The Faculty of Intensive Care Medicine

ICM ARCP Guidance in light of COVID-19 – revised May 2021

- **Identification of the critical progression points for each specialty**

  We have a single ICM CCT programme and 5 dual training programmes with our partner specialties: Anaesthesia, Acute Internal Medicine, Renal Medicine, Respiratory Medicine and Emergency Medicine.

  The critical progression points for all training programmes are the stage completion certificates issued at the end of Stage 1, Stage 2 and Stage 3. These are issued by ICM Regional Advisors and confirm that all the requisite competencies of the curriculum have been completed by the trainee for the current Stage of Training permitting the trainee to progress to the subsequent Stage of Training or be recommended for a CCT. The different training routes have slightly different requirements and are listed below and it should be noted that for dual programmes all requirements from both specialties must be completed before a trainee can progress:

Single ICM CCT:

STAGE 1	12 months ICM
	12 months Anaesthetics
	12 months Medicine
	12 months of any additional training
STAGE 2	3 months Paediatric ICM
	3 months Cardiac ICM
	3 months Neuro ICM
	3 months General ICM
	12 months Special Skills Year (SSY) in ICM - examples in SSY handbook
Exams	FFICM Exam (MCQ and VIVA (SOE and OSCE))
STAGE 3	12 months ICM

Dual CCT Training Programme's Stage requirements:

ICM and Anaesthesia

STAGE 1	18-24 months Anaesthetics (Basic) (depending on whether the trainee entered ICM from ACCS or CAT)
	24 months Anaesthetics (Intermediate)
	12 months ICM
	12 months Medicine
Exams	FRCA Final
STAGE 2	3 months Paediatric ICM/Anaesthesia
	3 months Cardiac ICM/Anaesthesia
	3 months Neuro ICM/Anaesthesia
	3 months General ICM
	12 months Anaesthesia
Exams	FFICM Exam (MCQ and VIVA (SOE and OSCE))
STAGE 3	12 months ICM

ICM and Acute Internal Medicine

STAGE 1	24 months Medicine
	12 months Acute Internal Medicine
	12 months ICM
	12 months Anaesthesia
STAGE 2	3 months Paediatric ICM
	3 months Cardiac ICM
	3 months Neuro ICM
	3 months Acute Internal Medicine
	12 months Acute Internal Medicine
Exams	FFICM Exam (MCQ and VIVA (SOE and OSCE))
STAGE 3	12 months ICM
	6 months Acute Internal Medicine
Exams	Acute Internal Medicine Specialty Certificate Examination (AIM SCE)

ICM and Emergency Medicine

STAGE 1	12 months Emergency Medicine (core)
	6 months Acute Medicine
	6 months Paediatric Emergency Medicine
	12 months Emergency Medicine (intermediate)
	12 months ICM
	12 months Anaesthesia
STAGE 2	3 months Paediatric ICM
	3 months Neuro ICM
	3 months Cardiac ICM
	15 months Emergency Medicine
Exams	FFICM Exam (MCQ and VIVA (SOE and OSCE))
STAGE 3	12 months ICM
	6 months Emergency Medicine
Exams	FRCEM Final

ICM and Renal Medicine

STAGE 1	24 months Medicine
	12 months Renal Medicine
	12 months ICM
	12 months Anaesthesia
STAGE 2	3 months Paediatric ICM
	3 months Cardiac ICM
	3 months Neuro ICM
	15 months Renal Medicine
Exams	FFICM Exam (MCQ and VIVA (SOE and OSCE))
STAGE 3	12 months ICM
	6 months Renal Medicine
Exams	Renal Medicine Specialty Certificate Examination (SCE)

ICM and Respiratory Medicine

STAGE 1	24 months Medicine
	12 months Respiratory Medicine
	12 months ICM
	12 months Anaesthesia
STAGE 2	3 months Paediatric ICM
	6 months Cardiac ICM
	3 months Neuro ICM
	12 months Respiratory Medicine
Exams	FFICM Exam (MCQ and VIVA (SOE and OSCE))
STAGE 3	12 months ICM
	6 months Respiratory Medicine
Exams	Respiratory Medicine Specialty Certificate Examination (SCE)

- **Definition of the minimum data set for each specialty, for each year of training**

  FICM response: Prior to mid-February 2020 Specialty Registrars (StR) should have been gathering evidence for their ARCPs as their training year progresses. We would therefore expect to have a fair representation of the usual ARCP checklist items for this period. The same is pertinent for the period from June to October 2020 following a relative return to normality following the first wave. Review of the ARCP outcomes from the period April to August 2020, demonstrates the issuance of mostly standard outcomes, and an expected number of 10.1 outcomes as a consequence of not being able to sit the FFICM exam. There were a number of unanticipated 10.2 outcomes; reviewing these suggest the majority were likely at the request of the individual StR.

