**, which triangulates well with the CfWI and ICNARC data covered above. When the supply of critical care capacity does not meet demand, difficult decisions need to be made by clinicians. This is a major source of stress to the multidisciplinary team.

Period	No. of Adult Critical Care Periods	% change on previous period
2018-19	291,679	-0.1
2017-18	291,836	-0.5
2016-17	293,170	+8.1
2015-16	271,079	+4.4
2014-15	259,691	+4
2013-14	249,735	+5.1
2012-13	237,710	-0.2
2011-12	238,248	+10.4
2010-11	215,728	*Not available*

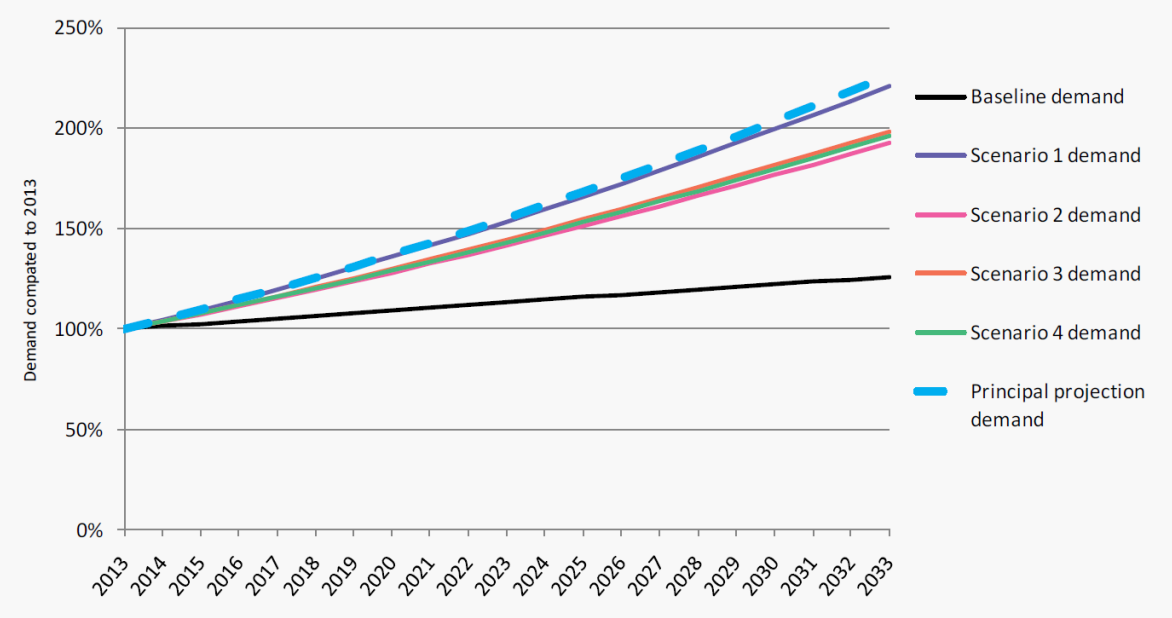
Taken from https://digital.nhs.uk/

2.3 Centre for Workforce Intelligence data

The Centre for Workforce Intelligence's (CfWI) review of the ICM and Anaesthetics workforce was published in March 2015. A number of key figures from the FICM were involved in all stages of the report's generation and our data was fed into their modelling.

The proposals and comments contained within the report are as follows:

- Health Education England (HEE) should continue to fill the current number of training posts for intensivists in England to minimise the risk of short-term undersupply. The report notes "HEE may wish to support the flexibility required to meet the needs of the future workforce by training an appropriate mix of specialists with single and dual CCTs, particularly noting that the future ICM service is likely be delivered mostly by intensivists with Dual CCTs."
- The report recognises that anaesthetists provide a notable level of service to ICM and that any changes to this provision would need to be counteracted with an increase in the provision of ICM.
- The report recognises, in line with the Intensive Care National Audit and Research Centre (ICNARC) research on projected usage of Level 2 and 3 bed days, 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.
- This translates to roughly **a 4-5% increase** in activity year on year.



The four scenarios considered cash-rich/cash-poor and reconfiguration states, all indicated a significant increase. These are naturally dependent on a number of variables, including the increased use of trained and regulated Advanced Critical Care Practitioners and reconfiguration of services, and the impact of initiatives like Enhanced Care delivery. However, the broad message of the report is one that the ICM community has been aware of for some time: **there needs to be more investment in the ICM workforce**. Although this report concentrates on England, the FICM continues to look at the wider UK, where we accept the same necessity for growth will be self-evident.

The full report can be downloaded at the link below. Two literature searches were conducted to supplement our submission to the Centre for Workforce Intelligence. They are now available online here: https://www.ficm.ac.uk/workforce/cfwi.

2.4 Demographic and bed days data

ICNARC has reviewed research on projected Level 2 and 3 bed days. ICNARC collects data relating to adult Critical Care services in 214 Critical Care units across England, Wales and Northern Ireland.

"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 at 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 2014)

Although ICNARC does not cover Scotland, this projection is likely to be similar for that required across all four home nations.

2.5 Resident tiers

The table below indicates the distribution of units by size across England, Wales and Northern Ireland and the number of tiers of resident staff (medical and/or ACCP) that are required to meet the minimum recommended staffing ratios. The number of patients each resident tier should look after is 8 or less, but the number of individuals required on a tier to run a rota taking into account training requirements, EWTD working regulations, contracts etc. is around 9.

The number of general adult intensive care units and their declared bed capacity in England and Wales (excludes specialist units for cardiac and neuro Critical Care) in 2018.

Number of beds on Unit	Number of Units of that bed number in England and Wales	Resident tiers required to meet 1:8 patient ratio
0-4	6	6
5-8	51	51
9-16	108	216
17-25	32	66
>25	17	68
Total	214	407

These data derive from the Case Mix Programme Database. The Case Mix Programme is the national, comparative audit of patient outcomes from adult Critical Care coordinated by the Intensive Care National Audit & Research Centre (ICNARC). For more information on the representativeness and quality of these data, please contact ICNARC.

3. Regional Workforce Engagement Data

KEY MESSAGES	
1	There is a general lack of staff and beds to currently run units with medical, nursing and Allied Health Professional (AHP) groups all affected. Geography is a contributing factor for some hospitals in attracting and retaining staff.
2	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.
3	The frequency of on-call and the lack of middle grade cover / trainee availability are significant problems in many units. Cardiac units were noted to be of special concern.
4	It would be easier to attract potential new consultants to smaller and remote units if trainees had more training exposure in these locations.
5	A need was identified for regional finance/planning of ACCP training to facilitate this growth plus an agreement on pay scales to stop poaching between hospitals.
6	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.
Key messages taken from FICM's Critical Engagements: Key Findings and Recommendations from the Regional Engagements (Mar 2018)	

The Faculty started holding Workforce Engagement Meetings in 2015. The Faculty has now held engagements in Wales, West Midlands, Scotland, Yorkshire & Humber, the North West, East Midlands, South West Peninsula, Thames Valley and Wessex. More information on the background to the engagement project and all of the reports produced to date can be found here: https://www.ficm.ac.uk/workforce/local-engagements.

The aim of these days is to:

- Describe current supply of ICM/Critical Care facilities locally and present an assessment of a likely future demand for the service.
- Identify the likely future location of Critical Care services based on current provision.
- Present the best estimates that can be made of current trained medical workforce in ICM locally, their distribution and demographic as well as the workforce in training.
- Conduct discussion sessions to reconcile supply and likely demand for ICM, with the current and projected workforce.

Critical Engagements: Key Findings and Recommendations from the Regional Engagements highlighted a number of messages from the first six engagements and we recommend you use that as a companion document to this. We have summarised some key messages from this document in the table above.

