The Faculty of Intensive Care Medicine

JRCPTB
Joint Royal Colleges of Physicians Training Board

GUIDANCE ON DUAL CCT PROGRAMMES IN INTENSIVE CARE MEDICINE and ACUTE INTERNAL MEDICINE

Contents

Revisions

V1.0: *October 2011*
V1.1: *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 AIM 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 Acute Internal Medicine [AIM] 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 dual-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 the Acute Internal Medicine curriculum.

Appointment to ICM/Acute Internal Medicine Dual CCTs

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 respective 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 Anaesthetic Trainees who subsequently wished to undertake dual CCTs in AIM and ICM would need to apply for CMT in order to meet the requirements of *The CCT in Acute Internal Medicine* and 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 AIM and General Internal Medicine (GIM) and 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; the single CCT in AIM an indicative duration of 5-6 years (depending on entry via CMT or ACCS); dual CCTs in ICM and AIM have an indicative length of 8.5 years. A diagrammatical breakdown of the dual CCT training programme can be found on page 5; the section below discusses the rationale for the dual-counting of competencies across each Stage of training.

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; AIM dual trainees will therefore spend this time training in medicine (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 AIM training can be achieved in either the full 2 years of Core Medical Training, or via the ACCS programme, which would achieve the full 12 months' medicine requirement of Stage 1 (6 months each in Acute and Emergency Medicine) and usually 6 months each in anaesthesia and ICM. At completion of CMT or ACCS (including a pass in the MRCP exam) trainees can apply for training posts leading to dual CCTs in ICM and AIM.

  Dual CCT trainees entering from CMT will therefore need to complete a 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 (subject to the provisions outlined above defining the necessary experience in anaesthesia and ICM)[4].

- ***Stage 2***
  Stage 2 ICM covers 2 years of ICM training in a variety of "special" areas including paediatric, neurosurgical and cardiac 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 three 3 month blocks in each of paediatric, neuro, and cardiac ICM. There is an additional 3 month training block within this year which should be spent in Acute Internal Medicine gaining experience of ambulatory care and the overall management of the acute medical unit.

  - **Special Skills year:** For dual CCT trainees, it is envisaged that the special skills year will consist entirely of 12 months of their partner CCT programme. Most trainees undertaking dual CCTs in AIM and ICM will therefore undertake the required AIM 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 AIM competencies required by their partner CCT. Specific focus should be placed on ensuring that the essential placements in cardiology, respiratory medicine and medicine for the elderly have been achieved. If the trainee already has pertinent experience in these areas then either exposure to a more advanced role in the AMU or to another acute medical specialty would be relevant to training in AIM here.

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

- ***Stage 3***
  Stage 3 ICM consists of the final 12 months of ICM and a final 6 months of AIM (with the AIM block finishing on the Acute Medical Unit with sessional exposure relevant to the trainee's outstanding training requirements). The FICM and JRCPTB accept that the acquisition of higher-level management skills can be achieved across both specialties.

[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.

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] but the use of this tool is mandated during the AIM part of training

In those instances where competencies can be dual-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 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 AIM 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 Acute Internal 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 Acute Internal Medicine SCE can be taken at any point during the totality of Higher Specialist Training. Dual CCT 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.

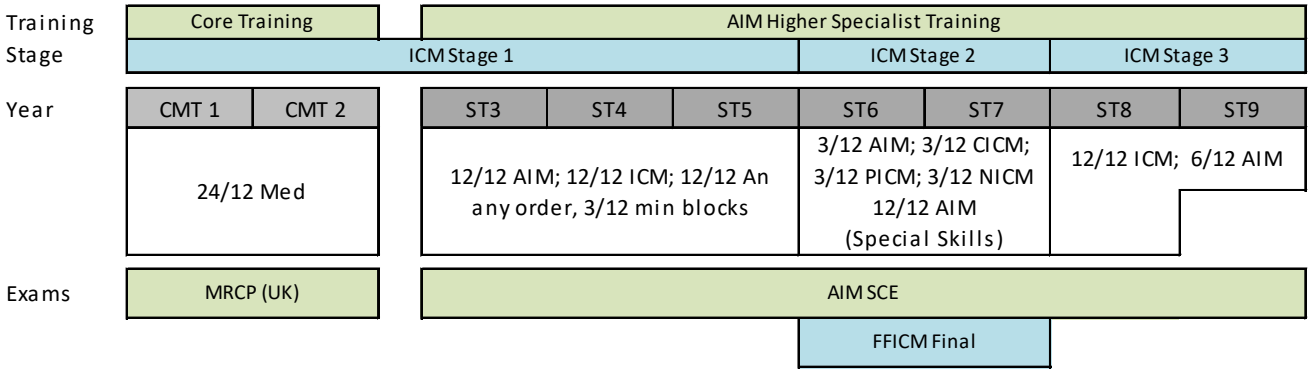
Dual CCT programmes in ICM and Acute Internal Medicine