  However, we are also aware that in practice many StRs often leave much of their formal evidence acquisition and documentation until nearer the deadline for their ARCP. In coming to an ARCP Outcome decision, the ARCP panel will continue to make allowance for the extraordinary circumstances prevalent for much of the time since mid-February 2020. The Faculty feel much greater emphasis will have to be placed on the Educational Supervisor's Structured Report (ESSR) to fairly compensate the StR for their inability to acquire evidence for a portion of their training year. Evidence in the portfolio will be expected to be representative and proportionate considering the last year's placement(s) and roles. Where the curriculum prescribed evidence may be lacking, alternative forms of evidence will be considered such as e-learning and alternative CPD activity. In reaching their decision as to the adequacy of the evidence presented, the ARCP panel will be mindful of the StR's performance in previous years of training and the clinical setting and circumstances in which the StR has been asked to perform. Where there is less formal evidence available than would normally be expected and the ARCP panel are recommending that training progresses to the next year of training, the StR must confirm they agree with the Panel that they feel competent to progress. Where a StR feels that, as a result of any deficiency in their training provision, they are not competent to progress, then a remedial plan to address the deficiencies - which should include additional training time - should be agreed by the Panel.

- **Provision of clear specialty-specific criteria for non-progression.**

  FICM response: The reasons for an ARCP Panel to recommend non-progression will remain unchanged. However, the above considerations must be in place where there is a lack of evidence. StR confirmation that they do not feel they are competent to progress should be an absolute bar to progression of training until the articulated deficiencies have been addressed.

- **Identification of specialty-specific situations that might require an ARCP panel of three members**

  FICM response: We do not feel this is necessary, as long as the ICM TPD or RA is involved as one of the two on the ARCP panel, then we would be happy. In line with current practice and to ensure fairness, neither individual can be the trainee's Educational Supervisor.

- **Provision of advice regarding what amendments to person specifications are necessary for any subsequent programmes trainees will be moving into to facilitate career progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19. Such changes may need to be enacted for a number of years.**

  FICM response: We would accept the changes made by the specialties of the core programmes that feed into ICM training (eg ACCS/EM/CAT/IMT).

- **Provision of advice regarding which capabilities may be gained, or examinations undertaken in an Acting Up position or in a Period of Grace after the point CCT would normally have been awarded, within a defined education/development plan.**

  FICM response: The curriculum already has provision for allowing a StR performing the role of a Consultant in an "acting up" capacity to count their last 3 months of training towards their CCT. This is dependent on them having already acquired the necessary curriculum competencies. This will remain unchanged and the StR can only be recommended for a CCT when training has been completed in full. Thus, no capabilities or examinations can be deferred until after a CCT has been awarded. The required evidence will be subject to the conditions and limitations stated above.

- **Development of a GG8-compliant, decision-aid describing acceptable compensatory evidence (with examples) that ARCP panels could consider where normal evidence is not available due to the current situation.**

  FICM response: The advice to ARCP Panel members will be that in principle the requirement to have achieved all required competencies to progress in training remains unchanged but that the evidence presented must be taken in context as described above. The StR's confirmation that they agree with the Panel's acceptance of their competency will be paramount.

  Since the StR's ability to achieve the required competencies will have been dependent on their training placements, it is likely a significant number of StRs will not have been able to achieve their competencies and the following guidance sets out some key principles for ARCP Panels. This guidance cannot be expected to cover every possible combination of circumstances which every individual may have experienced but it will address the expected most common scenarios and is an attempt to ensure both transparency and consistency.

  How to adapt the ARCP process is a more difficult question for ICM than for other specialties due to the varied background of our dual StRs and the placement requirements of the ICM programme in the different Stages of training. The process is further complicated by disruption to rotations by re-deployment to support surged ICU services, and the effects on progression of training in partner specialties, particularly anaesthesia. There will be even more need to consider the effects on individual StRs.

  The overriding principle is to ensure that the doctors who have been working extremely hard are not then penalised for their efforts by being mandated additional training time. This would be punitive and viewed as such by the doctors, and we must try to avoid this at all costs whilst ensuring patient safety is maintained. This aim has been recognised and agreed by the GMC as the regulator and the statutory education bodies of all 4 nations.

We need nevertheless to be assured as far as possible within the current circumstances (and recognising the overall aim) that the StR has achieved the necessary training goals whilst accepting that the normal evidence may be impossible for the trainee to acquire. The requirements for this exceptional period of training need to be taken in context but any decision on training progression must be consistent with our duty towards patients - whose safety remains the overriding priority.