4. Critical Care Bed Capacity

KEY MESSAGES	
1	The majority of Critical Care units do not have a full nursing complement.
2	2/5 of units have to close beds due to staffing shortages on at least a weekly basis.
3	4/5 of units had to transfer patients due to lack of bed capacity.
4	The current data collection and service modelling is not sufficient to truly ascertain the Critical Care needs of UK patients.
Key messages taken from FICM's Critical Capacity: A Short Research Survey of Critical Care Bed Capacity (Mar 2018)	

During the last two weeks of February 2018 as a short length research project, the FICM ran a survey of its membership to understand the complex picture behind the UK's current Critical Care bed capacity. From a series of local workforce engagements and censuses, FICM has regularly had the issue of bed capacity raised as a concern for both the continuing quality care of patients and the wellbeing of the clinicians who look after them. Figures have been routinely collected in England for some years, but it is commonly felt by ICM doctors, that this does not give an accurate reflection of the day-to-day pressures felt on the majority of High Dependency Units (HDUs) and Intensive Care Units (ICUs).

386 responses were received, accounting for approximately 20% of ICM consultants. As there are around 210 units in the UK, this is likely to cover a large number of units.

The Faculty liaised with the Guardian and released this data as an exclusive to them for publication. The final report was published in *Critical Capacity: A Short Research Survey of Critical Care Bed Capacity*.

The survey demonstrated that large numbers of units across the UK are either currently experiencing or moving towards a capacity crisis. Only a minority of units were not having to make difficult decisions to ensure that patients were able to receive the care they required.

The key messages are as follows:

- 3/5 of units do not have a full Critical Care nursing complement.
- Of those affected, the vast majority considered that bed capacity was inevitably impacted leading to cancelled operations. Quality of care and even patient safety might be impacted.
- 2/5 of units have to close beds due to staffing shortages on at least a weekly basis. Only 14% of units did not have to close beds.
- 4/5 of units had to transfer patients due to lack of beds. With 21% units doing this at least monthly.
- The bed fill rate for Northern Ireland and Wales was estimated to be at least 95%. Scotland was 84%. NHS England data put the Critical Care bed capacity rate at 87%, but a number of units responded to express doubt that the rate entered for their Trusts was a true reflection of their real capacity.

2020 Response

The Faculty produced '*Bridging Guidance for Critical Care During the Restoration of NHS Services'* to help identify the support required to resume regular practices after the initial COVID pandemic surge.

Key messages from the guidance include:

- Delivery of increased non-COVID activity whilst COVID patients remain in significant numbers within a hospital is likely to be extremely challenging for the existing Critical Care (CC) workforce without the ongoing support of some of the deployed additional workforce used to support the pandemic response. This must be factored into any planning of resumed activity.
- It is challenging to deliver Critical Care in more than one location to accommodate increased non-COVID activity alongside existing COVID work. Some hospitals will need to operate below previous baseline CC capacity to maintain safety and service resilience. This will have an impact on the speed and extent of restoration of non-COVID services, particularly the ability of CC services to support Level 2 surgical activity. This may also require an increase in non-clinical patient transfers and, where Critical Care networks exist, distribution of service pressures across the Network.

The Faculty of Intensive Care Medicine recommends that the Departments of Health for England, Northern Ireland, Scotland and Wales engage with Health Boards and Trusts to make modelling of Critical Care need, estate and workforce an urgent priority.

5. Nursing and Allied Health Professional (AHP) Workforces

KEY MESSAGES	
1	There is a considerable vacancy rate with the nursing workforce as well as significant turnover in some hospitals.
2	The provision of the full multidisciplinary team, including all Allied Health Professional colleagues, varies considerably both by region and by profession.
Key messages taken from CC3N's National Critical Care Non-Medical Workforce Survey Overview Report (Mar 2016) and CC3N's National Critical Care Nursing and Outreach Workforce Survey Overview Report (Apr 2018)	

5.1 Nursing

CC3N recently conducted a Critical Care nursing and outreach workforce survey (2018) and they have kindly provided us with the key messages below. It is available on the CC3N website at http://cc3n.org.uk

- 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.
- NMC report published in June 2017 highlighted that the number of EU trained nurses and midwives joining the register has dropped steeply (96%) since July 2016 that may be due to the introduction of new language controls for EU trained nurses and the impact of Brexit.
- 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 was undertaken in 2016, there has been an increase in the number of units having a supernumerary clinical coordinator rostered across all shifts.
- Although there has been an 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, although ACCPs can help retain senior nurses by the bedside.

- 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.

5.2 AHPs

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 nursing and AHP workforces. It is available on the CC3N website at http://cc3n.org.uk

Findings:

- 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 support of 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.

5.3 Pharmacy

Critical Care Pharmacists are essential to the safe and effective running of Critical Care services, supporting patients and improving outcomes. They form a central part of the multi-professional team, optimising medication therapy, improving quality and safety by resolving errors and undertaking wider professional support. Of the 186 units who responded to the National Critical Care Non-Medical Workforce survey, 165 (89%) had a dedicated Critical Care **Pharmacist;** 21 (11%) did not. The overview report is available on the CC3N website. As of July 2020, the Faculty has become the professional home for Critical Care Pharmacists.

The 2020 Bridging guidance released by the Faculty, identified challenges facing the critical care pharmacist workforce:

Clinical pharmacy services are integral to care of the critically ill patient. The pandemic has further emphasised the need for expert critical care pharmacist support to maintain patient safety and medication therapy during a period of considerable stress in the medicine supply system. Although the vast majority of critical care units have a clinical pharmacist assigned to them, not all are established critical care specialist pharmacists. The pandemic identified challenges in Critical Care Pharmacist workforce surge capacity and its ability to readily extend the scope of services, supervision and weekend service provision. Finally, the

small number of consultant-level Critical Care Pharmacists has limited the number of experts available to provide regional (ODN) and national medication continuity and service planning advice. The clinical pharmacy workforce is an important example of critical care staffing inequities. They must be included in the funded review of Critical Care services to ensure pharmacists have the appropriate training, accreditation and workforce numbers to meet the current and future needs of Critical Care 7/7.

6. Medical Workforce: Advanced Critical Care Practitioners

KEY MESSAGES	
1	ACCPs are a key contributor to the workforce and need to be supported and expanded.
2	ACCPs are expanding in number but without appropriate national and regional funding plans, will be unlikely to grow at the volume required to manage middle grade workforce requirements.

Advanced Critical Care Practitioners (ACCPs) are clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are highly experienced and educated members of the Critical Care team who are able to diagnose and treat or refer to specialists if needed. They are empowered to make high-level clinical decisions and will often have their own caseload. ACCPs are an emerging workforce who are part of the solution to the Critical Care middle grade workforce gap. Without regulation, these roles are restricted to existing nurses and physiotherapists, but with regulation could be accessible by a much broader workforce. Following agreement from ACCP members, the Faculty continues to work with HEE and other stakeholders through the Medical Associate Professionals Board to link the ACCP workforce into the developing training structures, funding and regulatory pathways.

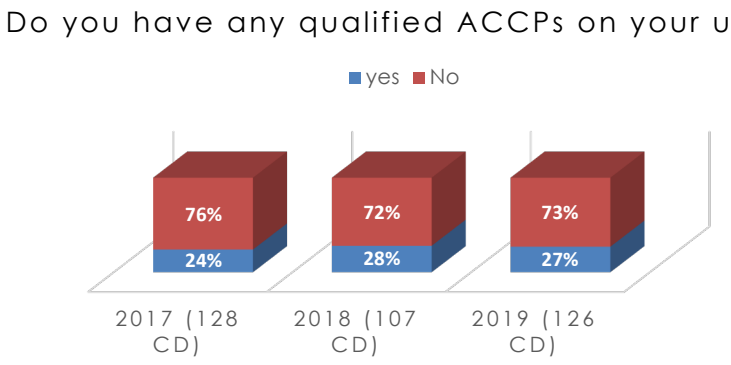
6.1 ACCP numbers

As of December 2020, there are 210 ACCPs registered with the Faculty of Intensive Care Medicine as ACCP Members. In addition, there are a small number who have undertaken training outside the curriculum who are undertaking supplementary training with the intention of achieving accreditation. There are estimated to be almost 100 additional ACCPs in training.

