

**GUIDANCE ON TRIPLE CCT
PROGRAMMES IN
INTENSIVE CARE MEDICINE,
RESPIRATORY MEDICINE
&
GENERAL INTERNAL MEDICINE***

* An application has been made by the JRCPTB to change the name of the specialty from General Internal Medicine to Internal Medicine. These names are used interchangeably in this document except where there is direct reference to the Certificate of Completion of Training (CCT).

Change log

This document outlines the training programme for doctors completing postgraduate training in Intensive Care Medicine, Respiratory Medicine and Internal Medicine in the UK.

This is Version 1.0. As the document is updated, version numbers will be changed, and content changes noted in the table below.

Version number	Date issued	Summary of changes

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NB: The following guidance discusses the implementation of the Triple CCTs in Intensive Care Medicine, Respiratory Medicine and General Internal Medicine whilst drawing heavily on information already available online. Further information can be found via the links below, and this document should be read in conjunction with these resources:

- [FAQs on National Recruitment to ICM](#)
- [Information on National Recruitment to Respiratory Medicine and Internal Medicine](#)
- [ICM Curriculum: Supporting Excellence](#)
- [Respiratory Medicine](#) and [Internal Medicine](#)

Introduction

Following the approval by the General Medical Council [GMC] of the standalone CCT in *Intensive Care Medicine* (2021), 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 doctors undertaking 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.

As General Internal Medicine (GIM)/Internal Medicine (IM) will be fully incorporated into RM from August 2022 and it will not be possible to train in RM alone doctors that successfully complete the CCT training programme will therefore gain a triple CCT in ICM, RM and GIM.

The FICM and JRCPTB have undertaken a cross-mapping exercise of all curricula to identify areas of overlap that will allow doctors to acquire the outcomes and capabilities in full of all three 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 three curricula overlap to allow triple-counting of capabilities and describes the layout and indicative timeframes of a Triple CCT programme. More detailed information on the respective capabilities and assessment methods discussed here can be found in [The CCT in Intensive Care Medicine](#) and in the [RM curriculum](#) and the [GIM/IM curriculum](#).

Appointment to ICM, RM and GIM CCTs

All appointments to the Triple CCT programme should adhere to the [GMC guidance](#) on Dual CCTs and to the ICM and RM CCT person specifications.

In order to train in RM, IM and ICM, a doctor would need to complete either Internal Medicine Stage 1 Training (IMT) or the ACCS (Internal Medicine) programme and pass the MRCP (UK) examination to be eligible to apply.

During the transition period, some trainees in ICM may not have the required experience to apply for HST in medicine, as this now requires completion of IMY3 capabilities. With further lobbying, we have obtained approval for the window of application to the second specialty to be extended to 2 years to allow completion of IMY3 capabilities. These could potentially be completed while within the ICM training scheme but would need to be carefully planned with respective trainers in ICM and medicine.

The ICM CCT programme may follow one of three Core Programmes: ACCS [Acute Care Common Stem], CAT [Core Anaesthetic Training] and IMT [Internal Medicine Training]. Doctors in training who have completed Stage 1 of Anaesthetic Training who subsequently wish to undertake triple CCTs in RM, GIM and ICM would need to apply for IMT or ACCS [Internal Medicine] to meet the requirements of *The CCT in RM* and re-enter at CT1. However, their previous time in anaesthetic training could be counted toward the indicative 12 months of Anaesthetics required for Stage 1 ICM, should they later be appointed to an ICM CCT programme.

Recruitment Process

Guidance on recruitment for an ICM CCT programme is available here: <http://ficm.ac.uk/national-recruitment-intensive-care-medicine>

Guidance on recruitment for a Respiratory Medicine and General Internal Medicine CCT programme is available here: <https://phstrecruitment.org.uk/>

Appointment to both programmes is required before the end of Stage 1 ICM.

