Sustainable Careers for Advanced Critical Care Practitioners

The Faculty of Intensive Care Medicine

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1. Introduction

Advanced Critical Care Practitioners (ACCPs) are permanent staff who form a vital role in many critical care units across the UK. Over time, the number of qualified ACCPs has grown, and the knowledge, experience, expertise, and capabilities of experienced ACCPs has increased enormously. There is therefore a need to formalise the career pathway for ACCPs to ensure a clear and consistent career framework and career trajectory, where seniority is appropriately recognised in terms which align nationally with other acute care practitioners. A formal career pathway will ensure parity between individuals of similar seniority whether in the same or different organisations, and it will support individuals, critical care units and organisations in delivering fairness and ensuring equity. Finally, career formalisation allows all elements of an ACCPs work and their wider role within the critical care unit to be fully recognised and in doing so ensure that this role remains appealing and sustainable in the years ahead. This document aims to provide this framework and in doing so guide ACCPs, critical care units and organisations in providing a clear, consistent, and supportive ACCP career pathway across the UK.

2. Key recommendations

1. Organisations who employ ACCPs, be they in training or following qualification, should align their banding structure with that described in this document. This follows the recommendations for advanced practice roles from the Centre for Advanced Practice, Health Education England[1]. Broadly: trainee ACCP (band 7), ACCP (band 8a), senior ACCP (band 8a or 8b, banding to be decided locally), lead ACCP (band 8b), ACCP consultant (band 8c).
2. The knowledge, skills, attitudes and experience that define each tier of ACCP seniority are described in this document.
3. We encourage open dialogue whereby ACCPs can agree their working patterns in consultation with the unit clinical lead, consultant ACCP supervisor and where applicable the lead ACCP.
4. With advancing seniority, and in consultation with the clinical lead or consultant ACCP supervisor, ACCPs may undertake additional non-clinical work to support the unit and the specialty of intensive care medicine. We advocate formal recognition of these roles and rostering them into a job plan that equates to 80/20 split of direct clinical care and supporting professional activities (SPA) respectively.
5. As experienced ACCPs take on other roles, it is important to maintain a predominantly clinical commitment for the retention of skills, knowledge, and capability. The FICM suggest that ACCPs clinical commitment should be no lower than 70% of whole-time activity.
6. We encourage open dialogue between the unit clinical lead, consultant ACCP supervisor or lead ACCP with ACCPs aged over 55 on what constitutes an appropriate working pattern with advancing age. This must be tailored to the physical and psychological needs of the ACCP whilst recognising that critical care is a 24/7 specialty.
7. We recommend 10 days of professional leave per year in addition to SPA time for a full time ACCPs with a study budget equivalent to that of deanery appointed junior doctors (prorated for those part time).

8. ACCPs whether in training or qualified, must have a dedicated educational supervisor who is a consultant in critical care medicine. A consultant ACCP supervisor must have this educational commitment recognised in their job plan. We recommend 0.25PA per trainee ACCP and 0.125PA per trained ACCP, unless specific demands suggest that this should be uplifted.
9. Staff new to the role of ACCP should be allocated a mentor. This should ideally be another more experienced ACCP in the same critical care unit; where this is not possible, a more experienced ACCP in a neighbouring unit within the same critical care Operational Delivery Network would be appropriate.
10. ACCPs should be independently represented at critical care unit meetings and in the Advanced Practice workstreams within the Trust. Where an ACCP is unable to attend, the consultant ACCP supervisor may represent their views.
11. The physical working conditions and facilities for rest applicable to ACCPs should align with other medical decision makers.

3. The need to formalise sustainable ACCP career progression

Advanced Critical Care Practitioners (ACCPs) are clinical professionals responsible for patients' care during their critical care admission. They are educated to a very high standard and are highly experienced, enabling them to make high-level clinical decisions for patients on the critical care unit. Their knowledge, skills and capabilities allow ACCPs to deliver high quality, timely, personal, and effective care to all patients on the critical care unit. ACCPs are usually (but not exclusively) drawn from a background in nursing, physiotherapy, pharmacy, or paramedical science; all are registered healthcare professionals.

The role of the ACCP and the training and governance structures which underpin it were set up in 2009. A key tenet of the training system is the formal ACCP curriculum which has been developed by the Faculty of Intensive Care (FICM). The FICM describe a clearly defined training pathway which can lead to ACCP qualification and FICM ACCP Membership.

