# Maximising training opportunities and minimising the impact of rotational training within the ICM CCT Programme

The Faculty of Intensive Care Medicine

**VERSION 1.0**
April 2025

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## Acknowledgements

This document has been based on the RCoA's *Recommendations to minimise the impact of rotational training within the Anaesthetics Training Programme* (August 2024).

## Revision Log

| Version | Revision | Date |
|---|---|---|
| 1.0 | Original publication. | April 2025 |
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# Contents

Introduction ..... 4
Why do we have rotational training? ..... 4
Rotational training in ICM: the requirements ..... 4
Rotational training: the challenges ..... 5
- Educational ..... 5
- Teamwork and cohesion ..... 5
- Structural and wellbeing ..... 5

Rotational training: impact of the 2021 ICM Curriculum ..... 7
- Enhancing Doctors Working Lives Working Group (NHSE) ..... 7

Recommendations ..... 7
- Training Deaneries ..... 8
  - In all Stages of training ..... 8
  - Within Stage 1 ..... 8
  - Within Stage 2 ..... 8
  - Within Stage 3 ..... 8
- Faculty of Intensive Care Medicine ..... 10
- The Statutory Education Bodies: NHSE, HEIW, NES & NIMDTA ..... 11
- Intensive Care Units: Managers and Trainers ..... 12

APPENDIX: Case Study Examples ..... 13
- East of England ..... 13
- East Midlands ..... 14
- London ..... 15
- Mersey ..... 15
- North West ..... 16
- Northern Ireland ..... 16
- Scotland (East) ..... 17
- Scotland (South East) ..... 17
- Wales ..... 17
- West Midlands ..... 18

## Introduction

The principles underlying rotational training have recently come under the spotlight. Intensivists in Training (IiTs) and trainers alike have raised concerns over the impact multiple rotations have on the educational effectiveness of placements. In addition, the impact of frequent rotations on wellbeing and quality of life for IiTs has been highlighted. This review will look at the use of rotations considering Intensive Care Medicine (ICM) training in 2024, IiT survey results, and the requirements of the 2021 Curriculum. At the end of this guide, we provide vignettes and case studies in which various regions have adopted strategies and flexible options to help minimise the adverse effects of rotational training, which may be amenable to adoption elsewhere in the UK.

## Why do we have rotational training?

Over the past 30 years many attempts have been made to streamline medical training. In the early 1990s Sir Kenneth Calman looked to restructure specialty training to 'produce a shorter, more structured and organised training pathway'. The Calman proposals also introduced the idea of regional programmes which required doctors in specialty training to rotate within a fixed geographical area as they worked through a specific curriculum. These 'Calman Numbers' were followed in 2005 by a challenging period in medical education triggered by the failed implementation of Modernising Medical Careers (MMC). MMC was a programme which re-classified the traditional grades of medical career before the level of consultant. It also cemented the principle of geographically focused training programmes within a region or nation. This change required the doctor to rotate through a variety of hospital settings, including District General Hospitals and Tertiary centres, whilst working through a competency-based curriculum. These training programmes would work towards a Certificate of Completion of Training (CCT) and entry onto the GMC Specialist Register.

Rotational training has now become commonplace in the delivery of medical specialty training. With training time reduced from pre-Calman days there has been a move to fixed, shorter placements, and regular rotations to move doctors in training through a number of hospitals to gain a wider range of experience and access to specific specialties to fulfil the requirements of the curriculum.

## Rotational training in ICM: the requirements

There is a recognition, in line with the nature of ICM specialty training, that IiTs need to rotate through several centres to attain all the capabilities of the 2021 curriculum. Once appointed to the ICM CCT programme, any outstanding aspects of Stage 1 could be completed in a single centre. However, the specialty ICM placements of Neuro, Cardiac and Paediatrics in Stage 2 may be located in different tertiary centres, which necessitates rotation (though capabilities can also be achieved in other placements during training). Stage 3 training is an opportunity for the IiT to explore future career locations; however, rotation should be limited to 2 placements, unless it is the explicit IiT's wish and has agreement from the TPD. Experiencing a wide range of clinical environments helps IiTs develop a more rounded approach to delivering high quality ICM care. Rotation within a training programme offers exposure to a broad range of clinical skills, ways and styles of working. It can offer additional potential benefits including:

1. Helping IiTs experience a greater diversity and breadth of exposure to different disciplines.
2. Developing confidence and competence, and a flexible and dynamic approach to teamworking through a wider clinical experience and locations.
3. Clarifying potential career pathways through a wider clinical exposure prior to making future plans.

4. An opportunity to work with patients representing wide and varied population demographics in different areas.
5. Supporting learning in specialist areas of ICM practice included in the curriculum.
6. Encouraging the 2-way distillation of the most up-to-date knowledge and experience across a region's network of hospitals, enhancing learning, developing practice and ensuring patient safety.
7. Encouraging unity and collaboration across the region's networks of hospitals.

## Rotational training: the challenges

Despite the requirements for rotating IiTs, and the potential benefits listed above, rotational training can bring associated challenges, for both those in training and those responsible for organising/supporting rotations.