6.2 Statistics on ACCPs from the FICM Workforce Census

ACCPs are undoubtedly an emerging workforce within Critical Care units. While data has been collected over the last three censuses on the presence of ACCPs on units, the nature of the questions posed has altered from year to year. For further information on the role of an ACCP and their training, please see the Faculty website.

In 2017, 2018 and 2019 we asked Clinical Directors (CD) to advise if their unit had ACCPs as part of the workforce; the results are as follows.



7. Medical Workforce: Census and Regional Data

KEY MESSAGES	
1	Current patterns of work are diverse and complicated but factors such as an increase in consultant delivered care, and reductions in the number of anaesthetists providing input to intensive care will mean more ICM consultants are required to provide the service.
2	We are seeing an increase in ICM only consultants and this is something that will need to be factored in as it impacts upon total sessions dedicated to ICM and therefore the frequency of on-call commitments.
3	The average number of DCC-PAs in ICM is between 4 and 5, meaning each dual ICM CCT holder will ultimately fill 50% of a whole time equivalent ICM consultant post.
4	The level of stress caused by an escalating workload (without increasing bed capacity and trainee expansion and their competency) and without considering the long term impact of onerous on-call commitments on consultants' health and wellbeing, may directly affect the recruitment and retention of ICM consultants.
5	There is considerable variation in the provision of ICM posts for recruitment across the country.
6	This variation has some correlation with provision of consultant posts, demonstrating an historical under provision in certain regions when compared to other regions.
7	Cardiac ICM workforce continues to face mounting challenges in recruitment due to current employment gaps, an anticipated surge in consultant retirements, lengthy training times, a rising non-surgical workload and perceived difficulties in joint accreditation.

The Faculty have now run seven annual censuses covering the years 2012, 2014, 2015, 2016, 2017, 2018 and 2019. The questions and focus of these individual censuses have evolved and adapted with time to suit the needs of the FICM Career, Recruitment and Workforce Committee (2017-current) and the FICM Workforce Advisory Group before it (2011-2016). These subtle differences allow for detailed data gathering on new and evolving practices relevant to the intensive care workforce, such as the emergence and growth of the Advanced Critical Care Practitioner (ACCP) role.

While annual differences are extremely useful, they can make presenting longitudinal data more challenging. The following section aims to present data from the censuses that has been collected for multiple years, although please note that sometimes these years are not always consecutive.

In addition, we are thankful to the Association for Cardiothoracic Anaesthesia and Critical Care (ACTACC) for the summary they have given of their census on cardiothoracic Critical Care in Section 6.2 below, which helps to highlight the additional challenges that the workforce is likely to face in the coming years. The 7th Key Message above is a summary of the overall finding of this important census.

7.1 Statistics on response rate and job structure

7.1.1 Overall response rate

NB: The census is distributed to a larger number of consultants every year as our database grows.

Year	Response rate	Year	Response rate
2014	40%	2017	39%
2015	43%	2018	39%
2016	38%	2019	47%

7.1.2 Respondents by Country

Country	2017 Percentage	2018 Percentage	2019 Percentage
England	82%	81%	81%
Northern Ireland	2%	3%	3%
Scotland	11%	11%	11%
Wales	5%	5%	5%

7.1.3 Respondents by Gender

The data below has been taken from the Faculty's inaugural census in 2012 and the most recent census in 2019. From this small snapshot on respondents' gender, an increase in female respondents between the first and last Faculty Census can be seen.

Year	% Female
2012	16.9%
2019	24%

7.1.4 Consultants practicing in ICM Only

In 2012, 5.3% of respondents advised that they were working in ICM only. This question has been repeated in subsequent censuses, the results at two-year intervals from the 2015, 2017 & 2019 Censuses shows a steady increase in consultants practicing solely in ICM.

Year	% working in ICM only
2015	6.3%
2017	7.9%
2019	9.9%

7.1.5 Partner Specialties

In 2012, 91.1% of respondents confirmed they worked in both Anaesthesia and ICM. This question has been repeated in the last 5 surveys 2015-2019, along with our other partner specialties and the average results can be seen below. Whilst those working in ICM and Anaesthesia constitutes the majority of respondents, this number is falling alongside a reduction in those training in dual ICM/Anaesthesia.

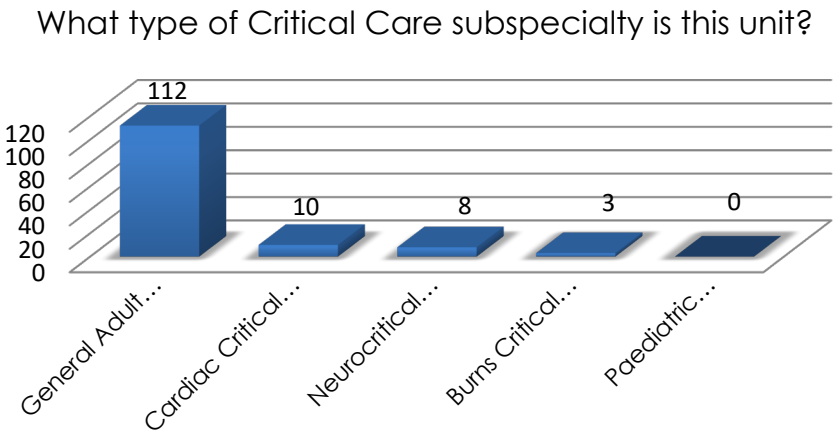
Other Specialty	Average (2015-2019)
Anaesthesia	83.4%
Acute Medicine	1.56%
Respiratory Medicine	1.76%
Renal Medicine	0.43%
Emergency Medicine	1.53%
Cardiology	0.53%
Infectious Diseases	0.08%

7.2 Specialist units

7.2.1 Specialist units' data for 2019

In 2019, as in previous surveys, Clinical Leads were asked to advise what type of Critical Care subspecialty their unit came under.

NB: These answers are limited to the survey responses. ICNARC records 283 units (as of 2018) for England, Northern Ireland and Wales alone. As the FICM and this Data Bank is concerned with Adult Critical Care, the number of Paediatric Critical Care Units responding is normally zero.



7.2.2 ACTACC Workforce Report on Cardiothoracic Critical Care

There are 32 adult Cardiothoracic Intensive Care Units in the UK. The number of consultants employed within each centre ranges from 7 to 40. In over 75% of units, consultants in Cardiothoracic ICM (CTICM) also undertake sessions in either Cardiothoracic Anaesthesia (CTA) or General Anaesthesia.

The 2016 ACTACC Workforce Report showed that over 70% of centres do not yet have separate on-call rotas for CTICM and CTA. For most of these centres (which on the whole have fewer ICU beds compared to centres with separate rotas), staffing limitations mean it is unlikely that separate rotas would be achievable within the next 5 years. Over 50% of centres have consultant vacancies and recruitment prospects remain challenging, with most centres employing locums. There is a further significant issue associated with a large anticipated number of consultant retirements within the next 4 years that can be traced back to the rapid expansion of cardiac surgery in the 1990s.

Trainee feedback from across the UK has demonstrated that there is little appetite or intention amongst trainees to undertake dual certification in anaesthesia and ICM, in addition to a further 18 months sub-specialty training in CTA/CTICM and Transesophageal Echocardiography (TOE) accreditation.

Cardiothoracic ICUs face similar challenges to generic ICUs in terms of junior medical staffing (reduced numbers, European doctors) and there is a noticeable expansion in the number of ACCPs being employed within cardiac units.

