The Faculty of
Intensive Care Medicine

The Royal 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.*
V1.2: *February 2019 – amended to reflect the College of Emergency Medicine's Royal College status, 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. The EM ARCP Decision aid has also been updated.*

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 Royal College of Emergency Medicine [RCEM] for the benefit of trainees undertaking dual CCTs in Intensive Care Medicine [ICM] and Emergency Medicine [EM] as well as those HE regions/deaneries, Training Programme Directors and Regional Advisors/Heads of Schools 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 RCEM 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 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.

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. The text 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; 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 MRCEM/FRCEM Intermediate 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 RCEM accept that the acquisition of higher-level management skills can be achieved across both specialties.

Assessments

The FICM and RCEM 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 RCEM will accept use of one WPBA for both assessment systems; for example, an assessment completed on the RCEM e-

[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.

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 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 EM therefore **must** pass the MRCEM/FRCEM Intermediate exam in order to meet the requirements of both curricula.

Dual CCTs trainees **must** pass both the FFICM Final and the FRCEM Final 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 FRCEM Final 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.

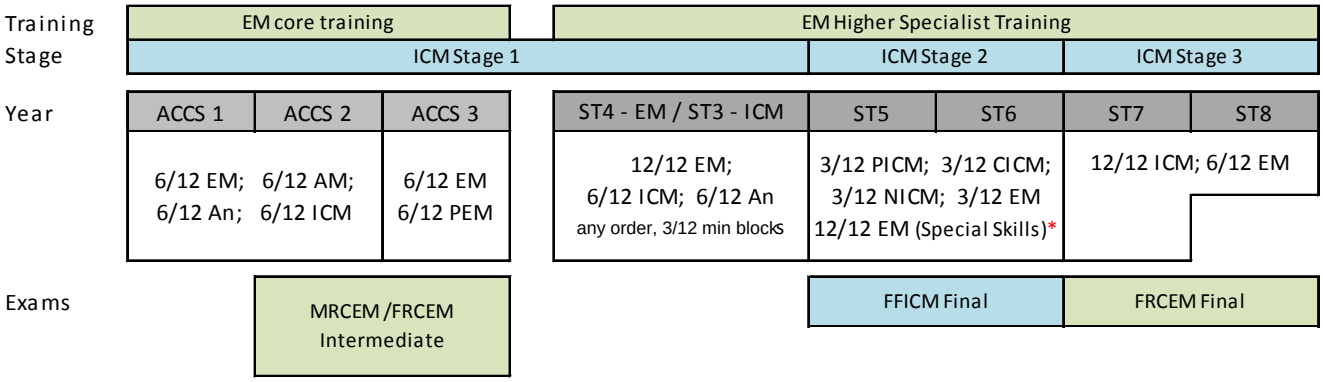
Dual CCT programmes in ICM and Emergency Medicine

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 CCT programme in Emergency Medicine and Intensive Care Medicine



NB: The order of training blocks within an overall training Stage (within Core and HST boundaries) is interchangeable. For example the 'Special Skills' year can be either of the two years that make up Stage 2 training, and the ICM, Medicine and Anaesthesia blocks required for Stage 1 can occur in any order across the overall training Stage (Minimum 3/12 block length). * = Dual Counted training.

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.
QI	Participation in a quality improvement project
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 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
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 learning 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.
QI	Participation in a quality improvement project
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 a year and evidence of reflection from 1 each year.
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 learning 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.
QI	Participation in a quality improvement project
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 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.

Emergency Medicine

	By end of 1st year of EM in dual training post	By end of 2nd year of EM in dual training post	By end of 3rd year of EM in dual training post
Structured training report (STR)	Annually	Annually	Annually
Faculty Educational Governance Report	Annually	Annually	Annually
Workplace Based Assessments			
Extended Structured Learning Events (ESLEs)	ESLE x 3 with a **consultant or equivalent**	ESLE x 3 with a **consultant or equivalent**	ESLE x 2 with a **consultant or equivalent**
HST paediatrics: Complex major or acute presentations	3 completed using CbD/Mini-CEX with a **consultant or equivalent**	Further 3 completed using CbD/Mini-CEX with a **consultant or equivalent**	
MSF	Annually	Annually	Annually
Activity	Cases seen in EM- upload evidence of numbers. Do not include patient identifiable data. If ED IT system allows.	Cases seen in EM- upload evidence of numbers. Do not include patient identifiable data. If ED IT system allows.	Cases seen in EM- upload evidence of numbers. Do not include patient identifiable data. If ED IT system allows.
Coverage of the Curriculum. Presentations to be sampled can be covered by completion of one or more of the following: ST3-6 MiniCEX/CBD, ESLE, Teaching and audit assessments, Evidence of learning e.g. RCEM Learning modules, Reflective entries that had a recorded learning outcome in the e-portfolio: FOAMed, teaching session, patient encounter etc.			
Common Competences CC 1-25	Progress towards Level 4 descriptors	Progress towards Level 4 descriptors	Assessed to Level 4 descriptors in a minimum of 23 out of 25
HST Major presentations HMP 1-5	3 presentations to be sampled	Remaining 2 presentations to be sampled	
HST Acute Adult Presentations HAP 1-36	18 presentations to be sampled	Remaining 18 presentations to be sampled	
Paediatric Major Presentations PMP 2,3,4,5,6	3 presentations to be sampled	Remaining 2 presentations to be sampled	
Paediatric Acute Presentations PAP 1,2,4,7,9,13,15,16	4 presentations to be sampled	Remaining 4 presentations to be sampled	
Procedures	Practical procedures in more complex cases - all should be recorded	Practical procedures in more complex cases - all should be recorded	Practical procedures in more complex cases - all should be recorded

Emergency Medicine *(continued)*

	By end of 1st year of EM in dual training post	By end of 2nd year of EM in dual training post	By end of 3rd year of EM in dual training post
Clinical governance activity	Progress towards Quality Improvement Project (QIP)	Progress towards Quality Improvement Project (QIP) advanced stage of completion	Completed QIP component FRCEM
Management and leadership	Completed a minimum of 2 items in total (including ST3 assignment) in the management portfolio	Completed a minimum of 3 items in total (including ST3 assignment) in the management portfolio	Completed a minimum of 4 items in total (including ST3 assignment) in the management portfolio, two of which will be the mandatory assignments
Examination	Project (QIP) Critical appraisal skills developed		Completed FRCEM
Life support	ALS/ATLS/APLS or equivalent (current provider)	ALS/ATLS/APLS or equivalent (current provider)	Holds valid ALS/ATLS/APLS or EPALS provider
Safeguarding Children	Level 3	Level 3	Level 3
Ultrasound	Progression with USS competences.	Progression with USS competences.	Level 1 final sign off
Complaints, Critical Incidents & SUIs	Any involvement recorded in STR with actions taken and associated reflective summary available	Any involvement recorded in STR with actions taken and associated reflective summary available	Any involvement recorded in STR with actions taken and associated reflective summary available

* 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.