The Faculty of Intensive Care Medicine

JRCPTB
Joint Royal Colleges of Physicians Training Board

GUIDANCE ON DUAL CCT PROGRAMMES IN INTENSIVE CARE MEDICINE AND RESPIRATORY MEDICINE

Contents

Revisions

V1.0: *October 2011*
V1.1: *August 2016*
V1.2*: January 2019 – amended to reflect the implementation of the FICM ePortfolio and the number of Mortality and Morbidity meetings required. All references to FFICM Primary exam have been removed and all references to audit have been changed to QI and the Respiratory Medicine ARCP decision aid has been updated.*

NB: This guidance is for the currently approved dual CCT programmes and is subject to change as future pathways will need to be approved by the GMC.

Introduction

Following the approval by the General Medical Council [GMC] of the standalone *CCT in Intensive Care Medicine* (2011), this guidance has been compiled by the Faculty of Intensive Care Medicine [FICM] and the Joint Royal College of Physicians Training Board [JRCPTB] for the benefit of trainees undertaking dual CCTs in Intensive Care Medicine [ICM] and Respiratory Medicine [RM] as well as those deaneries, Training Programme Directors and Regional Advisors responsible for creating and delivering such programmes.

The GMC guidance on dual CCTs states that "dual CCTs are available if the trainee can demonstrate achievement of the competencies/outcomes of both the approved curricula."[1] To this end, the FICM and JRCPTB have undertaken a cross-mapping exercise of both curricula to identify areas of overlap that will allow trainees to acquire the full competencies of both disciplines via a suitable choice of training attachments and educational interventions whilst avoiding undue prolongation of training.

This guidance deals specifically with those areas in which the two curricula overlap to allow double-counting of competencies, and describes the layout and indicative timeframes of a dual CCT programme. More detailed information on the respective competencies and assessment methods discussed here can be found in *The CCT in Intensive Care Medicine* and in the Respiratory Medicine curriculum.

Appointment to ICM/RM Dual CCT Programmes

GMC guidance on dual CCTs states that "appointment to dual CCT programmes must be through open competition," and that "both potential trainees and selection panels must be clear whether the appointment is for single or dual CCT/s."[2] All appointments should adhere to this guidance and to the ICM and RM trainee person specifications.

The ICM CCT programme may follow one of three Core programmes: ACCS [Acute Care Common Stem], CAT [Core Anaesthetic Training] and CMT [Core Medical Training]. Core Anaesthetic Trainees who subsequently wished to undertake dual CCTs in RM and ICM would need to apply for CMT in order to meet the requirements of the Respiratory Medicine CCT, and will need to re-enter at CT1. However, their previous time in CAT could be counted toward the 12 months' anaesthesia required for Stage 1 ICM (in blocks of no less than 3 months[3]), should they later be appointed to an ICM CCT programme.

Trainees who are undertaking dual training in Respiratory Medicine and General Internal Medicine (GIM) who wish to train in ICM should note that triple CCT programmes are not permitted.

Recruitment Process
Separate guidance on recruitment to ICM single and dual CCTs is published online at the FICM website National Recruitment page.

Acquisition and dual-counting of competencies

The single ICM CCT programme has an indicative duration of 7 years (from CT1); the single CCT in RM an indicative duration of 6-7 years from CT1 (depending on entry via CMT or ACCS); dual CCT training in ICM and RM has an indicative length of 8.5 years. A diagrammatic breakdown of the dual CCT training programme can be found on page 5; the section below discusses the rationale for the double-counting of competencies across each stage of training.

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1 http://www.gmc-uk.org/education/postgraduate/6790.asp

2 *Ibid*.

3 *The CCT in Intensive Care Medicine*, FICM, 3rd Edition August 2011 v1.0, p.I-17.

