The Faculty of Intensive Care Medicine

JRCPTB
Joint Royal Colleges of Physicians Training Board

GUIDANCE ON DUAL CCT PROGRAMMES IN INTENSIVE CARE MEDICINE AND RENAL 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 Renal 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 Renal 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 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 Renal Medicine curriculum.

Appointment to ICM/Renal 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 the ICM CCT person specification.

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 CCT in Renal 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 Renal Medicine 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 RM an indicative duration of 5-6 years (depending on entry via CMT or ACCS); dual CCTs in ICM and RM have an indicative length of 8.5 years. A diagrammatical breakdown of the dual CCT training programme can be found on pages 5; the section below discusses the rationale for the dual-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 single CCT ICM 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 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.[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 Renal Medicine.

  - **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. Most 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 Renal 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.

- ***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.

[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].

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 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 RM therefore **must** pass the MRCP (UK) exam in order to meet the requirements of both curricula – they are not required to also pass the FFICM Primary. Trainees passing the Faculty's FFICM Primary **only** would be eligible for a single CCT in ICM, but **not** dual CCTs with RM.

Dual CCT trainees **must** pass both the FFICM Final and the Renal 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 Renal 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.

Renal Medicine posts for Dual CCT training

The vast majority of current RM posts are for dual training in RM and General Internal Medicine. Deaneries should ensure that the RM training for the RM/ICM dual CCT involves sufficiently intense single specialty RM experience to deliver the learning outcomes of the RM CCT programme.

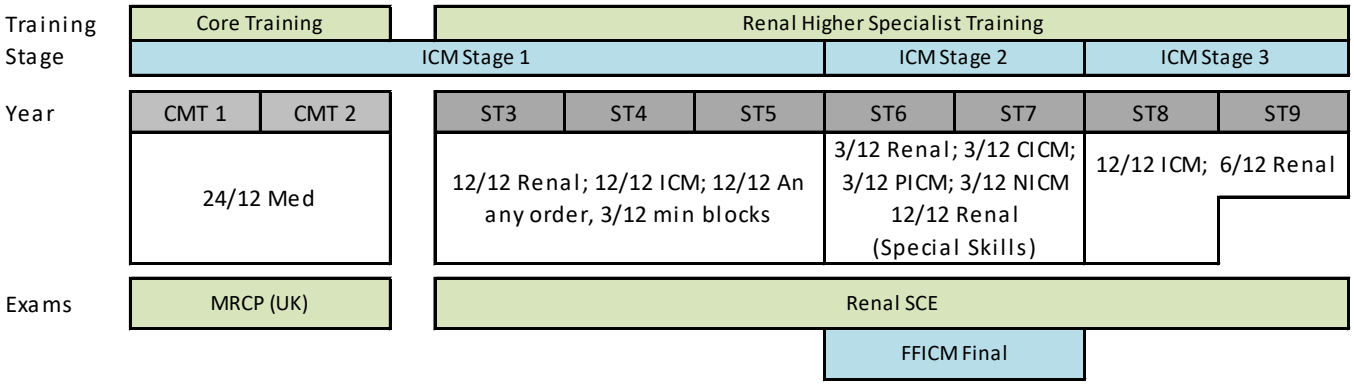
Dual CCT programmes in ICM and Renal Medicine

Below is an example programme for dual CCTs in ICM and RM. 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, 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 6/12 modules that make up the ACCS programme. Decisions will be made at local level on the arrangement of specific modules within each training Stage. Decisions will be made at local level on the arrangement of specific modules within each training Stage.

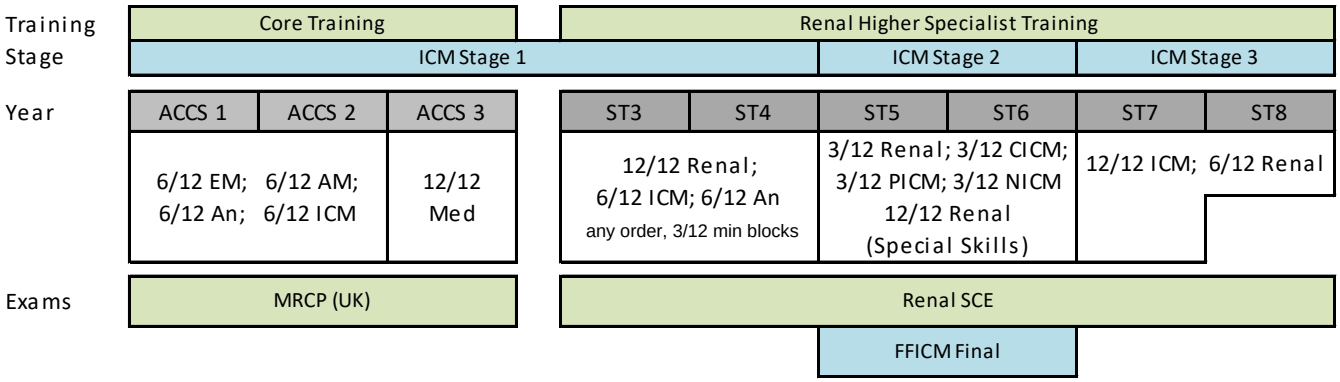
The indicative minimum timeframe for dual CCT training in RM and ICM is 8.5 years. Trainees who do not achieve the competencies required within this timeframe will require an extended period of training.