Below is an *example* programme for dual CCTs in ICM and AIM. 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. In addition, the Stage 2 Special Skills year can be in either year within that training Stage. The same is true of the 6 month modules that make up the ACCS programme. Decisions will be made at local level on the arrangement of specific modules within each training Stage.

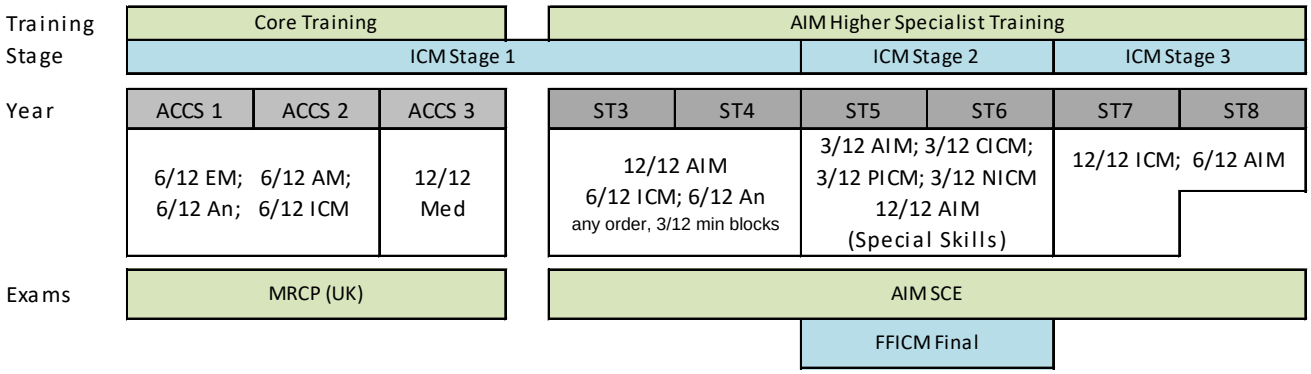
The indicative minimum timeframe for dual CCT training in AIM and ICM is 8.5 years. Trainees who do not achieve the competencies required within this timeframe will require an extended period of training.

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:



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 CCT in Acute Internal Medicine* curricula, 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 (i.e. if they have done two years of AIM then the AIM year 2 decision aid is relevant), 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.

Acute Internal Medicine

Curriculum domain		AIM year 1 (ST4)	AIM year 2 (ST5)	AIM year 3 (ST6-7)	AIM year 4 (ST9)
Educational Supervisor (ES) report	Overall report	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns
Management and leadership		Demonstrate acquisition of leadership skills in supervising the work of Foundation and Core Medical trainees during the acute medical take.	Demonstrate implementation of evidence based medicine whenever possible with the use of common guidelines. Demonstrate good practice in team working and contributing to multi-disciplinary teams.	Has senior level management skills for all medical presentations including complex cases. Reviews patients in ambulatory care and as newly presenting patient or in the inpatient setting. Supervises more junior doctors and communicates well with members of other professions and specialties within the acute medical unit. Provides input into organisational structures eg rota management, attendance at management meetings.	Creation of management and investigation pathways; instigates safe patient treatment. Liaises effectively with other specialties. Implements local clinical governance policies. Involvement in management within directorates, as an observer or trainee representative. Direct involvement in the organisation and managerial structure of the acute medical unit.
Multiple Consultant Report (MCR)	Each MCR to be completed by one clinical supervisor	4-6	4-6	4-6	4-6
SCE				AIM SCE taken	AIM SCE passed
ALS	Must be kept valid throughout training	Valid	Valid	Valid	Valid
AIM Audit or AIM Quality improvement projects	Quality improvement project assessment tool (QIPAT) or Audit Assessment (AA) to be completed	1	1	1	1
Supervised Leaning Events (SLEs) ACATs, CbDs, mini CEX	Minimum number of consultant SLEs per year ACATs to include a minimum of 5 cases	10 - to include at least 6 ACATs	10 - to include at least 6 ACATs	10 - to include at least 6 ACATs	10 - to include at least 6 ACATs)