The Faculty have therefore set out some principles below. However, the final decision on the achievement of competence and progression will remain with the ARCP Panel.

Stage 1 training

In line with what the Faculty expect other Colleges and Faculties to recommend, we will not make progression from Stage 1 dependent on any Core programme examination success. We will need the permission of the GMC for this and we will require further discussion for how to deal with subsequent exam failures in later years but for 2020-21ARCPs this should suffice. All examination time constraints would then be extended by 12 months.

Scenario 1: Since placements in Stage 1 are typically for 1 year there is the likelihood that a significant number of trainees may not have been planned to rotate. This means it should be possible to sign off the relevant year of training whether it was in medicine, ICM or anaesthesia as they will have spent their time in that specialty.

Where re-deployment has had to occur, consideration will need to be made in line with the ARCP derogation decision aid as to whether sufficient time has been spent in the complementary specialty training module to meet the majority of the competencies expected through an outcomes based assessment of overall competence. We recommend a maximum reduction of 2 months from a medical or anaesthetic year of training, if the StR is able to demonstrate satisfactory accrual of competence. The StR must also indicate agreement with any recommendation to progress that is less than the usual indicative times for specific training modules.

Action: The full year will be recognised in that specialty placement.

Scenario 2: Trainees were due to have more than 1 specialty placement but failed to rotate. The principle should be that all requirements for ICM, medicine and anaesthesia placements are fulfilled by the end of Stage 1. We can, however, be pragmatic about the time spent in each of the placements.

Action: Experience in Stage 1 should be as close as possible to the recommendations in the curriculum but if required, experience can be cross-counted in the final year of Stage 1. Where there has been a deficiency in a placement time in a year other than their year of progression to Stage 2 (whether single or dual) further time should be allocated in subsequent years of training in Stage 1 to address that deficiency where possible. This will allow the altered training programme to be as close as possible to the curriculum recommended placement times. Allowance can be made where it is felt by the ARCP panel that the necessary competencies have been achieved in a reduced placement time.

Stage 2 training

Just as for Stage 1, in line with what we expect other Colleges and Faculties will recommend, the Faculty will also agree that progression from Stage 2 should not be dependent on any examination success. We will need the continued permission of the

GMC for this. Progression to Stage 3 will not be dependent on examination success but completion of Stage 3 and recommendation for a CCT will require examination success. This will almost certainly require additional examination capacity and an additional sitting.

Fulfilling the training requirements of Stage 2 is slightly more problematic than Stage 1 since the trainees undertaking their ICM year will need to have spent a minimum of 3 months in each of the specialist ICUs. The situation will be confounded by the different arrangements different Deaneries have in place to facilitate this. In constructing this guidance, we have consulted with the Regional Advisors and Training Programme Directors.

The Faculty propose the below guidance for ARCP Panels:

Scenario 1 – a StR completes all 3 specialist ICU placements. The Faculty will allow ARCP Panels to be flexible on time spent but we would suggest that anything short of 4 weeks would be unlikely to be credible. The minimum evidence the ARCP Panel would accept would be the ESSR.

Action: The StR would progress to Stage 3 as normal. No additional training time.

Scenario 2 – a StR completes 2 of the 3 specialist placements. As above, 4 weeks placement in each specialist ICU as a minimum and the ESSR as the minimum acceptable evidence.

In this scenario, the StR will likely have spent at least 9 months in one placement e.g. neuro, cardiac or paeds. It is possible to spend 3+3 months in a specialist ICM even though the more common model is to spend 3 months in each specialist ICM and 3 months in General ICM (GICM). It is likely that neurosciences ICM, cardiothoracic ICM & Paeds ICM placements will actually have been substantially adult ICM with some specialist activity.

The potential governance issue for the ARCP Panel to consider is that specialist activity may have been minimal due to the current clinical activity, but the Panel should be pragmatic and accept this. This would mean the StR has spent 3 months of one specialist ICM, 6 months of the other specialist ICM and 3 months GICM. The latter mentioned 3 months GICM undertaken in the final year of Stage 2 could then count towards "Stage 3" following progression of training i.e. the final year of training. In Stage 3 they would then undertake the 3 months of the specialist ICM they have missed. The actual time spent in this specialist ICM placement in the trainee's final year could be modified by agreement for the 2021/22 ARCP process if the current exceptional circumstances prevail.

However, if the StR had spent 9 months in PICM it becomes a little more difficult to count the additional 3 months of paediatric ICM as adult GICM but the Faculty recommends that there is sufficient overlap between adult and paediatric practice that it would reasonable in these exceptional circumstances to be pragmatic to avoid unfairly treating a group of trainees, especially if there has been significant Adult ICM workload during this placement and evidence is there to support it.

