CONSULTATION

Curriculum for Training for

Advanced Critical Care Practitioners v1.2

Cover Design Not Final

Preface

This is the first edition of the curriculum for a Postgraduate Diploma/Masters level qualification in Advanced Critical Care Practice.

This curriculum is applicable for trainees entering training from September 2024.

Abbreviations

A list of commonly used abbreviations is provided in *Appendix 1*.

Practitioner registration

All ACCP trainees [tACCPs] must register with the Faculty as soon as possible after starting their ACCP training, via submission of an ACCP Trainee Registration Form to the Faculty. **There is no fee for registration,** but it is considered vital that tACCPs register to inform future training and workforce planning.

Advice

For information concerning ACCP training or career planning please see the FICM website: www.ficm.ac.uk.

For further advice, practitioners should approach their ACCP Local Clinical Lead [LCL], the National Lead for ACCPs and their local Higher Education Institution.

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Curriculum for Training for

Advanced Critical Care Practitioners

Part I

Handbook

Cover Design Not Final

Contents

1. Introduction

Revisions

V1.0 - 2015
V1.1 - 2018 - amended to reflect updates in terminology and definition
V1.2 - 2022 - review and update based on changes to the ICM curriculum and new alignment of Advanced Critical Care Practitioners [ACCPs] to the National Advanced Practice agenda via the Centre for Advanced Practice [Health Education England]

1.1 Aim

This curriculum identifies the aims and objectives, content, experiences, outcomes, and processes of postgraduate specialist training leading to a Masters qualification in Advanced Critical Care Practice or equivalent. It defines the structure and expected methods of learning, teaching, feedback, and supervision.

It sets out what knowledge, skills, attitudes, and behaviours the tACCP will achieve. A system of assessments is used to monitor the tACCPs progress through the stages of training. The objective of the programme is to produce high quality patient-centred practitioners with appropriate knowledge, skills, and attitudes to enable them to practice in Intensive Care Medicine.

1.2 Definition of Intensive Care Medicine

Intensive Care Medicine [ICM], also referred to as critical care medicine, is that body of specialist knowledge and practice concerned with the treatment of patients, with, at risk of, or recovering from potentially life-threatening failure of one or more of the body's organ systems. It includes the provision of organ system support, the investigation, diagnosis, and treatment of acute illness, systems management and patient safety, ethics, end-of-life care, and the support of families.

1.3 Definition of Advanced Practitioners

The role of the ACCP and underpinning structure was set up in 2009. An advanced practitioner is defined as:

Achieving a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice:

- Leadership and management
- Education and research
- Demonstration of core capabilities
- Area specific clinical competence

This document aims to align, where applicable, to the ICM curriculum (2021) and dovetails with the requirements of the General Medical Council's [GMC] "Excellence by design standards for post graduate curricula", the Generic Professional Capabilities framework [GPC] where applicable and acknowledges the Health Education England Advanced Practice Agenda. The Multi professional framework for advanced clinical practice in England (2017) requires that all health and care professionals working at an advanced

clinical practice level should have developed capabilities underpinned by evidence applicable to the speciality.

Whilst there are some key differences between the Advanced Clinical Practitioner [ACP] and Advanced Critical Care Practitioner [ACCP] role the similarities on core capabilities dovetail with the ACCP role although the two are not interchangeable. These capabilities are deliberately mapped to level 7 taxonomy to support practising at MSc level. tACCPs will meet the requirements for FICM membership at the PgDIp point in terms of academic, clinical knowledge, skills, and capabilities. tACCPs should complete a full MSc to facilitate career progression to match the advanced practice agenda.

The core capabilities of advanced practice ensure some standardisation across the advanced practice landscapes. The curriculum for ACCPs has been adapted to reflects this. The advanced practice standards outline capabilities which underpin practice in the form of the four pillars. Prospective tACCPs and supervisors should refer to the Multi Professional Framework for advanced clinical practice in England 2017.

In 2017, Health Education England [HEE], NHS England [NHSE] and NHS Improvement [NHSI] worked in partnership to develop the National Framework for Advanced Clinical Practice, which ensures that there is national consistency and understanding about advanced level practice. This is the first time that a national framework has existed in England and has established a shared understanding of the advanced level practitioners and how they can be deployed to deliver better patient care.

The framework offers opportunities for mid-career development of new skills such as prevention, shared decision making, and self-care. The framework includes:

- A national definition of the role
- Entry requirements
- Guidance and principles that advanced practitioners should adhere to in their professional practice
- A clear career pathway into and within the profession.

The HEE framework mirrors the objectives of the ACCP curriculum and provides opportunities for Health Care professionals to develop their career along the ACCP pathway
https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

Scottish Advanced Practice Toolkit (2008) describes Advanced Practice as a level of practice rather than a specific role or title encompassing:

- Advanced clinical practice
- Facilitating learning
- Leadership/management
- Research

"These themes are underpinned by autonomous practice, critical thinking, high levels of decision making and problem solving, values-based care and improving practice"

www.advancedpractice.scot.nhs.uk

NHS Wales (2009) Excellence, Assurance and Governance in a Learning Environment (EAGLE) sets out registration and regulation for Advanced Practice.

NHS Wales EAGLE Governance Framework

It should be noted that whilst this curriculum reflects the Skills for Health Career Framework, the levels within this framework do not automatically equate to NHS Agenda for Change pay Bands, which are beyond the purview of this document. The ACCP curriculum and ACCP Advisory Group deal with the training of ACCPs, not contractual employment arrangements.

- **<u>Clinical Practice</u> – in this context across the critical care setting.**
    - tACCPS will practice in compliance with their respective code of professional conduct and within the scope of practice of a tACCP and be accountable for their decisions, actions, and omissions at this level of practice.
    - The training programme will enable the tACCP to demonstrate a critical understanding of levels of responsibility and autonomy
- **Leadership and Management**
    - tACCPs should develop effective relationships within the multi professional team in ICU and the wider acute healthcare setting
    - It is anticipated that through the programme of training the leadership and management aspects of the ACCP role will develop concurrently and continue post qualification
- **Education**
    - tACCPs undergoing training will be encouraged to critically assess their own learning needs and engage in self-directed learning alongside their clinical practice.
- **Research**
    - The academic programme will develop the tACCP's critical appraisal and synthesis skills in relation to research in the critical care area and apply these to clinical practice

Fig 1: Skills for Health career framework

1.3.1 Career Progression

On Successful completion of training and when performing in the role of an ACCP there is a requirement to consolidate, maintain and extend the knowledge skills and competence as defined by FICM ACCP Curriculum (2022) and the FICM ACCP CPD/ Appraisal document . ACCPs will remain eligible to apply for FICM ACCP Membership at the completion of the two-years supernumerary training and academic period. Completion of a full MSc is essential for career progression and will be linked to Agenda for Change banding in individual organisations. AfC banding across all levels of the role should be aligned to the Centre for Advanced Practice [HEE] to ensure consistency and parity across the advanced practice agenda.

As a valuable member of the critical care workforce it is anticipated that as your career progresses there additional dimensions to service delivery and your role will be agreed with your ACCP Clinical Lead/line manager. This will support your progression through the Agenda for Change banding structure.

Further details regarding Career Progression can be found in the ACCP Sustainable Careers Document (2023)

1.4 The scope of Intensive Care practice

Intensive Care Medicine involves the combination of the ability to correct abnormal pathophysiology (support) whilst simultaneously making sure that the definitive diagnosis is accurately made and therefore that disease modifying therapy (definitive treatment/medicine) is applied, both components of the patient's overall care.

ICM comprises a constellation of knowledge and practice – almost all of which is well represented in a variety of other specialties. The ICM specialist transcends the traditional borders of medical specialities bringing all these competences together in one specialist and in so doing develops a unique approach to critical illness.

Intensive Care Medicine specialists are therefore medical experts in:

- Resuscitation
- Advanced physiological monitoring
- Provision of advanced organ support (often multiple)
- Diagnosis and disease management in the context of the most gravely ill patients in the hospital
- Provision of symptom control
- Management and support of the family of the critically ill patient
- End of life care
- Collaboratively leading the intensive care team
- Co-ordination of specialist and multi-specialty input to complicated clinical cases in the unique context of intensive care.

These specialists are based in Intensive Care Units [ICUs] which are hospital areas in which increased concentration of specially trained staff and monitoring equipment allow more detailed and more frequent monitoring and interventions for a seriously ill patient. Whilst practitioners may be based in Intensive Care and High Dependency Units their range of referral practice includes most of the acute hospital. Within a single day, ACCPs may find themselves involved in the care of patients ranging from the young adult to the very old, encompassing locations such as the Emergency Department and Acute Admissions Units.

1.5 Curriculum development process

This curriculum has been based on the FICM *Curriculum for Training in ICM* (2011), Updated Curriculum (2022) the National Competency Framework for Advanced Critical Care Practitioners (2008) and curricula from the established ACCP programmes from around the UK.

