The Faculty of
Intensive Care Medicine

JRCPTB

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

Contents

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 competences/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 CCT in Acute Internal Medicine*.

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.

Recruitment Process

Separate guidance on recruitment to ICM single and dual CCTs is being developed and will be published online at www.ficm.ac.uk.

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 these programmes can be found on pages 5 and 6; the 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 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 – and so are marked as 'any' in the single ICM CCT diagrams on p.6). 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 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

The FICM does not currently have an e-Portfolio system, but is actively investigating all available options. However, 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 that is then printed out and placed into the trainee's ICM portfolio, or an ICM WPBA which is scanned and uploaded to the physician e-Portfolio. 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 – 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 AIM.

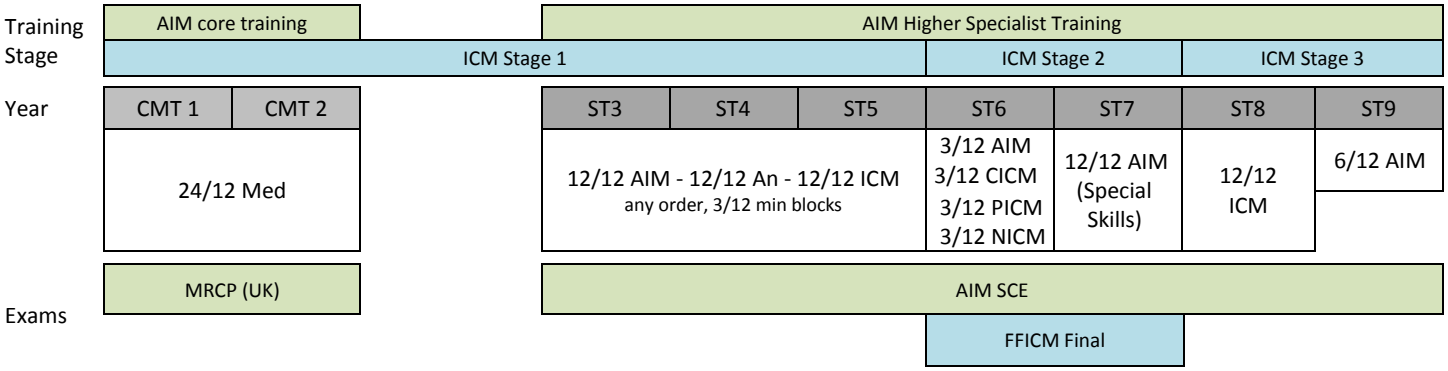
Dual CCT trainees **must** pass both the FFICM Final and the Acute Internal Medicine SCE [Specialty Certificate Examination] in order to gain both CCTs. The FFICM Final can be taken at any time during Stage 2 ICM, and must be passed before entry to Stage 3. The Acute Internal Medicine SCE can be taken 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 months modules that make up the ACCS programme. Decisions will be made at local level on the arrangement of specific modules within each training Stage.

The indicative minimum timeframe for dual CCT training in 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.

If enter from CORE MEDICINE:



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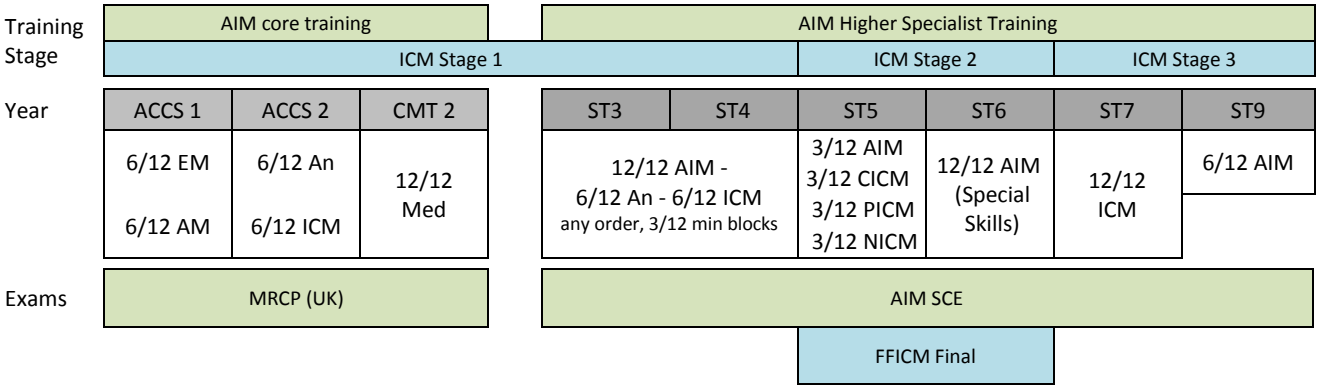
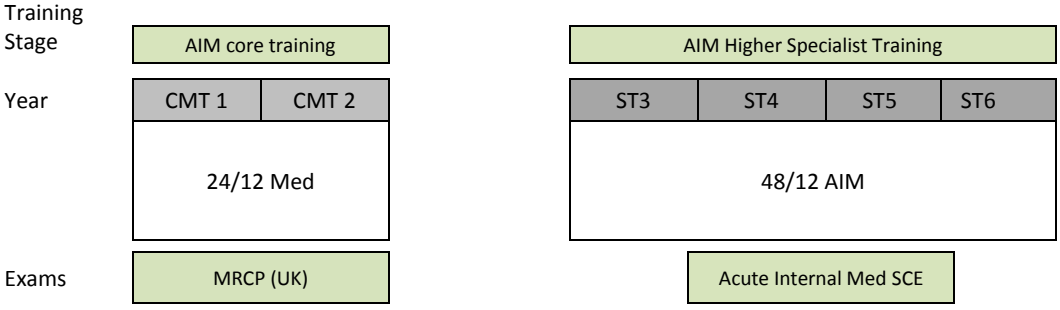