If grouped into themes, these challenges have educational, social, structural and wellbeing impacts to some IiTs:

### 1. Educational

i. An explicit understanding between IiT and their Clinical or Educational Supervisor (ES) is needed to maximise training opportunities, achieve required capabilities and identify additional opportunities available in each placement. This can be challenging to achieve during short placements.

ii. Frequent rotations may limit the opportunities to engage in further activities that are crucial for meeting all aspects of the curriculum (and specialising or excelling in some). Opportunities to participate in local quality improvement projects, teaching, and research may be constrained.

### 2. Teamwork and cohesion

i. Moving departments impacts on cohesion within teams. Shorter rotations can make it harder for IiTs to establish roots, a sense of belonging in a department, and make a substantial, positive contribution. It takes time to adapt, and IiTs may not have the chance to settle in before being uprooted once more.

ii. Teams work best when everyone knows each other. This knowledge and understanding comes with time. After spending a while in a department, engagement in social events is more likely to occur, which for many is key in feeling like an equally valued team member.

### 3. Structural and wellbeing

i. Moving frequently has a greater impact in those programmes covering larger geographical areas. This leads to longer commutes made, increased travel costs and reduced travel allowances. This is particularly difficult for those with caring roles who may have to regularly alter caring arrangements and established support networks due to changing working patterns.

ii. International IiTs moving frequently can be especially isolated and endure challenging times.

iii. Historically, many doctors enjoyed free or affordable accommodation, free parking, and good rest facilities. Unfortunately, these benefits are increasingly scarce in many hospitals, requiring IiTs to travel long distances at a significant personal cost, or relocate frequently, with considerable associated costs.

iv. The repetition of administrative activities, e.g. ID checks, compounds the disruption caused by changing workplaces. Each hospital has its own protocols, electronic health record systems, and administrative procedures. The frequent need to adapt to these differences can be inefficient and frustrating.

v. Adapting to new environments takes time, and initially, doctors often feel less efficient, confident, and supported. This adjustment period can impact both performance and their mental well-being.

These challenges may be exacerbated for programmes without a lead employer model. In several regions across the UK, adopting this model has already led to improvements for IiTs. Here are a few insights from IiTs in Northern Ireland and Wales on how this approach has enhanced their training experience:

- "A single lead employer model (SLE) was introduced for our specialty in 2021 with the aim of simplifying employment arrangements in rotational training. We have found this to be a positive move. Although each Trust will require some additional paperwork with each move, there is less of a burden on this and documentation such as providing pay slips and proof of address are no longer required at every changeover. Inaccuracies in salary when moving between Trusts in the region have been largely eradicated. It has not been a solution for all HR issues (for example, sickness absence, family and other statutory leave does require communication with the Trust as well as SLE and is not always seamless) but overall has created a better experience for rotational training."

  – *Dr Andrew Steele, ST8 ICM, IiT representative NI*

- **'Old' System**

  "Having experienced the previous system with eight rotations, I can remember day one of a new rotation including the long process of queuing to be seen by a member of HR to go through documents/evidence, apply for a new DBS check, see occupation health (information was never shared between occupational health departments, so I probably had more blood tests than required to check vaccination status). This would repeat every time we changed Health Boards (HB)! A few Health Boards would request for us to come see them in our own time prior to starting so that paperwork could be completed/cross checked. I often found myself having to investigate incorrect pay for first few months of new rotation, usually being placed on an emergency tax code."

  **'New' system - SLE**

  "Introduced in 2022 - no longer required to attend any HR or occupational health appointments – hurrah! Transition has (in my experience) been without issue, and a much-needed introduction of change. Front sheets for new rotations with details of placement/hours/pay are issued electronically but do need checking as I am aware some colleagues have had incorrect information which has affected pay. The only thing that was a bit tricky initially was navigating who to contact for queries in my training specialty, but once identified, on the few occasions I've needed to get in touch, the team have been responsive and helpful."

  - *Dr Sarah Elgarf, ST8 Anaesthesia & Intensive Care Medicine, South Wales*

- **'Pre-SLE era in Wales'**

  "Having rotated through 11 different posts before single lead employer (SLE) came into effect, I was glad to hear of its arrival and thought how proactive HEIW and the Welsh NHS were in instigating this. Prior to its introduction, each rotation to a different hospital trust/health board required a completely new batch of paperwork which seemed endless and took hours to complete correctly and return. A HMRC new starter form, health board registration documentation (a booklet in itself), payroll paperwork, occupational health clearance, DBS security check and official documents paperwork were included. The process also required attending the particular health board in person for a 'check' in your own time, prior to starting the post, plus any blood tests for occupational health clearance on the off chance the previous health board couldn't find your previous results, with the fear that your salary would not be paid without these. It was an annual palaver that with time junior doctors came to learn of the inefficiencies of the system. It was predictable that your first month or three's salary would be incorrect and that you'd be placed on an emergency tax code. This required spending time on the phone, often on hold for periods of time, whilst HMRC/payroll were contacted to sort out the issues.

