GUIDANCE ON DUAL CCTs PROGRAMMES IN INTENSIVE CARE MEDICINE and ANAESTHESIA

Contents

NB: The following discusses the implementation of Dual CCTs in Intensive Care Medicine and Anaesthesia whilst drawing heavily on information already available online. Further information can be found via the links below, and this document should be read in conjunction with these resources:

- FAQS on National Recruitment to ICM
- *The CCT in Intensive Care Medicine* (2011), Parts I-IV

Revisions

V1.0: *October 2011*
V1.1: *August 2012 – Updated to include Dual CCTs FAQ material*
V1.2: *August 2016 – Out of date FAQs removed, links updated for the new FICM website*
V1.3: *February 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 and expanded case summaries have been removed and all references to audit have been changed to QI. Diagrams of the training programme have been updated for clarity and an update regarding the timing of examinations has been included.*

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 Royal College of Anaesthetists [RCoA] for the benefit of trainees undertaking Dual CCTs in Intensive Care Medicine [ICM] and Anaesthesia, 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 RCoA 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 dual-counting of competencies, and describes the layout and indicative timeframes of a Dual CCTs programme. More detailed information on the respective competencies and assessment methods discussed here can be found in *The CCT in Intensive Care Medicine* and *The CCT in Anaesthetics*.

Appointment to ICM/Anaesthesia Dual CCTs

GMC guidance on Dual CCTs states that "appointment to Dual CCTs 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 CCTs/s"[2]. All appointments should adhere to this guidance and to the ICM and anaesthesia CCT 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 Medical Trainees who subsequently wished to undertake Dual CCTs in anaesthesia and ICM would need to apply for CAT in order to meet the requirements of *The CCT in Anaesthetics* and re-enter at CT1. However, their previous time in CMT could be counted toward the 12 months' medicine required for Stage 1 of ICM CCT training (in blocks of no less than 3 months[3]), should they later be appointed to an ICM CCT programme.

Recruitment Process

Guidance on ICM recruitment to ICM CCTs has been developed and is published online at http://ficm.ac.uk/national-recruitment-intensive-care-medicine . Further information relevant to Dual CCT recruitment will follow in due course.

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.

Structure of a Dual CCT programme including Anaesthesia and ICM

Both the anaesthetic and ICM CCT programmes have an indicative duration of 7 years; a Dual CCT programme in ICM and Anaesthesia has an indicative minimum duration of 8.5 years. It is technically possible for trainees entering via ACCS (Anaesthesia) to complete in 8.25 years, due to their completing 6/12 ICM within their Core programme rather than the 3/12 standard to all CAT trainees. This is reflected in the diagram below, which deals with the minimum requirements of the two CCTs. However, the FICM and RCoA accept that as a functional necessity of workforce planning trainees entering via ACCS (Anaesthesia) may also complete an 8.5 year programme depending on local arrangements. Trainees who do not achieve the competencies required within this timeframe will require an extended period of training.

'Spiral' Learning in the ICM and Anaesthetic training programmes

The ICM and anaesthetic training programmes are based on the 'spiral' learning concept that 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 independent practice in a specific post is achieved by the end of training as knowledge, skills, attitudes and behaviours metaphorically 'spiral' upwards.

The CoBaTrICE Methodology[4]

CoBaTrICE stands for 'Competency-Based Training in Intensive Care Medicine in Europe'. It is an international partnership of professional organisations and critical care clinicians working together to harmonise training in intensive care medicine worldwide. The CoBaTrICE programme links competencies with syllabus, assessment guidelines and online educational resources via their website. The FICM acknowledges the vital role that the CoBaTrICE project group's work has played in designing its curriculum.

The underlying principle of the CoBaTrICE project is that an intensive care doctor trained in one country should possess the same core skills and abilities as one trained in another, thereby ensuring a common standard of clinical competence. Assessment of competence is a continuous but progressive process. It is based on workplace-based assessment (i.e. formative assessment). This may include mini-clinical examination (Mini-CEX), direct observation of procedures (DOPS), and multi-source feedback, etc. These tools can be adapted to specific need. Also, giving and receiving feedback is a skill that can be learned and improved.