For reference, the individual CCT programmes for AIM and ICM are presented below.

Single CCT programmes in Acute Internal Medicine

If enter from CORE MEDICINE:



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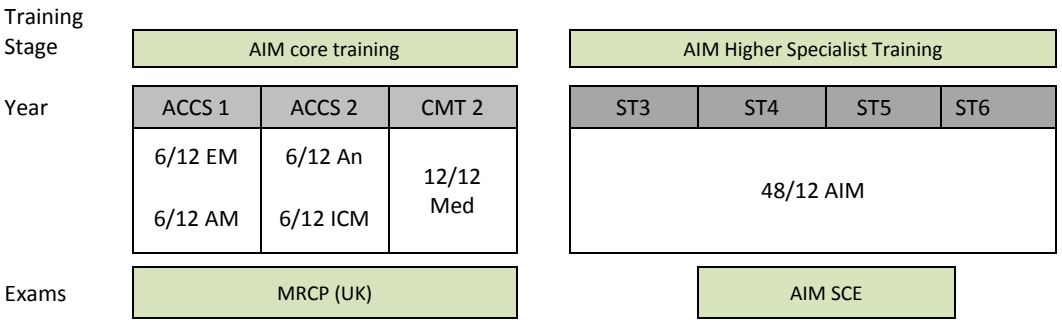

Single CCT programmes in ICM

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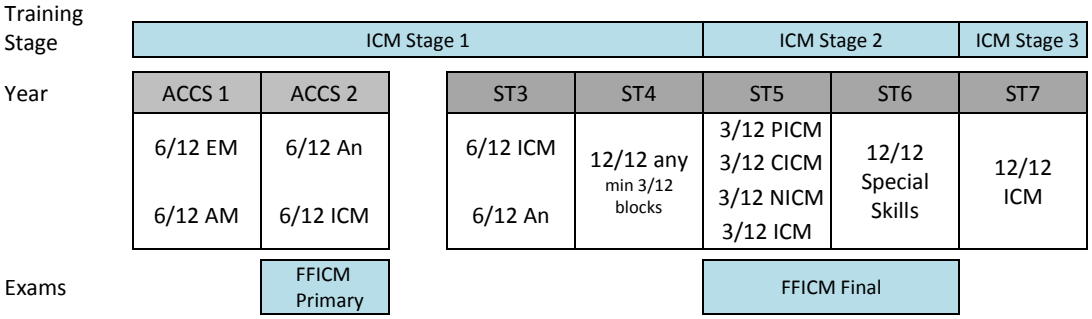
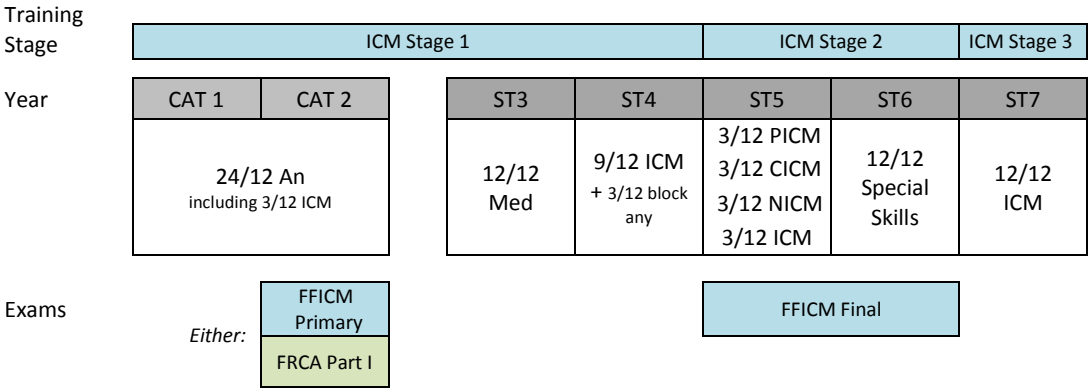