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):



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. There are separate ARCP aids for ICM and Renal Medicine. They are built upon the ARCP guidance within *The CCT in Intensive Care Medicine* and *The CCT in Renal Medicine* curricula, and are shown in those respective formats for ease of use by trainers. However, they are slightly amended 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.

Renal Medicine

Assessment Level (see detailed descriptors in the curriculum)	**Level 1**			**Level 2-3**		**Level 3-4**	
Single CCT	**End ST3**			**End ST4 = PYA**		**End ST5**	
Dual CCTs (entry via CMT) *	**End ST3**	**End ST4**	**End ST5**	**End ST5**	**End ST6 = PYA**	**End ST8**	**End ST9**
Dual CCTs (entry via ACCS)*	**End ST3**	**End ST4**	**End ST5**	**End ST5**	**End ST6 = PYA**	**End ST8**	**End ST9**
<u>Core Competencies</u> 1. Clinical Skills 2. Time management/Decisions 3. Patient focus and safety 4. Team working /Communication 5. Quality Improvement 6. Infection Control 7. Heath promotion/public health 8. Ethics/confidentiality 9. Consent and Legal Framework 10. Ethical Research 11. Evidence and guidelines 12. Audit 13. Teaching and Training 14. Personal Behaviour 15. Management/NHS Structure	Evidence of engagement with core competencies to be evaluated using work-place assessment tools (below) Minimum 1 audit (completed AA or QIPAT).			Evidence of engagement with core competencies to be evaluated using work-place assessment tools (below) Shortfalls to be identified at PYA. Minimum 1 audit (completed AA or QIPAT) Demonstrate involvement in portfolio research (+ online NIHR training).		Focus on complex situations, decision-making skills and team-leadership. Involved in management project (e.g. service delivery or development) and related Audit (AA or QIPAT) Management course completed.	
<u>Renal Specific: Good Clinical Care</u> 1. Common presentations 2. Advanced kidney disease management 3. Special Situations/skills 4. Leadership	Minimum of 2 of each SLE (mini-CEX, CbD, ACAT)to demonstrate exploration of curriculum. Educational supervisor to confirm satisfactory progress to appropriate level (see descriptors), focussing on common presentations and renal replacement.			Minimum of 2 of each SLE (mini-CEX, CbD, ACAT) to demonstrate engagement with curriculum. Educational supervisor to confirm satisfactory progress to appropriate level (see descriptors), to include special situations/skills, rarer diseases. Shortfalls to be identified at PYA.		Minimum of 2 of each SLE (mini-CEX, CbD, ACAT) to explore more advanced aspects of clinical care and leadership – e.g. conducting rounds and QA sessions.	
<u>Assessment Framework</u> 1. SCE 2. MSF 3. Educational Supervisors report 4. Multiple Consultant Supervisors report 5. ALS	Opportunity to pass Satisfactory Satisfactory 4-6 MCRs Valid			Opportunity to pass Optional Satisfactory 4-6 MCRs Valid		Passed Satisfactory Satisfactory 4-6 MCRs Valid	
<u>Procedures</u> (*minimum* documentation)**	Per procedure: x6 satisfactory DOPS, 3 different assessors on at least 2 occasions						

**In assessment of trainees undertaking dual training the level for a given ST year will depend on education opportunity likely to reflect local deanery arrangements.*

*** Essential: Non-tunnelled intravenous dialysis catheters. Non-essential: renal biopsy, tunnelled intravenous dialysis catheters, non-surgical insertion of peritoneal dialysis catheters. A total of at least 6 DOPS per procedure are required during the duration of training to demonstrate progression to the level of independent practice and being able to deal with any complications.*