Structure of a Triple CCT programme including RM, GIM and ICM

Prior to the introduction of the new 2021 ICM curriculum, doctors training in RM could also apply to train in ICM and achieve a dual CCT. The new curriculum for all Group 1 medical specialties now incorporates training in IM, resulting in dual CCTs in, for example, RM and GIM. The addition of ICM therefore results in a triple CCT. This new development adds extra content to the programme for physicians wishing to train in ICM, but also produces consultants with broad skills ideally suited to the changing demands of an evolving, modern Critical Care Service. The principles of training for a triple CCT are identical to those for dual CCTs. Delivery of training however needs to take into account managing three curricula rather than two. The addition of the CCT in GIM demands careful communication between the Training Programme Directors to plan for a rotation that is effective, and outcome focused. Cross-mapping exercises have shown a considerable overlap between the specialties, which allows the Learning Outcomes for the respective curricula to be achieved efficiently. However, there are capabilities which can only be achieved within a specific attachment. Consideration should be given to combining assessments and reviews wherever possible.

The RM, GIM and ICM CCTs are outcome-based programmes; the ICM CCT and the RM and GIM CCT have an indicative duration of 7 years. Following, a comprehensive mapping exercise, the capabilities and outcomes that can be achieved in all three curricula have been identified. As a result, a Triple CCT programme in ICM, RM and GIM has an indicative programme duration of 8.5-9.5 years. See the diagrams below for details. Doctors who do not achieve the capabilities required within this timeframe will require longer.

Below is an *example* programme for a triple CCTs in ICM, RM and GIM. These should not be considered as immutable formats. As the curricula are now outcome based, doctors may achieve capabilities at different rates and therefore may progress quicker or more slowly than the times indicated.

Important point of note: The order of training blocks **within an overall training Stage** (within Core and HST boundaries) is **interchangeable**. For example: in the Internal Medicine Training (IMT) route below, the 12/12 of Anaesthesia does not have to take place in one block but it must be completed before the doctor can exit Stage 1 ICM. There is total flexibility at the local level to arrange the order of the training (with a minimum 3/12 block length) via negotiation between RM, IM and ICM TPDs. This is true also of the 6/12 modules that make up the ACCS programme, in that there may be 2 x 3 month blocks. Likewise, the 'Special Skills' Year (which in the Triple CCT Programme is the Stage 2 indicative year of RM) can be either of the two years that make up Stage 2 training. Doctors can sit the FFICM at any point in Stage 2 training and the RM SCE at any point in Higher Specialist Training. Modules marked with an * indicate the doctor will be developing capabilities in all three specialties in these placements. This has been reviewed and agreed by the JRCPTB and FICM.

In order to maintain capabilities across the three CCTs, doctors will need to undertake learning opportunities in the other specialties when they are not available in the base specialty. An example would be release from an ICM block for an IM outpatient clinic once a fortnight. These arrangements will be made on an individual basis, guided by the TPDs and ARCP panels and would not be expected to include on call.

Below are example diagrams outlining the progress of the triple CCT training pathways. Currently there is debate about labelling specific training years, as there are pay implications in progression. The Colleges and Faculties are not involved in terms and conditions, so the diagrams relate only to the years used for specialty recruitment. Trainee experience and background will vary. The employer and TPD will determine the appropriate position on the pay scale for an individual doctor.

Fig 1: Example Triple CCT programme in Intensive Care Medicine, Respiratory Medicine and General Internal Medicine**If entering from INTERNAL MEDICINE TRAINING:**

Training Stage	Core Training (IM Stage 1)			Respiratory Medicine Higher Specialist and IM Stage 2 Training							
Stage	ICM Stage 1			ICM Stage 2			ICM Stage 3				
Year	IMY1	IMY2	IMY3	ST4 RM ST3 ICM	ST5	ST6	ST7	ST8	ST9	ST10	
	36/12 Internal Medicine			12/12 Resp; 12/12 ICM; 12/12 Anaes Any order 3/12 min blocks		6/12 CTICM*; 3/12 PICM; 3/12 NICM 12/12 Resp* (Special Skills) Any order		12/12 ICM; 6/12 Resp Any order			
Exams	MRCP (UK)			Resp Med SCE						FFICM Final	

***NB: 6/12 Cardiothoracic ICM Stage 2 block must include 2 sessions Resp Med OP clinics per week**

If entering from ACCS (Internal Medicine):

