The Faculty of
Intensive Care Medicine

JRCPTB

GUIDANCE ON DUAL CCT PROGRAMMES IN
INTENSIVE CARE MEDICINE and RESPIRATORY 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 Respiratory 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 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 double-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 in the Respiratory Medicine curriculum.

Appointment to ICM/RM Dual CCT Programmes

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 RM trainee 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 RM and ICM would need to apply for CMT in order to meet the requirements of the Respiratory Medicine CCT, and will need to 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 (from CT1); the single CCT in RM an indicative duration of 6-7 years from CT1 (depending on entry via CMT or ACCS); dual CCT training in ICM and RM has an indicative length of 8.5 years. A diagrammatic breakdown of these programmes can be found on pages 5 and 6; the section below discusses the rationale for the double-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; 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 – and so are marked as 'any' in the single ICM CCT diagrams on p.6). 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 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 cardiothoracic 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 two 3 month blocks in each of paediatric and neuro ICM, and a 6 month block in cardiothoracic ICM.   The 6 month cardiothoracic training time has been agreed as double-counting toward both the CCTs in ICM and RM.

    Important note: The 6 month block of cardiothoracic ICM **must** include 2 sessions of RM outpatient clinics per week. This is essential in building up exposure and developing competencies, particularly in chronic disease management, to the standard required for the RM CCT.

  - **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. 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 respiratory 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.

---

[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.

- *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.

  Out of Programme Experience
  Trainees should note that the 36 months of RM in the dual programme is a bare minimum. Therefore, it is not likely that the Respiratory Medicine SAC would allow any OOPE time to be counted toward these 36 months.

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]. Physician curricula also use an audit assessment tool and a teaching assessment tool. A patient questionnaire is being developed.

The FICM does not currently have an e-Portfolio system, but is actively investigating all available options. RM trainees will use the JRCPTB e-portfolio. In those instances where competencies can be double-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 double-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 curriculum 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 Respiratory 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 Respiratory Medicine SCE can be taken at any point during the totality of Higher Specialist Training. At present, for single specialty RM training, the recommended time to take the SCE is during the third year of training. Dual CCT trainees are advised to coordinate carefully with their respective specialty Regional Advisors 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.

Respiratory Medicine posts for Dual CCT training

The vast majority of current RM posts are for dual training in RM and General Internal Medicine. Deaneries must ensure that the RM training for the RM/ICM dual CCT involves more intense single specialty RM experience.

Dual CCT programmes in ICM and Respiratory Medicine

Below is an *example* programme for dual CCTs in ICM and RM. 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. Likewise, 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 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.

If entering from CORE MEDICINE:

Training Stage										
Resp Med core training			Resp Med Higher Specialist Training							
ICM Stage 1							ICM Stage 2		ICM Stage 3	

Year									
CMT 1	CMT 2		ST3	ST4	ST5	ST6	ST7	ST8	ST9
24/12 Med			12/12 Resp - 12/12 ICM - 12/12 An (any order, 3/12 min blocks)			6/12 CTICM / 3/12 PICM / 3/12 NICM	12/12 Resp (Special Skills)	12/12 ICM	6/12 Resp

Exams		
MRCP (UK)		
	Resp Med SCE	
	FFICM Final	

If entering from ACCS:

Training Stage									
Resp Med core training			Resp Med Higher Specialist Training						
ICM Stage 1						ICM Stage 2		ICM Stage 3	

Year									
ACCS 1	ACCS 2	CMT 2	ST3	ST4	ST5	ST6	ST7	ST8	
6/12 EM / 6/12 AM	6/12 An / 6/12 ICM	12/12 Med	12/12 Resp - 6/12 ICM - 6/12 An (any order, 3/12 min blocks)		6/12 CTICM / 3/12 PICM / 6/12 NICM	12/12 Resp (Special Skills)	12/12 ICM	6/12 Resp	

Exams		
MRCP (UK)		
	Resp Med SCE	
	FFICM Final	

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

Single CCT programmes in Respiratory Medicine

If entering from CORE MEDICINE:

Training Stage		
Resp Med core training		Resp Med Higher Specialist Training

Year					
CMT 1	CMT 2	ST3	ST4	ST5	ST6
24/12 Med		36/12 Resp Med — 12/12 may be counted from appropriate relevant Out of Programme experience			

Exams	
MRCP (UK)	Resp Med SCE

If enter from ACCS:

Training Stage	Anaes core training			Resp Med Higher Specialist Training			
Year	ACCS 1	ACCS 2	CMT 2	ST3	ST4	ST5	ST6
	6/12 EM 6/12 AM	6/12 An 6/12 ICM	12/12 Med	36/12 Resp Med 12/12 may be counted from appropriate relevant Out of Programme experience			
Exams	MRCP (UK)			Resp Med SCE			

Single CCT programmes in ICM

If enter from ACCS:

Training Stage	ICM Stage 1				ICM Stage 2	ICM Stage 3
Year	ACCS 1	ACCS 2	ST3	ST4	ST5	ST6	ST7

	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 ICM	12/12 Special Skills	12/12 ICM

Exams	FFICM Primary		FFICM Final		

If enter from CORE ANAESTHESIA:

Training Stage	ICM Stage 1			ICM Stage 2	ICM Stage 3

	CAT 1	CAT 2		ST3	ST4	ST5	ST6	ST7
	24/12 An including 3/12 ICM			12/12 Med	9/12 ICM + 3/12 block any	3/12 PICM 3/12 CICM 3/12 NICM 3/12 ICM	12/12 Special Skills	12/12 ICM

Exams	*Either:*	FFICM Primary FRCA Part I	FFICM Final		

If enter from CORE MEDICINE:

Training Stage	ICM Stage 1			ICM Stage 2	ICM Stage 3

	CMT 1	CMT 2		ST3	ST4	ST5	ST6	ST7
	24/12 Med			12/12 ICM	12/12 An	3/12 PICM 3/12 CICM 3/12 NICM 3/12 ICM	12/12 Special Skills	12/12 ICM

Exams	*Either:*	FFICM Primary MRCP (UK)	FFICM Final		

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 *Respiratory Medicine curriculum*, 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, 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 **CBD**s, **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.

Respiratory Medicine

	Stage 1 – 12 months RM required			Stage 2 – 18 months RM required (inc. dual counting of CTICM module as above)		Stage 3 – 6 months RM required	
	ST3	ST4	ST5	ST6	ST7	ST8	ST9
Clinical conduct (A1-2)	Satisfactory evidence from e-Portfolio and educational supervisor's report			Satisfactory evidence from e-Portfolio and educational supervisor's report		Satisfactory evidence from e-Portfolio and educational supervisor's report	
Core clinical skills (B1-8)	Competent B1-8 by ST5			Competent B1-8		Competent B1-8	
Medical leadership (C1-17)	Competent 25% by ST5			Competent 75% by ST7		Competent 100%	
Patient/Problem Scenarios (D1-7)	Competent 100% by ST5			Competent 100%		Competent 100%	
Clinical Subject Areas (E1-28)	Competent 25% by ST5			Competent 75% by ST7		Competent 100%	
Practical Procedures (F1-13)	Competent F 1,4,7,8 by ST5			Competent F 1,2,3,4,5,7,8; Experience F 11,12 by ST7		Competent F 1-8; Experience F 9-13 by ST9	
Bronchoscopy	2 Satisfactory DOPS plus sign off of *experience* by Educational Supervisor, plus evidence of skill maintenance (e.g. further satisfactory DOPS) by ST5			3 Satisfactory DOPS plus formal sign off of *competence* by Educational Supervisor; plus evidence of maintenance of competence (e.g. satisfactory DOPS) by ST7		Competence at basic diagnostic bronchoscopy maintained; DOPS evidence; plus sign off of experience by Educational Supervisor	
Pleural ultrasound, level 1 competence	Evidence of training/experience			Competent; formal sign off by Educational Supervisor/ Radiologist/DOPS by ST7		Competence maintained (evidence required e.g. DOPS)	
Pleural aspiration	Competent. DOPS and/or formal sign off by Educational Supervisor			Competent		Competent	
Chest Drain DOPS	Competent by ST5 satisfactory DOPS as evidence, plus formal sign off by Educational Supervisor			Competence maintained; evidence required e.g. satisfactory DOPS		Competence maintained; evidence required e.g. satisfactory DOPS	
NIV Competence	Competent by ST5; DOPS as evidence; Formal sign off by Educational Supervisor			Competence maintained; evidence required e.g. satisfactory DOPS		Competence maintained; evidence required e.g. satisfactory DOPS	
Spirometry	Competent			Competent		Competent	
Lung Function Interpretation	Experience			Competent		Competent	
CXR Interpretation	Competent			Competent		Competent	