If enter from CORE ANAESTHESIA:



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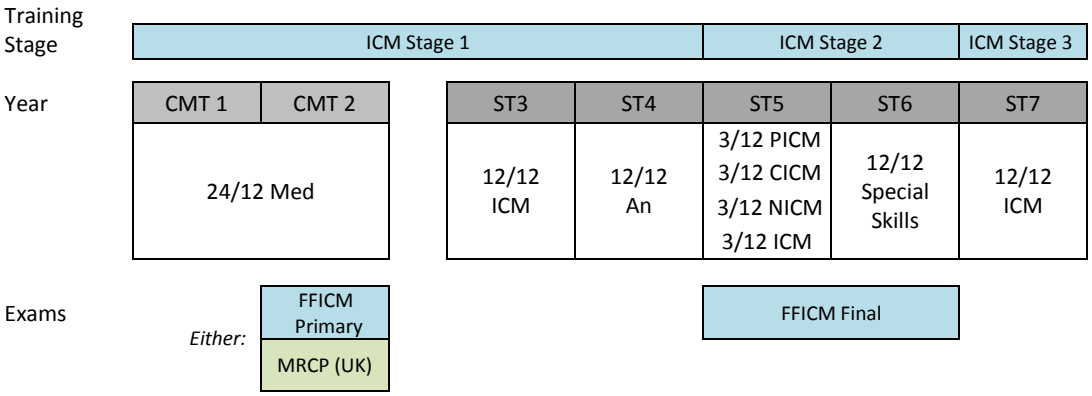

ARCP Decision Aids for Dual CCTs

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
Log book procedures	A total of more than 30 over the 3 year period (with an average of 10/year) to reflect choice of DOPS. Evidence of progression of skill.
Log book cases	Unit Admission data should be available to support yearly leaning outcomes Individual cases provide suitable case mix to achieve yearly learning outcome
Log book Airway skills	A total of more than 30 cases (with an average of 10/year) with evidence of progression of skill.
Exam	Possession of one of the designated core exams is needed for entry to HST in ICM.
ES report	Satisfactory report for each year.
Audit	At least 1 audit completed during each Stage of training.
Expanded Case summaries	A total of at least 4 cases must have been completed by end Stage 1 (of at least Level 2 standard).
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. Up to 5 CoBaTrICE competencies can be covered in each assessment.
	DOPS: chosen to reflect agreed CoBaTrICE competency assessments.
	MSF: A total of 2 from separate years of training
Morbidity and Mortality meetings	Attend at least 6 and evidence of reflection from 3 meeting.
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
Log book procedures	A total of more than 15 to reflect choice of DOPS. Evidence of progression of successful completion. A logbook should be maintained but no target numbers are required during the special skills modules.
Log book cases	Unit Admission data allows yearly leaning outcomes to be fulfilled Individual cases provide suitable case mix to achieve yearly learning outcome. A case logbook should be maintained during the special skills modules.
Log book Airway skills	A total of more than 30 cases with evidence of progression of skill.
Exam	Final FFICM must be obtained before progressing to Stage 3.
ES report	Satisfactory report for each year.
Audit	At least 1 audit completed during each Stage of training.
Expanded Case summaries	A total of at least 4 cases must have been completed by end Stage 2 (of at least Level 3 standard).
WPBA	At least 4 'Top 30' Cases as **CBD**s, **CEX** or both demonstrating at least 5 competencies each. At least 6 'Top 30' Cases from the special modules list (at least 2 from the paediatric, cardiac and neurology list) as **CBDs**, **CEX** or both. Up to 5 CoBaTrICE competencies can be covered in each assessment.
	DOPS: chosen to reflect agreed CoBaTrICE competency assessments.
	MSF: 1 per year.
Morbidity and Mortality meetings	Attend at least 4 and evidence of reflection from 1 meeting.
Journal clubs	Present at least twice
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)
Log book procedures	A total of more than 15 to reflect choice of DOPS. Evidence of progression of successful completion.
Log book cases	Unit Admission data allows yearly leaning outcomes to be fulfilled Individual cases provide suitable case mix to achieve yearly learning outcome.
Log book Airway skills	A total of more than 30 cases with evidence of progression of skill.
Exam	N/A
ES report	Satisfactory report.
Audit	At least 1 audit completed during each Stage of training.
Expanded Case summaries	2 cases must have been completed by end Stage 3 (of at least Level 4 standard).
WPBA	At least 5 'Top 30' Cases as **CBD**s, **CEX** or both, demonstrating at least 5 competencies each.
	DOPS: chosen to reflect agreed CoBaTrICE competency assessments.
	MSF: 1 per year.
Morbidity and Mortality meetings	Attend at least 4 and evidence of reflection from 1 meeting.
Journal clubs	Present at least once
External meetings as approved in PDP	Reflection on content
Management meetings	Attend at least 2.