From a governance perspective, it should be borne in mind that the purpose of the specialist placements are not to produce expert independent practitioners but rather to give a basic understanding of the specialist ICM requirements. The aims, plus or minus the content, of the Special Skills Year (SSY) can be revised by the ES and trainee in light of the opportunities available, and ARCP panel should review the evidence against the revised aims.

Progression in the partner specialty will be determined by the relevant Colleges' derogation guidance. Where re-deployment has occurred to support surge ICU capacity, the time in GICM could be considered towards Stage 3 training where the StR is considered ready for Stage 3. Stage 3 programme time could be re-adjusted to make up the partner specialty missing time and competencies where needed.

We note that the emergency, respiratory, renal and acute medical specialties all have 6 months training time following the Stage 3 year during which missing competencies could also be made up.

It appears that the anaesthetic dual specialty trainees are most likely to be affected by re-deployment, though it should be recognised and encouraged, via communications with relevant STCs, that transferable competencies can be gained and acknowledged

Single ICM CCT StRs undertaking Special Skills Year should be able to meet the expected curriculum competencies. The specific outcomes expected of each SSY should be reviewed at the ARCP; where any are considered crucial to have been completed, then specific targets should be set to be completed during Stage 3.

Action: The StR would count from this academic year, 3 months and 6 months of the relevant specialist ICMs and 3 months of GICM towards 'Stage 3'. In Stage 3 i.e. their final year of training they will undertake a placement in the missing specialist ICM for a minimum of 4 weeks but ideally 3 months. No additional training time required.

Stage 3 training

This should be straightforward in terms of placements and the minimum evidence relied upon should be the ESSR, and a reasonable sampling of confirmatory evidence is seen.

Where a StR has moved into Stage 3 without the FFICM exam following a 10.1, and is then unable to pass the exam, an extension to training (either via outcomes 10.2 or 3) would be expected. The length of extension granted would be subject to the CG8 guidance.

NB: The above guidance is provided with the understanding that there must be a further conversation at both national and local levels about the capacity of hospitals to provide training (and manage the related service need) now that carefully planned rotations have had to be so suddenly changed.

Summary

ARCP guidance on the balance between time and competencies during the pandemic

1. It is not expected that overall training time will be reduced during the pandemic. Therefore flexibility over time spent on attachments should not result in an earlier than expected CCT date.

2. Extra time spent in ICM may be accredited to the training programme if appropriate competencies are gained. For example, a Stage 2 dual trainee may spend an extra 2 months in ICM instead of Anaesthesia. This could be accredited to Stage 3, at the discretion of the ARCP panel. The ARCP panels of both specialties would assess the experience and competencies gained, and make a PROVISIONAL judgement that the Stage 3 ICM could be shortened, and the trainee's programme be adjusted. This would be reassessed during Stage 3, with extra time allocated if there is seen to be a deficit in training.

3. Competency based training may result in flexibility in duration of attachments, for example Medicine or Anaesthesia. The ARCP panel must be satisfied that appropriate competencies have been achieved.

Top tips:

Derogations
Trainees may not have achieved all competencies for a given stage, but may be allowed to progress if they fit one of the derogations agreed by the GMC.

Flexibility between stages
- Up to 3 months can potentially be carried between stages 1 and 2, assuming competencies are met and fully documented
- Up to 2 months can potentially be carried between stage 2 and 3, assuming competencies are thought to have been gained at the higher level.

Flexibility within stages
- Up to 2 months can potentially be taken from 1 year blocks, for example Medicine or Anaesthetics, assuming that competencies are fully met and documented.
- Flexibility in the SSY year in Stage 2 may include clinical experience during the pandemic. A pragmatic approach to how the SSY goals are engaged with and worked towards over the year will be taken.

Process for ARCP mediation (if required)

The principle will be to ensure progression wherever possible. There is the opportunity for the trainee to raise their own concerns regarding their readiness to progress. Should the ARCP Panel have a query prior to determining an outcome (or an RA/TPD ahead of a panel occurring), or have a disagreement with a trainee over suitable evidence or a point of progression for example, the ARCP Panel Chair (or RA/TPD if considering an issue prior to ARCPs) is able to contact FICM (contact@ficm.ac.uk) for a definitive answer on a particular matter, prior to issuing an outcome. These queries will be reviewed by the Lead RAs and/or the Chair/Deputy Chair of the Faculty's Training, Assessment and Quality Committee. This is particularly important for ICM, as we have trainees taking quite heterogeneous routes, so please do ask if unsure, so that we apply a consistent approach. FICM will keep a log of such questions, so as to ensure consistency of approach, and provide wider dissemination of potential learning points from the process.

There are already mechanisms for a trainee to appeal an ARCP outcome via local HEE/SEB procedures.