This curriculum documents considers guidance from **the NHS Litigation Authority [NHSLA]**, a Special Health Authority responsible for handling negligence claims made against NHS bodies in England[1]. The NHSLA has published standards expected of Trusts***. For training these emphasise the need for appropriate supervision and assessment, and the documentation of capabilities.***

1.5.1 Development group, consultation, and feedback

This curriculum which is based on the FICM curriculum has been developed by a curriculum development group of the RCoA and the FICM, all of whom are actively involved clinically in intensive care teaching and training, in conjunction with lay representatives and in consultation with representatives of Higher Education Institutions. This curriculum has been made available for consultation by the wider, multi-disciplinary ICM community. Feedback from all these groups was then used in the production of this final version. The HEIs delivering the training will have the opportunity to gain FICM accreditation.

1.6 Ongoing curriculum review

The ACCP curriculum as a programme of training will be modified as required, on implementation.

Minor changes will be inserted in the online manuals immediately. Major changes will be submitted to the FICM Board for approval as and when necessary and will be inserted into the curriculum when approval has been granted. Summaries of changes will be listed on the ACCP training pages of the FICM website as they occur.

Occasionally the Faculty may need to take decisions that may affect the immediate interpretation or application of specific items in this manual. These will be published on the FICM website and circulated to ACCP LCLs.

1.7 Structure of the curriculum manual

This curriculum document has three parts:

- **Part I** is the **Handbook**, an overview of capability-based training in Advanced Critical Care Practice. It includes background information, current criteria and standards for training and assessment methods.
- **Part I**I is the **Assessment System**, which provides the outcome paperwork for tACCPs to demonstrate their development as they progress through the ACCP training programme.
- **Part III** is the **Syllabus**, which details the ACCP Capabilities including core science, common capabilities derived from the Academy Common Competency Framework and specialist capabilities taken from ACCP Curriculum Part III document (FICM, 2015) along with relevant assessment tools.

[1] The Welsh Risk Pool and the Scottish Clinical Negligence and Other Risks (Non-Clinical) Indemnity Scheme [CNORIS] fulfil similar roles to the NHSLA. In Northern Ireland each Trust has its own risk assessment and negligence scheme.

2. Entry requirements and training pathways

2.1 ACCP Entry

Entry into ACCP training is possible providing the following criteria are met.

- Be registered as a healthcare professional, with recent experience of working within critical care and be able to demonstrate evidence of appropriate continuing professional development.
- Have a bachelor-level degree or be able to demonstrate academic ability at degree level [level 6].
- Be in a substantive recognised trainee Advanced Critical Care Practitioner post, having successfully met individual Trust /Health Board selection procedure in terms of skills and relevant experience. Having undertaken an appropriate ACCP selection process which considers the requirements of the four pillars and level 7 study.
- Be employed as an tACCP in a unit recognised for Medical Intensive Care training by FICM and with the capacity and ability to offer ACCP training. Please note amendments to training units pertinent to smaller units and the opportunity to host hub and spoke training.
- Be entered into a programme leading to an appropriate Masters degree with a Higher Education Institution ideally FICM accredited.

Eligibility under the statute to undertake non-medical prescribing is mandatory

2.2 Training Unit requirements

The training environment should provide appropriate training and supervision with an adequate exposure to a wide spectrum of critical illness. If necessary, rotations to other hospitals should be arranged. Departments in which training occurs must comply with the regulations and recommendations of the relevant national Departments of Health, the GMC, NMC, HPC and the FICM.

- Programmes which meet the requirements of this ACCP curriculum are encouraged to apply for FICM accreditation of their programme. If successful, these HEIs will be listed on the FICM ACCP pages on the website. Those courses meeting the training requirements set in this curriculum will produce ACCPs eligible for FICM recognition with membership status. The FICM Regional Advisor [RA] must approve training for ACCPs in the relevant unit.
- The RA should forward successful and unsuccessful applications to the FICM ACCP Sub-Committee for ongoing oversight and acknowledgement.

The RA should use this **form** to assess the unit's suitability and once completed, share a copy of this with FICM (contact@ficm.ac.uk)

To be approved as an ACCP Training Unit, the following aspects of organisation, environment and ethos towards training are required, and should be verified during the application process:

- Compliance with the regulations and recommendations of the relevant national Departments of Health, NMC, HPC and the FICM.
- Nominated ICM Consultant Lead for ACCPs with oversight to support trainers and tACCPs to engage in current training requirements. There should be formal links with an appropriate HEI providing the academic elements.
- Named Educational Supervisor [ES] who is an ICM Consultant for each tACCP to mentor progress and provide pastoral support. Depending on the size of Unit and numbers of tACCPs, this may be the Consultant Lead.

- The unit would be expected to be recognised for at least Stage 1 ICM training (by FICM and Statutory Education Bodies (SEBs)).
- A Unit with sufficient clinical activity to deliver the ACCP training syllabus and meet the curriculum requirements.
- Where this is not possible in a single ICU, alliance with a larger allied teaching hospital/District General Hospital [DGH] or tertiary centre, in a hub and spoke model, is proposed. The duration of attachments and supervisory structure may need to be addressed on an individual basis.
- FFICM Consultants should staff the unit as per GPICS standards. Where this may not be possible, out of hours cover for small and rural units arrangements for appropriate Consultant support as detailed in the GPICS V2 chapter on smaller remote and rural units should be in place.
- The recognised national standards, ethos, and enthusiasm of the unit to embrace training is of paramount importance.
- Sufficient training opportunities for all trainees (ACCPs and doctors in training) allocated to the unit at any one time must be maintained.
- Sufficient clinical supervision such that every ACCP in training can be responsible to a nominated Consultant at all times. The Consultant must be available to advise and assist them as appropriate.
- Consistent positive feedback from the GMC National Training Survey, and local training feedback surveys. Where poor feedback is received, the RA with the support of the FICM ACCP Sub-Committee will review ongoing eligibility as a training unit for ACCPs.

ADDITIONAL CONSIDERATIONS: It is recognised that some units are critical care units i.e., a flexible mix of ICU and HDU patients. In these situations, the average Level 3 occupancy should be related to bed numbers. Similarly, many units have adjacent ICU and HDU facilities, covered by the same medical staff. Here a similar calculation could be applied. Geographically separate units, for example separated by several floors or considerable horizontal distance of more than a few yards, should not be normally regarded as one unit.

2.3 Registration with Faculty

tACCPs must register with the FICM upon commencing the training programme.

2.4 HEI delivery

The Higher Education Institution (HEI) granting the MSc level 7 study is responsible for delivering this curriculum and ensuring the competence of the ACCPs it produces. This training must be done in collaboration with training units in partner hospitals. From 2022 there will be an opportunity for HEI's to obtain FICM accreditation.

Teaching within hospitals should be overseen by an ACCP Local Clinical Lead who will be a Consultant in ICM and should hold an honorary appointment with the HEI and be responsible to the HEI for the delivery of the clinical components of training. The LCL will be the point of liaison with the FICM as required.

The partner hospitals must satisfy themselves that the HEI can deliver the ACCP programme to the appropriate level, and the HEI must ensure that hospitals can deliver both competent and excellent clinical training and supervision in the workplace.

tACCPs must be entirely supernumerary during the first two years of their training; it is not possible for them to fill in staffing gaps on units. Failure to achieve this may lead to increased duration of training or be ineligible to apply for FICM ACCP Membership.

2.5 Clinical Teaching and training

Teaching and supervision in clinical practice by ICM Consultants should espouse the principles and values on which good practice is founded which derive from the GMC's *Good Medical Practice* (2013) standards.

Both tACCP and trainers must be familiar with this guidance as they are key to the delivery of the ACCP curriculum.

3. Content of learning

3.1 Underlying principles

The principles of the UK Advanced Critical Care Practitioner training programme are that it:

- Is outcome based
- Is planned and managed
- Promotes safe practice
- Is delivered by appropriately trained and appointed trainers
- Allows time for study
- Includes those core professional aspects of clinical practice that are essential in the training of all ACCPs
- Meets the service needs of the NHS
- Respects the rights and needs of patients
- Is prepared with input from the representatives of patients
- Accommodates the specific career needs of the individual tACCP
- Is evaluated
- Is subject to review and revision

3.1.1 The combined and parallel clinical and academic nature of the ACCP training programme

Existing ACCP training across the UK combines robust clinical education and assessment with a Higher Education Institution-based academic programme to full Masters level. Note ACCPs meeting the requirements of this curriculum will be eligible to apply for FICM membership at the Post Graduate Diploma (PGDip) point.

The clinical component is mainly delivered by clinically active subject matter experts in intensive care. The academic component is integral to the successful completion of the training programme particularly in basic sciences including physiology, pathophysiology and pharmacology and the development of critical thinking and disciplined noticing both in clinical practice and in appraisal of the literature.

tACCPs must acquire 60 academic credits per year via the completion of HEI modules; generally, two per year, though the exact format may vary for each HEI. The acquisition of the ability to undertake Non-Medical Prescribing [NMP] is pivotal to the success of the individual ACCP in practice and their full integration into the critical care team; the NMP module is nationally set and counts for 40 academic credits. tACCPs will usually undertake the NMP module in year 2 of their training programme; the exact timing of the module will be determined by the respective HEI.

