The Faculty of
Intensive Care Medicine

The College of Emergency Medicine

GUIDANCE ON DUAL CCTs PROGRAMMES IN INTENSIVE CARE MEDICINE and EMERGENCY MEDICINE

Contents

Revisions

V1.0: October 2011
V1.1: February 2013 – amended to reflect changes to FCEM exam regulations.

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 College of Emergency Medicine [CEM] for the benefit of trainees undertaking dual CCTs in Intensive Care Medicine [ICM] and Emergency Medicine [EM] 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 CEM have undertaken a cross-mapping exercise of both curricula to identify areas of overlap that will allow trainees to acquire the full competencies of both disciplines via a suitable choice of training attachments and educational interventions whilst avoiding undue prolongation of training.

This guidance deals specifically with those areas in which the two curricula overlap to allow dual-counting of competencies, and describes the layout and indicative timeframes of a dual CCTs programme. More detailed information on the respective competencies and assessment methods discussed here can be found in *The CCT in Intensive Care Medicine* and *The CCT in Emergency Medicine*.

Frequently Asked Questions relating to Dual CCTs can also be found on the FICM website.

Appointment to ICM/Emergency 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 and EM 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 or Medical Trainees who subsequently wished to undertake dual CCTs in EM and ICM would need to apply for ACCS posts in order to meet the requirements of *The CCT in Emergency Medicine* and re-enter at the appropriate level.

However, their previous time in CAT or CMT 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 published online at the FICM website National Recruitment page.

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.

Acquisition and dual-counting of competencies

The single ICM CCT programme has an indicative duration of 7 years; the single CCT in EM an indicative duration of 6 years; dual CCTs in ICM and EM have an indicative length of 8.5 years. Trainees who do not achieve the competencies required within this timeframe will require an extended period of training. 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.

- ***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; EM dual trainees will therefore spend this time training in EM (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.5-6). Core EM training is achieved via the ACCS programme, which delivers the full 12 months' medicine requirement of Stage 1 (6 months each in Acute and Emergency Medicine) and 6 months each in anaesthesia and ICM. At completion of ACCS (including a pass in the full MCEM exam) trainees can apply for training posts leading to dual CCTs in ICM and EM.

  Dual EM/ICM CCT trainees entering from ACCS will therefore need to complete a further 12 months of EM and 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 Emergency 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 EM and ICM will therefore undertake the required EM 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 Emergency competencies required by their partner CCT.

  This overall dual-counting of competencies allows dual EM 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 EM. The FICM and CEM 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 CEM 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].

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 CEM 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 EM therefore **must** pass the MCEM 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 EM.

Dual CCTs trainees **must** pass both the FFICM Final and the FCEM examinations 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 FCEM can only be taken after trainees have completed 2 years of full EM Higher Specialist Training (not counting any ICM time).

Trainees who do not achieve one of the required Final examinations will be ineligible for a CCT in the respective specialty.

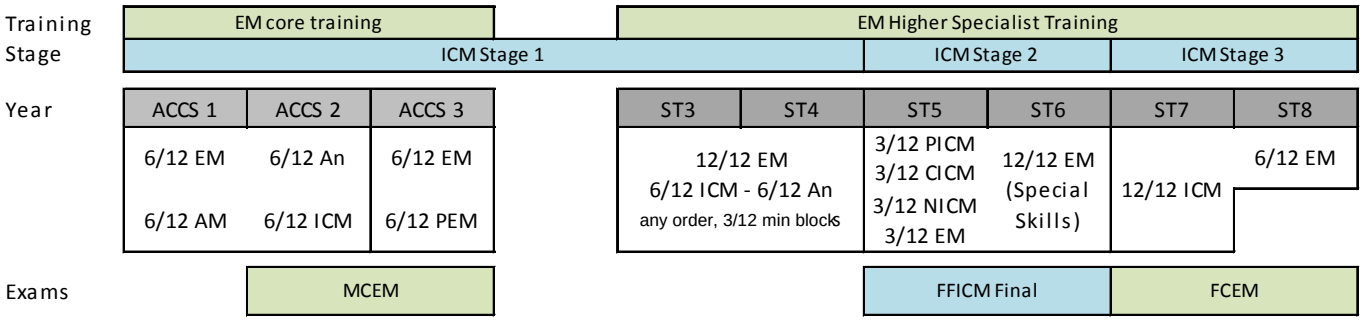
Dual CCT programmes in ICM and Emergency Medicine

Below is an *example* programme for dual CCTs in ICM and EM. 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, and the Stage 2 specialist PICM, CICM, NICM modules can occur in any order. 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.