Since 2009, there has been widespread growth in ACCP personnel in critical care units across the UK[2]. With increasing numbers and ever-increasing experience of ACCPs across the UK, the FICM ACCP Subcommittee (who are responsible for the national development of the ACCP role) recognise the requirement to provide some guidance around the ACCP career pathway. This is necessary to:

- Ensure that those interested in a career as an ACCP have a full understanding of what a long-term career pathway may look like before applying for training positions.
- Ensure that qualified ACCPs have a long-term career pathway to maintain enthusiasm and provide long term career opportunities and goals.
- Avoid a glass ceiling of development and stagnation in the role which risks losing highly trained, highly valuable individuals.
- Ensure that a career as an ACCP remains sustainable with advancing age.
- Provide a long-term career framework with banding aligned with Agenda for Change and the Centre for Advanced Practice[1] for the benefit of individuals, critical care units and organisations. This will help with recruitment, retention, departmental structure and guide

appropriate remuneration within and between organisations. This ensures parity, fairness, and transparency across organisations.

- Ensure that time for roles outside of direct clinical care, such as research, audit, morbidity and mortality reviews and quality improvement is formally recognised, and job planned.
- Recognise that individuals have differing levels of experience, ability, skill, knowledge, and responsibility, and that these should be recognised in terms of position, stature and remuneration. Ensuring clarity around what constitutes seniority and how that aligns with banding and remuneration will ensure consistency and fairness between ACCPs within an organisation and between ACCPs in different organisations.
- Help to achieve parity across a multidimensional workforce- within and outside of critical care. With growing numbers of Acute Care Practitioners (ACPs) working in other acute areas of care (such as the emergency department) it is essential that parity is maintained between practitioners of similar levels in differing areas of the acute care sector.
- Help individuals achieve a work/life balance.

4. Career pathway

The following represents broad guidance and there must be allowance for the fact that ACCPs may take on other professional roles not listed in the table below. Appropriate recognition of these roles must occur to facilitate ACCPs to move between the career structure in keeping with the agenda for change and advanced practice criteria[1]. Detailed examples of job descriptions can be found here, which have been mapped to the Agenda for Change.

Title	Band	Requirements
Trainee ACCP	**7**	• Registered healthcare professional with appropriate critical care experience eligible to undertake non-medical prescribing. • In a recognised ACCP training programme and working towards completion of an appropriate MSc/ PGDip via a recognised Healthcare Education Institution. • Following the FICM ACCP syllabus and curriculum. • Be supernumerary for two years whole time equivalent in clinical practice.
ACCP	**8a**	• Completion of the academic and clinical competencies to the standard required by the FICM (PGDip ACCP programme). • Successful application for FICM membership. • Fully completed an MSc. • Completion of an annual appraisal in line with the FICM ACCP appraisal process and in line with individual Trust/ Health Board values. • Usual expectation is to work on the medical rota encompassing days, nights and weekends.

Senior ACCP	**8a or 8b** (banding to be decided locally)	Both of: 1) Senior clinical work: • Working on the senior part of the medical rota encompassing days, nights and weekends. • May supervise junior medical staff and trainee ACCPs. 2) Undertakes extended skills following core training, such as: • Completion of FUSIC ultrasound course (or equivalent) and working towards the required number of supervised scans. • Fully engaged in and taking an active role in at least 2 of: quality improvement, audit or research. • Usual expectation is to work on a doctor or ACCP rota.
Lead ACCP	**8b**	All three of: 1) Senior clinical work: • Working on the senior part of the medical rota encompassing days, nights and weekends. 2) Undertakes extended skills following core training, such as: • Completion of FUSIC ultrasound course (or equivalent) and working towards the required number of supervised scans. • Fully engaged in and taking an active role in at least 2 of: quality improvement, audit or research. • Usual expectation is to work on a doctor or ACCP rota. 3) Undertakes managerial tasks such as: • Line management of trainee/junior ACCPs. • Oversees the development and annual appraisals of trainee/junior ACCPs in conjunction with the consultant ACCP supervisor. • Leads the development and delivery of ACCP service. • Responsibility for supervising junior medical staff. • Undertakes tasks such as: staffing, rostering, sickness reviews and liaison with the wider organisation. • Directly responsible for performance management of all ACCPs in the team and managing team members under local Trust/ Health Board disciplinary policy if required. • Participates in business case creation and recruitment of ACCPs (trainee/qualified), including advertisement, selection, interviewing and appointment of appropriate staff members. • Carrying out incident and Serious Incident (SI) investigations. • Attends and contributes to strategic meetings and development of related policies/procedures. • Has involvement in budgets, procurement and financial planning for the ACCP team.

Consultant ACCP	**8c**	A highly experienced ACCP who is working in a very senior capacity within the critical care unit. In addition to above: • Completion of higher training according to the requirements of the critical care unit and the organisation. • Able to lead a critical care ward round (with consultant oversight), incorporating technical and non-technical skills. • Has written or been a significant contributor to a Trust/Board level business case. • Is able to lead a resuscitation or intubation with confidence. • Adoption of senior leadership role within the organisation, such as significant contributor to divisional management, Trust quality improvement or safety role or serious incident investigation. • Actively involved in strategic unit or organisational development • There should be an attempt to reduce night-time frequency where the workings of the unit allow this.