3.1.2 Continual learning

The training programme is based on this concept which ensures that the basic principles learnt and understood are repeated, expanded, and further elucidated as time in training progresses; this also applies to the acquisition of skills, attitudes, and behaviours.

The outcome is such that mastery of the specialty to the level required to commence autonomous practice in a specific post is achieved by the end of training as knowledge, skills, attitudes, and behaviours

metaphorically spiral upwards. Following qualification, the continuing professional development of the ACCP will follow the same model.

3.2 Non-Medical Prescribing

All Non-Medical Prescribing [NMP] is underpinned by legislation and regulatory standards. Accordingly, all Non-Medical Prescribers must record their qualification with their professional regulator and have a responsibility to remain up to date with the knowledge and skills that enable them to prescribe competently and safely[2].

All ACCPs must comply with the NMP governance requirements of their trust / health board.

3.2.1 Standards for prescribing practice

The full set of standards for professional practice and behaviour set for nurse and midwife prescribers can be found in the code and in Standards of proficiency for nurse and midwife prescribers. Prescribers must be:

- Properly qualified
- Recorded on the register as holding a prescribing qualification
- Professionally accountable and working within their area of expertise
- Have a prescribing supervisor is an independent supervisor who completes assessment and teaching in practice (previously known as a designated medical practitioner (DMP)
- Maintain knowledge and skills through education and learning
- A thorough assessment of the patient has been made

3.3 General structure of the ACCP programme

3.3.1 Duration of training

The indicative duration of training is three years and should be full time for the first two years which must ***be supernumerary***. Training times are indicative and assume an average rate of gain of competency and may be extended for less than full time tACCPs or those experiencing difficulties.
The MSc is awarded by the HEI but the full assumption of the role of ACCP requires successful completion of assessment of clinical competence in the workplace by Consultant trainers in ICM.

ACCPs who have satisfactorily **completed** the clinical and academic requirements during the two-year supernumerary period can apply to become an ACCP Member of the Faculty (See Figure 2 below). It is expected the third year to complete the full MSc would be alongside clinical practice as an ACCP as part of the medical workforce for ICU.

3.3.2 Less Than Full Time [LTFT] Training

The provision of less than full time training is the responsibility of the HEI and LCL in conjunction with employers (see 4.4).

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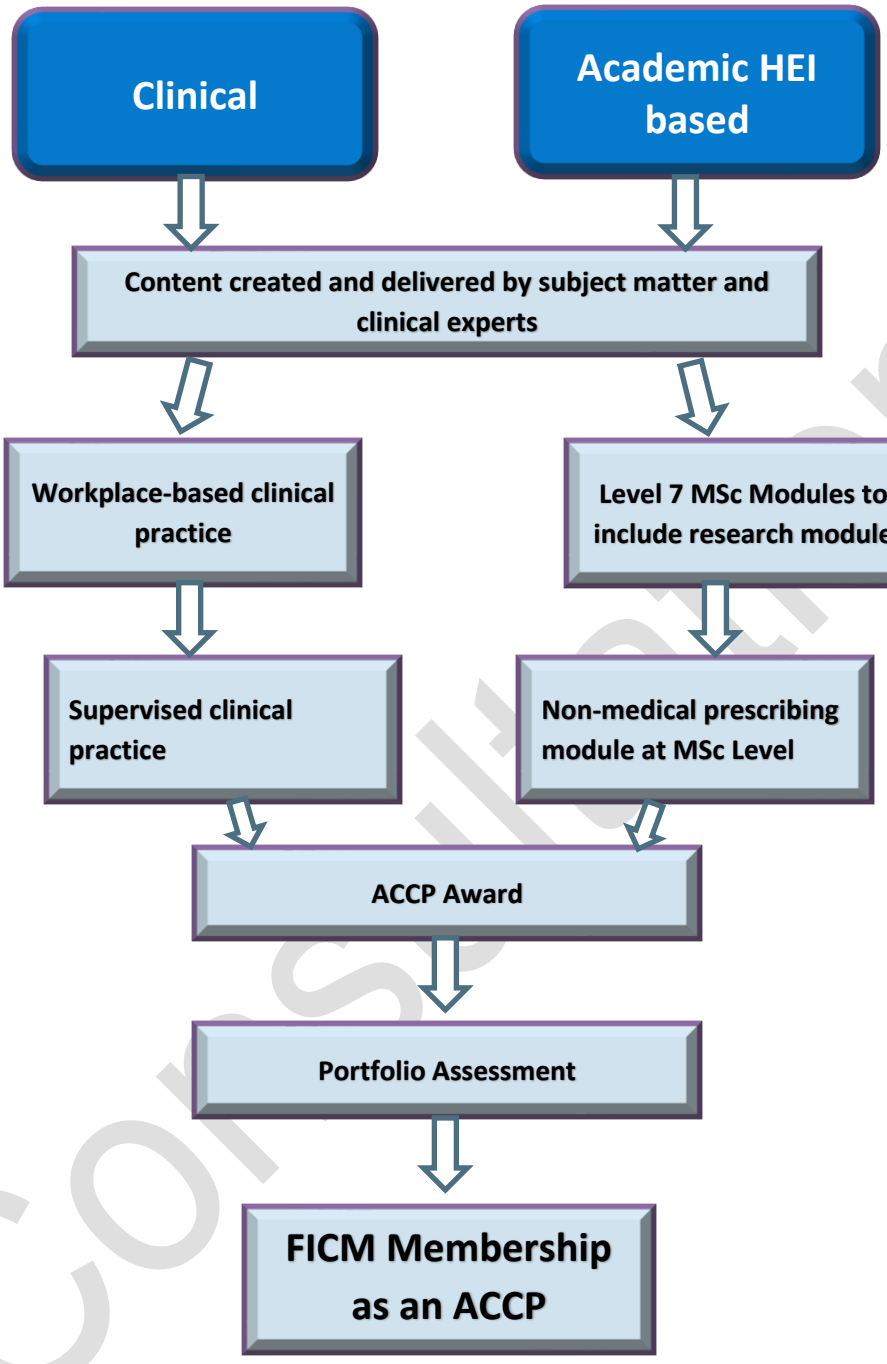
[2] National Prescribing Centre, 2012 http://www.npc.nhs.uk/

Fig 2: Pathway FICM ACCP Membership



3.4 Role of the Advanced Critical Care Practitioner [3]

- Undertake comprehensive clinical assessment of a patient's condition
- Request and perform diagnostic tests
- Initiate and manage a clinical treatment plan
- Provide accurate and effective clinical handovers
- Undertake invasive interventions within the scope of practice

[3] *National Competency Framework for Advanced Critical Care Practitioners*, 2008

- Provide professional leadership and support within a multi-professional team
- Work autonomously in recognised situations
- Demonstrate comprehensive knowledge across a range of subject areas relevant to the field of critical care
- Critically analyse, evaluate, and synthesise different sources of information for the purpose of assessing and managing the care of a critically ill patient
- Apply the principles of diagnosis and clinical reasoning that underlie clinical judgement and decision making
- Apply theory to practice through a clinical decision-making model
- Apply the principles of therapeutics and safe prescribing
- Understand the professional accountability and legal frameworks for advanced practice
- Function at an advanced level of practice as part of the multidisciplinary team as determined by the competency framework
- Apply the principles of evidence-based practice to the management of the critically ill patient
- Understand and perform clinical audit

These capabilities are included in the CoBaTrICE competency framework, albeit under a different domain structure. To ensure consistency with other training programmes we include these capabilities and their assessment framework in *Part IV*.

3.5 Local decisions about exact composition of programme

The exact nature of each training programme will be decided locally following discussion between Local Education and Training Boards, the ACCP, LCL the HEI and the local trainers. However, the overall programme must conform to the specifications outlined and deliver the training outcomes defined in this curriculum. FICM Accredited HEIs conform to these standards.

The overarching responsibility rests with the HEI awarding the MSc who must ensure the standards set are commensurate with independent practice and facilitate the production of a high-quality transferable qualification recognised nationally by the Faculty of Intensive Care Medicine.

The curriculum for ACCP provides a core set of capabilities required of all ACCPs. It is recognised that individual trusts in addition to this core skills set may wish to train their ACCPs to perform additional tasks or procedures dependent on the clinical case mix and requirements for their own units. The LCL and local trainers hold responsibility for ensuring appropriate governance structures are in place.

3.6 Enrolment with the Faculty and FICM ACCP Membership

All tACCPs must register with the Faculty as soon as possible after starting their ACCP training, via submission of an ACCP Trainee Registration Form to the Faculty. **There is no fee for registration,** but it is considered important that tACCPs register to inform future training and workforce planning. Registration also enables tACCPs to establish contact with the Faculty and remain abreast of developments in the field and ACCP related or relevant Faculty events and initiatives.

Upon completion of their training programme, ACCPs may apply for FICM ACCP Membership status.

It should be noted that submission of an ACCP Trainee Registration Form does **not** mean that the tACCP will automatically be awarded FICM ACCP Membership at the end of their training; this will be contingent on the content of their ACCP Membership application and the location/content of their ACCP programme.