7.3 Statistics on ICM as a Career

7.3.1 Intention to practice ICM for the remainder of career

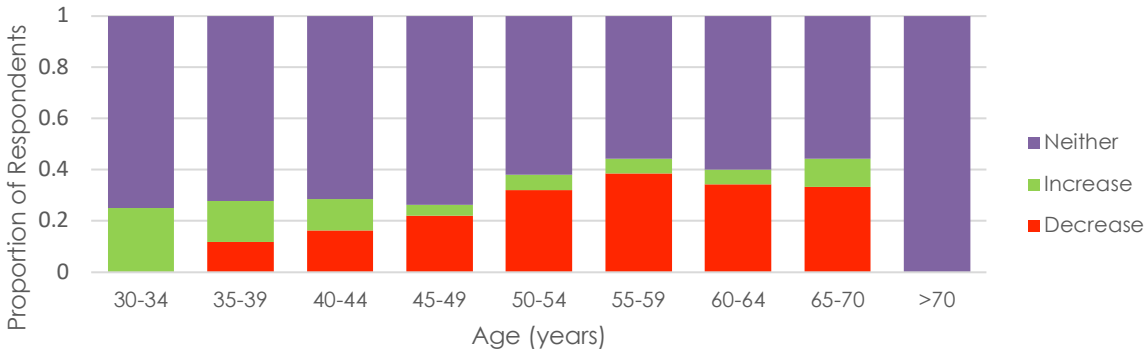
For the past six years, respondents have been asked to advise if they intend to practice ICM for the remainder of their career.

	2014	2015	2016	2017	2018	2019
Yes	78%	75%	60%	79%	79%	78%
No	22%	25%	38%	21%	20%	22%

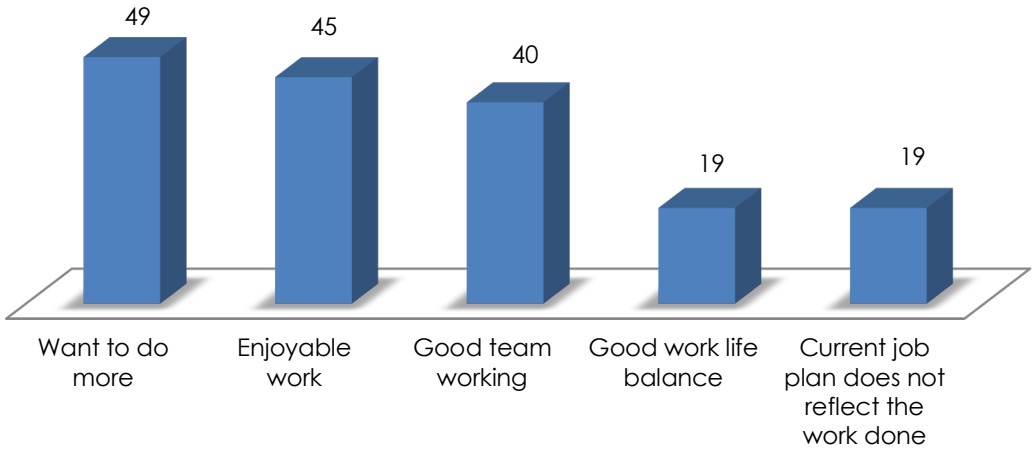
7.3.2 Plan of respondents to alter their commitment to ICM in the next two years

	2015 Percentage	2016 Percentage	2017 Percentage	2018 Percentage	2019 Percentage
Increase	13%	9.50%	10%	8%	9%
Decrease	11.30%	16.50%	16.70%	16%	23%
Neither	70.00%	72.50%	73.30%	75%	68%

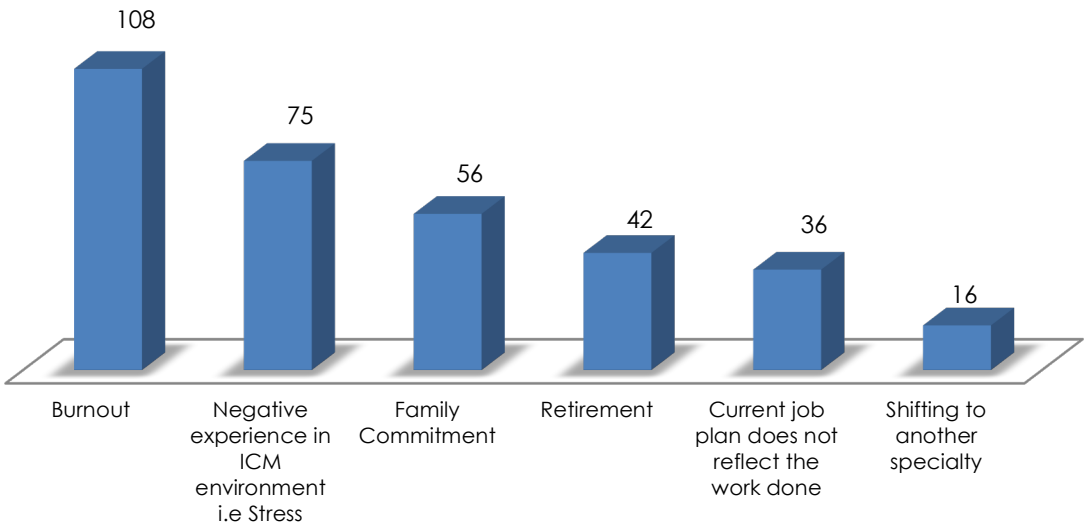
2019 - Change in ICM activity over next two years by age



2019 - Top reasons consultants wished to increase their commitment to ICM



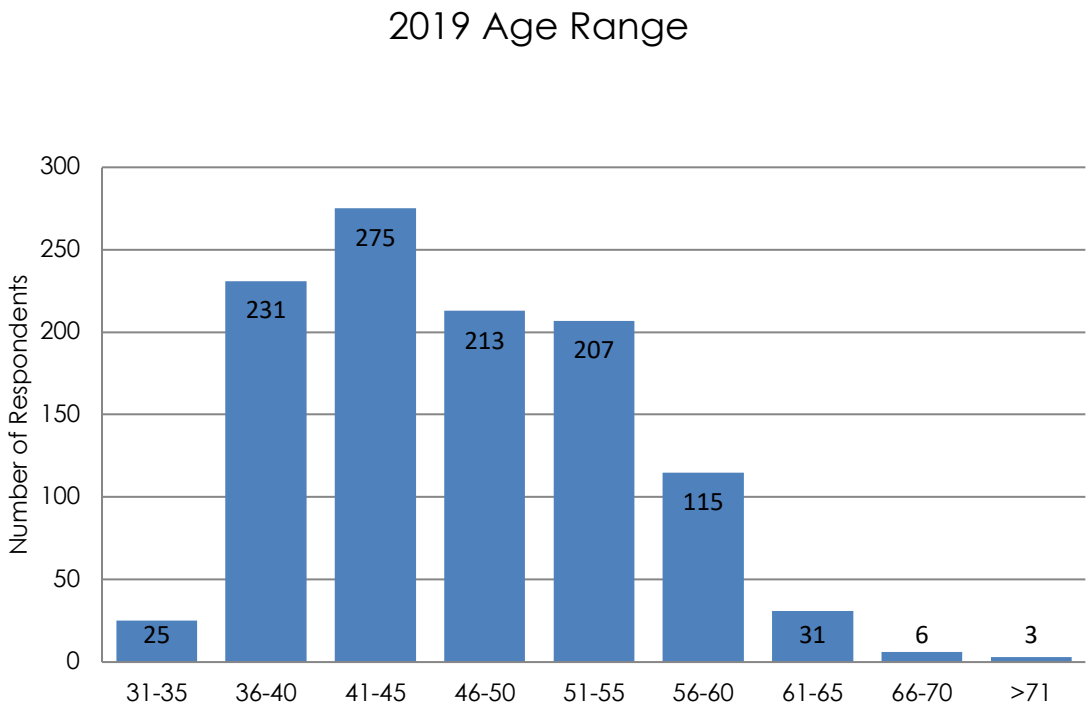
2019 - Top reasons consultants wished to decrease their commitment to ICM