"On establishment of SLE in April 2022, this became centralised and apparently streamlined. There were of course some issues in transition to the new system, which for some doctors took a while to resolve. However now embedded, No more forms and blood tests and in-person checks. There are occasionally still some hiccoughs with payroll, however these are more often than not, resolved quickly. My experience of communicating with payroll and NWSSP (Shared Services Partnership - who deal with junior doctor expenses and study budget), have been very positive, with staff wanting to help us junior doctors. This has been a huge, progressive change of culture in my career over the past 15 years."

*– Dr James Rees ST7 ICM & Anaesthetics, Wales*

## Rotational training: impact of the 2021 ICM Curriculum

The 2021 ICM Curriculum is an outcomes-based curriculum, i.e. what the IiT 'looks like' at the point of CCT. Significant aspects of the curriculum are based on spiral learning, meaning that basic principles learnt earlier during the training programme are revisited and enhanced as an IiT progresses. In particular, General ICM is encountered in Stages 1, 2 and 3. However, the indicative year-long placements of ICM, Anaesthesia and Medicine in Stage 1 could be undertaken in a single centre, negating the need for rotation during this period.

As discussed previously, the 2021 curriculum requires IiTs to undertake placements to achieve the competencies of Neuro, Cardiothoracic and Paediatric ICM in Stage 2, most likely in tertiary centres, though capabilities can be acquired in other settings that provide suitable capability acquisition.

### Enhancing Doctors Working Lives Working Group (NHSE)

In April 2024 NHSE published their latest guidance entitled *Improving the working lives of doctors in training*. The actions outlined are specifically aimed at addressing concerns of doctors in training and staff who rotate. There is a recognition that rotations can mean that doctors in training may experience low levels of choice and flexibility of when and where they work, high levels of uncertainty and competition about the next steps on the training pathway, duplicative inductions and pay errors as they move between employers.

## Recommendations

Taking the above into account, and the 2021 curriculum for a CCT in ICM, the Faculty recognises that there are some opportunities to reduce rotations for those seeking to do so. It is important to understand that for some, rotation is desired and, in some circumstances, extended placements are neither beneficial nor achievable within a region, where the requirements of all IiTs are considered equitably. We use survey data and other sources of information to assess the ongoing impact, quality and satisfaction of training and the nature of its delivery.

These recommendations serve as a guide for all bodies involved in Intensive Care Medicine training, encouraging efforts to minimise the frequency and impact of rotations where appropriate. Where relevant, we have also incorporated recommendations from NHSE's publication, *Improving the Working Lives of Doctors in Training*, as many of their suggestions are crucial for reducing the disruption caused by rotations and should be urgently implemented.

## Training Deaneries

**RECOMMENDATION 1: Heads of School (HoS) and Training Programme Directors (TPD) to review and look to minimise the number of rotations required to complete each stage of training**

### In all Stages of training

i. Recognise the additional challenges for dual/triple IiT. HoSs and TPDs should address training needs for 2/3 different specialties, with close working relationships between partner specialty TPDs and the Deanery.

ii. Dovetailing placements in the same training location for IiT transitioning between stages, or dual/triple CCT IiT moving to/from partner specialty programmes.

### Within Stage 1

iii. It is possible to gain all the capabilities required to complete Stage 1 training without needing to rotate if the IiT and TPD can see no detriment for future learning (or for other IiTs on programme). The IiT has undertaken a core programme, and consideration may be given to continuing in that training location, depending on discussions between the TPD and IiT, but also considering the experiences and requirements of all IiT on the programme.

### Within Stage 2

iv. Training could be delivered flexibly to minimise the need for 3-month rotations as much as possible within Stage 2, recognising that specialty ICM placements and SSY choice may negate this.

v. The need to visit tertiary units for cardiothoracic, neuro and paediatric ICM can potentially be aligned with the requirements of the other clinical domains to maximise curriculum coverage and be useful to gaining capabilities for Stage 3.

vi. Consideration may be given to having 4-month or longer placements in tertiary units for subspecialty ICM training, understanding that complementary evidence and competence can be gained in additional HiLLOs to those subspecialty ones.

### Within Stage 3

vii. The requirement to rotate will depend on the individual IiT's training needs and can be structured flexibly across the year, provided the curriculum requirements are met. While it is generally expected that Stage 3 training will comprise two placements, either as a 6/6, 9/3, 8/4 or other suitable split between general and specialist units, this is not mandatory. A single 12-month placement in one hospital may also be appropriate in some cases. The split and location of Stage 3 placements should be determined collaboratively between the IiT and their trainers to ensure the most beneficial training experience and to support the IiT's future career intentions.