3.7 Professional Registration for ACCPs

There is currently no specifically designated regulator for Advanced Practitioners. It is expected that ACCPs remain registered with their primary professional body, such as the Nursing & Midwifery Council [NMC] and the Health and Care Professions Council [HCPC.

tACCPs are all registered professionals and will continue to hold professional responsibility for their practice with their base regulator in the current climate.

Work by the Commission for Healthcare Regulatory Excellence (2009) now the Professional Standards Authority states the activities undertaken by professionals at a level of advanced practice in a clinical setting do not lie beyond the scope of their base regulator

4. Learning and Teaching

4.1 Educational strategies

The curriculum describes educational strategies that are suited to work-based experiential learning and to appropriate academic education. The manner in which the training programme is organised to deliver such training will vary depending on local facilities. However, a vitally important element of training is appropriately supervised direct participation in the care of patients with a wide range of conditions. Training should therefore be structured to allow the tACCP to be involved in the care of patients with the full range of critical illness and related problems. This may involve placements in other regional centres to allow exposure to all critical care conditions. During the training programme the tACCP must demonstrate increasing responsibility and capability across the full range of practice expected of an independent qualified ACCP.

4.2 Teaching and Learning Methods

The curriculum will be delivered through a variety of learning experiences. tACCPs will learn from practice clinical skills appropriate to their level of training and to their attachment within the department. An appropriate balance needs to be struck between work-based experiential learning, appropriate off-the-job education, and independent self-directed learning. ICM is a specialty that encompasses a huge range of clinical conditions and a significant number of practical skills, such that a significant proportion of learning should be work-based experience supported by a robust Structured Training Programme [STP].

The curriculum indicates where particular learning methods/experiences are especially recommended. It is for the HEI and LCL to tailor the exact balance of methods to the particular regional environment in the most suitable blended manner. tACCPs should have supervised responsibility for the care of patients. A guiding principle should be that the degree of responsibility taken by the tACCP will increase as competency increases. This means that the degree of clinical supervision will vary as training progresses, with increasing clinical independence and responsibility as learning outcomes and capabilities are achieved.

All tACCPs are adult learners and take responsibility for their own education. It is the responsibility of the trainers to ensure adequate and appropriate educational opportunities are made available to the tACCP. In turn the tACCP should be enthusiastic and pro-active in identifying their own gaps in knowledge, skills, attitudes, and behaviour. tACCPs need to take advantage of all the formal and informal learning opportunities that go on in departments.

The following identifies the types of situations in which tACCPs learn and draws from the Academy of Medical Royal Colleges [AoMRC] Medical Leadership Curriculum.

4.2.1 Learning from experience and practice

tACCPs spend a large proportion of time on workplace-based experiential learning during supervised clinical practice in hospital settings. Learning involves closely supervised clinical practice until competence is achieved.

The learning environment includes wards, clinics, laboratories, simulated activities, and meetings. These more informal settings are valuable situations in which to develop leadership abilities, alongside colleagues from other professions and fields of work. With increasing responsibilities and independence, the tACCP will take the lead for an area of work.

4.2.2 Learning from feedback

tACCPs learn from experience, and this can be enhanced by reflecting on feedback from colleagues and other staff, carers, and the public, as well as structured formative feedback from Consultant trainers.

4.2.3 Learning with peers

There are many opportunities for tACCPs to learn with their peers. Local and regional postgraduate teaching opportunities allow tACCPs at different phases of training to come together for group learning.

4.2.4 Learning in formal situations

A robust and thorough programme of formal lectures must be in place to deliver the scientific component of the curriculum, ideally this will be based in and taught by the HEI but with suitable scrutiny by the HEI this can be delivered in the workplace. The HEI is responsible for the standards of this formal programme.

In addition, there are many other opportunities including attending regional and national courses and conferences to meet educational needs.

4.2.5 Personal Study

Time should be provided during training for personal study for self-directed learning to support educational objectives or to attend formal courses in support of the stage of training, specialist interests and career aims.

4.2.6 Independent learning

This may include new learning technologies such as 'e-learning', which may be helpful in conveying the knowledge components of the curriculum.

4.2.7 Specific trainer input

It is important to recognise and capitalise on the experience and expertise within each department. Different members of the team can act as role models at different stages, including those from other professions or spheres of work.

4.3 Out of hours commitments

Most ICM work is unscheduled and at least 50% of admissions to ICUs occur 'out of hours' (evenings and weekends). In view of this it is essential for tACCPs to gain experience outside routine working hours with the **appropriate supervision**. This provides:

- An opportunity to experience and develop clinical decision making, with the inevitable reduction in out-of-hours facilities.
- An opportunity to learn when to seek advice and appreciating that, when learning new aspects of emergency work as tACCPs, they require close clinical supervision.
- A reflection of professional ICU practice, as in most hospitals patients are admitted 24 hours a day, seven days a week, so requiring dedicated out-of-hours emergency facilities.

ACCP involvement in out of hours working will depend on local circumstances and **appropriate supervision** should be in place, to enable development of key skills and capabilities. It is not recommended

for tACCPs to carry out night duties until at least after the first 6 months to ensure that academic and learning needs are met. The tACCP and Consultant ES should together, following discussions decide the most appropriate time to commence 'out of hours' working, especially night duties.

4.4 Less than full-time [LTFT] trainees

The provision of less than full time training is the responsibility of the HEI and LCL in conjunction with employers.

4.5 Maternity leave and sick leave

Local negotiation around maternity and sick leave will be managed by the tACCPs employing line manager in conjunction with the ACCP LCL. The duration of the programme will require to be extended. Maximum allowance is 2 weeks per year; greater duration of absence will necessitate prolongation of training time.

4.6 Accommodation for training and trainees

Any hospital with tACCPs must have appropriate accommodation to support training and education; this may be in the department or elsewhere in the hospital e.g., the Postgraduate Teaching Centre. The Faculty's guidelines are that this accommodation should include:

- A focal point for the ICU staff to meet so that effective service and training can be co-ordinated and optimal opportunities provided for gaining experience and teaching.
- Adequate accommodation for trainers and teachers in which to prepare their work.
- A private area where confidential activities such as assessment, appraisal, counselling, and mentoring can occur.
- A secure storage facility for confidential training records.
- A reference library where tACCPs have ready access to bench books (or an electronic equivalent) and where they can access information at any time.
- Access for tACCPs to IT equipment such that they can carry out basic tasks on a computer, including the preparation of audio-visual presentations; access to the internet is recognised as an essential adjunct to learning.
- A suitably equipped teaching area and a private study area.
- An appropriate rest area whilst on shift.

5. Assessment

Note: **This section must be read in conjunction with and implemented via the outcome paperwork provided in *Part II: Assessment System* of this curriculum manual.**

Assessment is through a mixture of formal tests of knowledge based in the HEI and workplace-based assessments undertaken in the clinical area. Assessment has several purposes. It is designed to provide reassurance to trainees, trainers, employers, and the public that training is progressing at a satisfactory rate. It may also identify areas of weakness where tACCPs will need further work to achieve learning outcomes. Assessments are also opportunities for tACCPs to demonstrate excellence in their field.

The tACCP is expected to undertake formal examinations of knowledge at least at the end of Year 1 (where success is necessary for progress to Year 2) and at the end of training where it will be a compulsory component of the successful completion of training.

It is essential that, on appointment to a training programme, tACCPs have information about the assessments that they are required to undertake and their timing. The ACCP LCL and ES should ensure that the tACCP is aware of their responsibilities in terms of workplace-based assessments [SLEs][4] and that they maintain their training portfolio.

The FICM has developed an integrated set of Supervised Learning Events [SLEs] which are to be used throughout the entire postgraduate training programme. A key component of the use of SLEs is the provision of detailed and constructive feedback enabling the tACCP to improve their practice; this feedback should cover analysis of the level at which the tACCP is functioning mapped against the capabilities. Each capability in the curriculum has been blueprinted against the suitable SLE assessment tools and the requirements of the GMC's Good Medical Practice[5]. The assessments presented here have been validated for medical training in the UK. SLEs must only be undertaken by those who are appropriately trained; if they are performed by others than Consultants in intensive care, a Consultant must take ultimate responsibility for the assessment outcome.

5.1 Workplace Assessments of progress

5.1.1 Choosing appropriate Assessment Instruments

The curriculum was reviewed, and the cognitive, psychomotor, and behavioural learning outcomes have been allocated to appropriate instruments for SLE. During the ACCP training programme the tACCP will progressively build a portfolio of evidence to demonstrate that he or she has mastered the capabilities as defined in *Part III*.

Every tACCP should have an ES who is an ICM Consultant, who will follow them throughout their training period and assist in monitoring and defining the tACCP's educational requirements. In addition, for each clinical attachment the tACCP should have a Clinical Supervisor [CS] responsible for supporting and guiding their progress in each clinical area. The CS may be and ICM Consultant or an experienced ACCP holding FICM membership working in close contact with the ES who holds responsibility for overall assessment and progress. The ES will provide an end of placement assessment based on SLEs and Multi-Source feedback [MSF] from members of the multi-disciplinary team. It may be appropriate for the ES and CS roles to be undertaken by the same person.