Curriculum domain		AIM year 1 (ST4)	AIM year 2 (ST5)	AIM year 3 (ST6-7)	AIM year 4 (ST9)
Multi-source feedback (MSF)	Minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical) for a valid MSF. Raters to be agreed with ES.	1	1	1	1
Common Competencies	Progress to be determined by sampling trainee's evidence and self-ratings. ES to record rating at group level and provide justification	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that level 3 or 4 achieved
Emergency Presentations	Cardio-respiratory arrest	Confirmation by educational supervisor that evidence recorded and AIM level achieved			
	Shocked patient	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that evidence recorded and AIM level achieved	
	Unconscious patient	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that evidence recorded and AIM level achieved	
	Anaphylaxis / severe adverse drug reaction	Confirmation by educational supervisor that AIM level achieved (after discussion of management if no clinical cases)			
Top Presentations	Progress to be determined by sampling trainee's evidence and self-ratings. ES to record rating at group level with justification	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that level is satisfactory for AIM stage	

Curriculum domain		AIM year 1 (ST4)	AIM year 2 (ST5)	AIM year 3 (ST6-7)	AIM year 4 (ST9)
Other Important Presentations	Progress to be determined by sampling trainee's evidence and self-ratings. ES should record rating at group level with justification	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that level is satisfactory for completion of AIM
Clinical activity	Acute Take				1250 patients seen before CCT
	Ambulatory care				300 new patients before CCT
Clinical experience	Acute Medical Unit				Completed before CCT
	Cardiovascular Medicine				Completed before CCT
	Respiratory Medicine				Completed before CCT
	Geriatric Medicine				Completed before CCT
	Intensive Care Medicine				Completed before CCT
	Specialist Skill training				Completed before CCT
Teaching	Overall teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance. 1 Teaching Observation before CCT
	External AIM				100 hours before CCT

Procedure	AIM year 1 (ST4)	AIM year 2 (ST5)	AIM year 3 (ST6-7)	AIM year 4 (ST9)	Comments
DC cardioversion (R)	Clinically independent				DOPS to be carried out for each procedure. Formative DOPS should be undertaken before summative DOPS and can be undertaken as many times as needed. Summative DOPS sign off for routine procedures *(R)* to be undertaken on one occasion with one assessor Summative DOPS sign off for potentially life threatening procedures (*PLT*) to be undertaken on at least two occasions with two different assessors (one assessor per occasion) if clinical independence required[5] CMT procedural skills must be maintained[6]
Knee aspiration (R)	Clinically independent				
Abdominal paracentesis (PLT)	Clinically independent				
Central venous cannulation by internal jugular, subclavian or femoral approach (support for U/S guidance may be provided by another trained professional)(PLT)	Clinically independent				
Intercostal drainage (1) pneumothorax insertion (PLT)[7]	Clinically independent				
Intercostal drainage (2) pleural effusion (support for U/S may be provided by another trained professional) (PLT)[5]				Clinically independent	
Arterial line (R)				Clinically independent	
Temporary cardiac pacing via transvenous route (PLT)				Skills lab training completed[8]	
Sengstaken-Blakemore Tube insertion (PLT)				Skills lab training completed[6]	

[5] *Clinically independent is defined as competent to perform the procedure unsupervised , be able to recognise complications and respond appropriately if they arise, calling for help from colleagues in other specialties when necessary. Support for ultrasound guidance is required from another trained professional where indicated. Two summative DOPS are required for life threatening procedures*

[6] *If a doctor has been signed off as competent in a procedure during CMT or ST3, then provided they continue to carry out that procedure it should not require further testing.*

[7] *Pleural procedures should be undertaken in line with British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended, except for large effusions. Ultrasound guidance should be provided by a pleural-trained ultrasound practitioner*

[8] *Obtaining clinical independence in these procedures is desirable but not mandatory*