5. Rotas, work schedules and recognition of additional roles

The FICM encourages open dialogue between ACCPs and the unit clinical lead, consultant ACCP supervisor and where applicable lead ACCP, for ACCPs to agree their working patterns within the unit. Where a team of trained ACCPs exist, the lead (or most senior) ACCP should assume responsibility for writing the ACCP rota, which should allow for a degree of self-rostering. This rota should dovetail with the medical rota. Rostering in this way recognises the permanent nature of the ACCP commitment to the critical care rota and supports sustainability through recognition of the value that permanent staff bring to the medical rota. The intention is to generate a working pattern which meets the clinical and non-clinical needs of the unit and fosters a sustainable and fulfilling pattern of work for ACCPs. The rota should be agreed and published with sufficient notice to allow plans for work/life balance to be made; a minimum notice period would be 6 weeks, but ideally 3 months. The rota must allow sufficient time for rest and recovery.

The FICM suggest a working pattern based on Agenda for Change. For full-time practitioners this represents 37.5 hrs a week, or 150 hours a month. Newly qualified ACCPs require a period of time on the medical rota where they are fully clinical, to continue building experience, confidence and capability. With advancing seniority, an ACCP will usually take on roles relating to audit, research, teaching or quality improvement, following discussion with the clinical lead, consultant ACCP supervisor or lead ACCP. These roles should be formally recognised with a recommended 80/20 split between clinical care and SPA. This would therefore equate to 7.5 hours a week of SPA or equivalent prorate, to undertake unit specific roles agreed by the unit clinical lead, consultant ACCP supervisor or lead ACCP. The SPA roles should appear on the ACCPs roster to ensure the entire clinical team recognise this time as SPA and to avoid the ACCP being drawn into clinical work. Ultimately the FICM encourage flexibility in working patterns, and collaboration between staff, such that where clinical need arises and the SPA time is surrendered for clinical care, then the ACCP is 'refunded' the SPA time on another date. As experienced ACCPs take on increasingly senior roles within the unit, the organisation, and the healthcare system, it is important that they maintain a predominantly clinical commitment for the

retention of skills, knowledge and capability. The FICM suggest that ACCPs clinical commitment should be no lower than 70% of whole-time activity.

ACCPs may be asked to undertake additional, extracontractual work to fill gaps in a medical rota. Additional work must have patient safety as its primary focus, balancing the need for staffing cover with appropriate time for staff rest between shifts. The FICM encourage an open dialogue between ACCPs and the unit clinical lead and consultant ACCP supervisor to agree appropriate remuneration for extracontractual work. It is possible through local arrangement, that remuneration for the ACCP aligns with the medical locum payments which would normally be offered to doctors working on the rota in question.

It is recognised that the onerous nature of regular night time shift work has a greater impact on individuals with advancing age[3]. The appeal therefore of regular night time working by ACCPs with advancing age is likely to wane. However, it must also be recognised that critical care is a 24 hour per day, 7 day per week specialty and critical care units are faced with the challenge of supplying appropriately skilled individuals across the 24-hour period. In order to deliver a sustainable career for ACCPs whilst also delivering an appropriate skill-mix, we encourage open dialogue between unit clinical leads, consultant ACCP supervisors or lead ACCPs and ACCPs aged over 55 on what constitutes an appropriate working pattern with advancing age[4]. This must be tailored to the physical and psychological needs of the ACCP, however units must ensure consistency and fairness to all ACCPs who work within their unit.

6. Study and professional leave

ACCPs will require study or professional leave to maintain their continual professional development in addition to SPA time. The FICM recommends 10 days of professional leave per year for a full time ACCP, with an associated study budget equivalent in value to deanery appointed junior doctors. Part time ACCPs should have both the time and the study budget allocated on a prorate basis. Incorporation of the ACCP study budget into the staffing budget will allow ease of access to the funds.

7. Supervision of ACCPs

ACCPs, whether trained or in training, must have an educational supervisor for professional guidance, education, mentorship, career advice, pastoral care, emotional and psychological support. The requirements placed upon this supervisor will be different for ACCPs in training than it will for trained ACCPs, but supervision is nevertheless essential throughout an ACCPs career. This individual should be a consultant (known as the consultant ACCP supervisor).