- ***Stage 1***
  For ICM CCT trainees ICM Stage 1 comprises the first 4 years of training (generally 2 years at Core level and 2 years Higher Specialist Training [HST]), with a minimum of 12 months' training each in ICM, anaesthesia and medicine (of which 6 months can be in Emergency Medicine) within this overall 4 years; the additional 12 months in this Stage is for exposure to acute specialist training and addresses the fact that not all of the ICM multiple cores are of the same length and content; RM dual trainees will therefore spend this time training in RM (single ICM CCT trainees may undertake this time in any of the acute specialties – depending on the needs of the service and local availability). Core training for RM consists of Core Medical Training and can be achieved in either the full 2 years of a formal Core Medical Training Programme, or via the ACCS programme, which would achieve the full 12 months' medicine requirement for Stage 1 (6 months each in Acute and Emergency Medicine) and 6 months each in anaesthesia and ICM. At completion of CMT or ACCS (including a pass in the MRCP exam, which is a pre-requisite for taking up, though not for applying for, an ST3+ post in the medical specialties) trainees can apply for training posts leading to dual CCTs in ICM and RM.

  Dual CCT trainees entering from CMT will therefore need to complete 12 months of ICM and 12 months of anaesthesia to complete Stage 1. Dual CCT trainees entering from ACCS will need to complete a further 6 months each of ICM and anaesthesia to complete Stage 1[4].

- ***Stage 2***
  Stage 2 ICM covers 2 years of ICM training in a variety of "special" areas including paediatric, neurosurgical and cardiothoracic ICM. Stage 2 also allows 12 months for the trainee to develop special skills that will "add value" to the service.

  - **Paeds/Neuro/Cardiothoracic training:** This Stage 2 year requires two 3 month blocks in each of paediatric and neuro ICM, and a 6 month block in cardiothoracic ICM. The 6 month cardiothoracic training time has been agreed as double-counting toward both the CCTs in ICM and RM.

    ***Important note*:** The 6 month block of cardiothoracic ICM **must** include 2 sessions of RM outpatient clinics per week. This is essential in building up exposure and developing competencies, particularly in chronic disease management, to the standard required for the RM CCT.

  - **Special Skills year:** The ICM CCT programme requires that during Stage 2 trainees develop and consolidate expertise in a 'Special Skill' directly relevant to ICM practice. For dual CCT trainees, it is envisaged that the special skills year will consist of 12 months of their partner CCT programme. Trainees undertaking dual CCTs in RM and ICM will therefore undertake the required RM training during this year – trainees wishing to undertake more specialised ICM during this year will have to negotiate such training blocks at local level and extend their training time in order to also complete all the respiratory competencies required by their partner CCT.

  This overall dual-counting of competencies allows dual RM and ICM CCT trainees to undertake Stage 2 without extension of their training.

[4] The FICM recognises that whilst an arrangement of two 6 month blocks is the most common combination for the ICM/anaesthesia year of ACCS (and is recommended by the Faculty), some regions allow trainees to divide this time into blocks of 3 and 9 months (weighted to either discipline). ACCS trainees undertaking only 3 months in one of the specialties during ACCS would need to undertake a further 9 months of it before completing Stage 1.

- ***Stage 3***
  Stage 3 ICM consists of the final 12 months of ICM and a final 6 months of RM. The FICM and JRCPTB accept that the acquisition of higher level management skills can be achieved across both specialties.

  Out of Programme Experience
  Trainees should note that the 36 months of RM in the dual programme is a bare minimum. Therefore, it is not likely that the Respiratory Medicine SAC would allow any OOPE time to be counted toward these 36 months.

Assessments

The FICM and JRCPTB utilise the same types of workplace-based assessment [WPBA]: DOPS [Directly Observed Procedural Skills], Mini-CEX [Mini Clinical Exercise], CbD [Case-based Discussion] and Multi-Source Feedback [MSF]. These assessment forms have areas of commonality across both specialties, with some specialty-specific differences in questions and assessment options. The ICM CCT also allows for the use of the physicians' Acute Care Assessment Tool [ACAT]. Physician curricula also use an audit assessment tool and a teaching assessment tool. A patient questionnaire is being developed.