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4 *Supervised Learning Events:* FICM ICM Curriculum: Supporting Excellence, August 2021.

5 *Good Medical Practice*. GMC, 2009.

One major goal of the initial meeting between tACCP and ES at the beginning of each training module is to agree on the areas to be covered. The tACCP and supervisor should meet every two months at minimum in order to monitor adequate training progression. The tACCP and assessor should agree on the capabilities that will be covered by a SLE prior to or immediately following the assessment. This should be an tACCP driven process.

Following a SLE the tACCP should fill in their Annual Training Record as appropriate with the type of SLE, capabilities covered and level of practice. A printout of the Record should be available at the quarterly meetings and Annual Review of Competence Progression [ARCP] to inform decision making.

5.1.2 The Available Assessment Methodologies

A pragmatic approach to the choice of assessment methods has been adopted. Assessment by the direct observation of work is based on the belief that an expert is able to make a judgment about the quality of an expert process by watching its progress. This is the methodology of the motor vehicle driving test and there is a long history of the use of observational assessment in the accreditation of practice. SLEs provide instantaneous, structured formative feedback to the tACCP.

SLEs used are the ICM Mini-CEX [I-CEX], Directly Observed Procedural Skills [DOPS], Case-based Discussion [CBD] and Acute Care Clinical Assessment Tool [ACAT]. These methodologies have a practical utility attested to by experience in their use and at least some objective evidence that correctly applied they have validity and reliability. Multi-Source Feedback [MSF] is another well-validated assessment tool for global performance, particularly in more complex areas such as team working. It is important that focused, formative verbal and written feedback is provided for each SLE. Assessment forms are available for download from the FICM website and are not included within this manual. The SLEs can be found here: (LINK WILL BE ADDED AFTER CONSULTATION PROCESS)

Multiple Consultant Reports [MCR] are an additional validated feedback process, brought in with the implementation of the 2021 ICM Curriculum: Supporting Excellence. The change to an outcomes-based approach to determining progression has placed more onus on the ES to make overarching, holistic judgements on whether the expected outcomes are being met at the relevant stage of training. This tool helps to support the ES in this decision making by requesting feedback from multiple Consultants that the tACCP has been working with, specifically in relation to the Capabilities.(LINK WILL BE ADDED AFTER CONSULTATION PROCESS)

5.1.3 How many Supervised Learning Events?

The purpose of SLEs is not to tick off each individual capability but through a process of supervised apprenticeship to provide a series of snapshots of work, from the general features of which it can be inferred whether the tACCP is making the necessary progress, not only in the specific work observed, but in related areas of the application of knowledge and skill. Given the inherent 2-year time restriction within the training programme, a minimum number of SLEs has been specified, but these numbers should be viewed as an absolute minimum. The actual number of observations of work required will depend on the individual tACCPs progress and guidance from their supervisors; tACCPs should be encouraged to undertake as many SLEs as they feel is needed to support their acquisition of competence. The Faculty's aim is always to maintain training standards and quality without developing undue 'assessment burden' for trainers and tACCPs.

Formative SLEs can be used to 'inform' the tACCP of their ability and skill level for events and procedures. However, for procedures, there should be a summative SLE to 'sign-off' the tACCP to carry out the skill/procedure independently.

As a minimum standard, tACCPs must have ***at least* two** pieces of satisfactory assessment evidence for every capability required for sign-off, though it is expected that tACCPs will ultimately have multiple assessment

mapping to multiple capabilities. For some sections of the curriculum (i.e., Practical Procedures) it is expected that more than one assessment will be required, at the discretion of local trainers.

Where an tACCP performs unsatisfactorily more assessments will be needed. It is the responsibility of the tACCP to provide sufficient evidence of satisfactory performance and satisfactory progress in their annual review. They will need evidence of performance in each block of training or section of the curriculum they have undertaken. It is the ES's responsibility to help the tACCP to understand what that evidence will be in their specific circumstances.

The ACCP LCL [ICM Consultant] in conjunction with other team members must complete a structured summary of the learner's performance via their Consultant feedback. The HEI Tutor will likewise summarise the tACCPs performance using the HEI End of Attachment Assessment. These forms should all be submitted, along with the ES's Report, at the tACCPs Annual Review; templates for each can be found in *Part II*.

Once again it must be stressed that there is no single, valid, reliable test of competence and the ARCP will review all the evidence, triangulating performance measured by different instruments, before drawing conclusions about a tACCPs progress (see *Part I*, section 6).

The following represents the **minimum** number of clinical assessments to be included in the tACCPs portfolio for submission at the end of each academic year.

Fig 3: *Minimum assessments*

Minimum Assessments per ACCP Academic Year	
Assessment	**Minimum No.**
Direct Observation of Procedural Skills [DOPS]	8
Acute Care Assessment Tool [ACAT]	4
Case-based Discussion [CBD]	10
ICM Mini-Clinical Evaluation Exercise [I-CEX]	2
Multi-Source Feedback [MSF] (including self-assessment exercise within specified domains)	1
Expanded Case Summary – 2000 words max. (to standard of case presentation in departmental meeting)	1
Logbook Summary – demonstrating activities, patient involvement, practical procedures, and critical incidents. ***Note:*** **No patient identifiable material should be stored or presented.**	1
Records of reflective practice – 500 words max.	2
Summary of all formal teaching sessions and courses attended	1

tACCPs should refer to the guidance notes on each assessment tool available from the FICM website[6]. Help should also be sought from their ES.

[6] http://www.ficm.ac.uk/curriculum-and-assessment/assessments-and-logbook

5.2 Observational Assessments

Assessment by the direct observation of work is based on the belief that an expert is able to make a judgement about the quality of an expert process by watching its progress. This is the methodology of the motor vehicle driving test and there is a long history of the use of observational assessment in the accreditation of practice. Assessments within the workplace provide instantaneous feedback to the tACCP.
Assessment forms are available for download from the FICM website.

5.2.1 Scoring observational assessments

The primary focus of an FICM assessment is to provide formative feedback however it is also of value to the tACCP to know whether the observer considers their performance is at the appropriate level or not. The decision is based on the observer's judgment, as an expert in the field. Whether the assessor believes the performance to be satisfactory or not they must offer formative feedback; both positive and negative. If the observer considers elements of performance to be unsatisfactory a grid is provided, which tabulates specific areas for concern, this will enable the tACCP to reflect on and improve their practice.

5.2.2 Case-based Discussion [CBD]

CBD can be used for a variety of training and assessment purposes as indicated in the curriculum section of this document. It will often focus on patient management. CBD is also used for assessing both generic, and clinical, knowledge and skills needed for effective practice, e.g., evidence-based practice, maintaining safety, teamwork, clinical research methodologies.

5.2.3 The ICM Mini Clinical Evaluation Exercise [I-CEX]

This is used to assess an tACCPs skill in real clinical encounters with patients. It involves the assessor directly observing a tACCP in a real clinical situation such as the initial assessment and treatment of a patient with sepsis in the admissions unit. It is designed to assess a variety of skills such as history taking, examination, communication skills and clinical judgement. Suitable areas for mini-CEX assessment are detailed in the syllabus.

5.2.4 Directly Observed Procedural Skills [DOPS]

This is an assessment of practical skills and ability. The assessor directly observes the ACCP undertaking a practical procedure and assesses their performance and gives feedback.

5.2.5 Multi-Source Feedback [MSF]

MSF is an objective, systematic collection of feedback of performance data, using a structured questionnaire, on an individual tACCP. This is derived from a number of stakeholders in their performance and will typically include a mixture of health care professionals and possibly others.

5.2.6 Acute Care Assessment Tool [ACAT]

The ACAT is designed to assess the tACCPs ability to manage a body of work over a more extended period of time. In the ICM environment this will usually be over a shift period and the assessment may focus on a variety of areas including record keeping, time management, team working, hand-over quality and team leadership.

5.2.6 Multiple Consultant Reports [MCR]

Multiple Consultant Reports [MCR] are an additional validated feedback process. This tool helps to support the ES in this decision making by requesting feedback from multiple Consultants that the tACCP has been working with, specifically in relation to the Capabilities.

5.3 Formative and Summative Assessments

Assessment of the tACCP is a continual process throughout the training period. It is achieved through a mixture of formal tests of knowledge based in the HEI and/or the training unit (including end of year summative assessments and intra-module assessments) together with formative clinical assessments (OSCEs, long case and portfolio vivas, clinical simulations) and workplace-based assessments undertaken in the clinical area. Appropriate scheduling, resources and marking formats must be applied to these assessments.

The Higher Education institute will oversee the administration of the requisite summative assessments as determined within the HEI course structure document. This will include both intra-module summative assessments e.g., during the Non-Medical Prescribing module, and the end of academic year triggered assessments.

Formative assessments in the form of SLEs will be carried out throughout the tACCPs training programme and 2-year supernumerary period in clinical practice, these should show progression and development. For procedures specifically Summative 'sign-off' SLEs should be completed to deem competency to carry out procedure independently.