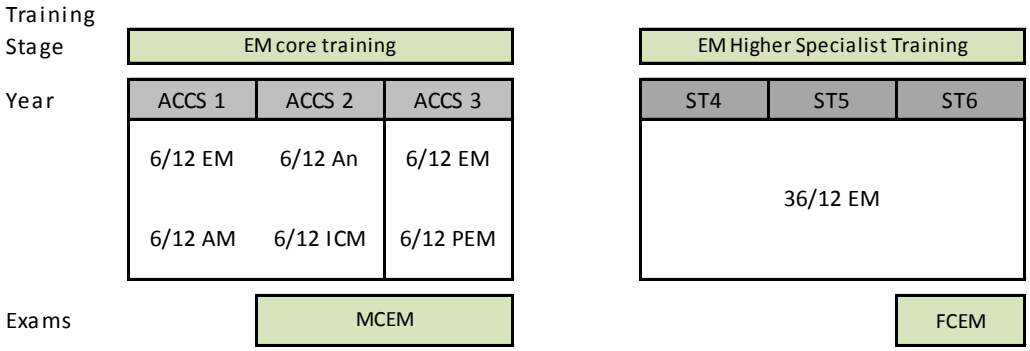
The indicative minimum timeframe for dual CCT training in EM and ICM is 8.5 years. Trainees who do not achieve the competencies required within this timeframe will require an extended period of training.

Example Dual CCTs programme in Emergency Medicine and Intensive Care Medicine



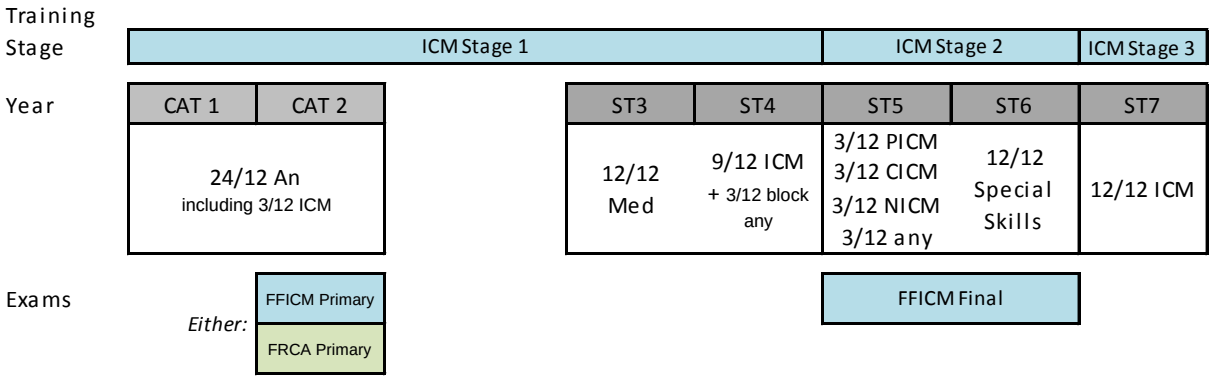
For reference, the individual CCT programmes for EM and ICM are presented below.

Single CCT programme in Emergency Medicine

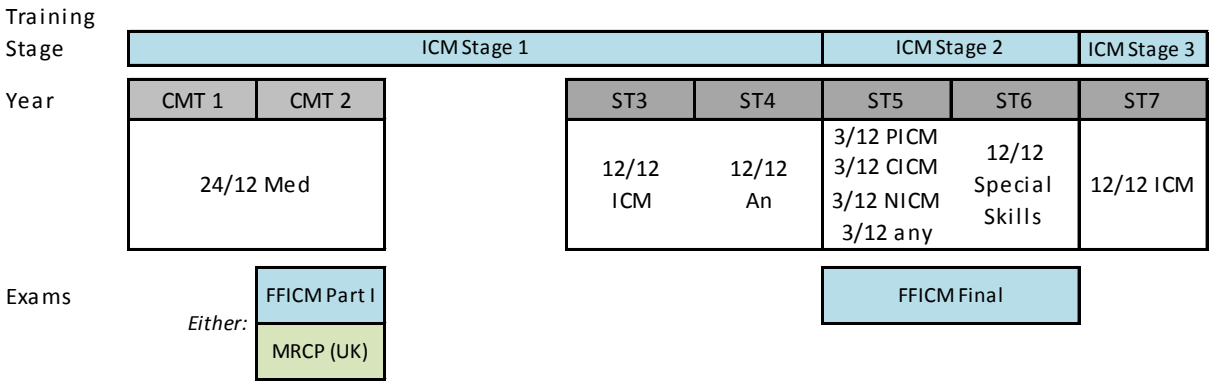


Single CCT programmes in ICM

Entry from CORE ANAESTHESIA:



Entry from CORE MEDICINE:



Entry from ACCS STREAMS:

Entry from ACCS - Basic 2 years only

Training Stage	ICM Stage 1				ICM Stage 2	ICM Stage 3
Year	ACCS 1	ACCS 2	ST3	ST4	ST5	ST6	ST7
	6/12 EM 6/12 AM	6/12 An 6/12 ICM	6/12 ICM 6/12 An	12/12 any min 3/12 blocks	3/12 PICM 3/12 CICM 3/12 NICM 3/12 any	12/12 Special Skills	12/12 ICM
Exams					FFICM Final		
	Either:	FFICM Primary FRCA Primary MRCP (UK)					

Entry from ACCS(ANAESTHESIA)

Training Stage	ICM Stage 1			ICM Stage 2		ICM Stage 3
Year	ACCS 1	ACCS 2	CAT 2	ST4	ST5	ST6	ST7
	6/12 EM 6/12 AM	6/12 An 6/12 ICM	12/12 An	6/12 ICM + 6/12 block any	3/12 PICM 3/12 CICM 3/12 NICM 3/12 any	12/12 Special Skills	12/12 ICM
Exams					FFICM Final		
	Either:	FFICM Primary FRCA Primary					

Entry from ACCS(ACUTE MEDICINE)

Training Stage	ICM Stage 1			ICM Stage 2		ICM Stage 3
Year	ACCS 1	ACCS 2	ACCS 3	ST4	ST5	ST6	ST7
	6/12 EM 6/12 AM	6/12 An 6/12 ICM	12/12 AM	6/12 An 6/12 ICM	3/12 PICM 3/12 CICM 3/12 NICM 3/12 any	12/12 Special Skills	12/12 ICM
Exams					FFICM Final		
	Either:	FFICM Primary MRCP(UK)					

Entry from ACCS(EMERGENCY MEDICINE)

Training Stage	ICM Stage 1			ICM Stage 2		ICM Stage 3
Year	ACCS 1	ACCS 2	ACCS 3	ST4	ST5	ST6	ST7
	6/12 EM 6/12 AM	6/12 An 6/12 ICM	6/12 PEM 6/12 EM	6/12 An 6/12 ICM	3/12 PICM 3/12 CICM 3/12 NICM 3/12 any	12/12 Special Skills	12/12 ICM
Exams					FFICM Final		
	Either:	FFICM Primary MCEM					

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 Emergency Medicine*, 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
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.

Emergency Medicine

	1st year of EM	2nd year of EM	3rd year of EM
Common Competences CC 1-25	Assessed to Level 4 descriptors in 50%	Assessed to Level 4 descriptors in 100%	
HST Major presentations HMP1-5	Have completed 3 using Mini-CEX/CbD	Remaining 2 using Mini-CEX/CbD	
HST Acute Adult Presentations HAP 1-33	Assessed in 9/33 using CbD/Mini-CEX/ACAT 8/33 covered using ACAT EM, reflective entries, e-modules, teaching and audit	8 assessed by CbD/Mini-CEX 8 covered using ACAT EM, reflective entries, e-modules, teaching and audit	
HST Paediatric Acute Presentations PAP = 10	Assessed in 5/10 using CbD/Mini-CEX/ACAT	Remaining 5 covered using ACAT/Mini-CEX/CbD	
Procedures	Practical procedures in more complex cases - all should be recorded Commences ultrasound scanning of patients – record/assessment Section A completed Commences triggered assessments	Practical procedures in more complex cases - all should be recorded Continues ultrasound scanning of patients – record/assessment - completion of triggered assessments and final sign off	Competent in ultrasound examination to level 1
Clinical skills	Able to look after several patients concurrently Supervises others	Looking after complex cases that are greyer and sicker- covering all presentations and procedures	
Safeguarding Children			Level 3
Management and leadership	HST management portfolio	HST management portfolio	HST management portfolio
MSF	Annually	Annually	Annually
Patient Survey			X1 before final ARCP
Examination	Commences work on Clinical Topic Review Critical appraisal skills developed	CTR advanced with personal work completed Submits to FCEM critical appraisal written examination	CTR complete FCEM
E-learning modules	30 from eLfh platform	30 from eLfh platform	30 from eLfh platform
Life support	Holds valid ALS/ATLS/APLS provider	Holds valid ALS/ATLS/APLS provider Ideally Instructor in one	Holds valid ALS/ATLS/APLS provider Instructor in one
Experience ** these are indicative numbers and a judgement on these numbers needs to be made at ARCP*	See >2000 cases /year of which 10% are cases in the resuscitation room* Evidence should be provided - log books, reports from computerised systems	See >2000 cases /year of which 10% are cases in the resuscitation room* Evidence should be provided - log books, reports from computerised systems	See >2000 cases /year of which 10% are cases in the resuscitation room* Evidence should be provided - log books, reports from computerised systems

* Please note that the ARCP decision tools are for guidance only. It is the responsibility of the ARCP panel to decide if the evidence presented by the trainee is sufficient to allow progression to the next level of training.