RM trainees will use the JRCPTB e-portfolio. In those instances where competencies can be double-counted, the FICM and JRCPTB will accept use of one WPBA for both assessment systems; for example an assessment completed on the physician e-portfolio can be scanned and uploaded to the trainee's ICM portfolio, or vice versa. Whilst the assessment of double-counted competencies must be tailored to fulfil the requirements of both curricula, it may be appropriate to use one assessment to cover an aspect of both areas of practice.

Examinations

Entry into ICM HST requires completion of one of the prescribed core training programmes, using that core's GMC-approved curriculum and assessment system and including successful completion of the relevant primary examination for that programme. This exam pass must occur before entry to HST. Trainees wishing to enter dual CCTs in ICM and RM therefore **must** pass the MRCP (UK) exam in order to meet the requirements of both curricula.

Dual CCT trainees **must** pass both the FFICM Final and the Respiratory Medicine SCE [Specialty Certificate Examination] in order to gain both CCTs. The FFICM Final can be taken at any time during Stage 2 ICM, and must be passed before entry to Stage 3. The Respiratory Medicine SCE can be taken at any point during the totality of Higher Specialist Training. At present, for single specialty RM training, the recommended time to take the SCE is during the third year of training. Dual CCT trainees are advised to coordinate carefully with their respective specialty Regional Advisors to avoid exam congestion. Trainees who do not achieve one of the required Final examinations will be ineligible for a CCT in the respective specialty.

Respiratory Medicine posts for Dual CCT training

The vast majority of current RM posts are for dual training in RM and General Internal Medicine. Deaneries must ensure that the RM training for the RM/ICM dual CCT involves more intense single specialty RM experience.

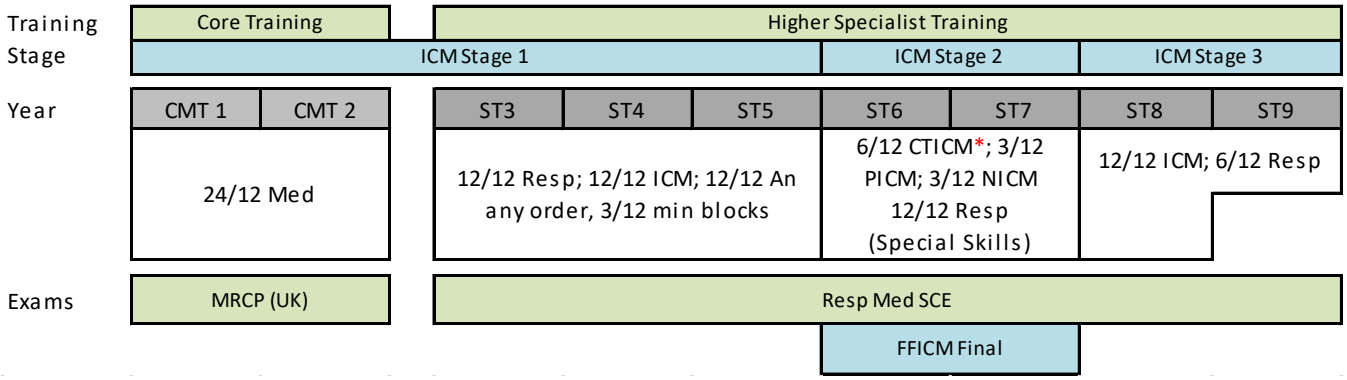
Dual CCT programmes in ICM and Respiratory Medicine

Below is an *example* programme for dual CCTs in ICM and RM. These should not be seen as immutable; there is scope within the construction of the two curricula to allow trainees to undertake the required modules *within an overarching Stage of training*, not within specific years. For example, the 12 months required in each of anaesthesia, medicine and ICM for Stage 1 training can be achieved in any CT or ST year before the completion of Stage 1, in minimum 3 month blocks. Likewise, the Stage 2 Special Skills year can be in either year within that training Stage. The same is true of the 6 months modules that make up the ACCS programme. Decisions will be made at local level on the arrangement of specific modules within each training Stage.