Training Stage	Core Training (IM Stage 1)				Respiratory Medicine Higher Specialist and IM Stage 2 Training							
Stage	ICM Stage 1				ICM Stage 2			ICM Stage 3				
Year	ACCS 1	ACCS 2	ACCS 3 IMY2	ACCS 4 IMY3	ST4 RM ST3 ICM	ST5	ST6	ST7	ST8	ST9		
	6/12 EM; 6/12 IM; 6/12 Anaes; 6/12 ICM		24/12 Internal Medicine		12/12 Resp 6/12 ICM; 6/12 Anaes Any order 3/12 min blocks		6/12 CTICM*; 3/12 PICM; 3/12 NICM 12/12 Resp* (Special Skills) Any order		12/12 ICM; 6/12 Resp Any order			
Exams	MRCP (UK)				Resp Med SCE						FFICM Final	

Shared capabilities for all CCTs

Please see the [Appendix](#) for further details.

The new curricula are outcome based, and there is therefore potential flexibility in the times given below, depending on trainee progress. All training times are indicative and can be altered at the discretion of the Annual Review of Competence Progression Panel in line with the General Medical Council's standards for postgraduate curricula.

- Stage 1 ICM, RM and Stage 2 IM**

On completion of ACCS (Internal Medicine) or Stage 1 of the IMT Training Programme (including a pass in the MRCP(UK)), doctors can apply for training posts leading to Triple CCTs in RM, GIM and ICM.

Stage 1 includes the doctor's Core Programme and the beginning of their Higher Specialty Training (HST). Stage 1 ICM is an indicative 4 years minimum in duration and for all Triple CCT doctors this will happen by default, 3 of these years must consist of indicative 12/12 months each in ICM, Anaesthetics and Medicine (for ACCS doctors 6/12 each of Internal Medicine and Emergency Medicine may count toward the Medicine requirement). The final 12 months can be in any of the above specialties.

Triple CCT doctors entering from IMT will therefore need to complete any remaining specific ICM training placements to make up the 12 months required, and the necessary 12 months of Anaesthetics to complete Stage 1 ICM. Triple CCT doctors entering from ACCS (Internal Medicine) will have completed the required 12 months of Medicine and 6 of the 12 months of Anaesthetics

as part of the ACCS (Internal Medicine) programme, along with 6 months of ICM. These doctors will therefore need to complete a further indicative 6 months each of ICM and Anaesthetics to complete Stage 1 of the ICM Training Programme.

- **Stage 2 ICM, RM and Stage 2 IM**

Stage 2 of the ICM Training Programme covers two indicative years of ICM training, of which an indicative year will be spent in a variety of 'special' areas including paediatric, neurosurgical and cardiothoracic Intensive Care Medicine and RM placements.

- **Paeds/Neuro/Cardio blocks:** Stage 2 in ICM for doctors following a triple CCT programme, requires an indicative 3 month block in Paediatric and Neuro ICM and an indicative 6 month block in Cardiothoracic ICM. The purpose of these attachments is not to produce specialists but to introduce doctors to these areas so that if and when they take up a consultant post in ICM/RM they will be useful members of the team able to recognise, resuscitate, stabilise and transfer critically ill patients who require specialist care and treatment.

For a Triple CCT in ICM, RM and GIM, the second year of Stage 2 comprises an indicative 12 months of Stage 2 Respiratory Medicine (this is referred to as the Special Skills Year (SSY) in the ICM CCT curriculum).

This overall dual/triple counting of capabilities allows triple RM, GIM and ICM CCT doctors to undertake their respective Stage 2s concurrently without an extension to training, unless a doctor has joined the Triple programme later on in one of their specialty training programmes.

- **Stage 3 ICM, RM and end of Stage 2 IM**

Stage 3 ICM consists of an indicative 12 months of ICM and 6 months of RM (with the RM block finishing on the Acute Medical Unit with sessional exposure relevant to the doctor's outstanding training requirements). The FICM and JRCPTB accept that the acquisition of higher-level management skills can be achieved across both specialties. These blocks can be completed in any order. A CCT is awarded in all three specialties when all the respective curricula's outcomes and capabilities have been attained. There will be one overall CCT date for the triple programme on completion.