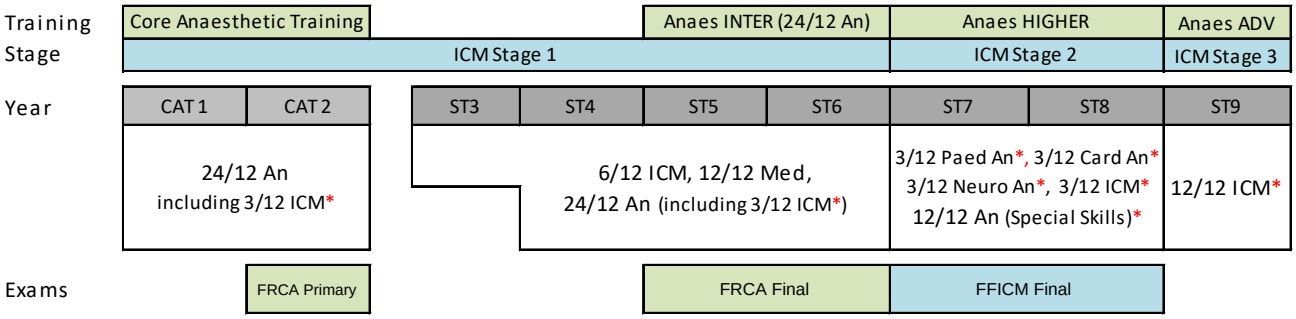
[4] http://www.cobatrice.org

Below is an *example* programme for Dual CCTs in ICM and anaesthesia. These should not be considered as immutable formats – there is scope within the construction of the two curricula to allow for trainees undertaking the required modules *within an overarching Stage of training* rather than specific years. For example, the 12/12 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. Likewise, the Stage 2 Special Skills year can be in either year within that training Stage. The same is true of the 6/12 modules that make up the ACCS programme. Decisions will be made at local level on the arrangement of specific modules within each training Stage. Where a training year is represented by a less than 12/12 block, this is purely to demonstrate acquisition of Stage requirements on the diagram – trainees would not be expected to mark time in that ST year but could progress within the programme.

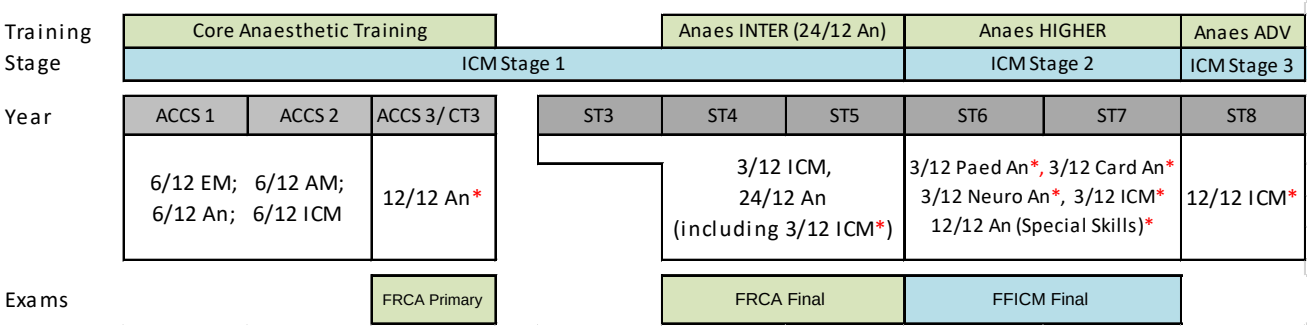
Important point of note: The order of training blocks within an overall training Stage (within Core and HST boundaries) is **interchangeable**. For example: in the Core Anaesthesia route below, the 12/12 of Medicine does not have to take place in ST4 – it must be completed before the trainee can exit Stage 1 ICM, but there is total leeway at local level to arrange the order of the training (with a minimum 3/12 block length) via negotiation between Anaesthesia and ICM TPDs. Likewise, the 'Special Skills' year can be either of the two years that make up Stage 2 training. Trainees can sit the FFICM examination at any point in Stage 2 training. Areas marked with an * are those modules agreed by the RCoA and FICM as dual counting across both CCTs.

Fig 2: **Example Dual CCTs programme in Anaesthesia and Intensive Care Medicine**

If entering from CORE ANAESTHESIA:



If entering from ACCS (Anaesthesia):



Dual counting competencies for both CCTs

As demonstrated by the * notations above, once trainees have completed **Stage 1 training**, the entirety of Stage 2 and Stage 3 ICM is dual-countable with Higher and Advanced level Anaesthesia. During Stage 1, both the 3/12 Basic and 3/12 Intermediate ICM blocks undertaken by all Anaesthesia trainees can be counted toward the CCT in ICM.

- **Stage 1 ICM and Core/Intermediate Anaesthesia**
  Stage 1 includes the trainee's Core programme and the beginning of their Higher Specialty Training. Stage 1 must be 4 years minimum in duration (for all Dual CCTs trainees this will happen by default), of which 3 must consist of 12/12 each in ICM, Anaesthesia and Medicine (for ACCS trainees 6/12 each of Acute and Emergency Medicine may count toward the Medicine requirement).

  Core level Anaesthesia comprises the full 2 years of Core Anaesthetic Training, which includes 3 months of basic level ICM. At completion of CAT (including a pass in the FRCA Primary), trainees can apply for training posts leading to Dual CCTs in Anaesthesia and ICM. Intermediate level Anaesthesia then includes a further 3 months of ICM at ST3/4 level.