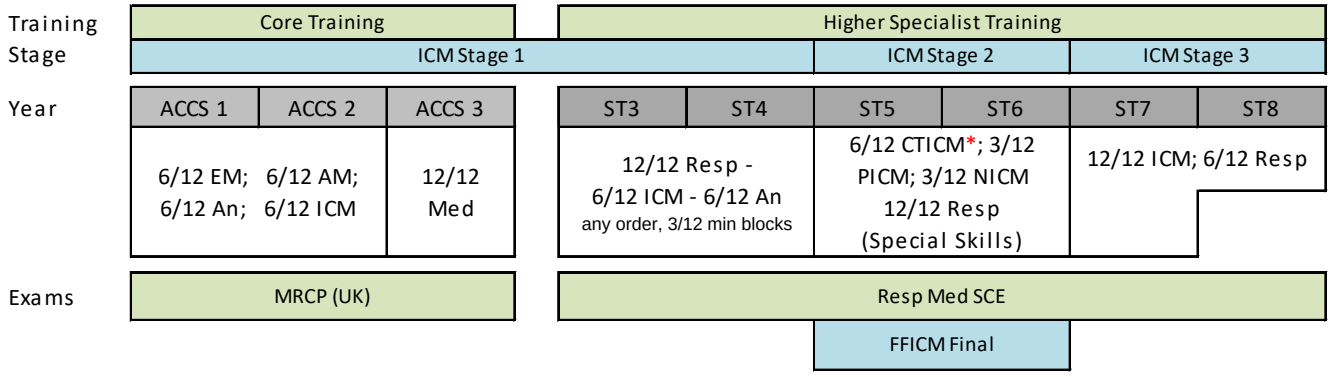
The indicative minimum timeframe for dual CCT training in RM and ICM is 8.5 years. Trainees who do not achieve the competencies required within this timeframe will require an extended period of training.

NB: This guidance is for the currently approved dual CCT programmes and is subject to change as future pathways will need to be approved by the GMC.

If entering from CORE MEDICINE:



If entering from ACCS (Acute Medicine):



***NB: 6/12 Cardiothoracic ICM Stage 2 block must include 2 sessions Resp Med OP clinics per week**

ARCP Decision Aids for Dual CCTs

The section below outlines the ARCP Progression Grids that should be used at the trainee's Annual Review of Competence Progression [ARCP] meeting. They are built upon the ARCP guidance within *The CCT in Intensive Care Medicine* and the *Respiratory Medicine curriculum*, and are shown in those respective formats for ease of use by trainers. However, they are slightly elongated to take account of the lengthened training required to obtain dual CCTs. The ARCP aids should be applied in direct accordance to the experience the trainee has had in the programme, and with recognition that there will be crossover.