**RECOMMENDATION 2: Each Deanery to review the provision and delivery of educational supervision**

i. Consideration to ensuring **ICM Faculty Tutor involvement when an IiT is in a partner specialty placement, either in Stage 1 or as a Dual/Triple CCT.** This can provide continuity and contact with ICM, and support IiTs during what can often be difficult and challenging transitions between specialties, even within the same hospital. This is a recognised aspect of the FT role and can generate significant workload including providing an ESSR and input to ARCP. This should be factored in and acknowledged in the FT's remuneration.

ii. **Consideration of implementing stage specific Educational Supervision.** If IiTs are to be placed with an ES for a stage it is paramount that supervision is of high quality. It may be prudent for an ES to focus on a particular stage of the curriculum to ensure they have a detailed understanding of what IiTs will need to accomplish in that stage (e.g. ES for Stage 1, ES for Stage 2 with experience of SSYs, ES for Stage 3).

iii. **Consideration of implementing Educational Supervision for the entire programme.** One of the significant benefits cited in maximising the length of placements is continuity of educational supervision. This can be beneficial for the IiT and trainer alike. The ES will have a better understanding of the IiT's needs, development and progress. It also allows the IiT to make longer-term plans. See the examples from the East Midlands and South East Scotland here.

iv. **Deaneries should ensure that training requirements discussed and agreed at ARCP are clearly communicated to trainers in the IiTs next rotational placement, as best practice.** This will facilitate a new rotation placement and mitigate the challenges described above.

**RECOMMENDATION 3: Intensivists in Training to be provided with advanced notice of rotations**

Whilst there is always a need for flexibility within the training programme to the benefit of all IiTs, consideration should be made to inform them of their likely rotations *as far in advance as possible*. This will require close liaison with partner specialty TPDs for those IiTs on the Dual/Triple ICM CCT Programmes.

i. In Stage 1 this should comprise the remaining aspects of their Stage 1 training on joining the CCT programme (some doctors have pre-existing training from other specialties and out of programme learning they can count). The Minimum Advanced Notice period: 8 weeks prior to starting Stage 1.

ii. Stage 2 should be the details of their Specialty ICM and SSY placements. This requires close liaison with partner specialty TPDs, for IiTs on a Dual/Triple ICM CCT Programme. Notification timescales should be considered closely by TPDs and acknowledging the complementary transferable competence and evidence that can be gained across specialties.

iii. The Stage 3 programme should be tailored to the future career aspirations and advanced skills (including leadership and management) and needs of the IiT. Longer timescales for notification of placements are impossible to mandate but close communication between IiT and TPD will ensure timely decisions.

Having advance notice of rotations can help mitigate the stresses of moving between placements, allowing IiTs to plan effectively. Flexibility and understanding are essential. IiTs and TPDs should feel able to request changes where mutually agreeable, especially if interest areas change or if a department has limits on the number of IiTs it can train at a particular stage of the curriculum. Additionally, rotation changes may occur at a later stage because of ARCP outcomes, statutory leave, or a change to working patterns (e.g., LTFT working).

**RECOMMENDATION 4: Intensivists in Training (IiT) should be involved in choosing their rotations**

Providing IiTs with an opportunity to be involved in the planning of their rotations will provide them with a greater sense of control over their training programme. We recognise that several Deaneries already allow IiTs to preference their placements in Stage 1 and all IiTs will be involved in the decisions made around their Stage 3 placement requests. Although it is desirable to involve the IiT in aspects of their training at Stage 1, consideration must be given to safe patient care, and the collective needs of all IiTs in the region's programme. IiTs should be reassured that hospitals in their region will be appropriate for their level of training as assessed by the Deanery, TPD and Regional Advisor.

We continue to support the best practice of Schools to enable, where appropriate, extra-regional placements, such as an OOPT for a Special Skills Year (SSY) where the SSY is not offered in the base region, at the Dean's discretion and in line with the IiT's educational needs. Similarly, this would be the case for inter-deanery transfers, regardless of the causative request.

## Faculty of Intensive Care Medicine

**RECOMMENDATION 5: The Faculty to continue to recommend to the ICM National Recruitment Office an earlier date for ICM offers to facilitate regions and TPDs to organise postings in sufficient time to inform Trusts/Health Boards and IiTs of their placements**

i. The Faculty should continue to explore appropriate flexibility within the curriculum. We have always supported our trainers and IiTs to be as flexible with the capabilities of the curriculum as they are able, to allow Supervised Learning Events (SLEs) to be used across multiple High-Level Learning Outcomes (HiLLOs) and across different stages of the curriculum, where appropriate. The length of training periods is indicative, and this permits rotas to be created with the continued delivery of safe patient care. However, each region can adjust their delivery of the curriculum to suit the needs of their region. The Faculty sets the curriculum and supports flexibility of curriculum and educational delivery if the standards are maintained.

ii. We continue to support the flexibility of progressing from Stage 2 to 3 when on a dual programme, if an exam aspect of the dual programme has not been completed. For example, a dual Anaesthesia-IiT, who has been unsuccessful in the Final FRCA but has passed the FFICM Examination, can start Stage 3 ICM without an extension to training, and vice versa. Similarly, a dual EM-IiT who has met all EM requirements can start their indicative final 6 months EM without FFICM success, with agreement of both specialty training leads and the IiT.