Assessments

The FICM and JRCPTB utilise the same forms of formative assessments called Supervised Learning Events [SLEs] or Workplace Based Assessments [WPBAs]: DOPS [Directly Observed Procedural Skills], Mini-CEX [Mini Clinical Evaluation 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 RM/IM part of training.

The RM and IM CCT also allows for the use of the Quality Improvement Project Assessment Tool (QIPAT), Patient Surveys [PS], and Teaching Observations [TO]. Ultrasound competence: doctors in training are required to achieve the level of 'Primary Operator' as described in the [British Thoracic Society Training Standards for Thoracic Ultrasound \(TUS\)](#).

In those instances where capabilities can be dual/triple-counted, the FICM and JRCPTB will accept the use of one SLE/WPBA for both assessment systems; for example, an assessment completed within the Respiratory Medicine training programme can be uploaded (where appropriate) as evidence to the ePortfolios for both RM and ICM, or vice versa.

Doctors in training will undertake workplace-based assessments (either SLEs or WPBAs) for the three specialties and will require ARCP outcomes in all three specialties. It will be possible for workplace-based assessments to be used to assess more than one specialty where overlap has been identified,

which will help to reduce the assessment burden. For instance, feedback from more than one specialty can be included in a single multisource feedback (MSF) summary.

The knowledge-based assessment for IM is the MRCP(UK) which is completed during Stage 1 IM training and there is no further requirement for a test of knowledge in higher training. Trainees will be required to pass the FFICM Final for Intensive Care Medicine and the specialty certificate examination (SCE) for Respiratory Medicine. These examinations are required as summative assessments in the respective specialty and the standard must be maintained for those in the combined programmes.

Examinations

Entry into a higher training programme in RM and IM requires completion of all Stage 1 requirements of the IM curriculum and a pass in MRCP(UK). The completion of these requirements also allows entry to HST in ICM and hence a triple CCT.

Triple CCT trainees **must** pass both the FFICM Final Examination and the Respiratory Medicine SCE in order to gain all CCTs. The FFICM Final Examination 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. Doctors undertaking the triple CCT are advised to coordinate carefully with their respective Regional Advisors (RAs) to avoid exam congestion. Doctors who do not achieve one of the required Final examinations will be ineligible for a CCT in the respective specialty (either ICM or RM/GIM).

Annual Review of Competence Progression (ARCPs)

In order for doctors to progress through training, they must have satisfied the requirements of the RM and IM, and ICM ARCP panels (evidenced in their respective portfolios), which may be held separately or in conjunction according to local arrangements. ARCP requirements are within each specialty curricula/ARCP decision aids.

Frequently Asked Questions:

[Please click here to be taken to the FAQ section of the FICM website.](#)

[Please click here to be taken to the FAQ section of the JRCPTB website.](#)

Appendix: Mapping of learning outcomes

The Faculty of Intensive Care Medicine (FICM) and the Joint Royal Colleges of Physicians Training Board (JRCPTB) have worked together to develop training programmes leading to CCTs in Intensive Care Medicine, General Internal Medicine and Respiratory Medicine (RM).

The learning outcomes of the specialties in these programme combinations have been mapped to show where outcomes can be achieved at the same time, partially achieved and where there is no overlap. Please see the tables below for reference:

ICM Curriculum

High Level Learning Outcomes (HiLLOs)	ICM	IM	RM
1. The doctor will be able to function successfully within NHS organisational and management systems whilst adhering to the appropriate legal and ethical framework	Full	Full	Full
2. The doctor will be focused on patient safety and will deliver effective quality improvement, whilst practising within established legal and ethical frameworks	Full	Full	Full
3. An Intensive Care Medicine specialist will know how to undertake medical research including the ethical considerations, methodology and how to manage and interpret data appropriately	Full	Full	Full
4. To ensure development of the future medical workforce, a doctor working as a specialist in Intensive Care Medicine will be an effective clinical teacher and will be able to provide educational and clinical supervision	Full	Full	Full
5. Doctors specialising in Intensive Care Medicine can identify, resuscitate and stabilise a critically ill patient, as well as undertake their safe intra-hospital or inter-hospital transfer to an appropriately staffed and equipped facility	Full	Partial	Partial
6. Intensive Care Medicine specialists will have the knowledge and skills to initiate, request and interpret appropriate investigations and advanced monitoring techniques, to aid the diagnosis and management of patients with organ systems failure. They will be able to provide and manage the subsequent advanced organ system support therapies. This will include both pharmacological and mechanical interventions	Full	Not met	Not met
7. Specialists in Intensive Care Medicine can provide pre-operative resuscitation and optimisation of patients, deliver post-operative clinical care including optimising their physiological status, provide advanced organ system support and manage their pain relief	Full	Not met	Not met
8. Doctors specialising in Intensive Care Medicine will understand and manage the physical and psychosocial consequences of critical illness for patients and their families, including providing pain relief, treating delirium and arranging ongoing care and rehabilitation. They will also manage the withholding or withdrawal of life-sustaining treatment, discussing end of life care with patients and their families and facilitating organ donation where appropriate	Full	Partial	Partial
9. Intensive Care Medicine specialists will have the skillset and competence to lead and manage a critical care service, including the multidisciplinary clinical team and providing contemporaneous care to a number of critically ill patients	Full	Not met	Not met
10. Intensive Care Medicine specialists will have developed the necessary skills of induction of anaesthesia, airway control, care of the unconscious patient and understanding of surgery and its physiological impact on the patient	Full	Not met	Not met

11. In order to manage acutely ill patients outside the Intensive Care Unit, an Intensive Care Medicine specialist will have the diagnostic, investigational and patient management skills required to care for ward-based patients whose condition commonly requires admission to the intensive care unit	Full	Full	Full
12. Doctors specialising in Intensive Care Medicine understand the special needs of, and are competent to manage patients with neurological diseases, both medical and those requiring surgery, which will include the management of raised intracranial pressure, central nervous system infections and neuromuscular disorders	Full	Partial	Partial
13. A specialist in adult Intensive Care Medicine is competent to recognise, provide initial stabilisation and manage common paediatric emergencies until expert advice or specialist assistance is available. They are familiar with legislation regarding safeguarding children in the context of Intensive Care Medicine practice	Full	Not met	Not met
14. Intensive Care Medicine specialists recognise the special needs of, and are competent to provide the perioperative care to patients who have undergone cardiothoracic surgery, including providing pain relief and advanced organ system support utilising specialised techniques available to support the cardiovascular system	Full	Partial	Not met

RM Curriculum

Curriculum Generic Capabilities in Practice (CiPs)	RM	IM	ICM
1. Able to function successfully within NHS organisational and management systems	Full	Full	Full
2. Able to deal with ethical and legal issues related to clinical practice	Full	Full	Full
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	Full	Full	Full
4. Is focussed on patient safety and delivers effective quality improvement in patient care	Full	Full	Full
5. Carrying out research and managing data appropriately	Full	Full	Full
6. Acting as a clinical teacher and clinical	Full	Full	Full
Internal Medicine Clinical CiPs	RM	IM	ICM
1. Managing an acute unselected take	Partial	Full	Not Met
2. Managing the acute care of patients within a medical specialty service	Full	Full	Partial

3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	Full	Full	Partial
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long term conditions)	Full	Full	Not Met
5. Managing medical problems in patients in other specialties and special cases	Full	Full	Partial
6. Managing a multi-disciplinary team including effective discharge planning	Full	Full	Partial
7. Delivering effective resuscitation and managing the acutely deteriorating patient	Full	Full	Full
8. Managing end of life and applying palliative care skills	Full	Full	Full
RM Specialty CIPs	RM	IM	ICM
1. Managing all aspects of thoracic malignancy and advanced or terminal respiratory disease including diagnostic pathways and working with the MDT	Full	Partial	Partial
2. Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease	Full	Partial	Partial
3. Managing complex and unusual respiratory infection including contact tracing and public health (in particular atypical pneumonia)	Full	Partial	Partial
4. Managing the service and patients with respiratory failure in multiple settings including hospital and, in the community	Full	Partial	Partial
5. Tertiary subspecialties interface: managing patients across the secondary and tertiary interface; in particular patients with lung and heart transplants and pulmonary hypertension	Full	Partial	Not met
6. Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine	Full	Partial	Partial