ICM Stage 1

Assessments	ICM remainder of Stage 1 training
Curriculum Coverage (Generic)	Satisfactory evidence of progression to achieve/maintain relevant level in **ALL** competencies by the planned completion date for Stage. This will require each competency to have **at least** 1 relevant piece of evidence.
Curriculum Coverage (Specific WPBAs)	Appropriate competence level to be attained, as outlined in the Training Progression Grid; multiple competencies may be assessed by each WPBA.
Top 30 cases	At least 10 'Top 30' cases to be covered utilising CBDs and/or CEX (5 per year).
Logbook procedures	Logbook evidence of performance of at least 10 of the procedures listed. 30 DOPS over course of Stage 1 (with an average of 10 per year of training) to demonstrate maintenance or progression of competence.
Logbook cases	Unit Admission data should be available to support yearly learning outcomes. Individual cases provide suitable case mix to achieve yearly learning outcomes. Logbook report (with summary) for each block/year of training
Logbook Airway skills	A total of more than 30 cases (with at least 10/year). CEX/DOPS to demonstrate appropriate progression, maintenance or achievement of competence at relevant level.
WPBA	A total of at least 10 general 'Top 30' cases as **CBD**s, **CEX** or both must have been completed by the end of Stage 1.
	DOPS: chosen to reflect agreed CoBaTrICE competency assessments.
	MSF: A total of 2 from separate years of training
Exam	Possession of one of the designated core exams is needed for entry to HST in ICM.
QI	Participation in a quality improvement project – evidence of involvement, with report update
ES Report	Satisfactory report required for each year of training. Reference to satisfactory completion of specialty blocks of training within this report, or as a separate report, is required.
Teaching delivered	Record of all teaching delivered, at least 1 formal/ year, including feedback. Need not all be ICM but ICM teaching should be pro-rata.
Morbidity and Mortality meetings (any relevant specialty)	Attend at least 4 a year and evidence of reflection from 1 each year.
Journal clubs	Present at least twice during Stage 1.
External meetings as approved in PDP	Reflection on content.
Management meetings	No mandatory requirement but attendance encouraged.

ICM Stage 2

Assessments	ICM Stage 2 training (minimum 24/12 duration) including paediatric; cardiothoracic and neurosurgery attachments
Curriculum Coverage (Generic)	Satisfactory evidence of progression to achieve/maintain relevant level in **ALL** competencies by the planned completion date for Stage. This will require each competency to have **at least** 1 relevant piece of evidence.
Curriculum Coverage (Specific WPBAs)	Appropriate competence level to be attained, as outlined in the Training Progression Grid; multiple competencies may be assessed by each WPBA.
Top 30 cases	At least 20 of the 'Top 30' cases to have been covered by the end of Stage 2, utilising CBDs and/or CEX and/or ACAT, with a minimum of 6 from the special modules list (at least 2 from paeds, cardiac and neuro).
Logbook procedures	Logbook evidence of performance of at least 10 of the procedures listed, at relevant level, during specialist ICM modules. 15 DOPS to demonstrate maintenance or progression of competence. A logbook of procedures should be maintained during the special skills module but there are no indicative numbers.
Logbook cases	Unit Admission data should be available to support yearly learning outcomes Individual cases provide suitable case mix to achieve yearly learning outcomes Logbook report (with summary) for each block/year of training
Logbook Airway skills	A total of more than 30 cases (with an average of 15/year). CEX/DOPS/ACAT to demonstrate appropriate progression, maintenance or achievement of competence at relevant level.
WPBA	A total of at least 10 general 'Top 30' cases as **CBD**s, **CEX** or both must have been completed by the end of Stage 1.
	DOPS: chosen to reflect agreed CoBaTrICE competency assessments.
	MSF: 1 for each year spent in this Stage (minimum of 2).
Exam	Final FFICM must be obtained before progressing to Stage 3.
QI	Participation in a quality improvement project – evidence of involvement, with report update
ES Report	Satisfactory report required for each year of training. Reference to satisfactory completion of specialty blocks of training within this report, or as a separate report, is required.
Teaching delivered	Record of all teaching delivered, at least 1 formal/ year, including feedback. Need not all be ICM but ICM teaching should be pro-rata.
Morbidity and Mortality meetings (any relevant specialty)	Attend at least 4 a year and evidence of reflection from 1 each year.
Journal clubs	Present at least twice during Stage 2
External meetings as approved in PDP	Reflection on content.
Management meetings	No mandatory requirement but attendance encouraged.