The best practice page on the FICM IiT section of the website highlights flexibility demonstrated across regions such as specialty placements in Stage 3 for career progression planning.

**RECOMMENDATION 6: The Faculty commits to continue to support its trainers to ensure that the 2021 curriculum is delivered to a consistently high standard across all regions/nations of the UK**

We continue to engage in providing training and support for Faculty Tutors and Educational Supervisors to help them develop a detailed understanding of the 2021 curriculum, examinations and ARCP requirements. This will ensure that everyone involved in the support of IiTs is clear on the requirements of the curriculum and hence what is available and achievable in each placement. We provide numerous resources online for trainers and IiTs to gain support, help and seek advice:

- See our Training Guide for IiTs and Trainers here
- See our Guidance for Trainers page here

**RECOMMENDATION 7: The Faculty to continue its engagement with Enhancing Doctors Working Lives workstream (NHSE WTE)**

We support the principles in the 2024 guidance *Improving the working lives of doctors in training* being applied to all 4 Statutory Education Bodies of NHS England (NHSE), Health Improvement Wales (HIW), NHS Education for Scotland (NES), and the Northern Ireland Medical and Dental Training Agency (NIMDTA).
Within the document there are many recommendations that will require financial support for SEBs, Deaneries and individual hospitals to deliver.

## The Statutory Education Bodies: NHSE, HEIW, NES & NIMDTA

**RECOMMENDATION 8: Those with responsibility for overseeing the delivery of ICM training programmes (Deans or equivalent) should ensure appropriate administrative and technological support is provided to their Heads of School and Training Programme Directors**

i. The management, communication and delivery of training programmes requires a significant amount of administrative time and technological resource. Across the UK, regions have had restructuring and reductions of staff, with ever-present financial constraints. The feedback from Heads of Schools and Training Programme Directors is that this has added to their own administrative burden and impacted on the timeliness and accuracy of ARCPs, communications with IiTs and notifications of rotations to departments, causing additional workload, stress and anxiety.

ii. TPD and lead trainer resource allocation needs to reflect the complexity of planning and delivering a programme, considering the plurality of core training and multiple dual/triple specialties at different training grades. There is a financial burden placed on IiTs personally to support educational activities that should be delivered within training.

**RECOMMENDATION 9: Implementation of the recommendations *for Improving the Working Lives of Doctors in Training* as a matter of priority**

The Faculty would ask the education bodies in all four nations to implement the recommendations as a matter of urgency. Those highlighted below will play a significant role in minimising the adverse effects of rotational training:

i. **Introduction of a Lead Employer Model:** The development of a central employer looking after all IiTs on a rotation has been shown to be beneficial. The avoidance of needing to change employer between placements has reduced the issues with incorrect or delayed salary payments, taxation issues and significantly reduced paperwork.

ii. **Reinstate monitoring of compliance with rota requirements:** Information regarding incoming doctors is provided to organisations within the required 12-week time frame and with improved accuracy.

iii. **Provide intensive support to providers** including a review and redesign of payroll processes to reduce payroll errors

iv. **Addressing the unique issues caused by rotations:** To include reviewing on-boarding processes, and other practical steps to help foster a sense of wellbeing and belonging such as reviewing the application processes for lockers or car parking spaces, and the availability of facilities.

v. **Make it easier for staff to move between organisations** via a Memorandum of Understanding (MOU) to enable providers to accept each other's mandatory training. This will remove the requirement for staff to repeat mandatory training in a new organisation.

vi. **Reform the existing approach to Statutory and Mandatory training:** There should be an agreed framework of statutory and mandatory training within regions across the UK, and systems should be put in place to enable the transferability of this training between organisations. These systems should be designed to provide a record of training completed which can be made available to host hospitals in advance of rotations. This will minimise the administrative burden for both intensivists in training and local departments.

## Intensive Care Units: Managers and Trainers

As part of the work to limit the impact of rotations on IiTs there are opportunities for departments of ICM and their associated Clinical Directors and Faculty Tutors to make a significant difference. We also wish to recognise the work already done within ICUs across the four nations to support and develop the next generation of Intensivists. This work often goes unnoticed, and we are grateful for all the support that is given.

Part of the strain associated with rotating into a new department can be alleviated through planning and preparation by the receiving department. We would encourage departments to review their current practice in line with the following recommendations.

**RECOMMENDATION 10: Delivery of induction and rota management**

Intensivists in Training are particularly impacted by induction and shift allocations due to multiple employer changes, so all employers/HR departments are required to ensure they:

i. Liaise closely with Units and Faculty Tutors to ensure that new starter contact information is provided to the relevant personnel coordinating rotas and local inductions.

ii. Provide work schedules at least eight weeks in advance and finalised duty rosters six weeks in advance.

iii. Improve rota management by exploring the opportunities technology offers to move towards greater self-rostering, so IiTs have greater control over their lives while meeting the needs of the service.

iv. Where rota changes are required with less than six weeks' notice, impacted IiTs should be involved in creating the new rota. In such situations all pre-existing leave arrangements must be accommodated.