5.4 Logbook and Portfolio

5.4.1 Logbook

tACCPs are required to keep a record of the cases that they manage. The FICM does not have a single specified logbook which tACCPs must use; rather it provides an ACCP Logbook Summary (see *Part II*) which details the information required. tACCPs may use their own preferred method to collect this information, providing it can output the necessary data.

Whatever the format, the logbook must be able to record the information required by the Logbook Summary and allow for the recording of any problems encountered during or after the relevant procedure. A completed Logbook Summary must be presented by the tACCP at each quarterly meeting with their ACCP LCL.

The logbook is a formal record of the various practical procedures that the tACCP will undertake. The aim is for the tACCP to eventually become proficient in each technique. Initially the majority of procedures will be closely supervised, but as the tACCPs technical ability develops, supervision will become less immediate and ultimately the ACCP should be able to perform these techniques independently.

The tACCP must have had a significant input into the care and management of the patient and this input should be mapped onto the major domains of the curriculum. Brief diagnostic information should also be included, for example using the ICNARC diagnostic criteria, along with an opportunity to place reflective comments in the case record. The case logbook will be part of the portfolio of evidence that the tACCP will collect to demonstrate their experience and competence.

In the event that assessments indicate underperformance in an area of practice the first response is to check from the logbook that the learner has had sufficient exposure to it. Lack of competence in the face of what is usually sufficient exposure is a cause for concern.

For certain procedures details of the site and specific technique used will also be recorded. The Logbook Summary contains a list of mandatory/core procedures in which the tACCP **must** become proficient and a list of procedures that may be required in specific areas, defined as specialist skills. Please note that the 'specialist skills' list is not exhaustive and can be added to for specific unit clinical need (e.g., cardiac/neuro).

Fig 4: *ACCP Logbook Procedures*

ACCP Logbook Procedures	
Core Skills	**Specialist Skills**
Peripheral venous cannulation	
Arterial cannulation	Pulmonary artery flotation catheter insertion
Central venous cannulation	
Nasogastric tube insertion	Insertion of TOE probe
Urinary catheterisation	Bronchoscopy
Defibrillation in cardiac arrest	Cardioversion/Defibrillation
Laryngeal mask airway insertion	Intra-aortic balloon pump removal
Dialysis catheter insertion	Thromboelastography/ROTEM analysis

The logbook must also record the level of supervision under which the tACCP carried out the respective procedures. The logbook should record the level of supervision using the levels of supervision (Direct Supervision (DS) – Indirect Supervision (IS) – Independent Practice (IP) – Demonstrates Knowledge (DK)) described in section 7.3 (*Fig.5*) of this curriculum manual. This list is not exhaustive and should reflect the service needs of the individual clinical area where applicable.

5.4.2 Training Portfolio

The tACCP must maintain a contemporaneous record of all their activities in sections of the portfolio as outlined below. The portfolio must contain a record of:

- Common and specialist capabilities as matched against curriculum
- DOPS assessments and guidance notes
- CBD assessments and guidance notes
- Mini-CEX assessments and guidance notes
- ACAT assessments and guidance notes
- Case Summaries
- Records of Reflective practice
- Multi-Source Feedback and guidance notes
- Logbook of Practical procedures
- Record of Summation of quarterly Consultant assessments with dialogue sheets
- Record of external and internal courses attended
- Record of course teaching days attended (minimum 80% attendance)
- University module credits
- Record of audit activity

- Record of teaching activity
- Record of research activity (if any)
- Record of critical incident reporting
- Record of patient and relative feedback
- Completed an Assessment of Training Document

5.4.3 Evidence of participation in and attendance at training events

Until recently evidence of attendance at a learning session was taken to be the standard for accumulation of credits in continuing education. Attendance does not assure that learning has occurred, but it does signify compliance with an appropriate learning plan. There are a number of aspects of training which support clinical practice but are situated more peripherally such as Research Methods, Management, Teaching and Assessment. At present there is little focused assessment in these areas and significant practical difficulties lie in the way of introducing assessment. The FICM requires that evidence of participation in learning is presented to the ARCP. These include attendance at specific courses, and local morbidity and mortality meetings (clinical review process) evidence of presentation at local audit and research meetings and records, and feedback from teaching the tACCPs has delivered.

5.4.4 Data Protection

All practitioners must be aware of the latest data protection legislation, e.g., the General Data Protection Regulation (2016) and UK Data Protection Act (2018) and implications of this legislation for their work.

5.4.5 Use of patient ID in logbooks

Patients must not be individually identifiable from the patient ID used. The GMC Confidentiality Guidance (glossary) defines anonymised data as:

> "Data from which the patient cannot be identified by the recipient of the information. The name, address and full postcode must be removed together with any other information which, in conjunction with other data held by or disclosed to the recipient, could identify the patient"'[7]

The FICM recommends that tACCPs only record the age (not date of birth) and sex of patients and that any other unique numbers retained (such as the patient's unit or CAI or CHI number) must be done so in complete compliance with data protection law.

5.5 Expanded Case Summaries

Commensurate with the planned spiral of learning in the curriculum all tACCPs will be expected to write selected case summaries during their training. To successfully complete each ARCP tACCPs will have had to submit one acceptable case summary each year, which will be evaluated locally by the tACCPs ES before progressing to the ARCP panel.

It is envisaged that the standard of these case summaries will reflect the standard of a case presentation at a departmental meeting. This might perhaps include case series which illustrate differences in management options. Cases are expected to contain references to back up the written statements. Examples of Expanded Case Summaries and their marking scheme can be found at www.ficm.ac.uk.

[7] http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

The purpose of the case summaries is to allow the candidate to demonstrate critical thinking, knowledge of recent literature in the field of ICM, critical appraisal, and a sound approach to evidence-based medicine.

5.6 Future ACCP Examination

It is the aspiration of the ACCP Advisory Group to produce a national exam as a benchmark of ACCP standards across the countries; this will likely take the form of an OSCE. It is not currently possible to deliver a national ACCP examination, but the Group intends to work towards this in future years.

5.7 HEI Assessments

tACCPs must acquire 60 academic credits per year via the completion of HEI modules; generally, two per year, though the exact format may vary for each HEI. tACCPs should record their HEI assessment progress via the HEI End of Attachment Assessment form which can be found in *Part II.*

The acquisition of the ability to undertake Non-Medical Prescribing [NMP] is pivotal to the success of the individual ACCP in practice and their full integration into the critical care team; the NMP module is nationally set and counts for 40 academic credits. tACCPs will usually undertake the NMP module in year 2 of their training programme.

6. Training Progression and Review

Note: **This section must be read in conjunction with and implemented via the outcome paperwork provided in *Part II: Assessment System* of this curriculum manual.**

Both tACCPs and supervisors need to ensure that training is both comprehensive and that progression of training is occurring at a satisfactory rate. The tACCP will undertake a number of meetings and assessments throughout the academic year with their ES and ACCP LCL or nominated deputy. These meetings form part of a structured assessment programme that allows regular review of educational objectives and overall competency progression.

The structure of these educational meetings and assessment programme is detailed below. The documentation templates required for each of these learning events can be found in *Part II: Assessment System* of this curriculum manual.

6.1 The Educational Supervisor's Report

The ES's structured report is a vital and essential piece of information which informs the ARCP meeting. An ES report template is available in *Part II* of this curriculum. The content of the report must reflect the learning agreement and objectives established at the initial appraisal. There must be appropriate supporting evidence available to the ES and this must be clearly documented in the report. If there has been any modification to the initial learning agreement during the relevant period of training the reasons for this must be included.

It is important to include other evidence to encourage and promote excellence. Logbooks, audit reports, research and publications are assessments of experience and are valid records of progress. The availability of a checklist may assist when assessing the portfolio so that any deficiencies are easily identified. They should also be able to suggest an appropriate outcome having reviewed and checked the documentation. The report must be discussed with the tACCP prior to submission so that they are aware of any concerns regarding their training progress, and tACCPs will receive feedback as part of the ARCP process.

6.2 Educational Agreement

tACCPs will meet with their ES at the start of each training attachment and create an Educational Agreement (see template in *Part II*). This should outline objectives in relation to clinical management, practical procedures, ICU management, audit, research, presentations, and teaching. Along with an agreed date for next review of progress.

6.3 Meetings with ACCP Local Clinical Lead

Each tACCP should meet with the ACCP LCL (or nominated deputy this may be another ICM Consultant) in order to undergo a formal review of progress and approval of the forthcoming targeted learning plan, which the tACCP should already have in place via their ES. These meetings should occur two to three times per year (as a minimum once per 6 months, including ARCP) in order to undergo formal review process during the 2-year training period and are in addition to the end of year appraisal meetings (which take place in months 12 and 24). If the LCL is the ES for an tACCP, involving another ES (or equivalent), may allow the trialogue to occur.

These meetings allow the ACCP LCL to maintain an overarching view of each tACCPs progress and correlate an individual's performance against an expected common standard.

Feedback forms will be issued to every Consultant within the teaching unit who has had direct contact with the tACCP (see *Part II* for forms). These forms will be collated by the ACCP LCL, and the results fed back to the tACCP during the meeting. On the basis of this feedback an abbreviated SWOT analysis should be conducted to allow the tACCP to address any potential areas of concern.