ICM Stage 3

Assessments	ICM Stage 3 training (12/12 ICM attachment)
Curriculum Coverage (Generic)	Satisfactory evidence of progression to achieve/maintain relevant level in **ALL** competencies.
Curriculum Coverage (Specific WPBAs)	Appropriate competence level to be attained, as outlined in the Training Progression Grid; multiple competencies may be assessed by each WPBA.
Top 30 cases	At least 5 'Top 30' cases to be covered utilising CBDs and/or CEX and/or ACAT.
Logbook procedures	There are no indicative numbers, however it is expected that practical skills will be incorporated into more complex WPBAs.
Logbook cases	Unit Admission data should be available to support yearly learning outcomes Individual cases provide suitable case mix to achieve yearly learning outcomes Logbook report (with summary) for each block/year of training
Logbook Airway skills	It is expected that airway skills will be incorporated into more complex WPBAs. A total of more than 20 cases with evidence of progression of skill is recommended.
WPBA	A total of at least 10 general 'Top 30' cases as **CBD**s, **CEX** or both must have been completed by the end of Stage 3.
	DOPS: chosen to reflect agreed CoBaTrICE competency assessments. There are no indicative numbers, however it is expected that practical skills will be incorporated into more complex WPBAs.
	MSF: 1 for each year spent in this Stage (minimum of 1).
Exam	N/A
QI	Participation in a quality improvement project – evidence of involvement, with report update
ES Report	Satisfactory report required for each block of training
Teaching delivered	Record of all teaching delivered, at least 1 formal/ year, including feedback. Need not all be ICM but ICM teaching should be pro rata.
Morbidity and Mortality meetings	Attend at least 4 a year and evidence of reflection from 1 each year.
Journal clubs	Present at least once
External meetings as approved in PDP	Reflection on content.
Management meetings	Attend at least 2.

Respiratory Medicine

	Stage 1 – 12 months RM required			**Stage 2** – 18 months RM required (inc. dual counting of CTICM module as above)		**Stage 3 –** 6 months RM required	
	ST3	**ST4**	**ST5**	**ST6**	**ST7**	**ST8**	**ST9**
Clinical conduct (A1-2)	Satisfactory evidence from e-Portfolio and educational supervisor's report			Satisfactory evidence from e-Portfolio and educational supervisor's report		Satisfactory evidence from e-Portfolio and educational supervisor's report	
Core clinical skills (B1-8)	Evidence of engagement B1-8 by ST5			Evidence of engagement B1-8		Evidence of engagement B1-8 Confirmation level achieved in educational supervisor's report	
Medical leadership (C1-17)	Evidence of engagement 25% by ST5			Evidence of engagement 75% by ST7		Evidence of engagement 100% Confirmation level achieved in educational supervisor's report	
Patient/Problem Scenarios (D1-7)	Evidence of engagement 100% by ST5			Evidence of engagement 100%		Evidence of engagement 100% Confirmation level achieved in educational supervisor's report	
Clinical Subject Areas (E1-28)	Evidence of engagement 25% by ST5			Evidence of engagement 75% by ST7		Evidence of engagement 100% Confirmation level achieved in educational supervisor's report	
Practical Procedures (F1-13)	Competent F 1,4,7,8 by ST5			Competent F 1,2,3,4,5,7,8; Experience F 11,12 by ST7		Competent F 1-8; Experience F 9-13 by ST9	
Bronchoscopy	2 Satisfactory DOPS plus sign off of *experience* by Educational Supervisor, plus evidence of skill maintenance (e.g. further satisfactory DOPS) by ST5			3 Satisfactory DOPS plus formal sign off of *competence* by Educational Supervisor; plus evidence of maintenance of competence (e.g. satisfactory DOPS) by ST7		Competence at basic diagnostic bronchoscopy maintained; DOPS evidence; plus sign off of experience by Educational Supervisor	
Pleural ultrasound, level 1 competence	Evidence of training/experience			Competent; formal sign off by Educational Supervisor/ Radiologist/DOPS by ST7		Competence maintained (evidence required e.g. DOPS)	
Pleural aspiration	Competent. DOPS and/or formal sign off by Educational Supervisor			Competent		Competent	
Chest Drain DOPS	Competent by ST5 satisfactory DOPS as evidence, plus formal sign off by Educational Supervisor			Competence maintained; evidence required e.g. satisfactory DOPS		Competence maintained; evidence required e.g. satisfactory DOPS	
NIV Competence	Competent by ST5; DOPS as evidence; Formal sign off by Educational Supervisor			Competence maintained; evidence required e.g. satisfactory DOPS		Competence maintained; evidence required e.g. satisfactory DOPS	
Spirometry	Competent			Competent		Competent	