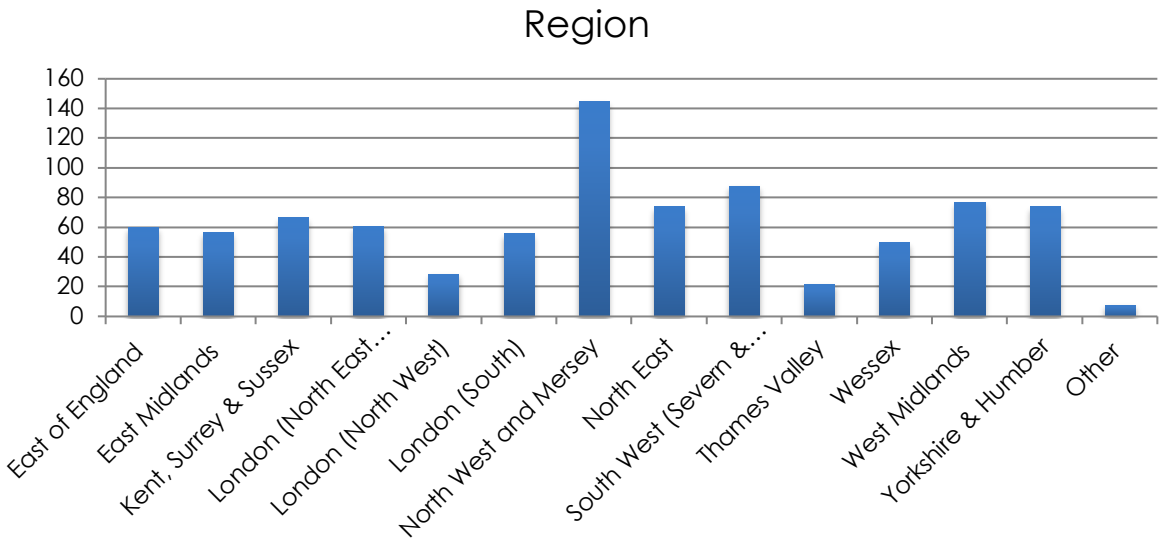
7.4 2019 Census in detail

The 2019 FICM Census was sent to 2373 consultants registered with the Faculty of Intensive Care Medicine. The following section displays details of the 1106 full census responders.

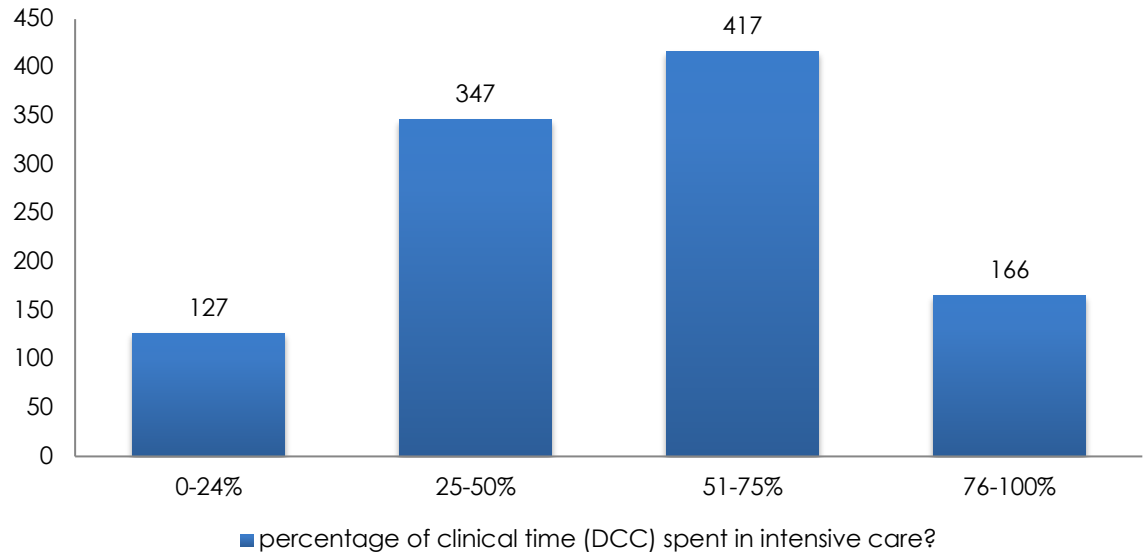
7.4.1 Age of respondents



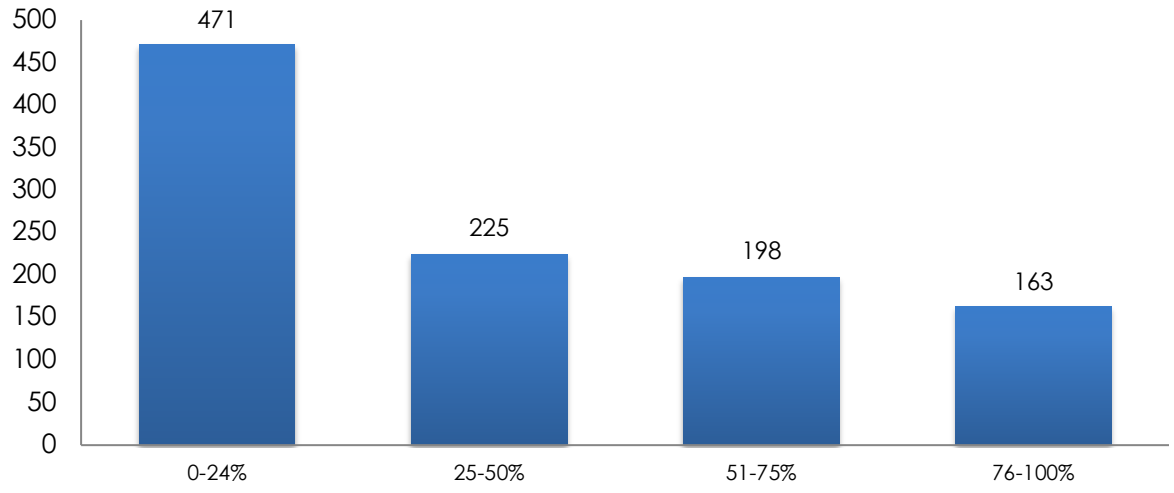
7.4.2 Responders from England broken down by region



7.4.3 Over a 12-month period, what percentage of clinical time (DCC) is spent in intensive care?



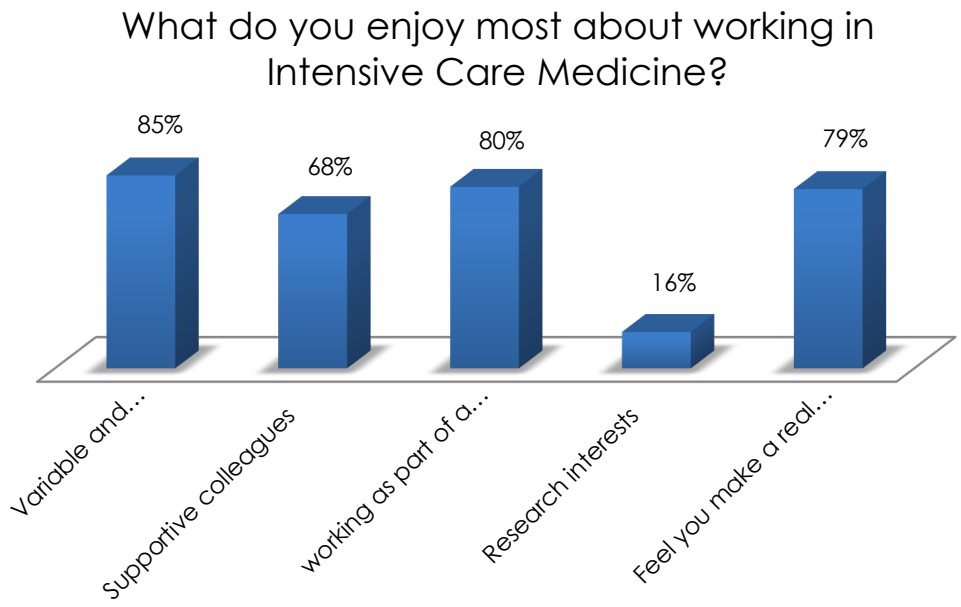
7.4.4 Over a 12-month period, what percentage of non-clinical time/SPA is spent in intensive care?