6.4 Annual Review of Competency Progression (ARCP)

At the end of each year the tACCP will undergo a formal ARCP in order to examine their overall performance and progress.

The ARCP is an assessment of the documentary evidence submitted by the tACCP. This should include, as a minimum, a review of the tACCPs training record, portfolio, and a structured report from the Educational or Clinical Supervisor. Assessment of the tACCP usually occurs in the workplace and academically by the HEI. The outcome of these assessments should be contained in the portfolio. Appraisal and annual planning are separate processes but can be combined with the ARCP as long as the outcome of the panel is decided prior to seeing the tACCP.

The data and documentation that will be required to inform this process are detailed below and constitute the ACCP's Professional Development Portfolio. This must be kept up to date throughout the training and must be available for inspection by the ACCP LCL /deputy at any time.

The tACCP must maintain a contemporaneous record of all their activities in sections as outlined below. These elements will be assessed at their annual review meeting:

- Record of official capabilities as matched against syllabus/curriculum
- Record of DOPS assessments
- Record of CBD assessments
- Record of Mini-CEX assessments
- Record of ACAT assessments
- Case Summaries
- Records of Reflective practice
- Multi-Source Feedback
- Logbook of Practical procedures
- Record of Summation of quarterly Consultant assessments, with dialogue sheets
- Record of external and internal courses attended
- Record of course teaching days attended (minimum 80% attendance)
- University modules
- Record of audit activity
- Record of teaching activity
- Record of research activity
- Record of critical incident reporting
- Record of patient feedback

6.4.1 The ARCP panel

There must be a minimum of two panel members, one of whom must be the ACCP LCL or their deputy and the other from the HEI. Where there is an unfavourable outcome, an external trainer should be consulted. All assessors must be appropriately trained.

External representation on the ARCP panel is encouraged to ensure UK wide consistency of programmes and standards. This can be facilitated much more easily now with virtual platforms being more readily available.

6.4.2 The ARCP process

The tACCP should be given at least 6 weeks' notice of the panel meeting date so that they have adequate time to gather their documentation and the ES report. Given the team nature of ACCP work it is recommended that this report draws on the views of the multi-disciplinary team during the tACCPs placement.

The panel will review the evidence provided and decide on an outcome (this may have been recommended by the ES). Where there is an unsatisfactory outcome of the meeting agreement needs to be reached on objectives that need to be met in order to produce a satisfactory outcome and also to define the timescale.

The provisional date of completion of training should be reviewed and any possible change documented.

The outcome of the ARCP should ensure that the HEI components have been met alongside the practical assessments within the workplace. Not all capabilities will have been met in year 1, however a varied spread of capabilities and abilities will be required. The second year ARCP should identify all capabilities met and evidenced with SLEs to cover the appropriate capabilities.

6.5 Independent Appraisal

Evidence to inform the ARCP must include a recent independent appraisal with base registration line manager.

6.6 Trainees in difficulty

ACCPs in training can encounter either personal or professional problems which may affect their performance. The use of personal development plans, appraisal, regular workplace and academic assessment, and educational supervision tACCPs who struggle to achieve their goals within the expected timescale can be more easily identified and may require support during their career.

Whatever the reason for difficulty it should be identified as early as possible.

Depending on the level of risk the ES will require a variable degree of support. It is highly recommended that all those involved in the education and clinical supervision of tACCPs are aware of their local strategy to ensure appropriate support can be provided to the tACCP and that patient safety is maintained.

HEIs and ACCP training centres must develop a clear strategy for dealing with such situations encompassing the spectrum of performance difficulties. HEIs often work in 3-month academic cycles, and this should be

kept in mind when supportive or remedial action is required. It is the responsibility of the ACCP LCL (or nominated deputy) to liaise with the HEI regarding tACCPs in difficulty.

Attempts to re-sit HEI assessments will be governed by the regulations of the specific HEI; the awarding institute's policies and procedures should be followed in such cases.

It is the decision of local trusts or boards whether employment in an ACCP training post is a seconded or a new appointment. Dependent on this, decisions over leaving the programme and subsequent employment rest with the employing organisation.

7. Supervision and Feedback

7.1 Role of the Educational and Clinical Supervisors

It is mandatory that the ES is an ICM Consultant. The clinical supervisor may be an experienced ACCP and is recommended to work alongside the tACCP's ES. It is recognised that competence in practice is achieved by supported exposure to practical learning experiences, and that reflective dialogue will help ensure that theoretical concepts are used to support advanced decision-making. The contribution of the Clinical Supervisor in relation to providing supervision, support, and opportunities to develop mastery and competence in a specialist area of advanced practice is crucial.

As a Supervisor you need to:

- Attend an initial meeting to facilitate your induction to the role, introduce the practice modules and the methods that will be used by the local University to support you in this new role. The workshop will also introduce the mastery element of the module and the skills and knowledge required to support tACCPs to achieve this level of practice.
- Attend formative progress meetings every three months with the ACCP LCL and tACCP.
- Liaise with the ACCP LCL regarding the tACCPs progress and highlight any areas of concern.
- Agree with your tACCP how work-based teaching, supervision and assessment will be conducted.
- Help to institute the competency framework for the advanced practice role that the tACCP will undertake.
- Use all the tools in the Portfolio as directed by the capability evidence log and engage with the triggered assessments at six-monthly intervals. Maintain the quality of the work-based capability assessment process commensurate with mastery.
- Ensure that all Practice Mentors working with the tACCP are aware of the guidelines relating to the tACCPs practice and are experienced professionally qualified practitioners.
- Facilitate learning in the clinical area.
- Encourage reflective activity and enquiry.
- Use all the tools in the Portfolio as directed by the capability evidence log and engage with the triggered assessments at six-monthly intervals.

tACCPs will initially work under your direct supervision/delegated supervision; however, this level of supervision will decrease to indirect and then proximal as they progress through the programme, demonstrating competence and confidence and becoming more autonomous within their role. Initially students will be working weekdays when maximum supervision and support is available, however, as they achieve their Portfolio benchmarks you, in conjunction with the LCLs, will decide when it is appropriate for them to progress from direct to indirect to proximal supervision and to out-of-hours working. It is anticipated that tACCPs will progress to proximal supervision by the end of Year 2.

7.1.1 ACCP trainees as trainers

By the time they complete their training programme, tACCPs must have learnt to assume responsibility for the support of more junior tACCPs. Second year tACCPs should support first year tACCPs to gain experience in supervision and support in preparation for becoming a qualified ACCP. As part of their CPD senior ACCPs should have the opportunity to contribute to the organisation and delivery of formal training under the supervision of the LCL or other designated trainers as identified in this curriculum. This is alongside but not a replacement for the tACCPs ES.

7.2 Criteria for appointment as an Educational Supervisor

Essential criteria:

- The ES's employing institution must be integrated into the local Schools of ICM, Anaesthesia, Medicine, Emergency Medicine, and Surgery.
- Willingness to teach and commitment to deliver 'hands on' teaching and training including preoperative and postoperative care.
- Regular clinical commitment (e.g., in operating theatres, Intensive Care Units).
- Robust evidence of recent continued CPD normally based on the previous two years.
- Being up-to-date and supported in a post with protected time for further CPD.
- Familiarity with the assessment procedures and documentation of the knowledge, skills, attitudes, and behaviour components of capability-based training.
- Willingness to continuously assess the tACCP throughout the appointment and to complete tACCPs' assessment forms on a regular basis as necessary.
- Participation in audit.
- Ability to detect the failing tACCP
- Successful completion of a 'Training the Trainers' course or equivalent
- Ability to use educational technology
- Familiarity with teaching evidence-based medicine
- Ability to provide remedial support to the tACCP in difficulty
- Willingness to guide and stimulate tACCPs to carry out audit and, if appropriate, clinical research
- Willingness to ensure that the volume and content of clinical training encounters and other sessions reflect the additional time required for training
- Willingness to mentor individual tACCPs

Every tACCP must have a nominated ES to oversee their individual learning.

7.3 Clinical Supervision

The critical nature of ICU work necessitates very close supervision of tACCPs. However, this must be balanced against the need for tACCPs to develop towards independent, expert practitioners. As always patient safety is the most important priority and must override any other apparent training needs.

Overall supervision (direct or indirect) will be provided by a Consultant in ICM but elements of supervision could be provided by other senior medical practitioners, where deemed appropriate by the LCL. Where the supervising Consultant in ICM is not physically present they must always be readily available for consultation, and it is identified that ultimate responsibility for standards of patient care lies with the Consultant in ICM.

Core capabilities based on the National Competency Framework for Advanced Critical Care Practitioners [2008] specifies practice and supervision levels as defined below:

Fig 5: *ACCP levels of supervision*

Direct Supervision (DS)	Is able to perform under full direct supervision (*Direct* = Consultant physically present and overseeing procedure)
Indirect Supervision (IS)	Can perform under indirect supervision (*Indirect* = supervising Consultant is not physically present but is available to tACCP within 5 to 30 minutes)
Independent Practice (IP)	Is able to perform fully independently without any Consultant input or monitoring.
Demonstrates Knowledge (DK)	Is able to demonstrate knowledge of the relevant procedure.