	Stage 1 – 12 months RM required			**Stage 2** – 18 months RM required (inc. dual counting of CTICM module as above)		**Stage 3 –** 6 months RM required	
	ST3	**ST4**	**ST5**	**ST6**	**ST7**	**ST8**	**ST9**
Lung Function Interpretation	Experience			Competent		Competent	
CXR Interpretation	Competent			Competent		Competent	
CT/CTPA/HRCT Interpretation	Experience			Experience		Competent	
ALS	Valid	Valid	Valid	Valid	Valid	Valid	Valid
SCE				Attempt/Pass (optional)	Attempt/Pass	Pass	Pass
DOPS	2 Bronchoscopy 1 Pleural aspiration 1 Chest drain 1 NIV			3 Bronchoscopy 1 Pleural aspiration (optional) 1 Chest drain 1 NIV (optional)		1 Bronchoscopy 1 Chest drain (optional)	
Procedure log book	Satisfactory record of bronchoscopy, pleural procedures, NIV +/- attendance Lung Function Lab			Satisfactory record of bronchoscopy, pleural procedures, NIV +/-attendance Lung Function Lab		Satisfactory record of ongoing bronchoscopy, pleural procedures, NIV experience	
mini-CEX/CbD	Minimum of 6 to sample curriculum			Minimum of 9 to sample curriculum		Minimum of 3 to sample curriculum	
MSF	One satisfactory ST3 - 5					One satisfactory ST7 or 8	
Patient Survey (PS)	One satisfactory ST3 - 5					One satisfactory ST7 or 8	
Use of evidence and audit (K1-2) **Audit assessment (AA)**	One satisfactory AA ST3 - 5 Satisfactory evidence from e-Portfolio			One satisfactory AA ST6 or 7 Satisfactory evidence from e-Portfolio		One satisfactory AA ST8 or 9 Satisfactory evidence from e-Portfolio	
Teaching and Training, J1 **Teaching Observation (TO)**	Evidence of involvement in teaching. Evidence of understanding principles of adult education Teaching course recommended (optional).			Portfolio evidence of ongoing participation plus evidence of implementation of principles of adult education. Teaching course recommended (optional)		Portfolio evidence of ongoing participation plus evidence of implementation of principles of adult education. Teaching course recommended (optional)	
Research	Evidence of critical thinking around relevant clinical questions. Evidence of developing research ideas and questions. Participation in journal clubs. Able to critically review the literature.			Evidence of preparation for ST8/9 requirements		One or more of: higher degree/ or full publication/ or national/international presentation (abstract) *and* assessed research course/ or research/research degree (MSc) in medical education	

	Stage 1 – 12 months RM required			**Stage 2** – 18 months RM required (inc. dual counting of CTICM module as above)		**Stage 3 –** 6 months RM required	
	ST3	**ST4**	**ST5**	**ST6**	**ST7**	**ST8**	**ST9**
Management and NHS structure (I 1)	Satisfactory evidence from e-Portfolio			Satisfactory evidence from e-Portfolio Have attended recognised course		Satisfactory evidence from e-Portfolio Have attended recognised course	
STP Attendance	70% by ST5			70% or appropriate alternative educational activities		70% or appropriate alternative educational activities	
RM Educational Supervisor's Report	Satisfactory			Satisfactory		Satisfactory	
Courses	Attendance at number and type appropriate for trainee			Attendance at number and type appropriate for trainee		Attendance at number and type appropriate for trainee	
National/International Meetings	Should have attended at least one since started training			Attendance		Attendance	
RCP CPD online diary							Registered
Multiple Consultant Report	4-6			6		2	