Consultant ACCP supervisors should have this educational role written into their job plans. The FICM recommends 0.25PA per trainee ACCP and 0.125PA per trained ACCP unless specific demands suggest that this should be uplifted. Examples of specific demands requiring an uplift in funding include ACCPs with particular educational or pastoral needs or following central guidance changes where an uplift in funding is provided. Consultant supervisors should have received appropriate training for the role of educational supervision and should remain up to date with both supervision and the ACCP role.

ACCPs should have annual appraisals in line with the FICM ACCP appraisal recommendations[5]. The FICM recommends appraisals are tripartite in nature, involving the ACCP, the consultant ACCP supervisor and the lead ACCP (if applicable) or matron for critical care (where no lead ACCP exists). Appropriate documentation for these appraisals can be found here. Appraisals are an opportunity to review the latest year of work and set agreed goals for the year ahead. Both retrospective and prospective discussions should include professional, personal and psychological matters which align with the needs of the unit and the individual ACCP, as well as reviewing Trust mandatory training requirements.

8. Mentoring

Taking on the role of ACCP represents a complete career shift for the majority of individuals starting their trainee and trained ACCP careers. For most staff this can be a challenging time. The FICM recommends that staff new to the role have an experienced ACCP mentor for personal, professional and psychological guidance, support and mentorship. For units that do not have an experienced ACCP, alternative arrangements may include an experienced ACCP in another critical care unit in the same or neighbouring critical care Operational Delivery Network.

9. Contribution to and advancement of the unit

The ACCP is in a unique position as a permanent member of staff who transcends roles across the multidisciplinary team. This puts them in a unique position to contribute to the workings of the unit and progress the quality of care that can be delivered. Such activity is likely to include:

- Governance
- Incident management and risk
- Audit and research
- Quality improvement
- Data collection
- Policy design and implementation
- Deliver teaching, training and induction
- Develop and foster relationships with other departments and services outside of the critical care unit- such as the emergency department, the critical care outreach team, medical admissions unit etc.

ACCPs should be supported and encouraged to undertake these activities as it will enrich the individuals and broaden their knowledge and experience, whilst having obvious benefits for the unit and the organisation. Time for this activity must be recognised and is described in section 5.

10. Leadership within the ACCP group

Leadership is one of the four pillars of advanced practice. ACCPs often have extensive leadership experience and as their capabilities and standing within the unit grows, their capacity and bandwidth

for leadership is likely to expand. This should be supported by unit lead consultants and managers and formal leadership training should be considered to support the ACCP in their advancing career. Study leave and financial arrangements to undertake such training is discussed in section 6.

11. Representation

ACCPs fulfil a unique and vital role in the workforce of a critical care unit. Because the role transcends medicine and spans other disciplines such as nursing and AHPs, ACCPs cannot be represented by these other disciplines. The ACCP role therefore requires independent representation at unit meetings. Where ACCP numbers are low, representation may be delegated to the consultant ACCP supervisor, although this should be a transient and temporary arrangement until the ACCPs can be made available or ACCP numbers grow to allow direct representation by ACCPs themselves.

The FICM encourage ACCPs to meet their consultant ACCP supervisor on a regular basis to ensure two-way transparency in any matters which may arise. This will allow any issues to be addressed in a timely fashion.

ACCPs should have independent representation on any Advanced Practice workstreams within the organisation. This will require close links with the Trust or Health Board advanced practice lead- something which would usually be delegated to the lead ACCP (where one exists). Where a lead ACCP does not exist, individual ACCPs will need to forge this link themselves to ensure appropriate representation at an organisational level.

12. Working conditions

ACCPs, as with other medical decision makers, must be afforded appropriate areas where breaks and rest can be taken at work. Access to a desk, a phone and a computer should align with other medical decision makers. Usually these will be shared facilities with other critical care staff, and the FICM encourages that to engender collaboration and team building.

Rest requirements should align with those of junior doctors which are tightly prescribed[6]. It is essential that ACCPs take breaks reliably, but in a flexible manner in line with other medical decision makers. This will foster improved cognitive performance and supports the sustainability of the role. It is feasible through local negotiation to agree a system whereby ACCPs are paid for breaks.

ACCPs must also have access to food and drink in and out of hours. Being unable to access these basic needs in the workplace makes the role more strenuous than it is already and prevents ACCPs and indeed all staff from being able to function at an optimal level.

13. Recommendations

1. Organisations who employ ACCPs, be they in training or following qualification, should align their banding structure with that described in this document. This follows the recommendations for advanced practice roles from the Centre for Advanced Practice, Health Education England[1]. Broadly: trainee ACCP (band 7), ACCP (band 8a), senior ACCP (band 8a or 8b, banding to be decided locally), lead ACCP (band 8b), ACCP consultant (band 8c).
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14. References

[1] The centre for advancing practice. Health Education England 2022. Available at https://advanced-practice.hee.nhs.uk/. (Accessed 12/09/2022).

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