# APPENDIX: Case Study Examples

These vignettes are published to support examples of curriculum implementation and working practices around the UK. Regions vary in their approaches to running programmes, based on hospital locations, the geography of the region, school oversight and many other factors. Hence widespread adoption may not be desired or suitable.

## East of England

As East of England (EoE) TPDs we were struggling with our capacity for Paediatric ICM Stage 2 training This was the bottleneck preventing expansion of ICM training in the EoE. Our increasing demand for PICU was multifactorial: expansion in resident numbers; increasing numbers of residents requiring full 3-month blocks (as opposed to day release with dual anaesthesia ICM residents); and increasing numbers of LTFT and out of sync residents.

The EoE, whilst a large geographic region, has only one PICU at Cambridge University Hospital (CUH). This unit accommodates eight three-month placements per year for Stage 2 ICM residents.

In order to expand our paediatric ICM capacity we approached the CUH based Paediatric and Neonatal Decision and Retrieval Team (PaNDR).

The perceived strengths of creating an ICM training post in paediatric retrieval included:

- Local, in region solution
- No additional travel - relatively centrally located within region
- Expected experience maps well to Stage 2 ICM curriculum competencies
- Flexibility with posts and timings could incorporate out of sync rotations if required
- PaNDR team very supportive of suggestion
- Trainees on PaNDR utilise the National Paediatric Retrieval Passport which details the competencies expected to be obtained during the placement. We have mapped this Passport against the Stage 2 ICM curriculum competencies
- Potential to expand post numbers in the future

We felt that this PaNDR placement would provide an ideal training environment for Consultants intending to work in a DGH. The PaNDR placement would provide a unique opportunity to master the initial stabilisation of the sick child and build ongoing future links with these services.

The identified weaknesses were as follows:

- Decision regarding which residents to place on PICU and which in PaNDR
  - Dual EM ICM trainees considered to be ideally suited to the PaNDR placement in view of their EM paediatric experience
  - Single ICM CCT trainee with DGH career intentions would also be ideally suited to the PaNDR placement
- Difficulty mapping to paediatric perioperative care competencies with PaNDR placement
  - Mitigated by 10-day PICU day release
- Risk of differential attainment
  - Nature of retrieval service means that each day is different
  - Experience between the ICM residents allocated to PaNDR may vary although this is also seen in PICU, especially with variations in seasonal activity

- Experience may vary between PaNDR and PICU placements. Different training pathways leading to the achievement of required capabilities already exist however within the programme between Dual Anaesthesia and ICM residents and non-anaesthesia ICM residents.
- Risk of PaNDR placement becoming more desirable than the PICU placements – could be mitigated by increasing PaNDR placements

We informed FICM of our intentions, but the decision to proceed was deemed a local one. We therefore allocated one of our EoE ICM expansion posts to PaNDR from August 2025. Our second LTFT dual ICM & EM IiT starts their placement in March. It is too early to assess the success of the programme, but we are closely monitoring the experience gained by the residents, both by direct communication and our regional end of placement survey.

*- Dr Natasha Lawrence (ICM Regional Advisor and TPD) & Dr Coralie Carle (TPD), East of England*

## East Midlands

- The East Midlands Intensive Care Medicine training programme assigns Educational Supervisors (ESs) for the entire duration of a resident doctor's CCT. The ES is appointed by the TPD at onboarding, with an initial meeting encouraged within the first month of starting the ICM CCT programme.

  We believe this longitudinal approach fosters a deeper relationship between trainers and residents, supporting the diverse backgrounds and unique training needs of everyone. ESs can be based at any hospital within the region, with meetings held in person or over Teams/Zoom depending on preference. Regular three-monthly check-ins are encouraged to assess progress and set goals. Wherever possible ESs with the same partner specialties as the resident are assigned. If this is not feasible, or if ICM is not the resident's primary specialty, then separate ESs are assigned for each specialty. This arrangement has been well received and, in some cases, has enhanced supervision by providing varied perspectives from different supervisors.

  Residents occasionally request to be reassigned for various reasons, and such requests are handled with care, with no adverse outcomes. The scheme is highly valued by our IiTs, and we take pride in the strong relationships we have between our residents and trainers.

  *- Dr Andrew Sharman, ICM Regional Advisor, East Midlands*

- Although our region is geographically smaller than some, we historically have a split between those residents based in the 'North' or 'South' of the region, focused on the two main teaching hospital sites, Nottingham University Hospitals (NUH), and University Hospitals of Leicester NHS Trust respectively (UHL).

  From a programme planning point of view, we aim to keep residents geographically as close to their base site as possible, however the Stage 2 year is problematic, requiring placements at specialist centres that are geographically split to achieve the required capabilities. As it stands, in the East Midlands region we split this year into two 6-month rotations, completing paediatric critical care and neurocritical care at NUH, and cardiac critical care and general ICM (or partner specialty) at UHL.