Supervising Consultants in ICM will be accountable overall for the work of the ACCP, in a similar manner to their responsibilities for trainee doctors. ACCPs will still be accountable for their own practice, within the boundaries of supervision and defined scope of practice. The General Medical Council's Good Medical Practice Guide (May 2001, 3rd edition) states that:

Delegation involves asking a nurse, doctor, medical student, or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

The ACCP will work in association with and under the supervision of the Consultant as an integral part of the critical care team.

Every tACCP must, at all times, be responsible to a nominated Consultant. The Consultant must be available to advise and assist the tACCP as appropriate. Sometimes this will require the Consultant's immediate presence but, on many occasions, less direct involvement will be needed. Supervision is a professional function of Consultants and they must be able to decide what is appropriate for each circumstance in consultation with the tACCP.

The safety of an individual hospital's supervision arrangements is the concern of the local department in conjunction with the hospital management; it is necessary for them to agree local standards and protocols that take account of their particular circumstances.

8 Managing Curriculum Implementation

8.1 Roles and Responsibilities

Capability based training relies on assessments made during clinical service. The responsibility for the organisation, monitoring and efficacy of this training and assessment is shared by a variety of authorities:

The FICM is responsible for:

- Advising the capabilities/learning outcomes in ACCP training
- Advising HEE, LETBs, Health Boards, HEIs and partner hospital on programmes of training.
- Evaluating the training of individual tACCPs who seek ACCP Membership of FICM

The HEI is responsible for:

- Producing and delivery an academic programme aligned to this FICM ACCP curriculum
- Provision of the award of MSc Advanced Critical Care Practice it is accepted HEIs may be in a process of transition in relation to the title of the award. However, the critical care taught content and alignment to this curriculum should be clear and evidenced in module descriptors.
- Assessment of academic competence
- Ensuring clinical and ESs are competent to supervise and assess clinical skills acquisition and assessment of clinical competence

The employer is responsible for:

- Ensuring appropriate terms of employment and facilitating supernumerary training
- Providing suitable training facilities
- Clinical governance
- Providing HR support

The ACCP LCL is responsible:

- To the HEI for the quality management of the training programme
- For the overall training arrangements in each Trust through the education and training structures in place locally.
- For ensuring that the ARCP process is organised correctly

8.2 Quality Assurance

This is defined as the arrangements (procedures, organisation) within local education providers (Health Board, NHS Trusts, Independent Sector) that ensure tACCPs receive education and training that achieves local, national, and professional standards.

The organisations responsible for this are local education providers (Health Boards, NHS Trusts, and the Independent Sector) and any other service provider that hosts and supports tACCPs. These organisations will have a Board level officer accountable for this function. Structures may vary regionally, but each organisation must take responsibility to ensure that standards and requirements are being achieved.

9 Equality and Diversity

Equality of opportunity is fundamental to the selection, training, and assessment of ACCPs. It seeks to recruit tACCPs regardless of race, religion, ethnic origin, disability, age, gender, or sexual orientation. Patients, tACCPs, supervisors, and all others amongst whom interactions occur in the practice of ACCP have a right to be always treated with fairness and transparency in all circumstances and. Equality characterises a society in which everyone has the opportunity to fulfil his or her potential. Diversity addresses the recognition and valuation of the differences between and amongst individuals. Promoting equality and valuing diversity are central to the ACCP curriculum. Discrimination, harassment, or victimisation of any of these groups of people may be related to: ability; age; bodily appearance and decoration; class; creed; caste; culture; gender; health status; relationship status; mental health; offending background; place of origin; political beliefs; race; and responsibility for dependants; religion; and sexual orientation.

The importance of Equality and Diversity in the NHS has been addressed by the Department of Health in England in 'The Vital Connection'[8], in Scotland in 'Our National Health: A Plan for Action, A Plan for Change'[9] and in Wales by the establishment of the NHS Wales Equality Unit. These themes must therefore be considered an integral part of the NHS commitment to patients and employees alike. The theme was developed in the particular instance of the medical workforce in *Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce*[10]. Furthermore, Equality and Diversity are enshrined in legislation enacted in both the United Kingdom and the European Union. Prominent among the relevant items of legislation are:

- Equality Act 2010 (which replaces many previous, disparate pieces of legislation) (the Act)
- Human Rights Act 1998
- Gender Recognition Act 2004
- Civil Partnership Act 2004
- Welsh Language Act 1993 (where applicable)

It is therefore considered essential that all persons involved in the management and delivery of training are themselves trained and well versed in the tenets of Equality and Diversity.

9.1 Protected characteristics

The Equality Act 2010 identifies the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

8 *The Vital Connection: An Equalities Framework for the NHS*: DH, April 2000.

9 *Our National Health: A Plan for Action, A Plan for Change*: Scottish Executive, undated.

10 *Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce*: DH Workforce Directorate, June 2004.

Practitioners must be aware of these protected characteristics and must treat patients with respect whatever their life choices and beliefs. They must not unfairly discriminate against patients by allowing their personal views (including any views about a patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status) to affect adversely their professional relationship with them or the treatment they provide or arrange. The Faculty has considered these protected characteristics in the production of this curriculum manual and does not believe there is any negative impact on the protected groups arising from the precepts of the ACCP training programme. Equality and Diversity information is collected by the Faculty from tACCPs as part of the tACCP registration process, on a voluntary basis.

As part of their professional development, tACCPs will be expected to receive appropriate training in Equality and Diversity and to apply those principles to every aspect of all their relationships. The delivery of this training is the responsibility of the employing Trust. A record of completion of this training must be held in the tACCPs portfolio. The benefits of this training are:

- To educate the tACCP in the issues in relation to patients, carers and colleagues and others whom they may meet in a professional context
- To inform the tACCP of his or her reasonable expectations from the training programme; and
- To advise what redress may be available if the principles of the legislation are breached.

Appendix 1: Abbreviations

The below is a list of abbreviations commonly used throughout this curriculum document:

Abbreviation	Term
ACCP	Advanced Critical Care Practitioner
APEL	Accreditation of Prior Experiential Learning
ANP	Advanced Nurse Practitioner
CoBaTrICE	Competency Based Training programme in Intensive Care Medicine for Europe
LCL	Local Clinical Lead
FICM	Faculty of Intensive Care Medicine
GMC	General Medical Council
HDU	High Dependency Unit
HEI	Higher Education Institution
HPC	Health and Care Professions Council
ICM	Intensive Care Medicine
ICU	Intensive Care Unit
NMC	Nursing & Midwifery Council for England and Wales
OSCE	Objective Structured Clinical Examination
RCoA-ARPC	Royal College of Anaesthetists' Anaesthesia-Related Professionals Committee
ARCP	Annual Review of Competency Progression
SOE	Structured Oral Examination
TPD	Training Programme Director
SLE	Supervised Learning Events
ES	Educational Supervisor

Appendix 2: Website Links and Documents

The General Medical Council Excellence by Design: standards for postgraduate curricula

https://www.gmc-uk.org/-/media/documents/excellence-by-design---standards-for-postgraduate-curricula-2109_pdf-70436125.pdf

The General Medical Council Generic Professional Capabilities Framework (GPC)

https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework

HEE Multi-professional Framework for Advanced clinical Practice in England

https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

Scottish Advanced Practice Toolkit (2008)

www.advancedpractice.scot.nhs.uk

NHS Wales 2009 Excellence, Assurance and Governance in a Learning Environment (EAGLE)

NHS Wales EAGLE Governance Framework

Assessment Guidance

http://www.ficm.ac.uk/curriculum-and-assessment/assessments-and-logbook

Appendix 3: Curriculum development group

The FICM wishes to gratefully acknowledge the efforts of the following contributors in the creation of the 2015 curriculum Version1:

Dr Anna Batchelor	RCoA-ARPC Chair and former ICM curriculum lead
Carole Boulanger	National ACCP training representative/Consultant ACCP
Dr Simon Gardner	National Clinical Lead for ACCPs
James Goodwin	Associate Director of Faculties, FICM
Jane McNulty	Lead ANP Lothian
Dr Graham R. Nimmo	National Clinical Lead for ACCPs
Annette Richardson	Nurse Consultant
Daniel Waeland	Head of Faculty, FICM

The FICM wishes to gratefully acknowledge the efforts of the following contributors in the Version 1.2 (2022) Curriculum update:

Carole Boulanger	Co-chair FICM ACCP Sub-Committee
Dr Gregor McNeil	Co-chair FICM ACCP Sub-Committee
James Goodwin	Associate Director of Faculties, FICM
Kate Mayes	Lead ACCP, Member of FICM ACCP Sub-Committee
Bill Allen; Dr Richard Brown; Dr Andrew Drummond; Richard Faulkner; Natalie Gardner; Dr Andrew Georgiou; Rachel Markham; Steven Simpson; Helen Singh	Members of FICM ACCP Sub-Committee
Dr Sarah Clarke	Representative, FICM Training Assessment & Quality Committee (TAQ)
Dr Matthew Williams	Representative, FICM Training Assessment & Quality Committee (TAQ)