Acute Internal Medicine

ST3 to CCT ARCP Decision Aids				
	1st Year AIM (ST4)	2nd Year AIM (ST5)	3rd Year AIM (ST6-7)	4th Year AIM (ST9)
Common Competences	Competent at level 3/4 descriptors in minimum of 1/3 (assessed by ACAT/CbD/Patient Survey/mini-CEX /Teaching Observation and to include satisfactory MSF)	Competent at level 3/4 descriptors in minimum of 2/3 (assessed by ACAT/CbD/Patient Survey/mini-CEX /Teaching Observation)	Competent at level 3/4 descriptors in over 90% (assessed by ACAT/CbD/Patient Survey/mini-CEX /Teaching Observation)	Competent at level 3/4 descriptors (assessed by ACAT/CbD/Patient Survey/mini-CEX /Teaching Observation and to include completed and satisfactory MSF
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. Trainees of this level must also demonstrate completion of at least 2 audits relevant to the practice of Acute Internal Medicine	Have 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 disparate specialties within the acute medical unit Provides input organisational structures e.g. rota management, attendance at managerial meetings.	Demonstrate adequate creation of management and investigation pathways and instigation of safe patient treatment Able to supervise more junior trainees and to liaise with other specialties. Awareness and implementation of local clinical governance policies and involvement in a local management role within directorates, as an observer or trainee representative Direct involvement in the organisation and managerial structure of the acute medical unit
Acute Medical Presentations (Symptom Based Competences)	Demonstrate senior clinical management skills for Top 20 presentations and knowledge of at least half of the 40 Other Presentations	Competent in the senior-level clinical management of all Top 20 and the 40 Other Presentations including some complex cases involving inpatients and acute take patients	Have senior level management skills for all medical presentations including complex cases.	Building on 3rd Year AIM, be able to supervise and lead a complete medical take of at least 20 patients including management of complex patients both as emergencies and in patients.

		Successful completion of at least two G(I)M audits (1 per year)	Reviews patients in ambulatory care and as newly presenting patient or in the inpatient setting	Remains competent in all practical procedures
Examination	MRCP(UK) held.	None.	Has completed relevant SCE in Acute Internal Medicine	None.
ALS	Valid.	Valid.	Valid.	Valid.
Annually Required	1 satisfactory MSF, 1 Patient Survey			1 satisfactory MSF, 1 Patient Survey
Logbook		Minimum of 1250 patients as seen on acute take during the period of training with evidence of individual activity to be provided. A minimum of 300 new patients seen in ambulatory care Evidence must be provided of a minimum of 100 hours external AIM training during the period of training. Evidence of experience in outpatients is not necessary unless G(I)M dual CCT is being undertaken but when experience of out patient activity is obtained in medical specialties this should be recorded in the logbook.		
Supervisors report		A structured educational supervisors report should be completed annually supplemented by a clinical supervisor report provided at the end of each attachment		
Minimum number of work place assessments by Consultant Assessors per year		6 x ACATs; 4 x CBDs; 4 x mini-CEX; Audit Assessment where relevant All assessments must be completed satisfactorily or evidence of greater numbers undertaken should be provided by the trainee and satisfactory progress demonstrated throughout each year of training. For 50% of mini-CEX and CbD assessment the trainee should chose the area of interest for the other half the assessor should choose the topic to be reviewed. Overall 50% of assessments must be performed by a senior doctor in a substantive post, this includes consultants and associate specialists but not locum doctors DOPS to standards recommended by National Specialty Guidelines until independence in procedures demonstrated		
Events giving concern		The following events occurring at any time may trigger review of trainee's progress and possible remedial training: issues of professional behaviour; poor performance in work-place based assessments; poor MSF performance; issues arising from supervisor report; issues of patient safety		