  We aim to plan residents' rotations well in advance, providing as much forward notice of the complete rotation as possible, however, this ultimately is never achieved due to a variety of reasons including residents taking on a second specialty, parental leave, exam failure requiring an extension to training, or other unforeseen circumstances (carers leave, career breaks, etc.). We also appreciate that a resident's interests may change over the period of their training and aim to be as flexible as possible,

providing rotations that fit their future career plans, along with supporting out of programme placements if this supports the resident doctor's overall career aspirations. Ultimately, we nurture a shared understanding that we will provide flexibility where possible, on the proviso that the rotation is covered, and our patients are catered for.

*- Dr Matt Charlton, ICM Training Programme Director. Glenfield Hospital, University Hospitals of Leicester NHS Trust*

## London

The ICM National Recruitment Office (ICMNRO) advises the Health Education Team of a successful ST3 appointment. A welcome letter is sent to the trainee from the Stage 1 TPD introducing themselves and the team, signposting the school website/information and asking for the FICM onboarding form to be completed and returned to the TPD as soon as possible. Any preferences regarding placements should be included in the onboarding form. The successful applicant is advised of the priority for placement preferences process. In London this is based on ranking at national recruitment. Area of residence is considered as much as possible in post allocation and commutes are kept to less than 60 minutes. If the recruit is dual/triple training, then placements are matched, as much as possible, with dual/triple training locations. Post availability and ranking in national recruitment is again considered. They are advised a mixture of their time will be spent in both district general hospital posts and major centres.

In several London regions a training plan (up to CCT) is devised after national recruitment and the IiT is informed of the placements. The IiT is advised the plan is provisional and they are made aware of any changes to placements with as much notice as possible (nationally agreed codes of practice are observed as a minimum).

*- Dr Charlotte Anderson, Head of School, ICM Pan-London Programme*

## Mersey

In Mersey, we have an Intensivist in Training (IiT) from an Acute and General Medicine background who joined the Intensive Care Medicine (ICM) training programme later than typical, at the end of ST5. This late entry resulted in a significant amount of time being spent on medical rotations before commencing the triple CCT pathway for ICM, Acute Internal Medicine (AIM), and General Internal Medicine (GIM).

The established guidance for medical triple CCT training stipulates that IiTs should spend 12 months in medicine during Stage 1, 12 to 15 months during Stage 2, and 6 months in Stage 3. However, in this specific case, the IiT had already completed 32 months of formal AIM/GIM training, achieving successful Annual Review of Competence Progression (ARCP) outcomes and passing the exit Specialty Certificate Examination (SCE) prior to embarking on the triple CCT pathway.

Upon commencing ICM training, the IiT successfully completed the capabilities required for Stage 1, as well as the placement for Stage 2, and passed the Fellowship of the Faculty of Intensive Care Medicine (FFICM) examinations at the beginning of Stage 2. Consequently, the conventional structure of Stage two, which entails 12 months of ICM training and 12 months in Medicine, could disadvantage the IiT by necessitating the repetition of a year of medical training.

Therefore, a collaborative decision was reached between the Schools of ICM and Medicine to condense Stage 2 to one year, eliminating the requirement for additional time spent in Medicine during this phase of training.

In conclusion, if IiTs meet the requirements of the triple CCT programmes, including the capabilities and examinations, they should not be disadvantaged and needlessly repeat blocks of training considered redundant. This approach could be adopted nationally to promote greater flexibility within the medical triple CCTs programmes.

- *Dr Paul Jeanrenaud, Training Programme Director, Mersey*

## North West

In the North West the Stage 2 sub-specialty ICM modules are three months, but if doctors are on the single ICM CCT Programme then we try to put a Stage 2 module and some general ICM at one hospital, to give a six-month hospital placement (though they still rotate within the hospital departments). This also occurs with the LTFT residents where possible.

If they are a dual or Triple ICM CCT, we liaise with the relevant TPD to see if they can have another three- or six-month placement at the same site. This means that a resident will have a six- or nine-month placement at the same hospital, though again does not negate the internal departmental rotation. It minimises travel and increases a single hospital site exposure. As per usual this is always fine for the big central hospitals. It's always a balance to ensure fair distribution for all residents on the programme.

We have used our medicine placements flexibly to provide an IMT3 year and support dual applications to Medicine (with the help of the IMT3 TPD).

We don't write the rotation too far in advance to allow IiTs some choice with their placements as they progress through (although we know there are pros and cons to this).

We work with the other specialty TPDs to try and support exam plans with placements i.e. anaesthesia placement whilst tackling FRCA etc. This only is possible due to the lovely working relationships we have with the other specialties in our region.

- *Dr Ajmal Eusuf (ICM Head of School) & Dr Emily Shardlow (ICM TPD) North West*

## Northern Ireland

- As part of Stage 3 ICM training we aim to offer all IiTs a DGH placement at a location close enough to their home to permit an on-call rather than resident rota pattern.
- Single Lead Employer in place since 2021.
- At onboarding to ICM specialty training, new IiTs meet with the RA and their individual training requirements are assessed. An overview of their training pathway and how this will potentially influence their future postings is discussed.
- Recognise that Stage 2 specialty ICM placements require 3 monthly rotations, which can be difficult. In our region, these units are within the same trust/health board, and this offsets some of the challenges. We are developing closer relationships with partner specialty TPDs to smooth out transitions that fall before and after this block of training.