7.4.5 Summary of Individual Data

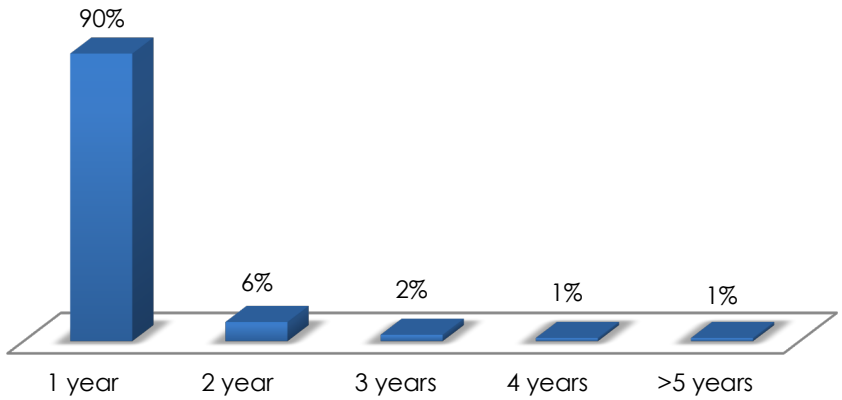
Individual Data	Total PAs in Job Plan	Total SPAs in Job Plan
Answers range	from 0 - 15	from 0 to 12
Mode	12	2
Median	11.5	2
Mean	11.04	2.2
Range	15	12

7.4.6 2019 Focus – Lifelong Critical Care

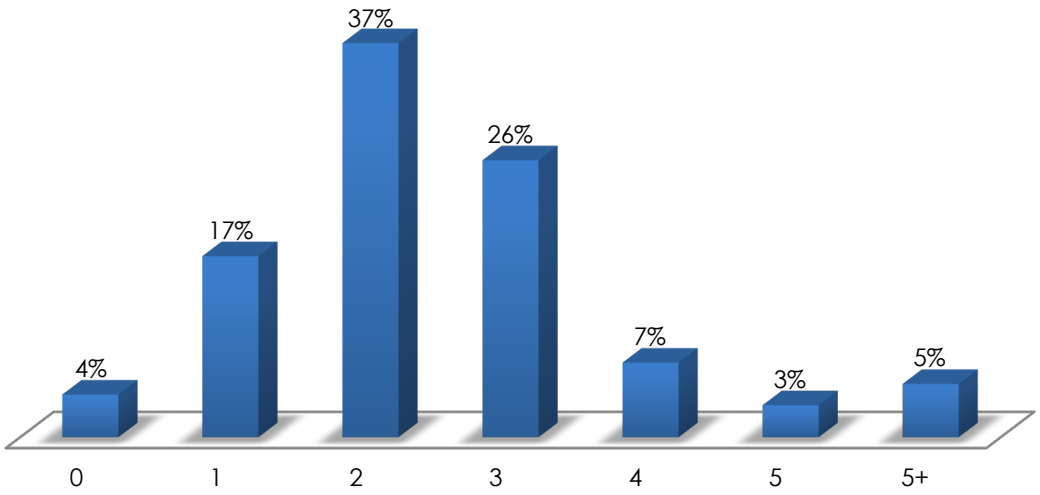


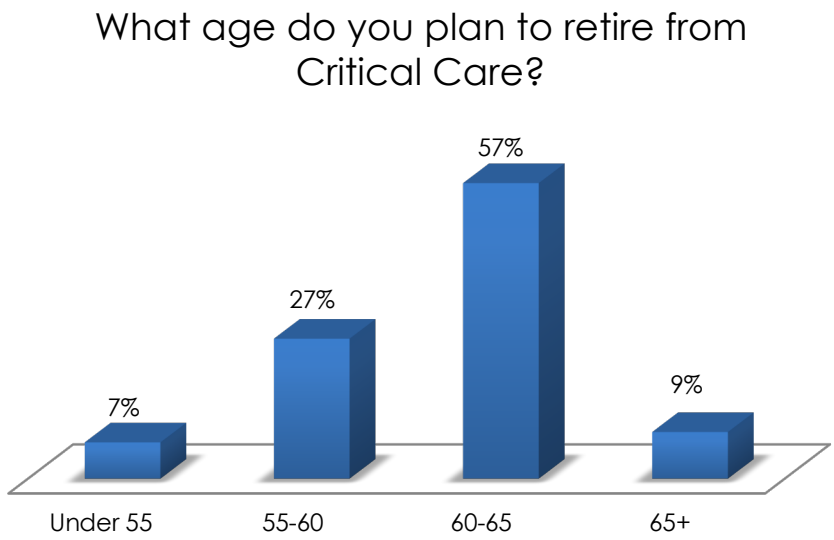
Variable and challenging case-mix	85%
Supportive colleagues	68%
Working as part of a multidisciplinary team	80%
Research interests	16%
Feel like you can make a real difference to the care of patients and relatives	79%

When was the last time that your job plan was reviewed?



On average how many times would you expect to be disturbed from sleep when on-call between midnight and 0700hrs?





Future Focus

In 2019 the census asked responders to suggest areas that they would like the Faculty to focus on in the future. Job planning advice, career development support and clinical leadership were all popular choices and the Faculty is pleased to advise that key projects such as hosting an annual Clinical Leads meeting, a mentoring scheme, consultant transition course templates and a proposed document on critical staffing, will address these areas.

7.4.7 Clinical Leads segment – Summary unit data

In total 130 Units were represented in the Clinical Leads section.

Unit Data	Staffed Critical Care beds	No. of consultants providing daytime clinical work	How many PAs of Critical Care time are required to cover the unit	What is the total number of CCMDS calendar bed days?
Answers ranged	from 4 to 46	from 1 to 35	from 10-175	from 99 to 13427
Mode	10	8	35	3500
Median	14	9	41	3742
Mean	15.9	9.40	47.39	4121
Range	42	34	165	13328

7.4.8 Unfilled Consultant posts

In 2019 we asked the Clinical Leads to report on the number of unfilled consultant posts within their units. A total of 58 (44.6%) of the 130 units responding to the census have unfilled consultant posts. 19 units (32.8%) had three or more unfilled posts, and 22 units reported that a post had been unfilled for over 12 months.

7.5 Frontline Voices 2020 survey

In October 2020, the Faculty surveyed our consultant fellows and members to find out about their experiences during the first wave of the COVID-19 pandemic. The results have been published in the report *Voices from the Frontline of Critical Care*.

Key Findings:

- 45% of respondents have seen a permanent increase in the Critical Care capacity of their directorates. **However, when asked if they consider any increase in capacity to be adequately staffed only 18% of respondents agreed.**

- 60% of respondents reported that their units are still attempting to follow the *Guidelines for the Provision of Intensive Care Services (GPICS)* but **54% of respondents have seen some relaxation of those standards including to their medical staffing.**

- **80% of respondents increased their working hours, and 71% report covering sick consultant colleagues.** Future uncertainties affect the wellbeing of the Faculty's fellows and members. How hospital structures support those working in Critical Care is vitally important for both recruitment and retention.

- **88% of respondents had leave cancelled.** Work/life balance is extremely important. Whilst the vast majority of respondents were happy to deliver the needed increase in work in the first wave, to do this over subsequent waves of the pandemic becomes increasingly difficult for individuals and their families. Supporting professional activities and agreed job plans will be even more important in subsequent COVID-19 waves.

- Faculty fellows and members understood the impact the first wave of COVID-19 had on non-critical care staff, and hugely appreciated their response to the crisis. The flexible increase in staffing was so important for care, although **the drop in GPICS standards underlines the need to increase the underlying Critical Care capacity, and the multi-disciplinary workforce.**

Key Recommendations from the report:

1. GPICS standards exist for reasons of best care, safety and governance. Units should be attempting to adhere to them or working towards achieving them.

2. Inability to meet GPICS standards needs to be brought to the attention of management structures within hospitals and plans for addressing deficiencies identified and implemented.

3. Supporting and maintaining the wellbeing of Critical Care staff is vitally important. Not only for recruitment by attracting multi-disciplinary team members in, but also for their retention in the specialty. Staff must not be taken for granted and listening to the voices from the frontline is only the start of this process.