  Dual CCTs trainees entering from CAT will therefore need to complete a further 6 months of ICM and the required 12 months of medicine to complete Stage 1 ICM. Dual CCTs trainees entering from ACCS (Anaesthesia) will have completed the required 12 months of medicine and 12 months of anaesthesia as part of ACCS (Anaesthesia), along with generally 6 months of ICM. These trainees will therefore need to complete a further 6 months of ICM to complete Stage 1[5].

- **Stage 2 ICM and Higher Anaesthesia**
  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. *The CCT in Anaesthetics* requires trainees to complete 3 months of Higher-Level ICM, which can be dual counted toward the ICM CCT.

  - **Paeds/Neuro/Cardio blocks:** Stage 2 requires a 3 month block in each of these areas. The purpose of these attachments is not to produce specialist intensivists but to introduce trainees to these areas so that if and when they take up a consultant post in ICM they will be useful members of the team able to recognise, resuscitate, stabilise and transfer critically ill patients who require specialist care and treatment. Training in stage 2 ICM/higher anaesthesia specialist modules should be dual counted for both programmes. The requirements are flexible so that Dual trainees can pick up these competencies in either their anaesthesia attachment or intensive care attachment. This is possible since many competencies are common to both programmes and can be acquired in theatre or on the intensive care unit. Trainees should spend time in both theatre and the intensive care unit. The minimum time spent in either should be that which is required to achieve those competencies unique to either theatre or ICU and the remaining time in the module may be spent in either location.

    This year of Stage 2 contains one more 3 month block, which can be spent in either general ICM (appropriate to Stage 2 learning outcomes) or further training in one of the above specialist areas. Dual CCTs trainees may spend this additional 3 months in general adult ICM to meet the Higher-level ICM requirements of *The CCT in Anaesthesia*, unless this has already been achieved earlier in their dual programme.

  - **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 CCTs trainees, it is envisaged that the special skills year will consist of 12 months of their partner CCT programme. Most trainees undertaking Dual CCTs in Anaesthesia and ICM will therefore undertake the required Higher level anaesthesia, notably completing the higher general units of training during this year – trainees wishing to undertake more

[5] 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.

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 Higher level anaesthesia required by their partner CCT.

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

- **Stage 3 ICM and Advanced Anaesthesia**
  The anaesthesia CCT programme allows for 12 months of ICM training as an anaesthetic Advanced module; this time can therefore be dual-counted to allow Dual CCTs trainees to undertake Stage 3 ICM without extension of their training.

Assessments

The FICM and RCoA utilise the same forms of workplace-based assessment [WPBA]: DOPS [Directly Observed Procedural Skills], Mini-CEX [Mini Clinical Exercise] (called either A-CEX or I-CEX respectively), CbD [Case-based Discussion] and Multi-Source Feedback [MSF]. These assessment forms have been designed for commonality across both specialties, with some specialty-specific differences in questions and assessment options. The ICM CCT also allows for the use of the Acute Care Assessment Tool [ACAT]; this assessment is acceptable for ICM CCT competencies but not the anaesthetic CCT.

In those instances where competencies can be dual-counted, the FICM and RCoA will accept use of one WPBA for both assessment systems; for example an assessment completed on the RCoA's e-Portfolio or LifeLong Learning platform can be scanned and uploaded to the trainee's ICM portfolio, or vice versa. Whilst the assessment of dual-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 curricula 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 Anaesthesia therefore must pass the Primary FRCA exam[6] in order to meet the requirements of both curricula. Trainees passing the Faculty's FFICM **only** would be eligible for a single CCT in ICM, but **not** Dual CCTs with anaesthesia.

Dual CCTs trainees **must** pass both the Final FRCA and FFICM Exams in order to gain both CCTs. The Final FRCA is taken during Intermediate level anaesthesia training[7], and must be passed before entry to Higher training. The FFICM Final can be taken at any time during Stage 2 ICM and must be passed before entry to Stage 3. Dual CCTs trainees are advised to coordinate carefully with their respective RAs 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.

Frequently Asked Questions:

Please click here to be taken to the FAQ section of the FICM website.

[6] ST3 applicants who are EEA nationals and have trained in a non-UK EEA nation may be eligible to apply without the Primary FRCA under the EU Directive 2005/36/EC. To qualify, training must meet defined criteria to be considered comparable to Core Anaesthetics Training in the UK. For further information please contact the Royal College of Anaesthetists.

[7] Those who have not completed the FRCA Final in its entirety by the end of Stage 1 may proceed to Stage 2 (anaesthetic special skills year only), as long as all units of intermediate anaesthetic training have been completed and an Intermediate Level Progress Report has been submitted to the RCoA. Please see the curriculum update notice *Timing of the FRCA Final examination: clarification for dual anaesthetic and ICM doctors in training* for details: https://www.ficm.ac.uk/sites/default/files/trg_2018.12_timingfrcafinalexam_dualprogfinal.pdf

ARCP Decision Aids

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 are shown in this format for ease of use by trainers. However, they are slightly amended to take account of the lengthened training required to obtain Dual CCTs.

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.