- *Dr Esther Davies, ICM TPD and RA, Northern Ireland*

## Scotland (East)

The East of Scotland (EoS) is the smallest ICM training region in the UK. Whilst Scotland functions largely as a single deanery, IiTs are appointed to one of 4 distinct regions. The numbers are small in the EoS with approximately 10 IiTs on the programme, presenting both unique challenges and benefits.

The smaller programme size allows for highly individualised support and greater flexibility within the training programme. IiTs complete the majority of their ICM training at a single large teaching hospital, where both Stage 1 and Stage 3 are delivered on-site, with no mandatory rotations to other centres. Stage 2, however, requires two external rotations: one to Glasgow for cardiothoracic training and one to Edinburgh for Paediatric ICM (PICM), with accommodation provided during these placements.

Feedback from IiTs is generally very positive, with high satisfaction scores in both the Scottish and GMC training surveys. While we acknowledge the potential limitations of single-centre training, the IiTs value this highly and report that they feel valued, known and treated as individuals. This setup also offers stability, allowing trainees to settle and build strong support networks while navigating the demands of ICM training.

*- Dr Judith Joss, East of Scotland ICM RA and TPD*

## Scotland (South East)

In South East Scotland we aim to provide an Educational Supervisor (ES) for the duration of training, with a Clinical Supervisor (CS) for each placement. We find this gives an excellent balance between direct clinical supervision while on placement, with continuity of oversight of training. Where possible we try and ensure that any doctors on the Dual or Triple ICM CCTs are paired with an ES who can supervise both programmes, with the goal of reducing the administrative burden for both trainer and resident intensivist.

*- Dr Neil Young, Lead RA for Scotland*

## Wales

- North Wales offers great ICM training and is a great place to live. However, any IiT who wishes to train here must travel to South Wales to undertake subspecialty blocks in Stage 2, and then again for 'high-volume' experience in Stage 3.

  Although a single deanery, the geographical separation of North and South Wales is considerable. As an immigrant from Scotland, I noticed that I can drive from my new home back to Glasgow in the same time than I can drive to South Wales! And yet we would never expect an IiT to rotate from Wales to Scotland as part of a standard training programme. To address this problem, we have established a partnership with the 'deanery next door' in Manchester. This is one hour away from North Wales and offers the full range of subspecialty training and high-volume ICM. The first IiT is due to arrive in 2025.

  I am immensely grateful to all the people that have worked together to make this happen; heads of school and educational directors in both regions; senior staff in affected healthcare organisations; and most crucially, the TPD in Manchester whose willingness to think differently was crucial to the project. I hadn't previously appreciated how many moving parts there are to this sort of thing, from programme planning to business cases to memoranda of understanding and Service License Agreements (SLAs). We will be very interested to see how things pan out when our pathfinder IiT arrives in Manchester next year.

*- Dr John Glen, Training Programme Director, Wales*

- Family life is of vital importance to me and minimising disruption to this was paramount when considering location of training. Though I began as a dual Emergency Medicine/ICM trainee, I opted to relinquish EM in favour of the opportunities Single CCT ICM training offered, namely the Special Skills Year.

  I began ICM training with a young and expanding family in North Wales. Wales is a large and geographically challenging area. The notion of being deployed to South Wales and therefore separated for periods was undesirable. I therefore chose to undertake my training in Mersey to guarantee that I would not spend periods away from home and my family. Commuting was tough at times and required some local allowances for rest around night shifts. The ICM SSY gave me the opportunity to undertake an OOPT in Wales, close to home, in a clinical area of interest to me that is now part of my consultant job plan. I am confident these choices improved my work-life balance and wellbeing through minimising disruption to home life.

- *Dr Gareth Emlyn Thomas, ICM Consultant, Betsi Cadwaladr University Health Board*

## West Midlands

- Although this is a large region, the TPD meets regularly with both existing IiTs and those new to the training programme and plans training placements with IiT input up to 2 years in advance.

- *Dr Rosie Worrall, Lead IiT Representative, West Midlands*

- Since joining ICM training in 2021 – both of my TPD's have been supportive and helpful regarding LTFT training. Upon appointment to the programme I contacted my TPD to discuss my intention to apply for LTFT training and I was signposted to the process, the percentage options and the application forms. My TPD asked new IiTs to the region a few questions to help them shape the training allocations:
  - Which hospitals would represent a difficult commute? (> 1 hour drive each way/impossible by public transport from your area)
  - Do you have any special circumstances? (e.g. disability, access, maternity leave, professional issues)

  They work really hard to minimise unnecessary rotations, discussing any training preferences and the commute with us prior to any official allocations. In programme I have also been able to alter my LTFT percentage whilst taking exams and doing a longer commute to the tertiary paediatric hospital for PICU.

- *Dr Gemma Talling, Intensivist in Training, Worcestershire Royal Hospital*

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