4. Enhanced Care recommendations, written and promoted by the Faculty, will allow for greater flexibility in future responses to surges in demand as well as safer care for those needing a higher level of care. Critical Care Directorates should make the case widely within their hospitals for enhanced surgical and medical care.

7.6 Doctor in training and consultant post data compared to population

FICMCRW agreed it would be important to consider regional variation in this data pack as doctors in ICM training programmes are becoming increasingly unlikely to move regions for a consultant job (due to family, social and financial commitments). For dual trained doctors, they have greater opportunity of in-region employment in either ICM or their partner specialty when they complete training.

The following data is extrapolated from three sources:

- Trainee posts for recruitment in 2019 and 2020 respectively
- Population data provided by the RCP London and amended based on Regional Advisor input.
- Consultant data extrapolated from the seven previous ICM censuses.

The data is then presented in a table comparing trainee post data against population and consultant post data against population. An arbitrary RAG rating system has been included along the following lines to highlight the variation:

- Trainee/Population: RED (over 800k), AMBER (over 350k), GREEN (under 350k)
- Consultant/Population: RED (over 50k), AMBER (over 30k), GREEN (under 30k)

Table 1 – Based on 2019 Trainee Posts

	Population / Trainee post	Population / Con post
KSS	879263	66110
West Midlands	810673	38085
East of England	744271	43461
Northern	587453	21440
East Midlands	459873	40340
Wessex	394978	34723
Wales	385302	29079
Scotland	355180	23679
Yorks & Humber	349853	31999
South West*	305697	23645
London	283122	30013
North Western*	264091	22736
Northern Ireland	261389	45743
Thames Valley	231630	42115

*For 2020 recruitment, we received what is currently a one-off expansion in numbers of 114 extra National Training Numbers (NTNs) across all four nations. This remains a single investment, but we have recorded the traffic light table against these new numbers to demonstrate the impact increasing training posts can have. In 2021, we are set to return to figures like those from 2019 unless there is continued investment in training numbers.

Table 2 – Based on 2020 Trainee Posts

	Population / Trainee post	Population / Con post
KSS	732719	65617
West Midlands	218258	37831
East of England	313377	43781
Northern	195818	20980
East Midlands	255485	39989
Wessex	315982	33615
Wales	237109	28808
Scotland	266385	23470
Yorks & Humber	180959	32195
South West*	194535	23645
London	212342	29698
North Western*	152586	22661
Northern Ireland	261389	43565
Thames Valley	178177	42894

Important notes about these tables:

- This is about posts on offer rather than fill rate. A region that has managed to secure enough funding to offer a good amount of posts may still have a low fill rate and a risk of under-producing CCT doctors.
- The limitation of the division of regional population data means some regions that have individual recruitment numbers, i.e. North West (Mersey) and North West (Manchester) are combined.
- London, which contains a disproportionate number of tertiary centres, will have a significant draw on the population of surrounding regions that is not reflected in the table above.

8. Medical Workforce: Doctors in Training

KEY MESSAGES	
1	The average number of doctors completing ICM training in the last five years is 66.
2	The vast majority of doctors who dual trained in two specialties are now working in both specialties post CCT.
3	The attrition rate against the ICM CCT programme from 2012 to 2020 is 8.6%
4	The gender ratio in the specialty is 65% male and 35% female. When compared to the census data of 2019 (24% of respondents were female), the specialty has the potential to move towards gender parity.
5	The number of posts for ICM is growing and there is a need to continue this trend (see section 5 below).
6	The workforce breakdown by partner specialty background is similar to that historically of the Joint CCT programme although there are greater numbers of non-anaesthetic applicants as recruitment to the dual training programme matures over time.
7	The regional picture is more nuanced with some regions clearly benefiting from growing their post numbers to increase recruitment despite the overall UK fill rates varying from year to year (72-96%).

8.1 A brief history of training in ICM

- 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 order to preserve workforce output during the transition from the Joint to the Single/Dual CCT, recruitment to the Joint CCT only ceased in June 2013 and trainees will be reaching CCT up until 2019, with a smaller number (i.e. less than full time trainees) beyond that.
- 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 Internal Medicine Training, Core Anaesthetic Training and all 3 versions of the Acute Care Common Stem programme.
- As well as training solely in the specialty, it is currently also possible to train in a Dual CCT Programme with Acute Internal Medicine, Anaesthetics, Emergency Medicine, Renal Medicine and Respiratory Medicine. Details of these programmes are available here: https://www.ficm.ac.uk/curriculum-assessment-training/dual-cct-guidance.
- A single ICM CCT Programme takes a doctor 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 doctors will take longer to complete their training.

- Further details on the ICM curriculum are available in the link below. Section 1.3 of Part I of the curriculum (The Handbook) contains details on the history of the specialty. https://www.ficm.ac.uk/training-examinations/curriculum-assessment-training.

8.2 Output / CCT

As a Joint CCT, trainees ultimately 'belonged' to their parent college and the FICM's predecessor IBTICM was not always able to maintain accurate data on trainee specifics.

Table 8.2.a below indicates the number of doctors who a CCT in ICM in both the Joint CCT programme and the ICM standalone curriculum, which commenced in 2012. Pre-2010, the IBTICM data collection system was not as robust as the one currently in place so numbers could be higher than published.

Table 8.2 a

Year	No of doctors attaining a CCT in ICM
2008	85
2009	88
2010	70
2011	89
2012	113
2013	96
2014	115
2015	108
2016*	94*
2017	97
2018**	59
2019	87
2020	85

** 2016 was the first year when doctors completed training against the standalone ICM curriculum as Single CCT holders. The figure for this year includes two single CCT holders and one dual trainee with ICM and Anaesthesia.*

*** 2018 was the predicted nadir in CCTs caused by the GMC ending the old 7.5 year joint programme without overlap with the new 8.5 year joint programme. 2019 represents the curve increasing back up to higher numbers, which we expect to see continue in 2020.*

In October 2019, the Faculty of Intensive Care Medicine carried out its first ICM CCT/CESR-CP Holders Survey. FICM's Careers, Recruitment and Workforce Committee (FICMCRW) undertook the survey in the hope of discovering the early career pathways of the ICM CCT/CESR-CP holders completing training against the standalone ICM training programme (launched in 2012).

The survey was sent to 91 Intensivists who had gained a CCT/CESR-CP against the standalone ICM training programme. Of those 91, 38 completed the survey, resulting in a 42% response rate.

Whilst FICM recognises the programme and the CCT/CESR-CP holder numbers are still in their infancy, the findings are still of enormous interest to FICMCRW. For example, responders mentioned the possibility of FICM launching a dedicated consultant transitioning course, and FICMCRW are pleased to advise work on a course template to be delivered locally is already underway.

Key points from the survey are as follows:

- All of the single ICM CCT survey responders have gained consultant posts
- The vast majority of trainees who dual trained in two specialties are now working in both specialties post CCT
- From the survey responders only one dual trained individual is working only in their partner specialty without any ICM sessions at present
- 71% of responders were working in the same region they trained in
- 65% of responders successfully gained post CCT/CESR-CP employment after only one application.

8.3 Attrition

Due to the late recruitment date of the Joint CCT (normally ST5), attrition rates were so small as to be statistically negligible. As we reach the ninth year point from the launch of the ICM CCT programme, where trainees are admitted at ST3, data is now available on attrition rates.

Between August 2012 and August 2020, 92 trainees have left the programme resulting in an attrition rate of 8.6% across the 8 years. There is variation between the training regions and FICM will continue to monitor both absolute numbers as well as those leaving the programme in each region. Cited reasons for leaving the programme are varied but the majority of departures occur in Stage 1 of ICM training.