	ST3	ST4	ST5	ST6	ST7	ST8	ST9
CT/CTPA/HRCT Interpretation	Experience			Experience		Competent	
ALS	Valid	Valid	Valid	Valid	Valid	Valid	Valid
Full MRCP (UK)	Achieved (from 1.8.11 this is an entry requirement for ST3)						
SCE				Attempt/Pass (optional)	Attempt/Pass	Pass	Pass
DOPS		2 Bronchoscopy 1 Pleural aspiration 1 Chest drain 1 NIV		3 Bronchoscopy 1 Pleural aspiration (optional) 1 Chest drain 1 NIV (optional)		1 Bronchoscopy 1 Chest drain (optional)	
Procedure log book	Satisfactory record of bronchoscopy, pleural procedures, NIV +/- attendance Lung Function Lab			Satisfactory record of bronchoscopy, pleural procedures, NIV +/-attendance Lung Function Lab		Satisfactory record of ongoing bronchoscopy, pleural procedures, NIV experience	
mini-CEX/CbD	Minimum of 6 to sample curriculum			Minimum of 9 to sample curriculum		Minimum of 3 to sample curriculum	
MSF	One satisfactory ST 3 - 5					One satisfactory ST 7 or 8	
Patient Survey (PS)	One satisfactory ST 3 - 5					One satisfactory ST 7 or 8	
Use of evidence and audit (K1-2) Audit assessment(AA)	One satisfactory AA ST3 - 5 Satisfactory evidence from e-Portfolio			One satisfactory AA ST6 or 7 Satisfactory evidence from e-Portfolio		One satisfactory AA ST 8 or 9 Satisfactory evidence from e-Portfolio	
Teaching and Training, J1 Teaching Observation (TO)	Evidence of involvement in teaching. Evidence of understanding principles of adult education Teaching course recommended (optional).			Portfolio evidence of ongoing participation plus evidence of implementation of principles of adult education. Teaching course recommended (optional)		Portfolio evidence of ongoing participation plus evidence of implementation of principles of adult education. Teaching course recommended (optional)	
Research	Evidence of critical thinking around relevant clinical questions. Evidence of developing research ideas and questions. Participation in journal clubs. Able to critically review the literature.			Evidence of preparation for ST8/9 requirements		One or more of: higher degree/ or full publication/ or national/international presentation (abstract) *and* assessed research course/ or research/research degree (MSc) in medical education	
Management and NHS structure (I 1)	Satisfactory evidence from e-Portfolio			Satisfactory evidence from e-Portfolio Have attended recognised course		Satisfactory evidence from e-Portfolio Have attended recognised course	

	ST3	ST4	ST5	ST6	ST7	ST8	ST9
STP Attendance	70% by ST5			70% or appropriate alternative educational activities		70% or appropriate alternative educational activities	
RM Educational Supervisor's Report	Satisfactory			Satisfactory		Satisfactory	
Courses	Attendance at number and type appropriate for trainee			Attendance at number and type appropriate for trainee		Attendance at number and type appropriate for trainee	
National/International Meetings	Should have attended at least one since started training			Attendance		Attendance	
RCP CPD online diary							Registered