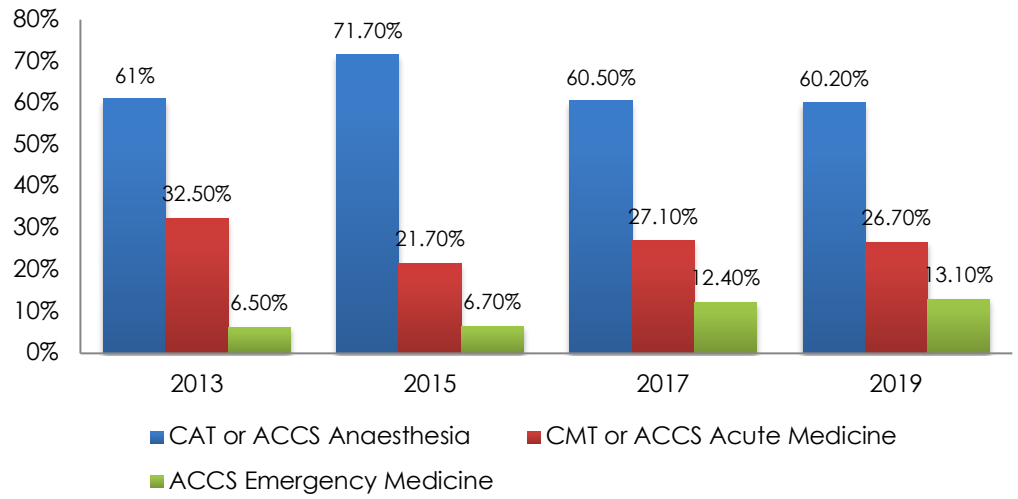
8.4 Gender

From our trainee membership database, of those trainees who are currently pursuing a Single or Dual CCT in ICM, 65% are male and 35% are female (*correct as of Feb 2021*).

8.5 Training background of ICM Doctors in Training

The graph below displays historical recruitment data from 2013 onwards. The data shows that whilst Core Anaesthetic Trainees continue to make up the majority of ICM ST3 applicants, other specialties, such as ACCS Emergency Medicine applicants, present a continual increase of applications from 2015 onwards. With an ICM post becoming part of the new Internal Medicine Training curriculum from 2018 onwards, the Faculty will continue to monitor medicine applicant numbers to highlight any increase to applicant numbers that this exposure to ICM might produce.

8.5.1 Background Core Training Programme of applicants



8.6 Cumulative recruitment statistics from 2012 - 2020

The following data tables display historical recruitment data from 2012 to 2020 concerning the total number of posts available each year and the number of posts that were filled.

	Applications	Shortlisted	Came to interview	Appointable
2012	127	116	112	86
2013	240	160	150	126
2014	277	243	233	202
2015	299	293	224	190
2016	255	251	228	195
2017	231	217	200	186
2018	293	287	228	206
2019	305	290	281	263
2020	430	376	n/a	376

	Applications	Posts	Ratio (App to Post)
2012	127	72	1.8
2013	240	88	2.7
2014	277	112	2.5
2015	299	137	2.2
2016	255	158	1.6
2017	231	163	1.4
2018	293	169	1.7
2019	305	170	1.7
2020	430	289	1.4

	Total New Posts	Filled	Fill Rate
2012	72	52	72%
2013	88	77	88%
2014	112	107	96%
2015	137	120	88%
2016	158	142	90%
2017	163	134	82%
2018	169	147	87%
2019	170	161	95%
2020	289	280	97%

The data table below shows the regional breakdown of posts available and posts filled for 2019 and 2020.

Deanery	Posts available 2019	Posts Filled 2019	%	Posts availabl e 2020	Posts Filled 2020	%
East of England	8	8	100%	19	19	100%
East Midlands	10	10	100%	18	15	83%
KSS	10	10	100%	12	12	100%
London	30	30	100%	40	40	100%
Mersey	6	6	100%	45	45	100%
North Western	20	18	90%			
Northern	5	5	100%	15	15	100%
Northern Ireland	5	5	100%	7	7	100%
Oxford	10	10	100%	13	13	100%
Scotland	16	15	94%	20	20	100%
Severn	7	6	86%	13	13	100%
SW Peninsula	4	4	100%	9	7	78%
Wales	8	8	100%	13	13	100%
Wessex	8	5	63%	10	8	80%
West Midlands	7	7	100%	26	24	92%
Yorkshire & Humber	15	14	94%	29	29	100%

NB: In April 2020, HEE confirmed funding for 100 additional ICM posts in England, and Northern Ireland (4), Scotland (6) and Wales (4) also confirmed additional posts in time for the offers to be released. This increased number of ICM posts, whilst greatly needed and appreciated, is not likely to be repeated in 2021. It is expected for 2021 figures to be similar to that of 2018/2019.

8.7 2019 Recruitment in detail

Recruitment data for 2019 Single & Dual Appointments

Stage	Number 2019 (2018 in brackets)
Applied	305 (293)
Shortlisted	290 (287)
Actually came to interview	281 (228)
Appointable (after veto and military)	263 (206)

Future training intention	% intending
Intending to Dual ICM with Anaesthetics	54%
Intending to Dual ICM with Medicine	21%
Intending to Dual ICM with Emergency Medicine	11%
Academia	2%
Intending to do single ICM CCT	9%

Background	2019 Appointments	TOTAL POSTS AVAILABLE
CAT or ACCS (Anaesthetics)	60.2%	161/169 FILL RATE: 95%
CMT or ACCS (Acute Medicine)	26.7%	
ACCS (Emergency Medicine)	13.1%	

8.8 2020 Recruitment in detail

Like many projects in 2020, the COVID-19 pandemic also affected ICM National Recruitment. The ICM National Recruitment Office, supported by the Faculty's recruitment leads, quickly implemented an alternative method of delivery that would enable recruitment to the ICM programme to continue. The decision was taken to use self-assessment scores,, with no face-to-face interview component.

In April 2020, HEE confirmed funding for 100 additional ICM posts in England, and Northern Ireland (4), Scotland (6) and Wales (4) also confirmed additional posts in time for the offers to be released. This increased number of ICM posts, whilst greatly needed and appreciated, is not likely to be repeated in 2021.

Recruitment data for 2020 Single & Dual ICM CCT Appointments	
Stage	**Number 2020 (2019 in brackets)**
Applied	**430 (305)**
Shortlisted	**376 (290)**
Appointable (after veto and military)	**376 (263)**

280 Appointed trainees – status at point of registration	**%**
Dual ICM with Anaesthetics	**35%**
Dual ICM with Medicine	**5%**
Dual ICM with Emergency Medicine	**8%**
Academia	**1%**
Single ICM Trainee	**51%**

TOTAL POSTS AVAILABLE
280/289 **FILL RATE: 96.9%**

9. Medical Workforce: Consultant Appointment Data

KEY MESSAGES	
1	The average number of consultant posts per year recruited to with ICM direct clinical care sessions is 146 over the last eight years. Over the same period the average number of doctors reaching CCT was 81, leading to an overall average shortfall of ICM trained doctors of 65 per year. This is currently filled by partner specialty trainees who train to an intermediate level in the specialty.
2	The number of Appointment Advisory Committees (AACs) cancelled increased significantly in 2014 and 2015; AACs can be cancelled for a variety of reasons however, the most common is a lack of suitable applicants. Cancellations fell in 2016 to 13, and continued to fall with 2019 reporting 8 cancellations and 2020 reporting 6 cancellations.

The FICM (and before its existence, the RCoA) provided Advisory Appointment Committee representatives for all posts involving Intensive Care Medicine sessions. Please find below a year-by-year breakdown of the number of consultant posts recruited to for ICM. The average for 2003-2012 is **131** and the average for the last eight years (2013-2020) is **146.**
**Please note that Scotland is not included in the data as it does not use the AAC process and foundation trusts do not always engage with the process either.*

A Critical Care consultant is defined as: a doctor who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine. A consultant in Intensive Care Medicine will have daytime Direct Clinical Care Programmed Activities in Intensive Care Medicine identified in their job plan. These programmed activities will be exclusively in ICM and the Consultant will not be responsible for a second specialty at the same time.

Year	Consultant posts	AACs Cancelled
2003	157	20
2004	132	8
2005	133	4
2006	99	5
2007	108	5
2008	149	6
2009	157	15
2010	144	17
2011	102	12
2012	133	9
2013	150	16
2014	144	27
2015	175	37
2016	169	13
2017	160	14
2018	124	9
2019	145	8
2020	102	6

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